TEXAS MEDICAID

PROVIDER PROCEDURES MANUAL

Volume 1

GENERAL INFORMATION

This manual is available for download at www.tmhp.com, and is also available on CD. There are many benefits to using the electronic manual, inc uding easy navigation with bookmarks and hyperlinked cross-references, the ability to quickly search for specific terms or codes, and form printing on demand.

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

PRELIMINARY INFORMATION

WELCOME: 2012 TEXAS MEDICAID PROVIDER PROCEDURES MANUAL

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

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

Texas Medicaid policy published in this manual was implemented on or before January 1, 2012. Policy updates effective after January 2, 2012, are published bimonthly in the *Texas Medicaid Bulletin.*

All Texas Medicaid policy updates that are published bimonthly in the *Texas Medicaid Bulletin* supplement this manual and update the policy it contains.

This manual and copies of the *Texas Medicaid Bulletin* are available on the TMHP website at www.tmhp.com.

The 2012 *Texas Medicaid Provider Procedures Manual* (TMPPM) is divided into two volumes as follows:

Volume I: General Information
Volume 1 applies to all health-care providers who are enrolled in Texas Medicaid and provide services to Texas Medicaid fee-for-service clients. The sections in Volume 1 include general information for enrolling in the program, receiving appropriate reimbursement, and claim submissions and appeals for services rendered. An index for Volume 1 and all handbooks appears at the end of Volume 1.

Volume 2: Provider Handbooks
Volume 2 includes 13 handbooks. Each handbook covers Medicaid policies, procedures, and claims filing requirements for specific products or services. Volume 2 includes the following handbooks:

- *Ambulance Services Handbook*
- *Behavioral Health, Rehabilitation, and Case Management Services Handbook*
- *Children's Services Handbook*
- *Clinics and Other Outpatient Facility Services Handbook*
- *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*
- *Gynecological and Reproductive Health and Family Planning Services Handbook*
- *Inpatient and Outpatient Hospital Services Handbook*
- *Medicaid Managed Care Handbook*
- *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*
- *Medical Transportation Program Handbook*
- *Nursing and Therapy Services Handbook*
- *Radiology and Laboratory Services Handbook*
- *Vision and Hearing Services Handbook*

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INTRODUCTION

Medicaid Program Administration

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

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

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

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

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

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

TMHP Website

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

- Provider education information and registration for upcoming education/training sessions (i.e., live workshops, webinars, computer-based training, and audio content).
- Publications, such as bulletins, banner messages, and provider manuals.
- A TMHP News section with announcements of program changes and other important information.
- Real-time and static fee schedules.
- Forums, polls, and questionnaires.
- Online provider enrollment.
- Complete instructions for setting up a Provider Administrator account and the use of online claims status inquiries (CSI), eligibility verification, and Electronic Remittance and Status (ER&S) Reports.

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

- Texas Medicaid enrollment information.
- CSIs.
- Eligibility verification.

- ER&S Report download option.
- Claims submission.
- Claims appeals.
- Online provider lookup.
- Online fee lookup (OFL) to obtain real time fee information for an individual or a range of procedure codes. Benefits and limitations for certain services and history up to 2-years is also available.
- Payment amounts search, view, and print capabilities.
- Notification of an invalid address on file for any Texas Provider Identifier (TPI) associated with a provider's National Provider Identifier (NPI).
- Notification of pending payments because of inaccurate or incomplete provider information.
- Manage hospital admission and discharge information on clients residing in an institution for mental diseases (IMD)

Important: *Natural disasters, such as floods or hurricanes, can impact the delivery of health care to Texas Medicaid clients. When disaster strikes, providers should monitor the TMHP website for special instructions.*

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

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 or (512) 335-5986
Provider Enrollment Fax	(512) 514-4214
Comprehensive Care Program (CCP) (CCP prior authorization status and general CCP and Home Health Services information)	1-800-846-7470 fax: (512) 514-4212
Children with Special Health Care Needs (CSHCN) Services Program AIS	1-800-568-2413
CSHCN Services Program Fax	(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]): Option 1 – TMHP in-home care customer service Option 2 – DME supplier with completed Title XIX form Option 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	(512) 514-4228 (512) 514-4230
Texas Health Steps (THSteps) Dental Inquiries	1-800-568-2460
THSteps Medical Inquiries	1-800-757-5691
Third Party Liability (TPL) (Option 2)	1-800-846-7307
Tort (Option 3)	1-800-846-7307
TPL/Tort Fax	(512) 514-4225
Medicaid Audit/Cost Reports	(512) 506-6117
Medicaid Audit Fax	(512) 506-7811
Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax	(512) 514-4229
Hysterectomy Acknowledgment Statements Fax	(512) 514-4218

Written Communication With TMHP

All CMS-1500 forms (excluding ambulance, radiology/laboratory, immunization services, rural health, and mental health rehabilitation) sent to TMHP for the first time, as well as claims being resubmitted because they were initially denied as *incomplete claims*, must be sent to the following address:

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

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

Correspondence	Address
Appeals/adjustments of claims (except zero paid/zero allowed on Remittance & Status [R&S] Reports) Electronically rejected claims past the 95-day filing deadline and within 120 days of electronic rejection report	Texas Medicaid & Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645
All first-time claims	Texas Medicaid & Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555
Ambulance Authorization (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations P O Box 200735 Austin, TX 78720-0735
CCP requests (prior authorization and appeals)	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735
CSHCN Services Program claims	Texas Medicaid & Healthcare Partnership CSHCN Services Program Claims PO Box 200855 Austin, TX 78720-0735
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
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
TMHP Fee-for-Service and ICF-MR Dental prior authorization requests	Texas Medicaid & Healthcare Partnership Fee-for-Service and ICF-MR Dental PO Box 204206 Austin, Texas 78720-4206

Correspondence	Address
TPL/Tort correspondence	Texas Medicaid & Healthcare Partnership Third Party Liability/Tort PO Box 202948 Austin, TX 78720-2948

Other TMHP Information

TMHP Contact Center

The TMHP Contact Center is available from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

The TMHP Contact Center assists with questions such as:

- Provider enrollment procedures
- Claims filing procedures
- Policy information

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

Provider calls, including those that were previously made to the Provider Relations territory representatives, are now handled first by the Contact Center. The Contact Center is well equipped to handle most inquiries about benefits and claims.

If the Contact Center representative determines that an inquiry can best be handled by the TMHP Provider Relations department, the inquiry will be forwarded to Provider Relations. For example, providers who want to talk to their Provider Relations representative about a visit, in-service, or training, can call the Contact Center, and the Contact Center will forward the request to Provider Relations.

Resolution of more complex issues that are referred to Provider Relations for further analysis can take up to 30 days from the date of the referral. For these issues, Provider Relations will contact the provider by phone or e-mail when the issue has been resolved.

For questions or information about Medicaid eligibility, clients are referred to their caseworker or the local HHSC office.

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 7 a.m. until 7 p.m., Central Time, Monday through Friday. AIS offers 15 transactions per call.

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

TMHP Provider Relations

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

Provider Relations activities include the following:

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

Call the TMHP Contact Center at 1-800-925-9126 for assistance.

TMHP Electronic Data Interchange (EDI) Help Desk

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

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

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

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

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

SECTION 1: PROVIDER ENROLLMENT AND RESPONSIBILITIES

1.1 Provider Enrollment

1.1.1 National Provider Identifier (NPI) and Taxonomy Codes

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). An NPI must be obtained before a provider can enroll as a Texas Medicaid provider.

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

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

Initial Texas Medicaid fee-for-service enrollment and reenrollment can be completed online. The Texas Medicaid application includes applications for the Texas Health Steps (THSteps) program for both medical and dental providers and case management for Children and Pregnant Women (CPW). Providers can also enroll in the THSteps program using a separate application. A link to the provider enrollment application is provided on the TMHP website homepage at www.tmhp.com.

1.1.2 Online Enrollment

Online enrollment has the following advantages:

- Applications are validated immediately to ensure that all fields have been completed.
- Most of the application can be completed online so that only a few forms need to be printed, completed, and mailed to TMHP.
- Applicants can view both incomplete and complete applications that have been submitted online.
- Some form fields are automatically completed, reducing the amount of information that has to be entered.
- Providers can complete the Provider Information Change (PIC) form online.
- Providers will receive e-mail notifications when messages or deficiency notices about their applications are posted online. The messages can be viewed on the secured access portion of the website. Providers may opt out of e-mail communication and receive messages or deficiency letters by mail.
- Providers can create templates, which make it easier to submit multiple enrollment applications.
- Providers who enroll as a group can assign portions of the application to performing providers to complete. Performing providers can complete their portion of a group application by logging into Provider Enrollment on the Portal (PEP) with their unique user name and password.
- Providers can navigate to completed sections of the application without having to click through all pages of the application.
- Information that is on file for owners and subcontractors of the applying provider are auto-populated in the application.

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

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

- Meet all applicable eligibility criteria.
- Be approved by the Texas Health and Human Services Commission (HHSC) for enrollment.
- Obtain an NPI from NPPES.
- File with TMHP the required Texas Medicaid enrollment application ensuring that the application is correct, complete, and includes all required attachments and additional information.

  Refer to: Subsection 2.5, "Out-of-State Medicaid Providers" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for criteria specific to out-of-state providers.

- Provide any additional information requested by TMHP, HHSC, or the HHSC Office of Inspector General in connection with the processing of the application.
- Be approved by HHSC for enrollment and enter into a written provider agreement with HHSC.

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

As an alternative to applying for enrollment online, a provider may file a paper enrollment application with TMHP. Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126. A paper enrollment application may also be requested from and must be submitted to the following address:

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

Note: *During the Texas Medicaid enrollment process, with HHSC approval, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice will never serve Medicare-eligible individuals (e.g., pediatrics, obstetrician/gynecologist [OB/GYN]).*

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

Refer to: Subsection 1.1.5.11, "Copy of License/Temporary License/Certification" in this section.

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

Refer to: Subsection 2.5, "Out-of-State Medicaid Providers" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional criteria that must be met for out-of-state providers to enroll in Texas Medicaid.

There are four types of enrollment for providers in Texas Medicaid, as follows:

- *Individual.* This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name, and social security or federal tax identification number of the individual. An individual may also enroll as an employee, using the

federal tax identification number of the employer. Certain provider types must enroll as individuals, including the following; dieticians, licensed vocational nurses, occupational therapists, registered nurses, and speech therapists.

- *Group.* This type of enrollment applies to health-care items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, and the individuals providing health-care items or services are required to be certified or licensed in Texas. The enrollment is under the name and federal tax identification number of the legal entity. For any group enrollment application other than as a THSteps medical checkup provider group, there must also be at least one enrolling performing provider.
- *Performing provider.* This type of enrollment applies to an individual health care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the federal tax identification number of the group, and payment is made to the group. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the federal tax identification number of their employer.
- *Facility.* This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers. However, certain provider types must enroll as facilities, including the following:
  - Ambulance and air ambulance
  - Ambulatory surgical center (ASC) and hospital-based ambulatory surgical center (HASC)
  - Birthing center
  - Catheterization lab
  - Chemical dependency treatment facility (licensed by the Texas Commission on Alcohol and Drug Abuse)
  - Consumer Directed Services Agency
  - County Indigent Health Care Program
  - Community mental health center
  - Comprehensive health center
  - Comprehensive outpatient rehabilitation facility/outpatient rehabilitation facility
  - Department of Assistive and Rehabilitative Services Division for Blind Services
  - Durable medical equipment (DME)
  - Durable medical equipment home health
  - Early Childhood Intervention
  - Federally Qualified Health Center (FQHC)
  - Freestanding psychiatric facility
  - Freestanding rehabilitation facility
  - Home Health/Home and community support services agency
  - Hospital/critical access hospital/out-of-state hospital
  - Military hospital

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

Providers must submit a separate Texas Medicaid Provider Enrollment Application for each enrollment type requested. For example, a health-care professional who is already enrolled with Texas Medicaid as an individual with his or her own practice, and who wishes to bill for services provided in connection with a group, must submit a separate enrollment application and be approved as a performing provider with the group. Similarly, a health-care professional who is enrolled as a performing provider with one group, but who wishes to bill for services provided in connection with another group, must submit a separate enrollment application and be approved as a performing provider with the other group.

During the PEP process, the taxonomy code for group providers is populated with either the multi-specialty (193200000X) or single-specialty (193400000X) group taxonomy code dependent on which specialty was chosen.

The multi- or single-specialty taxonomy codes for group providers are accurate and have been approved by HHSC. The most appropriate taxonomy codes should be selected for any performing providers that will be enrolled according to their specific performing provider type and specialty.

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

Refer to: Subsection 1.7, "Medicaid Waste, Abuse, and Fraud Policy" in this section for additional information.

1.1.3 Provider Enrollment Application Determinations

An application for provider enrollment may be approved, approved with conditions, or denied. The provider applicant is issued a notice of the enrollment determination.

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

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

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

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 date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal.

Refer to: Subsection 1.1.5.11, "Copy of License/Temporary License/Certification" in this section.

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 notice of Medicaid enrollment, by way of issuance of a provider identifier, the provider must contact the appropriate TMHP Authorization Department before providing services that require a prior authorization number to Medicaid clients. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted. Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the add date of the client's retro-

active eligibility in TMHP's system to obtain authorization for services that have already been performed. Providers should refer to the specific manual section for details on authorization requirements, claims filing, and 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 6: Claims Filing for assistance with claim submission. If additional general information is needed, providers may call the TMHP Contact Center at 1-800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided. Providers who have already been assigned a provider identifier and have questions about submitting claims may call the same number and select the option to speak with a TMHP Contact Center representative.

1.1.3.1 Provider Identifiers Deactivated After 24 Months of No Claim Activity

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

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

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

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

Providers that file claims only for managed care organizations (MCOs) directly to the health plans rather than to TMHP must request to be exempted from the 24-month claim activity requirement. If these providers do not request to be exempted, their provider identifiers will be deactivated after 24 months of inactivity.

1.1.3.2 Excluded Entities and Providers

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

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

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

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

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

1.1.4 Enrollment in Medicaid Managed Care Programs

Medicaid providers may be reimbursed for services rendered to Medicaid Managed Care clients; however, the provider must enroll with the client's health plan to be eligible for reimbursement for services rendered.

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

1.1.5 Required Enrollment Forms

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

1.1.5.1 Texas Medicaid Provider Enrollment Application

The Texas Medicaid Provider Enrollment Application must be submitted by all providers who want to enroll in Texas Medicaid, 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.

Refer to the checklist in the Texas Medicaid Provider Enrollment Application. This checklist explains, by provider type, the documents and information that must be provided with the application. Applications must be complete in order to process and issue a provider identifier. Each application/applicant is considered separate and should not be combined.

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

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

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

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

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

Refer to: Subsection 1.7, "Medicaid Waste, Abuse, and Fraud Policy" in this section.

1.1.5.2 HHSC Medicaid Provider Agreement

The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in Texas Medicaid and must be signed by the provider who is applying for enrollment. If the applicant is an entity, a principal of the entity who has the authority to bind the entity to the requirements of the HHSC Provider Agreement must sign the agreement. "Principal" is defined in the following section. (In the case of a corporation, see subsection 1.1.5.7, "Corporate Board of Directors Resolution" in this section.)

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

1.1.5.3 Provider and Principal Information Forms

The Provider Information Form (PIF-1) must be completed by, or on behalf of, all providers. If the provider is an entity, the PIF-1 must be completed on behalf of the entity. A separate Principal Information Form (PIF-2) must be completed by each principal of the provider.

Principals of the provider include all of the following:

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

Note: *This includes the on-site manager for each physical location of the provider in Texas.*

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

1.1.5.4 Disclosure of Ownership and Control Interest Statement

The Disclosure of Ownership and Control Interest Statement must be submitted as part of the enrollment application for all types of enrollment, except in the case of a performing provider who is applying to join an already enrolled group. 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.

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

Refer to: Subsection 1.7, "Medicaid Waste, Abuse, and Fraud Policy" in this section.

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

Refer to: Subsection 1.5.2, "Maintenance of Provider Information" in this section.

1.1.5.5 Internal Revenue Service (IRS) W-9 Form

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

1.1.5.6 Medicaid Audit Information Form

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

1.1.5.7 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 have it notarized. If a business is city or government-owned, this form is not required.

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

The Certificate of Good Standing must be submitted by all for-profit corporations. A for-profit corporation that is delinquent in Franchise Tax cannot be 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, which verifies that the corporation is not delinquent in Franchise Tax. Only an original or photocopy of a Certificate of Good Standing will be accepted (i.e., a printout from the Comptroller website will not be accepted). Corporations that are nonprofit with a "501(C)(3)" IRS exemption are not required to submit this form. These corporations must 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.

1.1.5.9 Certificate of Formation or Certificate of Filing/Certificate of Incorporation

All providers that are legal entities must submit the Certificate of Formation or Certificate of Filing form. Obtain the form from the Office of the Secretary of State. The name on this form must exactly match the legal name shown on the W-9 form. Out-of-state providers are exempt from submitting this form.

Texas corporations formed on or before December 31, 2005, must submit their Certificate of Incorporation.

1.1.5.10 Certificate of Filing

The Certificate of Filing and any required certifications to provide certain services in Texas 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.

Corporations that formed on or before December 31, 2005, must submit their Certificate of Authority.

1.1.5.11 Copy of License/Temporary License/Certification

Providers who must be licensed or certified in Texas must submit a copy of their current license or certification.

Once a provider is enrolled in Texas Medicaid, a reminder letter will be automatically generated and sent to the provider 60 days before the provider's license expires.

TMHP directly obtains licensure information from the following licensing boards:

- Texas Medical Board
- Texas Board of Nursing

TMHP does not directly obtain licensure information from the following license boards:

- Texas State Board of Dental Examiners
- Texas State Board of Examiners of Psychologists
- Texas State Board of Chiropractic Examiners
- Texas State Board of Podiatric Examiners

Dentists, psychologists, chiropractors, and podiatrists must submit a paper copy of their licenses at the time of renewal to maintain a current record with TMHP.

Dental providers are required to send TMHP a letter from the Texas State Board of Dental Examiners (TSBDE) to verify current licensure for the State of Texas. This process is required to prevent potential claim denials due to the provider having an expired license on file with TMHP.

The letter must contain the provider's specific identification information, license number, and licensure period. The general letter provided on the TSBDE website will not be accepted by TMHP as proof of current licensure. Providers must call the number provided on the general letter to receive a letter that is specific with their individual provider information.

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

1.1.5.12 Licensure Renewal

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

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

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

1.1.5.13 Medicare Participation

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

- Pediatric providers
- Family planning providers
- Case Management for CPW program providers
- Comprehensive Care Program (CCP) providers
- Licensed professional counselors (LPCs)
- Licensed marriage and family therapists (LMFTs)

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

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

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

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

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

1.1.5.14 Group Information Changes

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

Refer to: Subsection 1.7, "Medicaid Waste, Abuse, and Fraud Policy" in this section for additional information.

1.2 Payment Information

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

1.2.1 Using EFT

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

1.2.2 Advantages of EFT

Advantages of EFT include:

- Electronically-deposited funds are available more quickly than with paper checks.
- Providers do not have to worry about lost or stolen checks.

- TMHP includes provider and Remittance and Status (R&S) Report numbers with each transaction submitted. If the bank's processing software captures and displays the information, both numbers would appear on the banking statement.

1.2.3 EFT Enrollment Procedures

The Electronic Funds Transfer (EFT) Authorization Agreement can be found as Form 1.5 in this section and on the TMHP website at www.tmhp.com. Completed EFT forms can be faxed to 1-512-514-4214, or mailed to:

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

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

After the Electronic Funds Transfer (EFT) Authorization Agreement has been processed, TMHP issues a prenotification transaction during the next cycle directly to the provider's bank account. This transaction serves as a checkpoint to verify EFT is working correctly.

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

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

Refer to: Form 1.5, "Electronic Funds Transfer (EFT) Authorization (2 Pages)" in this section.

1.2.4 Stale-Dated Checks

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

1.3 Provider Reenrollment

Providers must submit a new application and a new provider identifier must be issued when there are changes in Medicare number, ownership, status, address, or principal information. The new application may be submitted electronically using PEP or by submitting a completed paper Texas Medicaid Provider Enrollment Application. A new application is required when one of the following changes:

1.3.1 Medicare Number

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

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

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

1.3.3 Physical Address

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

1.3.4 Change in Principal Information

As defined in subsection 1.1.5.3, "Provider and Principal Information Forms" in this section, change in principal information includes a change in corporate officers or directors, professional association membership, and managing employees. The change must be reported to TMHP within 10 calendar days of when it occurs.

Refer to: Subsection 1.5.2.2, "Online Provider Lookup (OPL)" in this section.

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

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

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

1.4 Change of Ownership Requirements

The new owner must do the following:

- Obtain recertification as a Title XVIII (Medicare) facility under the new ownership
- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership)
- Provide a separate change of ownership and Texas Medicaid provider enrollment application for all of the provider identifiers affected by the change of ownership
- Submit any new enrollment application relating to a change in ownership to TMHP Provider Enrollment within 10 calendar days of the change

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

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

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

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

1.5 Provider Responsibilities

1.5.1 Compliance with Texas Family Code

1.5.1.1 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.

1.5.1.2 Reporting Child Abuse or Neglect

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

According to *Rider 19 of the General Appropriations Act*, 78th Legislative Regular Session, 1999, 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 sexual or nonsexual abuse.

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

1.5.1.3 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.

1.5.1.4 Procedures for Reporting Suspected Sexual Abuse

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

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: Form 1.3, "Child Abuse Reporting Guidelines (2 Pages)" in this section.

1.5.1.5 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.

1.5.2 Maintenance of Provider Information

Within 10 calendar days of occurrence, providers must report changes in address (physical location or accounting), telephone number, name, federal tax ID, and any other information that pertains to the structure of the provider's organization (for example, performing providers). Changes in address, office telephone or fax number, and e-mail address should be updated online using the Online Provider Lookup (OPL) update page. Alternately, providers may update their address information using the Provider Information Change (PIC) Form referenced below on the TMHP website.

Refer to: Subsection 1.5.2.2, "Online Provider Lookup (OPL)" in this section.

Form 1.8, "Provider Information Change Form" in this section.

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

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

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

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

Refer to: Subsection 1.7, "Medicaid Waste, Abuse, and Fraud Policy" in this section.

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

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

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

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

1.5.2.1 NPI Verification

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

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

1.5.2.2 Online Provider Lookup (OPL)

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

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

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

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

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

- Primary physical address:
  - Street address lines 1 and 2
  - City, state, ZIP code
  - County
- Telephone numbers
- E-mail address
- Office hours
- Accepting new clients, current clients only, or not accepting new clients
- Additional sites where services are provided
- Languages spoken
- Additional services offered
- Medicaid waiver programs
- Client age or gender limitations
- Counties served

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

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

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

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

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

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

1.5.3 Retention of Records and Access to Records and Premises

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

The documentation includes the following, without limitation:

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

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

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

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

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

These documents and claims must be retained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding RHCs must retain their records for a minimum of six years, and hospital-based RHCs must retain their records for a minimum of ten years. These records must be made available immediately at

the time of the request to employees, agents, or contractors of HHSC 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.

1.5.3.1 Payment Error Rate Measurement (PERM) Process

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

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

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

1.5.4 Release of Confidential Information

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

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

1.5.5 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 Texas Medicaid.*

1.5.6 Tamper-Resistant Prescription Pads

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

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

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

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

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

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

1.5.7 Utilization Control — General Provisions

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

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

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

1.5.8 Provider Certification/Assignment

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

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

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

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

Refer to: Subsection 6.2, "Services, Benefits, Limitations, and Prior Authorization" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

1.5.8.1 Delegation of Signature Authority

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

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

1.5.9 Billing Clients

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

- Failure to submit a claim, including claims not received by TMHP
- Failure to submit a claim to TMHP for initial processing within the 95-day filing deadline (or the initial 365-day deadline, if applicable)
- Submission of an unsigned or otherwise incomplete claim such as omission of the Hysterectomy Acknowledgment Statement or Sterilization Consent Form with claims for these procedures
- Filing an incorrect claim
- Failure to resubmit a corrected claim or rejected electronic media claim within the 120-day resubmittal period
- Failure to appeal a claim within the 120-day appeal period. Errors made in claims preparation, claims submission, or appeal process
- Failure to submit a claim to TMHP within 95 days of a denial by 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 Texas Medicaid

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

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 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 any incidental services.

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

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

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

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

Form 1.6, "Private Pay Agreement" in this section.

1.5.9.1 Client Acknowledgment Statement

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

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

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

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

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

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

1.5.10 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 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 procedure code that matches the services provided based on the procedure code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

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

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

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

- (Mandatory) All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- (Mandatory) Medicaid-enrolled providers must submit claims with their own TPI except when under the agreement of a substitute physician or *locum tenens.*
- (Mandatory) Each page of the medical record documents the patient's name and Texas Medicaid number.
- (Mandatory) A copy of the actual authorization from HHSC or its designee (e.g., TMHP) is maintained in the medical record for any item or service that requires prior authorization.
- (Mandatory) Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.
- (Mandatory) The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. 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.

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

1.5.11 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 Texas Medicaid, and who do not have private insurance. Some clients may have to pay an enrollment fee.

To qualify for CHIP, a child must be:

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

CHIP benefits include:

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

Individuals may apply for CHIP by downloading and completing the application found on the CHIP 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.

1.6 Enrollment Criteria for Out-of-State Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more of the following requirements of 1 TAC §354.1442:

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

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

  Note: *An out-of-state provider seeking enrollment under this criterion must include with the enrollment application a copy of the claim that contains the diagnosis that indicates emergency care or medical record documentation. The documentation must demonstrate that emergency care was provided to a Texas Medicaid client. Providers enrolled under this criterion will be enrolled for a limited period of time.*

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

  Note: *An out-of-state provider seeking enrollment under this criterion must include with the enrollment application an explanation of the circumstances and demonstrate why the Texas Medicaid client's health would have been endangered if the client had been required to travel to Texas. Providers enrolled under this criterion will be enrolled for a limited period of time.*

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

  Note: *HHSC determines whether this criterion applies on a case-by-case basis. An out-of-state provider that seeks enrollment under this criterion must include with the enrollment application documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Providers that are enrolled under this criterion may be enrolled for a limited period of time.*

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

  Note: *HHSC determines whether this criterion applies on a case-by-case basis. An out-of-state provider that is located more than 50 miles from Texas and seeks enrollment under this criterion must include with the enrollment application documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a limited period of time.*

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

  Note: *HHSC determines whether this criterion applies on a case-by-case basis. An out-of-state provider that seeks enrollment under this criterion must include with the enrollment application documentation that explains why this criterion applies, and must provide any*

additional information requested by HHSC or its designee. An out-of-state provider does not meet this criterion merely on the basis of having established business relationships with one or more providers that participate in the Texas Medicaid program, because the criterion in that paragraph applies only to the customary or general practice of recipients in regard to a recipient's choice of provider. Such providers, if approved for enrollment, may be enrolled for a limited period of time.

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

Note: *Providers that seek enrollment under this criterion are encouraged to contact TMHP to request approval before filing an enrollment application. TMHP will coordinate the request with HHSC. HHSC determines whether this criterion applies on a case-by-case basis. The provider must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a limited period of time.*

Texas Medicaid does not cover transplant services rendered out-of-state that are also available in Texas. The provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation, when requesting an out-of-state prior authorization for a pre-transplant evaluation.

Providers that are located out-of-state and seek reimbursement under one or more of the above criteria must submit an enrollment application and be approved for enrollment.

An out-of-state provider that meets none of the above criteria but is eligible to receive reimbursement for Medicare crossover claims involving Texas Medicaid dual eligible clients, may seek enrollment in order to receive such reimbursement. Such providers, if approved for enrollment, will be restricted to receiving reimbursement only for Medicare crossover claims.

Refer to: Subsection 2.6, "Medicare Crossover Claim Reimbursement" in this section.

Payments to out-of-state providers enrolled in Texas Medicaid are made according to the usual, customary, and reasonable charges or the stipulated fee for services as appropriate for the provided care. Reimbursement may not exceed the lesser of:

- The Medicaid reasonable charge or fee determined for the same services in Texas; or
- If agreed to by HHSC, 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: Subsection 9.2.1, "Prior Authorization" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

1.7 Medicaid Waste, Abuse, and Fraud Policy

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

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

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

In addition, providers are responsible for the delivery of health-care items and services to Medicaid clients in accordance with all applicable licensure and certification requirements and accepted medical community standards and standards. Such standards include those related to medical record and claims filing practices, documentation requirements, and records maintenance. The TAC requires providers to follow these standards. For more information, consult 1 TAC §371.1617(a)(6)(A).

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

- CPT as set forth in the American Medical Association's most recently published "CPT books", "CPT Assistant" monthly newsletters, and other publications resulting from the collaborative efforts of American Medical Association with the medical societies.
- Healthcare Common Procedure Coding System (HCPCS) as developed and maintained by the federal government.
- National Correct Coding Initiative (NCCI), as set forth by the Centers for Medicare & Medicaid Services (CMS), and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations that a provider must not bill together. One of the codes in the pair is considered a part of the primary procedure and not reimbursable to the same provider on the same date of service.

Exception: *NCCI outlines use of modifiers some of which are not currently recognized by Texas Medicaid. See the list of modifiers utilized by Texas Medicaid in subsection 6.3.5, "Modifiers" in* Section 6, "Claims Filing" (*Vol. 1, General Information*).

- *Current Dental Terminology* (CDT) as published by the American Dental Association.
- *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM).
- *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR).

Failure to comply with the guidelines provided in these publications may result in a provider being found to have engaged in one or more program violations listed in 1 TAC § 371.1617.

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

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

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

Administrative sanctions include, without limitation:

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

Administrative actions include:

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

Anyone facing an administrative sanction has a right to formal due process. This formal due process may include a hearing before an administrative law judge. Conversely, anyone facing an administrative action is not entitled to formal due process. People who induce, solicit, receive, offer, or pay any remuneration (including, but not limited to, bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or Texas

Medicaid may be in violation of state statutes and guilty of a federal felony offense. State law also allows for the suspension of providers convicted of a criminal offense related to Medicare or Texas Medicaid. The commission of a felony in Medicaid or Medicare programs may include fines or imprisonment ranging from five years to life in prison. Examples of inducements include a service, cash in any amount, entertainment, or any item of value.

As stated in 1 TAC § 371.1617, following is a nonexclusive list of grounds or criteria for the Inspector General's administrative enforcement and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were 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 Texas Medicaid or other HHS program or not permitted by Texas Medicaid or other HHS program policies;
   i) Presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;
   j) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from Texas Medicaid, other HHS program, or Medicare or has been excluded from and not reinstated within Texas Medicaid, other HHS program, or Medicare;
   k) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items that are not reimbursable by the Texas Medicaid or other HHS program;
   l) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for a service or item which requires a prior order or prescription by a licensed health-care practitioner when such order or prescription has not been obtained;
   m) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for an item or service substituted without authorization for the item or service ordered, prescribed or otherwise designated by the Texas Medicaid or other HHS program;
   n) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person who is owned or controlled, directly or indirectly, by an excluded person; *and*

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

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 Texas Medicaid all information that is required by 42 CFR §434.10(b).

3) Program-Related Convictions.
   a) Pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, Texas Medicaid, other HHS program, or any other state's Medicaid program;
   b) Pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;

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

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

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

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

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

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

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

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

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

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

10) Cost-Report Violations.

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

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

c) Including unallowable cost items on a cost report;

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

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

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

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

11) Kickbacks and Referrals.

a) Violating any of the provisions specified in 1 TAC §371.1721(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 these practices may result in provider exclusion or suspension from Texas Medicaid. Providers are notified in writing of any actions taken as well as procedures for appeal and reinstatement. The written notification will specify the date on which Medicaid program participation may resume. The reinstated person may then apply for a contract or provider agreement.

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

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

1.7.1 Reporting Waste, Abuse, and Fraud

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

HHSC-OIG encourages providers to voluntarily investigate and report fraud, waste, abuse, or inappropriate payments of Medicaid funds in their own office. Providers are required to report these activities to HHSC-OIG when identified. HHSC-OIG will work collaboratively with self-reporting providers. For more information on provider self-reporting, visit
http://oig.hhsc.state.tx.us/ProviderSelfReporting/Self_Reporting.aspx.

1.7.2 Suspected Cases of Provider Waste, Abuse, and Fraud

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

1.7.3 Employee Education on False Claims Recovery

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

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

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

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

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

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

An MCO that provides or arranges for the provision of health-care services to an individual under Texas Medicaid must establish and maintain a special investigative unit (SIU) that works in cooperation with HHSC-OIG and the Attorney General's Office, as required by Tx. Govt. Code 1TAC§533.012, 1TAC§531.113, and 1§531.1131 and 1 TAC§353.501-353.505 and 370.501-370.505.

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

1.7.5 MCO SIU Case Referrals

An MCO or SIU must refer a case to both HHSC-OIG and OAG-MFCU in the following situations:

- When waste, abuse or fraud is discovered in the Medicaid or CHIP programs. (The MCO SIU must immediately notify the HHSC-OIG and OAG-MFCU and begin payment recovery efforts, unless HHSC-OIG or OAG-MFCU notifies the MCO to stop the recovery effort, as provided in Tx. Govt. Code §531.1131.)

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

1.8 Texas Medicaid Limitations and Exclusions

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

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

- Autopsies
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Dentures or endosteal implants for adults
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunizations or vaccines unless they are otherwise covered by Texas Medicaid (These limitations do not apply to services provided through the THSteps Program.)
- Immunotherapy for malignant diseases
- Infertility
- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for persons with intellectual disabilities
- Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client's condition
- Intragastric balloon for obesity
- Joint sclerotherapy

- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- More than $200,000 per client per benefit year (November 1 through October 31) for any 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 CCP or clients with an organ transplant.)
- More than 30 days of inpatient hospital stay per spell of illness (Each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital.)

Important: *CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients who are 20 years of age and younger. Some 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 who are 20 years of age and younger.*

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

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

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

- Prosthetic and orthotic devices (except CCP)
- Prosthetic eye or facial quarter
- Psychiatric services:
  - Outpatient behavioral health services for which no prior authorization has been given

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

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

- Quest test (infertility)
- Recreational therapy
- Review of old X-ray films
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia
- Separate fees for completing or filing a Medicaid claim form (The cost of claims filing is to be incorporated in the provider's usual and customary charges to all clients.)
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies that are not reasonable and necessary for diagnosis or treatment
- Services or supplies that are not specifically provided by Texas Medicaid
- Services or supplies provided in connection with cosmetic surgery except:
  - As required for the prompt repair of accidental injury
  - For improvement of the functioning of a malformed body member
  - When prior authorized for specific purposes by TMHP (including removal of keloid scars)
- Services or supplies provided outside of the U.S., except for deductible 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 that are payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services that are provided by an interpreter (except sign language interpreting services requested by a physician)
- Services that are provided by ineligible, suspended, or excluded providers
- Services that are provided by the client's immediate relative or household member

- Services that are provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for certain health and disability related and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent (This policy complies with 42 CFR §441.250, Subpart F.)
- Take-home and self-administered drugs except as provided under the Vendor Drug or family planning pharmacy services or for clients being treated for a substance use disorder
- Tattooing (commercial or decorative only)
- Telephone calls with clients or pharmacies (except as allowed for case management)
- Thermogram
- Treatment of flatfoot conditions for solely cosmetic purposes, the prescription of supportive devices (including special shoes), and the treatment of subluxations of the foot

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

1.9 Forms

1.1 Authorization to Release Confidential Information (2 Pages)

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

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 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.

1.2 Authorization to Release Confidential Information (Spanish) (2 Pages)

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

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 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.

1.3 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.

Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring

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): _____

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.

1.5 Electronic Funds Transfer (EFT) Authorization (2 Pages)

Electronic Funds Transfer (EFT) Notification

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- 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, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- 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. 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 a voided check or signed letter from your bank on bank letterhead with the agreement to the TMHP address indicated on the form.***

Call the **TMHP Contact Center** at **1-800-925-9126** if you need assistance.

Electronic Funds Transfer (EFT) Notification

NOTE: *Complete all sections below and* ***attach a voided check or a signed letter from your bank on bank letterhead.***

Type of authorization: ☐ New ☐ Change			
Provider name:		**Billing TPI:** *(9-digit)*	
National Provider Identifier (NPI)/Atypical Provider Identifier (API):		**Primary taxonomy code:**	
List any additional TPIs that use the same provider information:			
TPI:	**TPI:**	**TPI:**	**TPI:**
TPI:	**TPI:**	**TPI:**	**TPI:**
Provider accounting address: Number Street Suite City State ZIP			
Provider phone number:			
Bank name:		**Bank phone number:**	
ABA/Transit number:		**Account number:**	
Bank address:		**Account type:** *(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 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:	**E-mail address:** *(if applicable)*
Contact name:	**Contact phone number:**

Return this form to:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Rev. 10/22/09

1.6 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: _____

1.7 Provider Information Change (PIC) Form Instructions

Instructions for Completing the Provider Information Change Form

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 Texas Medicaid fee-for-service and the CSHCN Services Program, changes to the accounting or mailing address require a copy of the W-9 form.
- For Texas Medicaid fee-for-service, a change in ZIP Code requires copy of the Medicare letter for Ambulatory Surgical Centers.

Federal Tax Identification Number (TIN)

- Federal 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 Federal TIN.

Provider Demographic Information

An online provider lookup (OPL) is available, which allows users such as clients and providers to view information about Texas State Health-Care Programs 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

1.8 Provider Information Change Form

Provider Information Change Form

Texas Medicaid fee-for-service and Children with Special Health Care Needs (CSHCN) Services Program 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.

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—Federal Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

Federal 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
Fax: 512-514-4214

Effective Date_01012009/Revised Date_04202012

SECTION 2: TEXAS MEDICAID FEE-FOR-SERVICE REIMBURSEMENT

2.1 Payment Information

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

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

2.2 Fee-for-Service Reimbursement Methodology

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

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

2.2.1 Online Fee Lookup (OFL) and Static Fee Schedules

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

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

The online OFL can be used to:

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

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

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

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

- *Ambulance.* The Medicaid rates for ambulance services are calculated in accordance with 1 TAC §355.8600.
- *Ambulatory Surgical Center (ASC).* The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121.
- *Blind Children's Vocational Discovery and Development Program.* The Medicaid rate for this service is calculated in accordance with 1 TAC §355.8381.

- *Case Management for Children and Pregnant Women.* The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401.
- *Targeted Case Management for Early Childhood Intervention (ECI).* The Medicaid rate for this service is reimbursed in accordance with 1 TAC §§355.8421.
- *Specialized Skills Training for ECI.* The Medicaid rate for this service is reimbursed in accordance with 1 TAC § 355.8422
- *Certified Nurse-Midwife (CNM).* The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161.
- *Certified Registered Nurse Anesthetist (CRNA).* According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service.
- *Certified Respiratory Care Practitioner (CRCP) Services.* The Medicaid rate per daily visit for 99503 is calculated in accordance with 1 TAC §355.8089.
- *Chemical Dependency Treatment Facility (CDTF).* The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241.
- *Chiropractic Services.* The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8081 and 1 TAC §355.8085.
- *Dental.* The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8081, 1 TAC §355.8085, 1 TAC §355.8441(11), and 1 TAC §355.455(b).
- *Durable Medical Equipment (DME).* Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021 (b). Comprehensive Care Program (CCP) is reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8441 (2)(3).
- *Family Planning Services.* The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8584.
- *Genetic Services.* The procedure codes and Medicaid rates for genetic services are listed in the OFL or the Physician - Genetics fee schedule on the TMHP website at www.tmhp.com.
- *Hearing Aid and Audiometric Evaluations.* Newborn hearing screenings are provided at the birthing facility before hospital discharge and, as such, are reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services at 1 TAC §355.8085, 1 TAC §355.8141, and 1 TAC §355.8441.
- *Texas Medicaid (Title XIX) Home Health Services.* The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).
- *Independent Laboratory.* The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/Texas Health Steps medical and newborn screening laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on the Medicare payment for that service.
- *Indian Health Services.* The reimbursement methodology for services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620.
- *In-Home Total Parenteral Nutrition (TPN) Supplier.* The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087.

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

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

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

Reimbursement for non-emergent and non-urgent services that are rendered by the facility during the emergency room visit will be reduced by 40 percent. Reimbursement will not be reduced for those services that were rendered to address conditions that meet any of the following criteria:

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

Services that are rendered in the emergency department that do not meet the above criteria will be reduced by 40 percent.

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

Refer to: Subsection 8.2.60.3, "Physician Services Provided in the Emergency Department" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information about non-emergent and non-urgent services rendered in the emergency department.

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

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

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

2.2.1.2 Drugs and Biologicals

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

The following guidelines should be used with respect to fee decisions for physician-administered drugs and biologicals:

- Fees for biologicals and infusion drugs furnished through an item of implanted DME are based on the lesser of the billed amount or 89.5 percent of the average wholesale price (AWP).
- Fees for drugs and biologicals, other than biologicals and infusion drugs that are furnished through an item of implanted DME, that are covered by Medicare are based on the lesser of the billed amount or 106 percent of average sales price (ASP).

- Fees for those drugs and biologicals not listed in the first two bullets above that are covered by Medicare are based on the lesser of the billed amount or one of the following:
  - 89.5 percent of AWP if the drug and biological is considered a new drug and biological (i.e., approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of Texas Medicaid)
  - 85.0 percent of AWP if the drug and 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 and biologicals when AWP or ASP calculations are determined to be unreasonable or insufficient.

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

2.2.2 Cost Reimbursement

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

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

- 1 TAC §355.743—Mental health (MH) case management
- 1 TAC §355.746—Mental retardation (MR) service coordination
- 1 TAC §355.781—MH rehabilitative services
- 1 TAC §355.8443—School Health and Related Services (SHARS)
- 1 TAC §355.8061—Payment for Hospital Services
- 1 TAC §355.8055—Reimbursement Methodology for Rural and Certain Other Hospitals
- 1 TAC §355.8054—Children's Hospital Reimbursement Methodology
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology

2.2.3 Reasonable Cost and Interim Rates

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

2.2.4 Hospitals

Inpatient hospital services are reimbursed as follows:

- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8054—Children's Hospital Reimbursement Methodology
- 1 TAC §355.8055—Reimbursement Methodology for Rural and Certain Other Hospitals
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058—Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060—Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061—Payment for Hospital Services
- 1 TAC §355.8064—Reimbursement Adjustment for Hospitals Providing Inpatient Services to SSI and SSI-Related Clients
- 1 TAC §355.8065—Disproportionate Share Hospital (DSH) Reimbursement Methodology

- 1 TAC §355.8068—Supplemental Payments to Certain Urban Hospitals
- 1 TAC §355.8069—Supplemental Payments to Certain Rural Public Hospitals
- 1 TAC §355.8070—Supplemental Payments to Private Hospitals
- 1 TAC §355.8071—Supplemental Payments to Children's Hospitals
- 1 TAC §355.8072—Supplemental Payments to State-Owned Hospitals

2.2.5 Provider-Specific Visit Rates

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

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

2.2.6 Manual Pricing

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

2.3 Reimbursement Reductions

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

2.4 Additional Payments to High-Volume Providers

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

Outpatient hospital services are those services provided by outpatient hospitals and ASCs/HASCs. The definition of a high-volume outpatient hospital provider is one that was paid a minimum of $200,000 during the qualifying period. 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 72.27 percent to 76.03 percent. ASCs/HASCs that qualify as high-volume providers also receive a 5.2 percent increase in payment rates.

2.5 Out-of-State Medicaid Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more requirements of 1 TAC §355.8083. TMHP must receive claims from out-of-state providers within 365 days from the date of service.

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

Refer to: Subsection 1.6, "Enrollment Criteria for Out-of-State Providers" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.6 Medicare Crossover Claim 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 Medicare 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

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

- The coinsurance and deductible payment on valid, assigned Medicare claims
- The amount that remains after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service

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

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

2.6.2.1 Exceptions

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

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

2.6.3 Part C: Medicare Advantage Plans (MAPs)

2.6.3.1 Contracted MAPs

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

2.6.3.2 Noncontracted MAPs

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

- The coinsurance and deductible payment

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

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

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

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

2.7 Federal Medical Assistance Percentage (FMAP)

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

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

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

SECTION 3: TMHP ELECTRONIC DATA INTERCHANGE (EDI)

3.1 TMHP EDI Overview

The Texas Health and Human Services Commission (HHSC) and the Texas Medicaid & Healthcare Partnership (TMHP) encourage providers to submit claims using electronic methods. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers can access TMHP's electronic services through the TMHP website at www.tmhp.com, TexMedConnect, vendor software, and third party billing agents. Providers may also submit claims using paper forms.

3.1.1 Advantages of Electronic Services

- *It's fast.* No more waiting by the mailbox or telephone inquiries; know what's happening to claims in less than 24 hours and receive reimbursement for approved claims within a week. 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 computer-based training (CBT) for TexMedConnect, Medicaid billing, and many other topics, including those for the Children with Special Health Care Needs (CSHCN) Services Program, and Long Term Care, as well as a large library of reference materials and manuals on www.tmhp.com.
- *It's safe.* TMHP EDI services use VPN and SSL connections, just like the United States government, banks, and other financial institutions, for maximum security.
- *It's accurate.* TexMedConnect and most vendor software programs have features that let providers know when they've made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what's wrong, so the claim can be corrected and resubmitted right away. Denied claims appear on the provider's Remittance and Status (R&S) Report along with paid and pending claims.
- *It's there when it's needed.* Electronic services are available day and night; from home, the office, or anywhere in the world.
- *It makes record keeping and research easy.* Not only can TexMedConnect be used to send and receive claims, it can check client eligibility, retrieve Electronic Remittance and Status (ER&S) Reports, perform claim status inquiries, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

3.1.2 Electronic Services Available

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

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

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

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

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

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

3.2 Electronic Billing

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

3.2.1 TexMedConnect

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

- An internet service provider (ISP)
- Microsoft® Internet Explorer® 7.0 and 8.0

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

3.2.2 Vendor Software

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

3.2.3 Third Party Billing Agents

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

3.3 Gaining Access

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

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638, Option 3. Providers that use a billing agent do not need a submitter ID.

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

Refer to: Form 3.1, "Electronic Remittance and Status (ER&S) Agreement (2 pages)" in this section.

3.4 Training

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

3.5 Electronic Transmission Reports

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

Refer to: Subsection 1.5.3, "Retention of Records and Access to Records and Premises" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*), for more information about provider responsibility and electronic submissions.

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

3.6 Provider Check Amounts Available Online

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

The features of the online check amount include:

- The ability to search information up to one year before the date of the search.
- All results are displayed on a single screen.
- All results can be printed on a single report.
- The 52 weeks of reimbursement payment information includes the:
  - Payment date

- Payee name
- Payment amount
- Program for which payment was issued
- Hold amount
- Payment status

Providers must have or must create an administrative account to view their payment amounts online. Providers can then grant "View Payment Amounts" security permission to the office staff of their choice. Providers can access their check amounts by logging into their accounts from the TMHP website and then pressing **View Payment Amounts**.

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

3.7 Third Party Vendor Implementation

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

3.7.1 Automated Maintenance Process for All Electronic Submitters

All submitter folders have a maximum limit of 7500 files, and no files can be more than 30 days old. Files that exceed these limits will be purged by TMHP on a daily basis. Providers should review, retrieve, and backup their electronic response files within 30 days. Files not retrieved within the 30-day time period or files that exceed a maximum file count of 7500 will be purged by TMHP. All electronic submitters are responsible for the maintenance of their submitter folders. Files that are submitted using EDI version 5010 are limited to a maximum of 5,000 transactions per file. Files that have more than 5,000 transactions will be rejected.

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

3.7.2 Supported File Types

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

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

Electronic Transaction Types	
837I	Institutional claims
837P	Professional claims

3.8 Forms

Note: *Forms are available on the TMHP website at www.tmhp.com.*

3.1 Electronic Remittance and Status (ER&S) Agreement (2 pages)

Electronic Remittance and Status (ER&S) Agreement

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/API 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 03032011

ER&S Agreement — Submission Instructions

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

Effective Date_07302007/Revised Date_06012007

3.2 Claim Status Inquiry (CSI) Authorization Form

Claim Status Inquiry Authorization

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)/Atypical Provider Identifier (API) 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/API 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_03032011

SECTION 4: CLIENT ELIGIBILITY

4.1 General Medicaid Eligibility

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

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

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

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

4.1.1 Retroactive Eligibility

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

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

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

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

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

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

Refer to: Subsection 4.1, "Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)" in this section.

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

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

4.1.3 Medicaid Buy-In Program for Employed Individuals with Disabilities

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

Participants will receive the Your Texas Benefits Medicaid card, which indicates the Medicaid services for which they are eligible. MBI participants in urban service areas will be served through Texas Medicaid fee-for-service.

4.1.4 Newborn Eligibility

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

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

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

If the hospital or birthing center notifies HHSC Eligibility Services that a newborn child was born to a Medicaid-eligible mother, then the hospital caseworker, mother, and attending physician (if identified) should receive a Medicaid Eligibility Verification (Form H1027) from HHSC a few weeks after the child's birth. Form H1027 includes the child's Medicaid identification number and effective date of coverage. After the child has been added to the HHSC eligibility file, a Your Texas Benefits Medicaid card is issued. Newborn clients will receive the Your Texas Benefits Medicaid card approximately 2 weeks after birth.

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

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

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

Refer to: Form 4.1, "Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)" in this section.

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

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

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

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

4.1.6 Foster Care

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

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

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

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

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

Reminder: *Adoption agencies/foster parents are no longer considered third party resources (TPRs). Medicaid is primary in these circumstances.*

4.1.7 Medicaid Managed Care Eligibility

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

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

4.2 Eligibility Verification

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

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

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

4.2.1 Advantages of Electronic Eligibility Transactions

Eligibility transactions through TexMedConnect or EDI have the following advantages:

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

Electronic eligibility responses contain:

- Restrictions applicable to the client's eligibility such as limited, emergency, or womens health.

- Medicare eligibility and effective dates, including Part A, B, and C.
- Complete other insurance information, including name and address, and effective dates. EDI transactions also indicate the patient relationship to policy holder.

4.3 Medicaid Identification and Verification

Providers are responsible for requesting and verifying current eligibility information from clients by using the methods listed above or by asking clients to produce their Your Texas Benefits Medicaid card or Medicaid Identification form (H1027).

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

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

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

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

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

HHSC issues one of the following only when a client's Your Texas Benefits Medicaid card has been lost or stolen or for temporary emergency Medicaid:

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

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

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

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

Providers must review limitations identified on the Medicaid electronic eligibility file, AIS, the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com, or the Medicaid Eligibility Verification (Form H1027-A). 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.

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

Refer to: Subsection 4.13, "Third Party Liability (TPL)" in this section.

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

4.4 Restricted Medicaid Coverage

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

4.4.1 Emergency Only

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

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

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

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

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

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

4.4.2 Client Limited Program

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

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

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

After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System (MFADS), qualified medical personnel validate the initial identification and determine candidates for 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 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.

4.4.2.1 Limited Medicaid Identification

Clients with limited status receive the Your Texas Benefits Medicaid card with "LIMITED" printed on the card. The designated provider and pharmacy names are printed on the card under the word "LIMITED." Only one client is identified on a LIMITED Your Texas Benefits Medicaid card.

The Limited Program may also alert providers by means of a message on the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com, when the card 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.

When limited Texas Medicaid fee-for-service clients attempt to obtain nonemergency services from someone other than their designated primary care provider, the provider must do one of the following:

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

4.4.2.2 Exceptions to Limited Status

Limited clients may go to any provider for the following services or items:

- Ambulance services
- Anesthesia
- Annual well-woman checkup
- Assistant surgery
- Case management services
- Chiropractic services
- Counseling services provided by a chemical dependency treatment facility
- Eye exams for refractive errors
- Eyeglasses
- Family planning services (regardless of place of service [POS])
- Genetic services
- Hearing aids
- Home health services
- Laboratory services (including interpretations)
- Licensed clinical social worker (LCSW) services

- Licensed professional counselor (LPC) services
- Mental health rehabilitation services
- Mental retardation diagnostic assessment (MRDA) performed by an MRDA provider
- Nursing facility services
- Primary home care
- Psychiatric services
- Radiology services (including interpretations)
- School Health and Related Services (SHARS)
- Comprehensive Care Program (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

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

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

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

4.4.2.3 Selection of Designated Provider and Pharmacy

Texas Medicaid fee-for-service clients identified for 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).

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

When a candidate for the designated provider is determined, HHSC contacts the provider by letter. If 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.

4.4.2.4 Pharmacy services

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

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

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

The following are allowable circumstances for pharmacy override approval:

- The recipient moved out of the geographical area (more than 30 miles from the lock-in pharmacy).
- The limited pharmacy does not have the prescribed medication, and the medication will remain unavailable for more than two to three days.
- The limited pharmacy is closed for the day, and the recipient needs the medication urgently.
- The limited pharmacy does not carry the medication and is either unable to order it or unwilling to stock it.
- The pharmacy no longer wants to be the designated pharmacy for a particular limited client.
- The client has valid complaints against the limited pharmacy or its staff.

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

4.4.2.5 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, convicted of, or admits to a 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 with a Limited Status as noted on the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com.

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 can reach the Limited Program by calling the HHSC OIG Hotline at 1-800-436-6184 to request this review.

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

4.4.2.6 Referral to Other Providers

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

4.4.2.7 Hospital Services

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

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

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

4.4.2.8 Limited Status Claims Payment

Payment for services to a limited Medicaid client is made to the designated provider only, unless the services result from a designated provider referral or emergency. An automated review process determines if the claim includes the limited primary care provider's provider identifier as the billing, performing, or referring provider. If 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 subsection 4.4.2.2, "Exceptions to Limited Status" in this section. Appeals for denied claims are submitted to TMHP and must include the designated Medicaid provider identifier for reimbursement consideration.

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

4.4.3 Hospice Program

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

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. Texas Medicaid clients who are 20 years of age and younger and elect hospice care are not required to waive their rights to concurrent hospice care and treatment. Concurrent hospice care and treatment services include:

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

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

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

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

4.4.3.1 Hospice Medicaid Identification

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

4.4.3.2 Physician Oversight Services

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

4.4.3.3 Medicaid Services Unrelated to the Terminal Illness

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

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

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

4.4.4 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.

4.4.4.1 PE Medicaid Identification

PE indicates clients with presumptive eligibility. PE clients may be identified by visiting the Your Texas Benefits Medicaid card web site at www.YourTexasBenefitsCard.com. Medicaid coverage for PE continues through the last day of the month indicated on the Your Texas Benefits Medicaid card web site. The Your Texas Benefits Medicaid card website at will indicate 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).

A woman who is certified for regular Medicaid receives the regular Your Texas Benefits Medicaid card. Other family members who are determined to be eligible for Medicaid receive a separate Your Texas Benefits Medicaid card 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.

4.4.4.2 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. Client eligibility for PE coverage must be determined by a PE provider. Once eligibility is determined, services may be obtained from any enrolled Medicaid provider.

4.4.4.3 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).
- Be determined by HHSC to be capable of making PE determinations.
- 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 Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about the enrollment procedures for Texas Medicaid.

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.

4.4.4.4 Process

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

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

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

4.5 CHIP Perinatal Program

The Children's Health Insurance Program (CHIP) Perinatal Program provides CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid-eligible women. This program allows pregnant women who are ineligible for Medicaid because of income (186 to 200 percent of the FPIL) or immigration status (with an income at or below 200 percent of FPIL) to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the coverage period. Continuous Medicaid coverage for 12 months is provided from birth to CHIP Perinatal newborns whose mothers are at or below 185 percent of FPIL and received Emergency Medicaid for the labor and delivery. The 12 months of continuous Medicaid coverage for the newborn is available *only* if the mother received Medicaid for labor and delivery.

4.5.1 Program Benefits

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

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

Program benefits after the child is born include:

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

4.5.2 Claims

Providers who serve CHIP Perinatal clients must follow the claims filing guidelines in subsection 6.20.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in Section 6, "Claims Filing" (*Vol.1 General Information*).

4.5.3 Client Eligibility Verification

A number is issued for the baby based on the submission of the Emergency Medical Services Certification Form H3038 for the mother's labor with delivery.

Establishing Medicaid for the newborn requires the submission of the Emergency Medical Services Certification Form H3038 for the mother's labor with delivery. If Form H3038 is not submitted, Medicaid cannot be established for the newborn from the date of birth for 12 continuous months of Medicaid coverage. Once enrolled, clients are identified as type program (TP) 30 for the mother and TP 45 for the newborn.

Establishing Medicaid (and issuance of a Medicaid number) can take up to 45 days after Form H3038 is submitted. Medicaid eligibility for the mother and infant can be verified via the online lookup on the TMHP website at www.tmhp.com or by calling AIS at 1-800-925-9126.

For clients enrolled in the CHIP Program, the CHIP health plan assigns a client ID to be used for billing. Providers should contact the CHIP health plan for billing information.

Newborns at or below 185 percent of FPL are eligible to receive Medicaid benefits beginning at the date of birth and will not be assigned a client ID from the CHIP health plan.

HHSC requires the expectant mother's provider to fill out the Emergency Medical Services Certification (Form H3038).

The expectant mother will receive this form from HHSC before her due date, along with a letter reminding her to send information about the birth of her child after delivery. The letter will instruct the expectant mother to take the form to her provider, have the provider fill out the form, then mail the form back to HHSC in a preaddressed, postage-paid envelope. In many cases this activity will occur after delivery when the mother is being discharged from the hospital.

Once HHSC receives the completed the Emergency Medical Services Certification (Form H3038), Emergency Medicaid coverage will be added for the mother for the period of time identified by the health care provider. The Emergency Medical Services Certification (Form H3038) is the same form currently required to complete Emergency Medicaid certification.

The CHIP perinatal mother whose income is at or below 185 percent of the FPIL will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid. HHSC will determine the woman's eligibility for Emergency Medicaid by using income and other information the mother to-be provided when she originally applied for coverage, as well as information included on the Emergency Medical Services Certification (Form H3038).

If a woman fails to return the completed Emergency Medical Services Certification (Form H3038) within a month after her due date, HHSC will send her another Emergency Medical Services Certification Form H3038 with a postage-paid envelope. If the woman fails to submit Emergency Medical Services Certification (Form H3038), and the hospital cannot locate a Type Program 30 for her in the TMHP online provider lookup tool, then the hospital can bill her for facility fees incurred during her stay.

4.5.3.1 Confirming Receipt of Form H3038

Providers who would like to confirm receipt of form H3038 can contact MAXIMUS at 1-877-KIDS-NOW (1-877-543-7669), prompt #6 (for reporting changes) after 48 hours from fax submission. If the submission is by regular mail, providers should allow five business days before contacting MAXIMUS. When calling this number, providers should be prepared to provide the following information:

- National Provider Identifier (NPI)
- Provider name
- Name of person calling
- CHIP perinatal case number (Without the case number, MAXIMUS cannot provide confirmation of receipt. Confirmation of receipt cannot be provided based on client name or address.)

Each form H3038 should be faxed one at a time, rather than in a batch. It is important that the form be filled out completely and accurately. If the form is not filled out accurately, it will delay processing and MAXIMUS may not be able to confirm receipt after 48 hours from fax submission.

4.5.3.2 Eligibility Verification for Clients Without a Medicaid ID

Providers should first attempt to verify if a Medicaid number has been issued by calling TMHP at 1-800-925-9126 and using the prompt for AIS or speaking to a representative. Providers can also use TexMedConnect to check client eligibility. If a provider is unable to locate a Medicaid number for the mother or infant 45 days after form H3038 was faxed, the provider can contact the HHSC Central Processing Center (CPC) in one of the following ways:

- By email at CPC@hhsc.state.tx.us, with a copy to Gordon.Cappon@hhsc.state.tx.us
- By telephone at 1-866-291-1258

CPC needs the following information to respond to requests or inquiries. Providers should submit the information only once. All submissions must be sent in a secure manner. If there are multiple inquiries that are over 45 days, providers can submit them together.

Required information includes the following:

- CHIP perinatal case number
- Mother's name as it appears on her CHIP Perinatal card
- Dates of service
- Date Form H3038 was faxed to MAXIMUS

- Baby's first and last name
- Baby's date of birth
- Name and telephone number of the person completing the request

CPC will research inquiries and respond to the provider within 10 business days. This time frame is an approximation and may only apply if all information, including complete contact information, is provided and fewer than 25 names were submitted.

4.5.3.3 Mother's eligibility

For mothers who currently receive CHIP perinatal and have an income at or below 185 percent of the FPIL, and who receive Emergency Medicaid coverage, providers can check eligibility by performing an eligibility verification on the TMHP website at www.tmhp.com or by calling the TMHP AIS at 1-800-925-9126.

4.5.3.4 Newborn's eligibility

For CHIP Perinatal newborns with a family income at or below 185 percent of the FPIL, providers can obtain eligibility information and the newborn's PCN by performing an eligibility verification on the TMHP website or by calling the TMHP Contact Center at 1-800-925-9126.

TMHP cannot provide CHIP Perinatal Program eligibility information for the newborn or mother, regardless of the client's income level. For CHIP Perinatal Program eligibility information, contact the CHIP health plan.

A report of birth remains an important step to ensure timely Medicaid eligibility for the newborn. A birth must be reported to the state via the typical birth registry process (e.g., use of Texas Electronic Registration system [TER]). In TER, the screen containing the Medicaid/CHIP number should continue to be populated with the mother's alpha-numeric CHIP Perinatal Program number (e.g., J12345678). In addition, a mother can report the birth by calling 1-877-KIDS-NOW (1-877-543-7669).

4.5.4 Submission of Birth Information to Texas Vital Statistics Unit

Hospital providers must submit birth registry information to the DSHS Vital Statistics Unit in a timely manner. Once received by the Vital Statistics Unit, birth information is transmitted to the state's eligibility systems, so a PCN (Medicaid number) can be issued for newborns at or below 185 percent FPIL. Hospitals should use the CHIP Perinatal health plan ID to enter the mother's CHIP perinatal coverage ID number in the Medicaid/CHIP number field on the Texas Electronic Registration (TER) screen. This number will appear as an alpha-numeric combination, starting with a letter followed by eight digits. For example: G12345678.

For more information, go to the HHSC website at www.hhsc.state.tx.us/chip/perinatal/VitalStatisticsInstructions_062807.pdf, or call Texas Vital Statistics at 1-800-452-9115.

4.6 Medically Needy Program (MNP)

The MNP with spend down is limited to children 18 years of age and younger and pregnant women.

The MNP provides Medicaid benefits to children (18 years of age and younger) and pregnant women whose income exceeds the eligibility limits under Temporary Assistance for Needy Families (TANF) or one of the Medical Assistance Only (MAO) programs for children but is not enough to meet their medical expenses. Coverage is available for services within the amount, duration, and scope of Texas Medicaid. Individuals are considered adults beginning the month following their 19th birthday.

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

- Pregnant women.

- Children 18 years of age and younger.

MNP provides access to Medicaid benefits. Applications are made through HHSC. HHSC determines eligibility for the appropriate Medicaid program.

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

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

Newborns of mothers who must meet a spend down before becoming eligible for Medicaid are *not* automatically eligible for the full year of newborn coverage. The newborn and mother are eligible for the birth month and the two following months. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in subsection 3.2.4, "Newborn Care" in *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for these newborns.

4.6.1 Spend Down Processing

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

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

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

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

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

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

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

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

Clients have 30 days to submit their bills or completed claim forms. Thirty-day extensions are available to the client as necessary to gather all needed information. The provider can assist by furnishing the additional information to the applicant.

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

- Providing clients with current itemized statements or completed claim forms.
- Encouraging clients to submit *all* of their medical bills or completed claim forms incurred from *all* providers at the same time.
- Submitting manual claim forms directly to MNC or to applicants for the MNP, that can be used to meet spend down.

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

MNC informs the applicant and HHSC when the spend down is met. HHSC certifies the applicant for Medicaid and sends the Medicaid Identification form to the applicant when Medicaid eligibility is established. The TMHP MNC mails notification letters to providers when clients have met spend down and TMHP has not yet received any claim for the client's bills. The notification letter states that an invoice was submitted for the spend down and that the provider should submit claims for any bills that fall within the indicated spend down month. Clients are encouraged to inform medical providers of their Medicaid eligibility and make arrangements to pay the charges used to meet the spend down amount. When notified of Medicaid eligibility, the provider asks if the client has retroactive eligibility for previous periods. All bills submitted to MNC are returned to the client, except for claim forms. An automated letter specific to the client's spend down case is attached, indicating which:

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

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

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

4.6.2 Closing an MNP Case

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

- Bills were not received within the designated time frame (usually 30 days from the date on which the case is established by the HHSC worker).

- The client failed to provide requested additional case/billing information within 30 days of the MNC request date.
- Insufficient charges were submitted to meet spend down, and the client did not respond to a request for additional charges to be submitted within 30 days of the notification letter.

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

Note: *For information regarding the Medically Needy Program for CSHCN Services Program clients refer to the CSHCN Services Program Provider Manual.*

4.7 Medicaid Buy-in for Children (MBIC) Program

The MBIC program is mandated by S.B. 187, 81st Legislature, Regular Session, 2009, to provide acute care Medicaid coverage for children who are 18 years of age and younger and have disabilities. This program creates a state option for children who are ineligible for Supplemental Security Income (SSI) for reasons other than disability.

Children with disabilities must meet the following requirements to be eligible for MBIC:

- Be 18 years of age or younger.
- Have a family income that is no more than 300 percent of FPL before allowable deductions.
- Meet citizenship, immigration, and residency requirements.
- Be unmarried.
- Not reside in a public institution.

Exception: *Clients who are enrolled in the MBIC program before they enter a nursing facility or intermediate care facility for persons with mental retardation or related conditions (ICF-MR) will continue to receive MBIC benefits until eligibility for the appropriate institutional Medicaid program is determined.*

MBIC clients will be enrolled as Medicaid fee-for-service. MBIC clients are identified by Type Program (TP) 88 on the Your Texas Benefits Medicaid card. MBIC clients have access to the same benefits as Medicaid clients who have disabilities. Claims and prior authorization requests for MBIC clients may be submitted according to current guidelines for Medicaid fee-for-service as indicated in this manual.

MBIC benefits are available to enrolled clients through the end of the month that contains their nineteenth birthday. Clients whose birthday falls on the last day of February of a leap year (e.g., February 29, 2004) will be eligible for benefits through the end of March following their nineteenth year.

4.8 Texas Medicaid Wellness Program

High-cost/high-risk fee-for-service (FFS) and managed care clients may be eligible to receive targeted care management services through the Texas Medicaid Wellness Program. The Wellness Program replaces the Disease Management program that was mandated by Human Resources Code 32.057 & 059. The Wellness Program administrator is McKesson Health Solutions.

The goal of the Wellness Program is to promote improved health outcomes by supporting and sustaining the client-provider relationship. The Wellness Program will contact Medicaid high-cost/high-risk clients to provide comprehensive care management services regardless of disease condition. The Wellness Program also has a diabetes self-management training (DSMT) component and will offer 10 hours of DSMT plus 3 hours nutritional counseling to all clients who have diabetes. Additionally, clients who have a body mass index (BMI) above 25 will receive vouchers for a weight loss program.

The Wellness Program offers the following:

- Provider portal
- Practice support facilitators
- Collaborative learning
- Support for practice transformation initiatives

Providers must submit claims and prior authorization requests for Wellness Program clients following the guidelines for Medicaid FFS services as defined in this manual or modified by website articles.

Providers may refer potential clients to the Wellness Program at 1-877-530-7756.

4.9 Women's Health Program (WHP)

The goal of the WHP 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. Not all Medicaid family planning benefits are payable under WHP.

The WHP provides an annual family planning exam, family planning services, and contraception for women who meet the following qualifications:

- Are from 18 through 44 years of age
- U.S. citizens or eligible immigrants
- Reside in Texas
- Do not currently receive full Medicaid benefit (including Medicaid for pregnant women), CHIP, or Medicare Part A or B
- Have a household income at or below 185 percent of the federal poverty level
- Are not pregnant
- Are not sterile, infertile, or unable to get pregnant because of medical reasons
- Do not have private health insurance that covers family planning services (unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person)

Refer to: Subsection 3.2, "WHP Overview" in the *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

4.10 Medicaid for Breast and Cervical Cancer (MBCC)

Through MBCC, the state of Texas provides full 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 (NBCCEDP) and were found to need treatment for breast or cervical cancer, including precancerous conditions. The goal of the program is to improve timely access to breast and cervical cancer treatment for uninsured women identified by NBCCEDP.

DSHS receives the CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services (BCCS) program.

4.10.1 Initial MBCC Program Enrollment

A woman may be eligible for *initial* enrollment in the MBCC Program if she has active disease as indicated by a biopsy-confirmed precancerous or cancerous breast or cervical diagnosis as specified in "Medicaid for Breast and Cervical Cancer Guidelines for Determination of Qualifying Diagnosis," which is available on the DSHS website at www.dshs.state.tx.us/chscontracts/pdf/MBCCQualifyingDx072009.pdf.

Women who only require monitoring for hormonal treatment or triple negative receptor breast cancer (TNRBC) do not qualify for *initial* MBCC enrollment.

4.10.2 MBCC Program Eligibility

To be eligible for MBCC, a woman must be diagnosed and in need of treatment for one of the following biopsy-confirmed breast or cervical cancer diagnoses:

- Grade 3 cervical intraepithelial neoplasia (CIN III)
- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

In addition, a woman may be eligible for MBCC with a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

After a woman has received an eligible breast or cervical cancer diagnosis from a provider, a BCCS provider must review her diagnosis to help determine her eligibility for MBCC. Once a BCCS provider has reviewed the diagnosis, her application is sent to HHSC to determine eligibility for the program. The client cannot apply for MBCC at an HHSC benefits office.

In addition to having received an eligible diagnosis, a woman must meet the following criteria to qualify for benefits:

- A household income at or below 200 percent of the FPL
- 64 years of age or younger
- U.S. citizen or eligible immigrant
- Uninsured or otherwise not eligible for Medicaid

A woman who is eligible to receive Texas Medicaid under MBCC receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

4.10.3 Continued MBCC Program Eligibility

After a woman is enrolled in the MBCC program, eligibility may *continue* if she meets one of the following criteria:

- She is being treated for active disease as defined above,
- She has completed active treatment while in MBCC and is currently receiving hormonal treatment,
- She has completed active treatment while in MBCC and is currently receiving active disease surveillance for TNRBC.

A woman may continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer. Women who are no longer in MBCC may reapply if they are diagnosed with a new breast or cervical cancer or a metastatic or recurrent breast or cervical cancer.

Note: *Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression in order quickly to treat cancerous and precancerous conditions that arise from the presence of a previously diagnosed TNRBC.*

If the client's cancer is in remission and the physician determines that the client requires only routine health screening for a breast or cervical condition (e.g. annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the client is not considered to be receiving treatment; and MBCC coverage will not be renewed. A client who is subsequently diagnosed with a new, metastatic, or recurrent breast or cervical cancer may reapply for MBCC benefits.

4.11 Medicare and Medicaid Dual Eligibility

MQMB clients are eligible for Medicaid benefits not covered by Medicare in addition to Medicaid payment of the Medicare deductible and/or coinsurance.

QMB clients are not eligible for Medicaid benefits other than the Medicare deductible and coinsurance liabilities and payment of the Medicare Part B premium. Certain clients also receive payment of Medicare Part A premium. Clients limited to QMB are not eligible for THSteps or CCP Medicaid benefits.

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

Refer to: Section 6: Claims Filing (*Vol. 1, General Information*) for more information about filing claims for MQMBs and QMBs.

4.11.1 QMB/MQMB Identification

The term "QMB" or "MQMB" on the Your Texas Benefits Medicaid card website indicates the client is a Qualified Medicare Beneficiary or a Medicaid Qualified Medicare Beneficiary. The Medicare Catastrophic Coverage Act of 1988 requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals determined to be QMBs or MQMBs who are enrolled in Medicare Part A and meet certain eligibility criteria (see 1 TAC §§358.201 and 358.202).

Refer to: Form 4.1, "Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)" in this section for examples of the Your Texas Benefits Medicaid Card.

4.11.2 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 Texas Medicaid pay all Medicare deductible and coinsurance payments to nursing facilities, regardless of whether the provider has filed the claims as assigned to Medicare. The following 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.

4.11.3 Clients Without QMB or MQMB Status

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

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

Refer to: Subsection 2.6, "Medicare Crossover Claim Reimbursement" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.11.4 Medicare Part C

Providers can receive information about a client's Medicare Part C eligibility through TexMedConnect or EDI. In response to an eligibility inquiry, providers receive the client's Medicare Part C eligibility effective date, end date, and add date.

HHSC contracts with some Medicare Advantage Plans (MAPs) and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the HMO and must not be billed to TMHP or a Medicaid client.

TMHP now processes certain claims for clients enrolled in a Medicare Advantage Plan (Part C).

Refer to: Subsection 6.13, "Medicare Claims" in Section 6, "Claims Filing" (*Vol.1, General Information*).

A list of MAPs that have contracted with HHSC is available in the "EDI" section of the TMHP website at www.tmhp.com. The list will be updated as additional plans initiate contracts.

4.12 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.

4.13 Third Party Liability (TPL)

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

To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third party insurance that the provider knows about or should know about before billing Texas Medicaid. All claims for clients with other insurance coverage must reference the information (see subsection 6.12, "Other Insurance Claims Filing" in Section 6, "Claims Filing" [*Vol. 1, General Information*]), regardless of whether a copy of the EOB from the insurance company is submitted with the claim.

Refer to: Subsection 7.2, "Refunds to TMHP" in Section 7, "Appeals" (*Vol. 1, General Information*) for information regarding refunds to TMHP resulting from other insurance payments and conditions surrounding provider billing of third party insurers.

Eligible clients enrolled in private HMOs must not be charged the co-payment amount because the provider has accepted Medicaid assignment.

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

A TPR is a source of payment for medical services other than Medicaid, the client, and non-TPR sources. TPR includes payments from any of the following sources:

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

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

Refer to: Subsection 4.13.4, "THSteps TPR Requirements" in this section for THSteps TPR exceptions.

Family planning (including Title XIX and the DSHS Family Planning Program) services providers cannot bill a client's TPRs before filing the claim with TMHP. Federal regulations protect the client's confidential choice of birth control and family planning services. Confidentiality is jeopardized when seeking information from TPRs.

SHARS providers are not required to file claims with private insurance before billing Medicaid.

Early Childhood Intervention (ECI) providers are not required to file claims with private insurance before billing Medicaid for Targeted Case Management services.

Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.

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

- DARS, Blind Services
- Texas Kidney Health Care Program
- Crime Victims' Compensation Program
- Muscular Dystrophy Association
- CSHCN Services Program

- Texas Band of Kickapoo Equity Health Program
- Maternal and Child Health (DSHS Family Planning Program)
- State Legalization Impact Assistance Grant (SLIAG)
- Adoption Agencies
- Home and Community-based Waivers Programs through DADS

Note: *Claims for clients who are seeking disability determination must be submitted to DARS for consideration of reimbursement. Refer to the DARS website at www.dars.state.tx.us for additional information about disability determinations and claims filing.*

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

If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP using the filing deadlines identified under subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

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

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

Medicaid-eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered by Texas Medicaid. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to TMHP for any additional allowable amount.

4.13.1 Your Texas Benefits Medicaid Card

Client TPR and other insurance information may be verified using the Your Texas Benefits Medicaid card website at www.yourtexasbenefitscard.com.

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

Providers that are aware that a client has other health insurance that is not indicated on the Your Texas Benefit Medicaid card website must notify TMHP of the details concerning the type of policy and scope of benefits.

Providers can notify TMHP by calling TPR at 1-800-846-7307, Option 2, sending a fax to (512) 514-4225, or submitting Form 4.4, "Other Insurance Form" to the following address:

Texas Medicaid & Healthcare Partnership
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

4.13.2 Workers' Compensation

Payment of covered services under Workers' Compensation is considered reimbursement in full. The client must not be billed. Services not covered by Workers' Compensation must be billed to TMHP.

4.13.3 Adoption Cases

- TMHP/Medicaid, not the adoption agency, should be billed for all medical services that are a benefit of Texas Medicaid.

- If a claim is inadvertently sent to the adoption agency before it is sent to TMHP, TMHP must receive the claim within 95 days of the date of disposition from the adoption agency denial, payment, request for refund or recoupment, to be considered for payment.
- If the adoption agency inadvertently makes a payment for services covered by Medicaid, the provider should refund the payment to the agency.

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

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

4.13.4 THSteps TPR Requirements

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

TMHP processes the claim for payment, determines whether a TPR exists, and seeks payment from the TPR.

Refer to: Subsection 4.5.2, "Third Party Resources (TPR)" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information.

4.13.5 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 paper claim form, and Blocks 31-34 on the UB-04 CMS-1450 paper claim form.

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

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

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

4.13.5.1 Accident Resources, Refunds

Acting on behalf of HHSC, TMHP has specific rights of recovery from any settlement, court judgment, or other resources awarded to a client with Medicaid coverage (Texas Human Resources Code, Chapter 32.033). In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for Medicaid payments. If a provider receives a portion of a settlement for services also paid by Medicaid, the provider must make a refund to TMHP. Any provider filing a lien for the entire billed amount must contact the TPL/Tort Department at TMHP for Medicaid postpayment activ-

ities to be coordinated. A provider may not file a lien for the difference between the billed charges and the Medicaid payment. A lien may be filed for services not covered by Medicaid. A lien is the liability of the client with Medicaid coverage.

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

The provider furnishes TMHP with the following information:

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

This information enables TMHP to pursue reimbursement from any settlement. Providers must use the Form 4.7, "Tort Response Form" to report accident information to TMHP. When the form is completed, providers must remit it to the TMHP TPL/Tort Department (the address and fax number are on the form).

Providers may contact the TMHP TPL/Tort Department by calling 1-800-846-7307, Option 3, sending a fax to (512) 514-4225, or mailing to the following address:

Texas Medicaid & Healthcare Partnership
TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

4.13.6 Third Party Liability - Tort

HHSC contracts with TMHP to administer third party liability cases. To ensure that Texas Medicaid is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases. TMHP also identifies and recovers Medicaid expenditures in casualty cases involving Medicaid clients.

The Human Resources Code, chapter 32, section 32.033 establishes automatic assignment of a Medicaid client's right of recovery from personal insurance as a condition of Medicaid eligibility.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, Medicaid clients, and state agencies. Referrals should be submitted to the following address:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX, 78720-2948
Fax: (512) 514-4225

Referrals must be submitted on Form 4.5, "Authorization for Use and Release of Health Information (2 pages)" in this section.

TMHP releases Medicaid claims information when an HHSC Authorization for Use and Release of Health Information Form is submitted. The form must be signed by the Medicaid client. Referrals are processed within ten business days.

Refer to: Form 4.5, "Authorization for Use and Release of Health Information (2 pages)" at the end of this section.

An attorney or other person who represents a Medicaid client in a third party claim or action for damages for personal injuries must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid client, or from the date on which a potential third party is identified. The following information must be included:

- The Medicaid client's name, address, and identifying information.
- The name and address of any third party or third party health insurer against whom a third party claim is or may be asserted for injuries to the Medicaid client.
- The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the Medicaid client for which a third party may be liable for payment, whether or not the claim was submitted to or paid by TMHP.

If any of the information described above is unknown at the time the initial notice is filed, it should be indicated on the notice and revised if and when the information becomes known.

An authorization to release information about the Medicaid client directly to the attorney or representative may be included as a part of the notice and must be signed by the Medicaid client. The HHSC Authorization for Use and Release of Health Information Form must be used.

HHSC must approve all trusts before any proceeds from a third party are placed into a trust.

Providers may direct third party liability questions to the TMHP TPL/Tort Contact Center at 1-800-846-7307, Option 3.

4.13.6.1 Providers Filing Liens for Third Party Reimbursement

Any provider filing a lien for the entire billed amount must contact the TMHP TPL/Tort Department for Medicaid postpayment activities to be coordinated.

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

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

4.13.6.2 Informational Claims

If providers determine that a third party may be liable for a Medicaid client's accident-related claim, they can submit an informational claim to the TMHP Tort Department to indicate that a third party is being pursued for payment. This allows providers to secure the 95-day claims filing deadline in the event that the payment is not received from the third party.

TMHP processes informational claims for all claims administered by TMHP, including fee-for-service claims and carve-out services. TMHP does not process informational claims for managed care claims that are administered by the client's MCO or dental plan.

4.13.6.3 Submission of Informational Claims

Providers must submit informational claims to TMHP:

- On a CMS-1450 UB-04 or CMS-1500 paper claim form. Informational claims cannot be submitted to TMHP electronically or by fax.
- On an Informational Claims Submission Form. Providers should complete only one form per client, regardless of how many separate informational claims are being submitted with the form.
- By certified mail.
- Within the 95-day claims filing deadline. Informational claims will not be accepted after the 95-day claims filing deadline.

Refer to: Form 4.3, "Informational Claims Submission Form" in this section.

Providers must complete either the Insurance Information field (liable third party) or the Attorney Information field on the Informational Claims Submission Form.

Providers must send the informational claims and the Informational Claims Submission Form by certified mail to TMHP at:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

TMHP will send providers a letter to confirm that the informational claim was received. The letter will provide the date on which TMHP must receive a request from the provider to convert the informational claim to a claim for payment. If TMHP receives an informational claim that cannot be processed, TMHP will notify the provider of the reason.

Providers can inquire about the status of an informational claim by calling the TMHP TPL/Tort Department at 1-800-846-7307, Option 3. If a provider has not received confirmation that TMHP has received the informational claim within 30 days, the provider should contact the TMHP TPL/Tort Department at 1-800-846-7307, Option 3 to validate the status of the request.

4.13.6.4 Informational Claim Converting to Claims for Payment

If providers have submitted an informational claim to TMHP but have not received payment from the liable third party, they must make one of the following determinations and notify TMHP within 18 months of the date of service:

- Providers can continue to pursue a claim for payment against the third party and forego the right to convert an informational claim to a claim for payment by Texas Medicaid.
- Providers can submit a request to convert to the informational claim to a claim for payment consideration from Texas Medicaid.

Providers that decide to convert an informational claim to a claim for payment consideration must submit a request to TMHP. The request must be submitted:

- On provider letterhead.

- With the client's name and Medicaid ID, the date of service, and total billed amount that was originally submitted on the UB-04 CMS-1450 or CMS-1500 paper claim form
- By fax or by mail to:

TMHP/Tort Department
P0 Box 202948
Austin, TX 78720-2948
Fax: (512) 514-4225

TMHP will not accept any conversion request that is submitted more than 18 months after the date of service, regardless of whether an informational claim was submitted timely to TMHP. All payment deadlines are enforced regardless of whether the provider decides to pursue a third party claim. The conversion of informational claims to actual claims is not a guarantee of payment by TMHP.

4.14 Health Insurance Premium Payment (HIPP) Program

The HIPP Program reimburses for the cost of medical insurance premiums. A Medicaid client is eligible for the HIPP Program when Medicaid finds it more cost effective to reimburse a Medicaid client's group health insurance premiums than to reimburse his or her medical bills directly through Medicaid.

By ensuring access to employer sponsored health insurance, individuals who are eligible for the HIPP Program may receive services that are not normally covered through Medicaid. Also, members of the family who are not eligible for Medicaid may be eligible for the HIPP Program.

Providers can benefit from this program by helping the uninsured population, saving money for the state of Texas, and receiving a higher payment from the group health insurance carrier. Providers can increase HIPP Program enrollment by displaying brochures to educate their Medicaid clients about the program.

For more information, call the TMHP-HIPP Program at 1-800-440-0493 or visit www.gethipptexas.org.

4.15 Long-Term Care Providers

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

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

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

4.16 State Supported Living Centers

Inpatient hospital care for individuals who are eligible for Supplemental Security Income (SSI) Medicaid and reside in a State Supported Living Center (SSLC) must be billed to TMHP. Medicaid providers who render off-campus acute care services to Medicaid-eligible SSLC residents are also required to submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by DADS.

Claims and prior authorization requests for acute care services that are rendered to these clients must be submitted directly to Medicaid.

Providers may contact DADS for assistance or information about billing procedures for state school services.

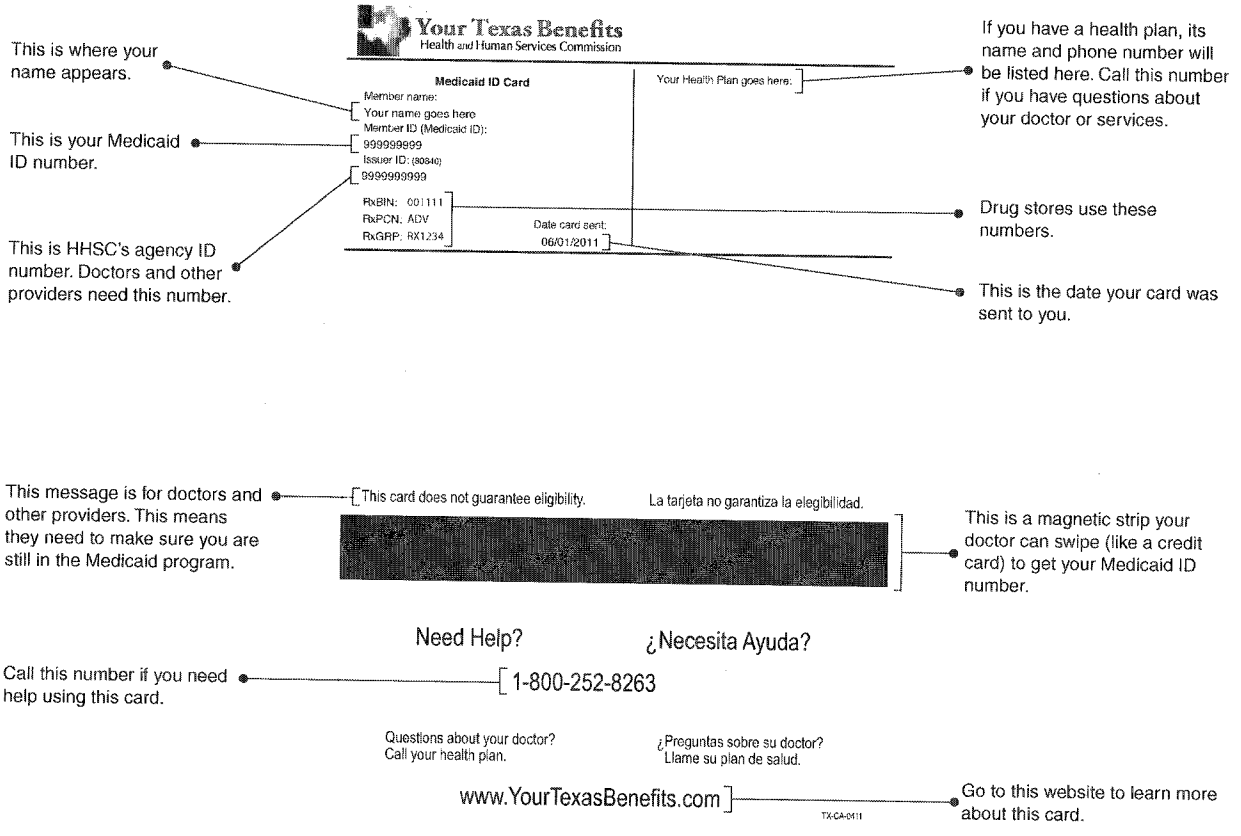
4.17 Forms

4.1 Your Texas Benefits Medicaid Card - Your New Medicaid ID (English)

TEXAS
Health and Human
Services Commission

Your Texas Benefits Medicaid card – Your new Medicaid ID

- The Your Texas Benefits Medicaid card takes the place of the paper Medicaid ID (Form 3087) you've been getting in the mail each month. July will be the last month you will get the paper form.
- Each person who gets Medicaid gets a card. For example, if you have 3 people in your home who get Medicaid, there should be 3 cards – one for each person.
- Take this card when you go to a Medicaid doctor, dentist, or drug store.
- Carry and protect the card just like your driver's license or a credit card.
- If you lose the card, call 1-855-827-3748. The number is free to call.
- The sample below tells you more about what's on the front and back of your card:



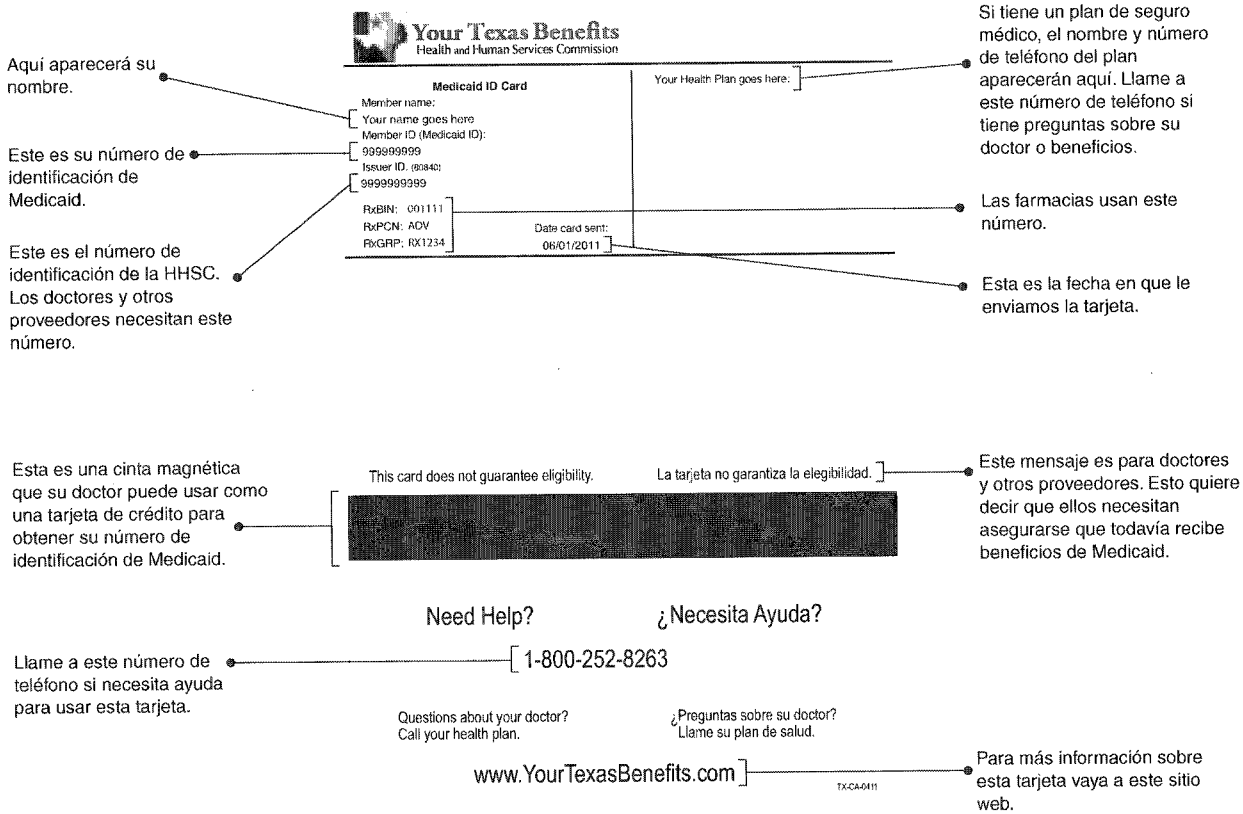
TX-INS-2-0411

4.2 Your Texas Benefits Medicaid Card - Your New Medicaid ID (Spanish)

TEXAS Health and Human Services Commission

Su tarjeta de beneficios de Medicaid
Your Texas Benefits
Su nueva identificación de Medicaid

- En vez de la tarjeta de identificación de Medicaid (Forma 3087) que recibe por correo cada mes, ahora recibirá la tarjeta de beneficios de Medicaid *Your Texas Benefits*. La última vez que recibirá su identificación de Medicaid en papel será en el mes de julio.
- Cada persona que recibe beneficios de Medicaid recibirá una tarjeta. Por ejemplo, si hay 3 personas en su hogar que reciben beneficios de Medicaid, debe haber 3 tarjetas, una para cada persona.
- Lleve esta tarjeta con usted cuando vaya a un doctor, dentista o farmacia de Medicaid.
- Lleve la tarjeta con usted en todo momento y protéjala como haría con su licencia de conducir y sus tarjetas de crédito.
- Si pierde su tarjeta llame al 1-855-827-3748. Las llamadas son gratis a este número de teléfono.
- Los ejemplos de abajo le dan más información sobre la información que verá en la parte del frente y de atrás de su tarjeta:



TX-INS-2-0411

4.3 Informational Claims Submission Form

TMHP

Informational Claims Submission Form

You must complete either the Attorney Information section or the Insurance Information section.
You must submit only one form per client, even if you are submitting more than one informational claim.
*All of the fields marked with an * are required. Forms that are submitted without the required fields will be returned for correction.*

Date / /

Client Information

Name: (Last, First, MI)

*Medicaid number:	Date of birth:

Accident Information

*Date of loss: / /	Type of accident:

Describe the injuries that the client received in the accident:

Attorney Information *You must complete either this section or the Insurance Information section.*

*Name:	Contact name:	
Street address:		
City:	State:	ZIP Code:
*Telephone:	Fax:	

Insurance Information *You must complete either the Attorney Information section or this section.*

*Company name:	Contact name:	
Street Address:		
City:	State:	ZIP Code:
Adjuster's name:	Claim number:	
Policyholder name:	Policy number:	
*Telephone:	Fax:	

Provider Information

Name:	Telephone:	
Street address:		
City:	State:	ZIP Code:
*TPI:	NPI:	

Mail completed copy to:

Tort Department
PO Box 202948
Austin, TX 78720-2948
1-800-846-7307, Option 3

Effective Date_02222010/Revised Date_02032010

4.4 Other Insurance Form

OTHER INSURANCE FORM

Client Name: _____

Client Medicaid Number: _____

Insurance Company Name: _____

Insurance Company Address 1: _____

Insurance Company Address 2: _____

Insurance Company Phone #: _____

Policy Holder Name: _____

Policy Number: _____ Policy Holder SSN: _____

Employer Name: _____ Employer Phone: _____

Group Number: _____

Type of Coverage: _____

Ins. Eff. Date: _____ Ins. Term. Date: _____

List any family members that are on the 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 78720-2948

4.5 Authorization for Use and Release of Health Information (2 pages)

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

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 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.

4.6 Authorization for Use and Release of Health Information (Spanish) (2 pages)

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

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) _____

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

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 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.

4.7 Tort Response Form

Tort Response Form

Client Information						
Today's date: / /			Client ID number:			
Date of birth: / /			Social Security Number:			
Last name:			First name:			
Information Provided By:						
Attorney ☐	Insurance ☐	Provider ☐	Recipient ☐	HHSC ☐	DSHS ☐	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 78720-2948
Fax: 1-512-514-4225

Effective Date_01012008/Revised Date_11192008

SECTION 5: FEE-FOR-SERVICE PRIOR AUTHORIZATIONS

5.1 General Information About Prior Authorization

Some fee-for-service Medicaid services require prior authorization as a condition for reimbursement. Information about whether a service requires prior authorization, as well as prior authorization criteria, guidelines, and timelines for the service, is contained in the handbook within Volume 2 that contains the service.

Prior authorization is not a guarantee of payment. Even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons, e.g., the client is ineligible on the date of service (DOS) or the claim is incomplete. Providers must verify client eligibility status before providing services.

In most instances prior authorization must be approved before the service is provided. Prior Authorization for urgent and emergency services that are provided after business hours, on a weekend, or on a holiday may be requested on the next business day. TMHP considers providers' business hours as Monday through Friday, from 8 a.m. to 5 p.m., Central Time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary denials, the request for prior authorization must contain correct and complete information, including documentation of medical necessity. The documentation of medical necessity must be maintained in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for prior authorization.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for the TMHP-approved holidays.

Note: *Authorization requests for services administered by a client's managed care organization (MCO) or dental plan must be submitted to the client's MCO or dental plan according to the guidelines that are specific to the plan under which the client is covered.*

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prior authorizations.

5.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Automated Inquiry System (AIS) or TexMedConnect to verify eligibility frequently while providing services to the client. Client eligibility can also be verified through the Your Texas Benefits Medicaid card website at www.yourtexasbenefitscard.com. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (*Vol. 1, General Information*).

5.1.2 Prior Authorization Requests for Newly Enrolled Providers

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

Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the date the new provider identifier is issued (add date) to obtain authorization for services that have already been performed. Providers should refer to specific handbook sections for details about authorization requirements, claims filing, and timeframe guidelines for authorization request submissions.

Refer to: Section 1: Provider Enrollment and Responsibilities (*Vol. 1, General Information*).

5.1.3 Prior Authorization for Services Rendered Out-of-State

Texas Medicaid covers medical assistance services that are provided to eligible Texas Medicaid clients while they are in a state other than Texas; however, clients are not covered if they leave Texas to receive out-of-state medical care that can be received in Texas. Services that are provided outside of the state are covered by Texas Medicaid to the same extent that medical assistance is furnished and covered in Texas when the service meets one or more requirements of Texas Administrative Code (TAC) Title 1 §354.1440.

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

Services that are rendered outside of the state must be prior authorized by Texas Medicaid, and TMHP must receive claims from out-of-state providers within 365 days of the date of service. Out-of-state providers that seek reimbursement for services that are rendered outside of the state must submit a Texas Medicaid Provider Enrollment application and be approved for enrollment in Texas Medicaid.

Transplant services that are provided out-of-state but available in Texas will not be reimbursed by Texas Medicaid. When requesting an out-of-state prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an out-of-state pre-transplant evaluation.

Medical assistance and transplant services that are provided to eligible Texas Medicaid clients must meet the criteria included in subsection 1.6, "Enrollment Criteria for Out-of-State Providers" (*Vol. 1, General Information*). If services are rendered to eligible Texas Medicaid clients that do not meet the criteria, the services are not a benefit of Texas Medicaid and will not be considered for reimbursement.

Refer to: Subsection 1.6, "Enrollment Criteria for Out-of-State Providers" in Section 1, "Provider Enrollment and Responsibilities" (*Vol.1, General Information*).

Subsection 2.5, "Out-of-State Medicaid Providers" in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol.1, General Information*).

5.1.4 Prior Authorization Requests for Clients with Private Insurance

If a client's primary coverage is private insurance and Medicaid is secondary but prior authorization is required for Medicaid reimbursement, providers must follow the guidelines and requirements listed in the handbook for that service.

5.1.5 Prior Authorization Requests for Clients with Medicare/Medicaid

If a client's primary coverage is Medicare, providers must always confirm with Medicare whether a service is a Medicare benefit for the client.

If a service that requires prior authorization from Medicaid is a Medicare benefit and Medicare approves the service, prior authorization from TMHP is not required for reimbursement of the coinsurance or deductible. If Medicare denies the service, then prior authorization is required. TMHP must receive a prior authorization request within 30 days of the date of Medicare's final disposition. The Medicare Remittance Advice and Notification (MRAN) that contains Medicare's final disposition must accompany the prior authorization request.

If a service requires prior authorization through Medicaid and the service is not a benefit of Medicare, providers may request prior authorization from TMHP before receiving the denial from Medicare.

Note: *Refer to the appropriate handbooks in this manual for additional prior authorization guidelines for clients with dual eligibility.*

5.1.6 Prior Authorizations for Personal Care Services (PCS)

Before sending a prior authorization request for personal care services to TMHP, the Texas Department of State Health Services (DSHS) will fax the communication tool to the provider. The provider must verify that the information listed on the tool is accurate. If any information on the communication tool is inaccurate, the provider must call the DSHS case manager listed on the tool within three business days of receipt to explain the inaccuracy. The DSHS case manager will correct the communication tool and will fax the updated tool to the provider. The provider must review the updated communication tool and call the DSHS case manager if any inaccuracies remain.

If the provider does not contact the DSHS case manager within three business days of receipt of the communication tool, the case manager will send a prior authorization request to TMHP to have the authorization issued with the information provided on the communication tool.

Important: *If a provider fails to notify the DSHS case manager of inaccurate information within three business days of receipt of the communication tool, HHSC will not consider making changes to authorizations for past dates of service.*

It is the PCS provider's responsibility to know the prior authorization period for each client who has an open authorization and to ensure that, before the authorization expires, a DSHS case manager has conducted a reassessment and extended the authorization through TMHP. If a provider has not received an updated provider notification letter from TMHP within 30 days of the authorization's expiration date, the provider should do one of the following:

- Call the TMHP PCS Prior Authorization Inquiry Line at 1-888-648-1517 and ask whether an authorization is in process.
- Call the TMHP PCS Client Line at 1-888-276-0702, Option 2, and ask for a referral to have DSHS conduct a reassessment.
- Call the DSHS regional office, and notify the DSHS case manager that a new authorization has not been received.

Clients can experience a gap in service if an authorization is not updated before it expires. Providers will not be reimbursed for services provided after an authorization has expired and before a new authorization has been issued.

Providers must retain current client information on file.

5.1.6.1 Verifying the Texas Provider Identifier (TPI) on PCS Authorizations

When an authorization notification letter is received by a PCS provider, the provider should verify that the correct TPI was used on the prior authorization for the PCS client. Providers must verify that the TPI on the prior authorization is correct for the location at which the client is receiving services.

Providers who provide services through the Agency option or the Consumer Directed Services (CDS) option must ensure that the TPI on the prior authorization is accurate for the option the client is using. If a provider discovers that the TPI used on the prior authorization is incorrect, the provider should contact the DSHS case manager and ask for the correct TPI to be submitted to TMHP.

5.1.7 Prior Authorization for Outpatient Self-Administered Prescription Drugs

Refer to: Subsection B.1.3, "Obtaining Outpatient Prescribed Drug Prior Authorization for FFS Clients" in Appendix B: Vendor Drug Program (*Vol. 1, General Information*).

5.2 Authorization Requirements for Unlisted Procedure Codes

Providers have the option to obtain prior authorization before rendering the service if all of the required information is available. When requesting a fee-for-service prior authorization for an unlisted procedure code, providers must submit the following information with the prior authorization request:

- Client's diagnosis.
- Medical records that show the prior treatment for this diagnosis and the medical necessity of the requested procedure.
- A clear, concise description of the procedure to be performed.
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested.
- Documentation that this procedure is not investigational or experimental.
- Place of service in which the procedure is to be performed.
- The physician's intended fee for this procedure including the manufacturer's suggested retail price (MSRP) or other payment documentation.

If any of this information is unavailable at the time the prior authorization is requested, the request will be returned as incomplete; however, this is not a denial of reimbursement. If the required information becomes available before the service is performed, the prior authorization request can be resubmitted, or the required medical necessity and payment documentation can be submitted with the claim after the service is provided to be considered for reimbursement.

The prior authorization number must appear on the claim when it is submitted to TMHP. Claims submitted without the appropriate prior authorization will be denied.

5.3 Benefit Code

A benefit code is an additional data element that identifies a state program.

Providers that participate in the following programs must use the associated benefit code when they submit prior authorizations:

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
Texas Health Steps (THSteps) Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1

*Agencies only—Benefit codes should not be used for individual family planning providers.

Program	Benefit Code
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) providers	EC1
Tuberculosis (TB) Clinics	TB1
Texas Medicaid Home Health Durable Medical Equipment (DME)	DM2
Case Management Mental Retardation (MR) providers	MH2

*Agencies only—Benefit codes should not be used for individual family planning providers.

5.4 Submitting Prior Authorization Forms

Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.

If essential fields are not completed, TMHP will return the original request to the provider and will document on the fax cover sheet the fields that must be completed by the provider before submitting the request to initiate the prior authorization process.

The following prior authorization request forms contain essential fields that must be completed by the provider:

- CCP Prior Authorization Request Form
- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

The following essential fields must be completed on the CCP Prior Authorization Request Form and Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form:

- Client's Name
- Client's Medicaid Number
- Supplier's Name
- Supplier's Texas Provider Identifier (TPI) and National Provider Identifier (NPI)
- HCPCS (Healthcare Common Procedure Coding System) Code

The CCP Prior Authorization Request Form states that if any portion of the form is incomplete, the form will be returned; however, as long as the essential fields on the form have been completed, TMHP Prior Authorization can initiate the prior authorization process.

If an essential field on any of these prior authorization forms is not completed, TMHP will send the provider a copy of the form along with a fax cover sheet that includes the following statement:

> *TMHP Prior Authorization could not process this request because the request form is missing (applicable essential field[s]). Please resubmit the request with this information for processing by TMHP.*

If the form is returned to TMHP with all essential fields completed, TMHP will initiate the prior authorization process.

5.5 Prior Authorization Submission Methods

Prior authorization requests can be submitted by fax, mail, telephone, and online through the TMHP website at www.tmhp.com. The methods to use to request the prior authorization depends on the service being requested.

5.5.1 Prior Authorization Requests Through the TMHP Website

Online prior authorization requests for some services in the following areas can be submitted through the TMHP website at www.tmhp.com:

- Home Health
- Comprehensive Care Inpatient Psychiatric (CCIP)
- CCP
- Ambulance
- Substance Use Disorder (SUD) (Abuse and Dependence) services

The benefits of submitting prior authorization requests through the TMHP website include:

- Online editing to ensure that the required information is being submitted correctly.
- The prior authorization number is issued within seconds of submission and confirms that the prior authorization request was accepted. Before providing services, providers must confirm that the prior authorization was approved.
- Notification of approvals and denials are available more quickly.
- Extension requests and status checks can be performed online for prior authorization requests that were submitted online.

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

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

Prior authorizations that are submitted online will be processed using the same guidelines as prior authorizations submitted by other methods.

Before providers can submit online prior authorization requests, providers must register on the TMHP website and assign an administrator for each Texas Provider Identifier (TPI) and National Provider Identifier (NPI), if one is not already assigned. Users who are configured with administrator rights automatically have permission to submit prior authorization requests.

The TPI administrator can assign submission privileges for nonadministrator accounts. Billing services and clearinghouses must obtain access to protected health-care information through the appropriate administrator of each TPI/NPI provider number for which they are contracted to provide services.

5.5.1.1 Document Requirements and Retention

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

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

Documentation requirements include, but are not limited to, the following:

- Documentation that supports the medical necessity for the service requested.
- Completion and retention in the client's medical record of all required prior authorization forms

- Adherence to signature and date requirements for prior authorization forms and other required forms that are kept in the client record, including the following:
  - All prior authorization forms completed and signed before the online prior authorization request is made
  - Original handwritten signatures (Computerized or stamped signatures are not accepted by Texas Medicaid.)
- A printed copy of the Online Request Form, which must be retained in the client's medical record

Any required documentation that is missing from the client's medical record subjects the associated payments for services to be recouped.

5.5.1.1.1 Acknowledgement Statement

Before submitting each prior authorization request, providers (and submitters on behalf of providers) must affirm that they have read, understood, and agree to the certification and terms and conditions of the prior authorization request.

Providers and submitters are separately held accountable for their declarations after they have acknowledged their agreement and consent by checking the "We Agree" checkbox after reviewing the certification statement and terms and conditions.

5.5.1.1.2 Certification Statement:

"The Provider and Authorization Request Submitter certify that the information supplied on the prior authorization form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Authorization Request Submitter understand that payment of claims related to this prior authorization will be from federal and state funds, and that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

"By checking 'We Agree' you agree and consent to the Certification above and to the TMHP 'Terms and Conditions.'"

5.5.1.1.3 Terms and Conditions:

"I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or U.S. Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by Medicaid for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charge. I certify that the services listed above are/were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

"Notice: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim, based on information provided on the Prior Authorization form, will be from federal and state funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state law."

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

5.5.2 Prior Authorization Requests to TMHP by Fax, Telephone, or Mail

When submitting prior authorization requests through fax or mail, providers must submit the requests on the approved form. If necessary, providers may submit attachments with the form. Providers must follow the guidelines and requirements listed in the handbook for the service. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Prior authorization requests must be signed and dated by a physician or dentist who is familiar with the client's medical condition before the request is submitted to TMHP. When allowed, prior authorizations must be signed and dated by an advanced practice registered nurse (APRN) or physician assistant (PA) who is familiar with the client's medical condition before the request is submitted to TMHP. Prior authorization requests for services that may be signed by a licensed health-care provider other than a physician, dentist, or when allowed by an APRN and PA, do not require handwritten signatures and dates. Electronic signatures from a registered nurse (RN) or therapist are acceptable when submitting therapy requests for CCP.

All signatures and dates must be current, unaltered, and handwritten. Computerized or stamped signatures and dates are not permitted. Prior authorization requests that are submitted without a handwritten signature and date will be denied. TMHP will not authorize any dates of services on the request earlier than the date of the provider's signature. The prior authorization request that contains the original signature must be kept in the client's medical record for future access and possible retrospective review. These documentation requirements also apply to telephone authorizations. To avoid delays, providers are encouraged to have all clinical documentation at the time of the initial telephone authorization request.

5.5.2.1 TMHP Prior Authorization Requests by Fax

Contact	Fax Number
Ambulance Authorization (includes out-of-state transfers)	1-800-540-0694
Ambulance Authorization Fax	1-512-514-4205
Home Health Services Fax	1-512-514-4209
CCP Fax	1-512-514-4212
CCIP	1-512-514-4211
CCIP Fax	1-512-514-4211
Outpatient Psychiatric Fax	1-512-514-4213
TMHP Special Medical Prior Authorization (SMPA) Fax (including transplants)	1-512-514-4213

5.5.2.2 TMHP Prior Authorization Requests by Telephone

Contact	Telephone Number
Home Health Services (including DME): Option 1 - TMHP in-home care customer service Option 2 - DME supplier with completed Title XIX form Option 3 - RN with completed POC	1-800-925-8957
Ambulance Authorization (including out-of-state transfers)	1-800-540-0694

5.5.2.3 TMHP Prior Authorization Requests by Mail

Contact	Address
Ambulance (includes out-of-state transfers)	Texas Medicaid & Healthcare Partnership Ambulance Prior Authorizations PO Box 200735 Austin, TX 78720-0735
CCP	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) Prior Authorization PO Box 200735 Austin, TX 78720-0735
Dental	Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917
Home Health Services	Texas Medicaid & Healthcare Partnership Home Health Services Prior Authorization PO Box 202977 Austin, TX 78720-2977
SMPA	Texas Medicaid & Healthcare Partnership Special Medical Prior Authorization 12357-B Riata Trace Parkway Austin, TX 78727 Fax: 1-512-514-4213

5.5.3 Radiology Prior Authorizations Through MedSolutions

MedSolutions, Inc., performs radiology prior authorization services on behalf of TMHP.

Refer to: Subsection 3.2.6, "Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) to determine which radiology services require a prior authorization through MedSolutions.

5.5.3.1 Online Prior Authorizations Through MedSolutions

Radiology prior authorization requests may be submitted through the MedSolutions website at www.medsolutionsonline.com. The TMHP website at www.tmhp.com also has links to the MedSolutions website.

5.5.3.2 Prior Authorizations to MedSolutions by Fax, Telephone, or Mail

When submitting radiology prior authorization requests to MedSolutions by fax or mail, providers must use the approved Form RL.1, "Radiology Prior Authorization Request Form" in the *Radiology and Laboratory Services Handbook* (*Vol 2., Provider Handbooks*).

Telephone: 1-800-572-2116
Fax: 1-800-572-2119
Mail: Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd., Suite 800
Franklin, TN 37067

5.5.3.3 Retroactive Authorization Requests

Retroactive authorization requests for outpatient diagnostic computed tomography (CT), magnetic resonance (MR), positron emission tomography (PET) and cardiac nuclear imaging services for Texas Medicaid fee-for-service clients must be submitted online to MedSolutions. The retroactive authorizations requests must be submitted to MedSolutions no later than 14 calendar days after the day on which

the study was completed, regardless of the method of submission. If the retroactive authorization request is submitted after the allotted time, the authorization request will not be processed. Providers can refer to the TMHP website for MedSolutions' contact information and methods of submission.

5.6 Verifying Prior Authorization Status

Prior Authorizations are processed based on the date the request is received. Requests with all required information can take up to three business days after the date of receipt for TMHP to complete the authorization process.

Providers can check the status of prior authorizations requested online through the TMHP website at www.tmhp.com.

Providers may also check status of prior authorizations that are issued by TMHP by using the following numbers.

Contact	Telephone Number
Personal Care Services (PCS) Prior Authorization Inquiry Line	1-888-648-1517
CCP and Home Health Status Line	1-800-846-7470
All other authorization requests	1-800-925-9126

To check the status of radiology prior authorization requests that are submitted to MedSolutions, providers should contact MedSolutions directly at www.medsolutionsonline.com or 1-800-572-2116.

5.7 Prior Authorization Notifications

TMHP sends a notification to the provider when the prior authorization is approved, denied, or modified. If TMHP receives prior authorization requests with incomplete or insufficient information, TMHP will ask the requesting provider to furnish the additional documentation needed before TMHP can make a decision on the request. If the requesting provider does not respond to the request for additional information, the prior authorization request will be denied. It is the requesting provider's responsibility to contact the appropriate provider, when necessary, to obtain the additional documentation.

5.8 Prior Authorization Denials Appeals Process

Prior Authorizations that are denied by TMHP can be resubmitted to the TMHP Prior Authorization Department with new or additional information for reconsideration.

If the request is denied a second time, or if the provider has no new or additional information, the provider may file an Administrative Appeal to HHSC. Providers must include a copy of the denial letter.

It is strongly recommended that providers maintain a list that details the prior authorizations, including:

- Client's name
- Client's Medicaid number
- Date of service
- Provider Identifier
- Items submitted

This information will be required if a provider needs to file an administrative review.

5.9 Closing a Prior Authorization

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

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

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

5.10 Submitting Claims for Services That Require Prior Authorization

Claims submitted for services that require prior authorization must indicate the authorization number, provider identifier, procedure codes, dates of service, required modifiers, number of units, and the amount for manually priced procedure codes as detailed on the authorization letter. If the prior authorization letter shows itemized details and the provider rendered all services listed, the details on the claim must match the details on the prior authorization letter.

Important: *Claims processing and payment may be delayed if the detailed information on the authorization letter and the claim details do not match exactly.*

Claims for prior authorized services must contain only one prior authorization number per claim. Prior authorization numbers must be indicated on the applicable electronic fields or in the following blocks for paper claim forms:

Paper Claim Form	Block for Prior Authorization Number
CMS-1500 (professional) claim form	Block 23
UB-04 CMS-1450 (institutional) claim form	Block 63
American Dental Association (ADA) claim form	Block 2
Family Planning 2017 claim form	Block 30

Refer to: Subsection 6.1.3, "TMHP Paper Claims Submission" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

5.11 Guidelines for Procedures Awaiting Rate Hearing

For procedure codes that require prior authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider handbook. Providers must obtain a timely prior authorization for services provided. Providers must not wait until the rate hearing process for the procedure codes is completed to request prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions. Providers are also responsible for meeting the initial 95-day filing deadline and for ensuring that the prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Claims for procedure codes awaiting a rate hearing are denied. No further action on the part of the provider is necessary. Once the rates are established, TMHP automatically reprocesses the claims. If the required prior authorization number is not on the claim at the time of reprocessing, the claim is denied for lack of prior authorization.

SECTION 6: CLAIMS FILING

6.1 Claims Information

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

Medicaid providers are also required to complete and sign authorized medical transportation forms (e.g., Form 3103, Individual Driver Registrant (IDR) Service Record, or Form 3111, Verification of Travel to Healthcare Services by Mass Transit) or provide an equivalent (e.g., provider statement on official letterhead) to attest that services were provided to a client on a specific date. The client presents these forms to the provider.

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

6.1.1 TMHP Processing Procedures

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

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

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

Medicaid claims are subject to the following procedures:

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

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

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

6.1.1.1 Fiscal Agent

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

Note: *The fiscal agent arrangement does not affect Long Term Care (LTC) and Department of State Health Services (DSHS) Family Planning providers.*

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

The fiscal agent:

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

6.1.1.2 Payment Error Rate Measurement (PERM)

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

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

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

- The statistical contractor will provide support to the program by identifying the claims to be reviewed and by calculating each state's error rate.
- The data documentation contractor will collect medical policies from the State and medical records from providers.

- The review contractor will perform medical and data processing reviews of the selected claims in order to identify any improper payments.

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

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

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

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

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

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

6.1.2 Claims Filing Instructions

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

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

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

6.1.2.1 Wrong Surgery Notification

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

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

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

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

Providers must notify Texas Medicaid of a wrong surgery or invasive procedure by submitting one of the following E diagnosis codes or modifiers with the procedure code for the rendered service:

Code	Description	Type of Claim
E Diagnosis Codes		
E8765	Performance of wrong operation (procedure) on correct patient	Inpatient hospital
E8766	Performance of operation (procedure) on patient not scheduled for surgery	
E8767	Performance of correct operation (procedure) on wrong side or body part	
Modifiers		
PA	Surgical or other invasive procedure on wrong body part	Professional or outpatient hospital
PB	Surgical or other invasive procedure on wrong patient	
PC	Wrong surgery or other invasive procedure on patient	

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

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

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

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

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

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

6.1.2.2 Maximum Number of Units allowed per Claim Detail

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

6.1.2.3 Tips on Expediting Paper Claims

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

General requirements

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

Data Fields

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

Attachments

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

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

6.1.3 TMHP Paper Claims Submission

All paper claims must be submitted with a TPI and NPI for the billing and performing providers. All other provider fields on the claim forms require an NPI only. If an NPI and TPI are not included in the billing and performing provider fields, or if an NPI is not included on all other provider identifier fields, the claim will be denied.

6.1.4 Claims Filing Deadlines

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

Exception: *Unless otherwise stated below, claims must be received by TMHP within 95 days 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 2012 and 2013:

Date	Holiday
January 2, 2012*	New Year's Day (federal holiday)
January 16, 2012	Martin Luther King, Jr. Day
February 20, 2012	Presidents Day
May 28, 2012	Memorial Day
July 4, 2012	Independence Day
September 3, 2012	Labor Day
October 8, 2012*	Columbus Day (federal holiday)
November 12, 2012*	Veteran's Day (federal holiday)
November 22, 2012	Thanksgiving Day
November 23, 2012	Day After Thanksgiving
December 24, 2012	Christmas Eve Day
December 25, 2012	Christmas
December 26, 2012	Day After Christmas
January 1, 2013	New Year's Day
January 21, 2013	Martin Luther King, Jr. Day
February 18, 2013	Presidents Day
May 27, 2013	Memorial Day
July 4, 2013	Independence Day

*** Federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.**

The following are time limits for submitting claims:

- Inpatient claims filed by the hospital must be received by TMHP within 95 days of 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 who are 20 years of age and younger.
  - 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 or from the discharge date for inpatient claims.
  Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI's electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all *applicants* become eligible *clients*. Providers that submit claims electronically within the 365-day federal filing deadline for services rendered to individuals who do not currently have a Texas Medicaid identification number will receive an electronic rejection. Providers can use the TMHP rejection report as proof of meeting the 365-day federal filing deadline and submit an administrative appeal.

Important: *Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.yourtexasbenefitscard.com. A copy is required during the appeal process if the client's eligibility becomes an issue.*

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

  Providers must submit a paper MRAN received from Medicare or a Medicare intermediary, the computer-generated MRANs from the CMS-approved software application MREP for professional services or PC-Print for institutional services, or the TMHP Standardized MRAN Form 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 is subject to the 95-day filing deadline (from date of discharge).

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

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

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

Refer to: Subsection 4.13, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for examples of non-TPRs.

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

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

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

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

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

Subsection 6.1.4.2, "Exceptions to the 95-Day Filing Deadline" in this section.

"Automated Inquiry System (AIS)" in "Preliminary Information" (*Vol. 1, General Information*) to learn how to retrieve client eligibility information by telephone.

Subsection 4.13, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Subsection 4.2, "Eligibility Verification" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

Subsection 6.11.7, "Provider Inquiries—Status of Claims" in this section.

6.1.4.1 Claims for Clients with Retroactive Eligibility

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

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

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

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

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

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

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

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

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

6.1.4.2 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. TAC allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances.

6.1.4.3 Appeal Time Limits

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

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

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

6.1.4.4 Claims with Incomplete Information and Zero Paid Claims

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

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

- Provider identifiers
- Client Medicaid number
- Dates of service
- Total billed amount

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

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

6.1.4.5 Claims Filing Reminders

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

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

Electronic billers should notify TMHP about missing claims when:

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

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

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

6.1.5 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of LTC and the DSHS Family Planning Program.

The 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 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/Children with Special Health Care Needs (CSHCN) Service Program 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 subsection 7.1.5, "Paper Appeals" in Section 7, "Appeals"* (Vol. 1, General Information) *for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

6.1.5.1 Filing Deadline Calendar for 2012

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)	04/05 (096)	04/30 (121)
01/02 (002)	04/06 (097)	05/01 (122)
01/03 (003)	04/09 (100)	05/02 (123)
01/04 (004)	04/09 (100)	05/03 (124)
01/05 (005)	04/09 (100)	05/04 (125)
01/06 (006)	04/10 (101)	05/07 (128)
01/07 (007)	04/11 (102)	05/07 (128)
01/08 (008)	04/12 (103)	05/07 (128)
01/09 (009)	04/13 (104)	05/08 (129)
01/10 (010)	04/16 (107)	05/09 (130)
01/11 (011)	04/16 (107)	05/10 (131)
01/12 (012)	04/16 (107)	05/11 (132)
01/13 (013)	04/17 (108)	05/14 (135)
01/14 (014)	04/18 (109)	05/14 (135)
01/15 (015)	04/19 (110)	05/14 (135)
01/16 (016)	04/20 (111)	05/15 (136)
01/17 (017)	04/23 (114)	05/16 (137)
01/18 (018)	04/23 (114)	05/17 (138)
01/19 (019)	04/23 (114)	05/18 (139)
01/20 (020)	04/24 (115)	05/21 (142)
01/21 (021)	04/25 (116)	05/21 (142)
01/22 (022)	04/26 (117)	05/21 (142)
01/23 (023)	04/27 (118)	05/22 (143)
01/24 (024)	04/30 (121)	05/23 (144)
01/25 (025)	04/30 (121)	05/24 (145)
01/26 (026)	04/30 (121)	05/25 (146)
01/27 (027)	05/01 (122)	05/29 (150)
01/28 (028)	05/02 (123)	05/29 (150)
01/29 (029)	05/03 (124)	05/29 (150)
01/30 (030)	05/04 (125)	05/29 (150)
01/31 (031)	05/07 (128)	05/30 (151)
02/01 (032)	05/07 (128)	05/31 (152)
02/02 (033)	05/07 (128)	06/01 (153)
02/03 (034)	05/08 (129)	06/04 (156)
02/04 (035)	05/09 (130)	06/04 (156)
02/05 (036)	05/10 (131)	06/04 (156)
02/06 (037)	05/11 (132)	06/05 (157)
02/07 (038)	05/14 (135)	06/06 (158)
02/08 (039)	05/14 (135)	06/07 (159)
02/09 (040)	05/14 (135)	06/08 (160)
02/10 (041)	05/15 (136)	06/11 (163)
02/11 (042)	05/16 (137)	06/11 (163)
02/12 (043)	05/17 (138)	06/11 (163)
02/13 (044)	05/18 (139)	06/12 (164)
02/14 (045)	05/21 (142)	06/13 (165)
02/15 (046)	05/21 (142)	06/14 (166)
02/16 (047)	05/21 (142)	06/15 (167)
02/17 (048)	05/22 (143)	06/18 (170)
02/18 (049)	05/23 (144)	06/18 (170)
02/19 (050)	05/24 (145)	06/18 (170)
02/20 (051)	05/25 (146)	06/19 (171)
02/21 (052)	05/29 (150)	06/20 (172)
02/22 (053)	05/29 (150)	06/21 (173)
02/23 (054)	05/29 (150)	06/22 (174)
02/24 (055)	05/29 (150)	06/25 (177)
02/25 (056)	05/30 (151)	06/25 (177)
02/26 (057)	05/31 (152)	06/25 (177)
02/27 (058)	06/01 (153)	06/26 (178)
02/28 (059)	06/04 (156)	06/27 (179)
02/29 (060)	06/04 (156)	06/28 (180)
03/01 (061)	06/04 (156)	06/29 (181)
03/02 (062)	06/05 (157)	07/02 (184)
03/03 (063)	06/06 (158)	07/02 (184)
03/04 (064)	06/07 (159)	07/02 (184)
03/05 (065)	06/08 (160)	07/03 (185)
03/06 (066)	06/11 (163)	07/05 (187)
03/07 (067)	06/11 (163)	07/05 (187)
03/08 (068)	06/11 (163)	07/06 (188)
03/09 (069)	06/12 (164)	07/09 (191)
03/10 (070)	06/13 (165)	07/09 (191)
03/11 (071)	06/14 (166)	07/09 (191)
03/12 (072)	06/15 (167)	07/10 (192)
03/13 (073)	06/18 (170)	07/11 (193)
03/14 (074)	06/18 (170)	07/12 (194)
03/15 (075)	06/18 (170)	07/13 (195)
03/16 (076)	06/19 (171)	07/16 (198)
03/17 (077)	06/20 (172)	07/16 (198)
03/18 (078)	06/21 (173)	07/16 (198)
03/19 (079)	06/22 (174)	07/17 (199)
03/20 (080)	06/25 (177)	07/18 (200)
03/21 (081)	06/25 (177)	07/19 (201)
03/22 (082)	06/25 (177)	07/20 (202)
03/23 (083)	06/26 (178)	07/23 (205)
03/24 (084)	06/27 (179)	07/23 (205)
03/25 (085)	06/28 (180)	07/23 (205)
03/26 (086)	06/29 (181)	07/24 (206)
03/27 (087)	07/02 (184)	07/25 (207)
03/28 (088)	07/02 (184)	07/26 (208)
03/29 (089)	07/02 (184)	07/27 (209)
03/30 (090)	07/03 (185)	07/30 (212)
03/31 (091)	07/05 (187)	07/30 (212)
04/01 (092)	07/05 (187)	07/30 (212)
04/02 (093)	07/06 (188)	07/31 (213)
04/03 (094)	07/09 (191)	08/01 (214)
04/04 (095)	07/09 (191)	08/02 (215)
04/05 (096)	07/09 (191)	08/03 (216)
04/06 (097)	07/10 (192)	08/06 (219)
04/07 (098)	07/11 (193)	08/06 (219)
04/08 (099)	07/12 (194)	08/06 (219)
04/09 (100)	07/13 (195)	08/07 (220)
04/10 (101)	07/16 (198)	08/08 (221)
04/11 (102)	07/16 (198)	08/09 (222)
04/12 (103)	07/16 (198)	08/10 (223)
04/13 (104)	07/17 (199)	08/13 (226)
04/14 (105)	07/18 (200)	08/13 (226)
04/15 (106)	07/19 (201)	08/13 (226)
04/16 (107)	07/20 (202)	08/14 (227)
04/17 (108)	07/23 (205)	08/15 (228)
04/18 (109)	07/23 (205)	08/16 (229)
04/19 (110)	07/23 (205)	08/17 (230)
04/20 (111)	07/24 (206)	08/20 (233)
04/21 (112)	07/25 (207)	08/20 (233)
04/22 (113)	07/26 (208)	08/20 (233)
04/23 (114)	07/27 (209)	08/21 (234)
04/24 (115)	07/30 (212)	08/22 (235)
04/25 (116)	07/30 (212)	08/23 (236)
04/26 (117)	07/30 (212)	08/24 (237)
04/27 (118)	07/31 (213)	08/27 (240)
04/28 (119)	08/01 (214)	08/27 (240)
04/29 (120)	08/02 (215)	08/27 (240)
04/30 (121)	08/03 (216)	08/28 (241)
05/01 (122)	08/06 (219)	08/29 (242)
05/02 (123)	08/06 (219)	08/30 (243)
05/03 (124)	08/06 (219)	08/31 (244)
05/04 (125)	08/07 (220)	09/04 (248)
05/05 (126)	08/08 (221)	09/04 (248)
05/06 (127)	08/09 (222)	09/04 (248)
05/07 (128)	08/10 (223)	09/04 (248)
05/08 (129)	08/13 (226)	09/05 (249)
05/09 (130)	08/13 (226)	09/06 (250)
05/10 (131)	08/13 (226)	09/07 (251)
05/11 (132)	08/14 (227)	09/10 (254)
05/12 (133)	08/15 (228)	09/10 (254)
05/13 (134)	08/16 (229)	09/10 (254)
05/14 (135)	08/17 (230)	09/11 (255)
05/15 (136)	08/20 (233)	09/12 (256)
05/16 (137)	08/20 (233)	09/13 (257)
05/17 (138)	08/20 (233)	09/14 (258)
05/18 (139)	08/21 (234)	09/17 (261)
05/19 (140)	08/22 (235)	09/17 (261)
05/20 (141)	08/23 (236)	09/17 (261)
05/21 (142)	08/24 (237)	09/18 (262)
05/22 (143)	08/27 (240)	09/19 (263)
05/23 (144)	08/27 (240)	09/20 (264)
05/24 (145)	08/27 (240)	09/21 (265)
05/25 (146)	08/28 (241)	09/24 (268)
05/26 (147)	08/29 (242)	09/24 (268)
05/27 (148)	08/30 (243)	09/24 (268)
05/28 (149)	08/31 (244)	09/25 (269)
05/29 (150)	09/04 (248)	09/26 (270)
05/30 (151)	09/04 (248)	09/27 (271)
05/31 (152)	09/04 (248)	09/28 (272)
06/01 (153)	09/04 (248)	10/01 (275)
06/02 (154)	09/05 (249)	10/01 (275)
06/03 (155)	09/06 (250)	10/01 (275)
06/04 (156)	09/07 (251)	10/02 (276)
06/05 (157)	09/10 (254)	10/03 (277)
06/06 (158)	09/10 (254)	10/04 (278)
06/07 (159)	09/10 (254)	10/05 (279)
06/08 (160)	09/11 (255)	10/09 (283)
06/09 (161)	09/12 (256)	10/09 (283)
06/10 (162)	09/13 (257)	10/09 (283)
06/11 (163)	09/14 (258)	10/09 (283)
06/12 (164)	09/17 (261)	10/10 (284)
06/13 (165)	09/17 (261)	10/11 (285)
06/14 (166)	09/17 (261)	10/12 (286)
06/15 (167)	09/18 (262)	10/15 (289)
06/16 (168)	09/19 (263)	10/15 (289)
06/17 (169)	09/20 (264)	10/15 (289)
06/18 (170)	09/21 (265)	10/16 (290)
06/19 (171)	09/24 (268)	10/17 (291)
06/20 (172)	09/24 (268)	10/18 (292)
06/21 (173)	09/24 (268)	10/19 (293)
06/22 (174)	09/25 (269)	10/22 (296)
06/23 (175)	09/26 (270)	10/22 (296)
06/24 (176)	09/27 (271)	10/22 (296)
06/25 (177)	09/28 (272)	10/23 (297)
06/26 (178)	10/01 (275)	10/24 (298)
06/27 (179)	10/01 (275)	10/25 (299)
06/28 (180)	10/01 (275)	10/26 (300)
06/29 (181)	10/02 (276)	10/29 (303)
06/30 (182)	10/03 (277)	10/29 (303)
07/01 (183)	10/04 (278)	10/29 (303)
07/02 (184)	10/05 (279)	10/30 (304)
07/03 (185)	10/09 (283)	10/31 (305)
07/04 (186)	10/09 (283)	11/01 (306)
07/05 (187)	10/09 (283)	11/02 (307)
07/06 (188)	10/09 (283)	11/05 (310)
07/07 (189)	10/10 (284)	11/05 (310)
07/08 (190)	10/11 (285)	11/05 (310)
07/09 (191)	10/12 (286)	11/06 (311)
07/10 (192)	10/15 (289)	11/07 (312)
07/11 (193)	10/15 (289)	11/08 (313)
07/12 (194)	10/15 (289)	11/09 (314)
07/13 (195)	10/16 (290)	11/13 (318)
07/14 (196)	10/17 (291)	11/13 (318)
07/15 (197)	10/18 (292)	11/13 (318)
07/16 (198)	10/19 (293)	11/13 (318)
07/17 (199)	10/22 (296)	11/14 (319)
07/18 (200)	10/22 (296)	11/15 (320)
07/19 (201)	10/22 (296)	11/16 (321)
07/20 (202)	10/23 (297)	11/19 (324)
07/21 (203)	10/24 (298)	11/19 (324)
07/22 (204)	10/25 (299)	11/19 (324)
07/23 (205)	10/26 (300)	11/20 (325)
07/24 (206)	10/29 (303)	11/21 (326)
07/25 (207)	10/29 (303)	11/26 (331)
07/26 (208)	10/29 (303)	11/26 (331)
07/27 (209)	10/30 (304)	11/26 (331)
07/28 (210)	10/31 (305)	11/26 (331)
07/29 (211)	11/01 (306)	11/26 (331)
07/30 (212)	11/02 (307)	11/27 (332)
07/31 (213)	11/05 (310)	11/28 (333)
08/01 (214)	11/05 (310)	11/29 (334)
08/02 (215)	11/05 (310)	11/30 (335)
08/03 (216)	11/06 (311)	12/03 (338)
08/04 (217)	11/07 (312)	12/03 (338)
08/05 (218)	11/08 (313)	12/03 (338)
08/06 (219)	11/09 (314)	12/04 (339)
08/07 (220)	11/13 (318)	12/05 (340)
08/08 (221)	11/13 (318)	12/06 (341)
08/09 (222)	11/13 (318)	12/07 (342)
08/10 (223)	11/13 (318)	12/10 (345)
08/11 (224)	11/14 (319)	12/10 (345)
08/12 (225)	11/15 (320)	12/10 (345)
08/13 (226)	11/16 (321)	12/11 (346)
08/14 (227)	11/19 (324)	12/12 (347)
08/15 (228)	11/19 (324)	12/13 (348)
08/16 (229)	11/19 (324)	12/14 (349)
08/17 (230)	11/20 (325)	12/17 (352)
08/18 (231)	11/21 (326)	12/17 (352)
08/19 (232)	11/26 (331)	12/17 (352)
08/20 (233)	11/26 (331)	12/18 (353)
08/21 (234)	11/26 (331)	12/19 (354)
08/22 (235)	11/26 (331)	12/20 (355)
08/23 (236)	11/26 (331)	12/21 (356)
08/24 (237)	11/27 (332)	12/26 (361)
08/25 (238)	11/28 (333)	12/26 (361)
08/26 (239)	11/29 (334)	12/26 (361)
08/27 (240)	11/30 (335)	12/26 (361)
08/28 (241)	12/03 (338)	12/26 (361)
08/29 (242)	12/03 (338)	12/27 (362)
08/30 (243)	12/03 (338)	12/28 (363)
08/31 (244)	12/04 (339)	12/31 (366)
09/01 (245)	12/05 (340)	12/31 (366)
09/02 (246)	12/06 (341)	12/31 (366)
09/03 (247)	12/07 (342)	01/02 (002)
09/04 (248)	12/10 (345)	01/02 (002)
09/05 (249)	12/10 (345)	01/03 (003)
09/06 (250)	12/10 (345)	01/04 (004)
09/07 (251)	12/11 (346)	01/07 (007)
09/08 (252)	12/12 (347)	01/07 (007)
09/09 (253)	12/13 (348)	01/07 (007)
09/10 (254)	12/14 (349)	01/08 (008)
09/11 (255)	12/17 (352)	01/09 (009)
09/12 (256)	12/17 (352)	01/10 (010)
09/13 (257)	12/17 (352)	01/11 (011)
09/14 (258)	12/18 (353)	01/14 (014)
09/15 (259)	12/19 (354)	01/14 (014)
09/16 (260)	12/20 (355)	01/14 (014)
09/17 (261)	12/21 (356)	01/15 (015)
09/18 (262)	12/26 (361)	01/16 (016)
09/19 (263)	12/26 (361)	01/17 (017)
09/20 (264)	12/26 (361)	01/18 (018)
09/21 (265)	12/26 (361)	01/22 (022)
09/22 (266)	12/26 (361)	01/22 (022)
09/23 (267)	12/27 (362)	01/22 (022)
09/24 (268)	12/28 (363)	01/22 (022)
09/25 (269)	12/31 (366)	01/23 (023)
09/26 (270)	12/31 (366)	01/24 (024)
09/27 (271)	12/31 (366)	01/25 (025)
09/28 (272)	01/02 (002)	01/28 (028)
09/29 (273)	01/02 (002)	01/28 (028)
09/30 (274)	01/03 (003)	01/28 (028)
10/01 (275)	01/04 (004)	01/29 (029)
10/02 (276)	01/07 (007)	01/30 (030)
10/03 (277)	01/07 (007)	01/31 (031)
10/04 (278)	01/07 (007)	02/01 (032)
10/05 (279)	01/08 (008)	02/04 (035)
10/06 (280)	01/09 (009)	02/04 (035)
10/07 (281)	01/10 (010)	02/04 (035)
10/08 (282)	01/11 (011)	02/05 (036)
10/09 (283)	01/14 (014)	02/06 (037)
10/10 (284)	01/14 (014)	02/07 (038)
10/11 (285)	01/14 (014)	02/08 (039)
10/12 (286)	01/15 (015)	02/11 (042)
10/13 (287)	01/16 (016)	02/11 (042)
10/14 (288)	01/17 (017)	02/11 (042)
10/15 (289)	01/18 (018)	02/12 (043)
10/16 (290)	01/22 (022)	02/13 (044)
10/17 (291)	01/22 (022)	02/14 (045)
10/18 (292)	01/22 (022)	02/15 (046)
10/19 (293)	01/22 (022)	02/19 (050)
10/20 (294)	01/23 (023)	02/19 (050)
10/21 (295)	01/24 (024)	02/19 (050)
10/22 (296)	01/25 (025)	02/19 (050)
10/23 (297)	01/28 (028)	02/20 (051)
10/24 (298)	01/28 (028)	02/21 (052)
10/25 (299)	01/28 (028)	02/22 (053)
10/26 (300)	01/29 (029)	02/25 (056)
10/27 (301)	01/30 (030)	02/25 (056)
10/28 (302)	01/31 (031)	02/25 (056)
10/29 (303)	02/01 (032)	02/26 (057)
10/30 (304)	02/04 (035)	02/27 (058)
10/31 (305)	02/04 (035)	02/28 (059)
11/01 (306)	02/04 (035)	03/01 (060)
11/02 (307)	02/05 (036)	03/04 (063)
11/03 (308)	02/06 (037)	03/04 (063)
11/04 (309)	02/07 (038)	03/04 (063)
11/05 (310)	02/08 (039)	03/05 (064)
11/06 (311)	02/11 (042)	03/06 (065)
11/07 (312)	02/11 (042)	03/07 (066)
11/08 (313)	02/11 (042)	03/08 (067)
11/09 (314)	02/12 (043)	03/11 (070)
11/10 (315)	02/13 (044)	03/11 (070)
11/11 (316)	02/14 (045)	03/11 (070)
11/12 (317)	02/15 (046)	03/12 (071)
11/13 (318)	02/19 (050)	03/13 (072)
11/14 (319)	02/19 (050)	03/14 (073)
11/15 (320)	02/19 (050)	03/15 (074)
11/16 (321)	02/19 (050)	03/18 (077)
11/17 (322)	02/20 (051)	03/18 (077)
11/18 (323)	02/21 (052)	03/18 (077)
11/19 (324)	02/22 (053)	03/19 (078)
11/20 (325)	02/25 (056)	03/20 (079)
11/21 (326)	02/25 (056)	03/21 (080)
11/22 (327)	02/25 (056)	03/22 (081)
11/23 (328)	02/26 (057)	03/25 (084)
11/24 (329)	02/27 (058)	03/25 (084)
11/25 (330)	02/28 (059)	03/25 (084)
11/26 (331)	03/01 (060)	03/26 (085)
11/27 (332)	03/04 (063)	03/27 (086)
11/28 (333)	03/04 (063)	03/28 (087)
11/29 (334)	03/04 (063)	03/29 (088)
11/30 (335)	03/05 (064)	04/01 (091)
12/01 (336)	03/06 (065)	04/01 (091)
12/02 (337)	03/07 (066)	04/01 (091)
12/03 (338)	03/08 (067)	04/02 (092)
12/04 (339)	03/11 (070)	04/03 (093)
12/05 (340)	03/11 (070)	04/04 (094)
12/06 (341)	03/11 (070)	04/05 (095)
12/07 (342)	03/12 (071)	04/08 (098)
12/08 (343)	03/13 (072)	04/08 (098)
12/09 (344)	03/14 (073)	04/08 (098)
12/10 (345)	03/15 (074)	04/09 (099)
12/11 (346)	03/18 (077)	04/10 (100)
12/12 (347)	03/18 (077)	04/11 (101)
12/13 (348)	03/18 (077)	04/12 (102)
12/14 (349)	03/19 (078)	04/15 (105)
12/15 (350)	03/20 (079)	04/15 (105)
12/16 (351)	03/21 (080)	04/15 (105)
12/17 (352)	03/22 (081)	04/16 (106)
12/18 (353)	03/25 (084)	04/17 (107)
12/19 (354)	03/25 (084)	04/18 (108)
12/20 (355)	03/25 (084)	04/19 (109)
12/21 (356)	03/26 (085)	04/22 (112)
12/22 (357)	03/27 (086)	04/22 (112)
12/23 (358)	03/28 (087)	04/22 (112)
12/24 (359)	03/29 (088)	04/23 (113)
12/25 (360)	04/01 (091)	04/24 (114)
12/26 (361)	04/01 (091)	04/25 (115)
12/27 (362)	04/01 (091)	04/26 (116)
12/28 (363)	04/02 (092)	04/29 (119)
12/29 (364)	04/03 (093)	04/29 (119)
12/30 (365)	04/04 (094)	04/29 (119)
12/31 (366)	04/05 (095)	04/30 (120)
01/01 (001)	04/06 (096)	05/01 (121)

6.1.5.2 Filing Deadline Calendar for 2013

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)	04/08 (098)	05/01 (121)
01/02 (002)	04/08 (098)	05/02 (122)
01/03 (003)	04/08 (098)	05/03 (123)
01/04 (004)	04/09 (099)	05/06 (126)
01/05 (005)	04/10 (100)	05/06 (126)
01/06 (006)	04/11 (101)	05/06 (126)
01/07 (007)	04/12 (102)	05/07 (127)
01/08 (008)	04/15 (105)	05/08 (128)
01/09 (009)	04/15 (105)	05/09 (129)
01/10 (010)	04/15 (105)	05/10 (130)
01/11 (011)	04/16 (106)	05/13 (133)
01/12 (012)	04/17 (107)	05/13 (133)
01/13 (013)	04/18 (108)	05/13 (133)
01/14 (014)	04/19 (109)	05/14 (134)
01/15 (015)	04/22 (112)	05/15 (135)
01/16 (016)	04/22 (112)	05/16 (136)
01/17 (017)	04/22 (112)	05/17 (137)
01/18 (018)	04/23 (113)	05/20 (140)
01/19 (019)	04/24 (114)	05/20 (140)
01/20 (020)	04/25 (115)	05/20 (140)
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09/19 (262)	12/23 (357)	01/17 (017)
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09/22 (265)	12/27 (361)	01/21 (021)
09/23 (266)	12/27 (361)	01/21 (021)
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09/28 (271)	01/02 (002)	01/27 (027)
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10/07 (280)	01/10 (010)	02/04 (035)
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11/08 (312)	02/11 (042)	03/10 (069)
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11/13 (317)	02/18 (049)	03/13 (072)
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11/16 (320)	02/19 (050)	03/17 (076)
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11/18 (322)	02/21 (052)	03/18 (077)
11/19 (323)	02/24 (055)	03/19 (078)
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11/22 (326)	02/25 (056)	03/24 (083)
11/23 (327)	02/26 (057)	03/24 (083)
11/24 (328)	02/27 (058)	03/24 (083)
11/25 (329)	02/28 (059)	03/25 (084)
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11/27 (331)	03/03 (062)	03/27 (086)
11/28 (332)	03/03 (062)	03/28 (087)
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12/03 (337)	03/10 (069)	04/02 (092)
12/04 (338)	03/10 (069)	04/03 (093)
12/05 (339)	03/10 (069)	04/04 (094)
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12/24 (358)	03/31 (090)	04/23 (113)
12/25 (359)	03/31 (090)	04/24 (114)
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12/31 (365)	04/05 (095)	04/30 (120)
01/01 (001)	04/06 (096)	05/01 (121)

6.2 TMHP Electronic Claims Submission

TMHP uses the HIPAA-compliant American National Standards Institute (ANSI) ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security.

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

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

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

6.2.1 Benefit and Taxonomy Codes

Providers that submit electronic claims are required to submit new data fields. The Benefit Code field (when applicable), Address field, and Taxonomy Code field must be completed before submitting electronic claims.

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

Group billing providers are not required to submit a taxonomy code on all electronic claims.

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. TMHP will reject claims for non-group billing providers (individuals and facilities) that are submitted without a taxonomy code.

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

6.2.2 Electronic Claim Acceptance

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

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

6.2.3 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

- *Client information does not match.* Client information does not match the PCN on the TMHP eligibility file. The name, date of birth, sex, and nine-digit Medicaid identification number must be an exact match with the client's identification number on TMHP's eligibility record. If using TexMedConnect, send an interactive eligibility request to obtain an exact match with TMHP's record. If not using TexMedConnect, verify through the TMHP website or call AIS at 1-800-925-9126 to verify client information. A lack of complete client eligibility information causes a rejection and possibly delayed payment. To prevent delays when submitting claims electronically:
  - Always include the first and last name of the client on the claim in the appropriate fields.

- Always enter the client's complete, valid nine-digit Medicaid number. Valid Medicaid numbers begin with 1, 2, 3, 4, or 5. CSHCN Services Program client numbers begin with a 9.
- When submitting claims for newborns, use the guidelines in the following section.

- *Referring/Ordering Physician field blank or invalid.* The referring physician's NPI must be present when billing for consultations, laboratory, or radiology. Consult the software vendor for this field's location on the electronic claims entry form.
- *Performing Physician ID field blank or invalid.* When the billing provider identifier is a *group* practice, the performing provider identifier for the physician who performed the service must be entered. Consult the software vendor for this field's location on the electronic claim form.
- *Facility Provider field blank or invalid.* When place of service (POS) is anywhere other than home or office, the facility's provider identifier must be present. If the provider identifier is not known, enter the name and address of the facility. Consult the software vendor for this field's location on the electronic claims entry form.
- *Invalid Type of Service or Invalid Type of Service/Procedure code combination.* In certain cases some procedure codes will require a modifier to denote the procedure's type of service (TOS).

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

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

6.2.3.1 Newborn Claim Hints

The following are to be used for newborns:

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

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

- *Admit hour outside allowable range* (such as 24 hours).
- *Billed amount blank.*
- *Health coverage ID blank or invalid.* This number *must* be the valid nine-digit Medicaid client number. *Incorrect data* includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- *Referring physician information on outpatient claim is blank* when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician's NPI is required in Fields 78–79. Consult the software vendor for the location of this field on the electronic claims entry form.

6.2.4 TMHP EDI Batch Numbers, Julian Dates

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

- *JJJ – Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be F43.
- *Y – Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "2" in this position indicates the year 2012.
- *SSSS* = The unique 4-character sequence number assigned by EDI to the claim filed.

6.2.5 Modifier Requirements for TOS Assignment

Modifiers for TOS assignment are *not* required for Texas Health Steps (THSteps) Dental claims (claim type 021), 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, and THSteps medical checkup are assigned the appropriate TOS based on the provider type or specific procedure code, and will not require modifiers.

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

6.2.5.1 Assistant Surgery

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

6.2.5.2 Anesthesia

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

6.2.5.3 Interpretations

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

6.2.5.4 Technical Components

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

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

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									
77401	77402	77403	77404	77406	77407	77408	77409	77411	77412
77413	77414	77416	77417	93005	93017	93041	93225	93226	93721

6.2.6 Preferred Provider Organization (PPO)

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

6.3 Coding

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

Important: *Claims for anesthesia must have the 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

6.3.1 Diagnosis Coding

Texas Medicaid 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 Texas Medicaid 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.

All diagnosis codes that are submitted on a claim must be appropriate for the age of the client as identified in the ICD-9-CM description of the diagnosis code. Claims that are denied because one or more of the diagnosis codes submitted on the claim are not appropriate for the age of the client may be appealed with the correct diagnosis code or documentation of medical necessity to justify the use of the diagnosis code.

ICD-9-CM codes for external causes of injury and poisoning (E codes) and morphology of neoplasms (M codes) are not valid as a primary diagnosis.

All V-codes are acceptable as diagnoses except the following nonspecific codes:

Diagnosis Codes									
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	V1200	V1201	V1202	V1203
V1209	V121	V122	V1260	V1261	V1269	V1270	V1271	V1272	V1279
V1300	V1321	V1329	V133	V134	V1361	V1369	V137	V138	V139
V140	V141	V142	V143	V144	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

Diagnosis Codes									
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	V609	V6110	V6111	V6112	V6120	V6129	V613
V6141	V6149	V616	V617	V618	V619	V620	V621	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	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
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 code V717 results in claim denial with explanation of benefits (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 unless otherwise stated in other sections of this manual.

6.3.1.1 Place of Service (POS) Coding

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

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

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

POS	2-Digit Numeric Codes (Electronic Billers)	1-Digit Numeric Codes (Paper Billers)
Office	11, 15, 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 a rural health clinic (RHC) are billed using national POS code 72.*

6.3.2 Type of Service (TOS)

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

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

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

6.3.2.1 TOS Table

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

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

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

6.3.3 Procedure Coding

The procedure coding system used by Texas Medicaid is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health-care providers and third party payers a common coding structure that is designed around a five-character numeric or alphanumeric base for all codes.

HCPCS consists of two levels of codes including the *Current Procedural Terminology* (CPT®) *Professional Edition* (Level I) and the HCPCS codes approved and released by CMS (Level II).

At the beginning of each year, TMHP applies the annual HCPCS additions, changes, and deletions that include the program and coding changes related to the annual HCPCS, Current Dental Terminology (CDT), and CPT updates. These updates ensure an up-to-date coding structure by using the latest edition of the CPT and nationally established HCPCS codes released by CMS. Scheduled updates are announced in Medicaid bi-monthly bulletins.

Most added procedure codes that are not directly replacing a discontinued procedure code must go through the rate hearing process, as required by Chapter 32 of the *Human Resources Code*, §32.0282, and Title 1 of the *Texas Administrative Code*, §355.201, which require public hearings to receive comments on Texas Medicaid payment rates. The two levels of codes are as follows:

6.3.3.1 Level I

CPT® Professional Edition:

- 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

6.3.3.2 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

6.3.3.3 Rate Hearings

All of the new procedure codes are adopted in accordance with CMS effective dates. Added procedure codes that are not directly replacing a discontinued procedure code must go through the rate hearing process. Health and Human Services Commission (HHSC) conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate.

Services provided before the rates are adopted through the rate hearing process are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted. The client cannot be billed for these services. Providers are responsible for meeting the initial 95-day filing deadline. Once the reimbursement rates are established in the rate hearing and applied, TMHP will reprocess claims, and no further action on the part of the provider is necessary.

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

Authorization guidelines for procedure codes awaiting a rate hearing are available in subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing" in Section 5, "Prior Authorization" (*Vol. 1, General Information*).

6.3.4 National Drug Code (NDC)

The NDC is an 11-digit number on the package or container from which the medication is administered. All Texas Medicaid fee-for-service and Family Planning providers must submit an NDC for professional or outpatient claims submitted with physician-administered prescription drug procedure. Codes in the A code series do not require an NDC.

N4 must be entered before the NDC on claims.

The unit of measurement codes can also be submitted, however, are not required. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit

Unit quantities can also be submitted, however, are not required.

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field:

UB-04 CMS 1450

Block No.	Description	Guidelines
43	Revenue codes and description	Enter N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). **Optional:** The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted, however, are not required. Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025

CMS-1500

Block No.	Description	Guidelines
24A	Dates of service	In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231
24D	Procedures, services, or supplies	**Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.
24G	Days or units	**Optional:** In the shaded area, enter the NDC unit of measurement code.

Family Planning 2017

Block No.	Description	Guidelines
32A	Dates of service	In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231
32D	Procedures, services, or supplies CPT/HCPCS Modifier	**Optional:** In the shaded area, enter a 1-through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. A decimal point must be used for fractions of a unit.
32F	Days or units	**Optional:** In the shaded area, enter the NDC unit of measurement code.

The Drugs Requiring NDC for Texas Medicaid Reimbursement list is available on the TMHP website at www.tmhp.com. The list contains those physician-administered, multiple-source drugs that the U.S. Secretary of Health and Human Services has determined to have the highest dollar volume of physician-administered drugs that are dispensed through Medicaid.

6.3.5 Modifiers

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

Modifier	Special Instructions/Notes (if applicable)
Ambulance	
ET	Use for all emergency transport services.
GY	Use to indicate that no medical necessity existed for a transport.
Surgeons	
53	Use for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeon who performs the surgical procedure only must bill the surgical code with modifier 54 and is reimbursed 70% of the global fee.
55+	Provider who performs the postoperative care only must bill the surgical code with modifier 55 and is reimbursed 20% of the global fee.
56+	Providers who perform the preoperative care only must bill the surgical code with modifier 56 and is reimbursed 10 percent of the global fee.
58+	Staged or related procedure or services by the same physician during the postoperative period.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
76+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
77+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.

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

Modifier	Special Instructions/Notes (if applicable)
78+	Return to the operating room for a related procedure during the postoperative period.
79+	Unrelated procedure or service by the same physician during the postoperative period.
Assistant Surgeons	
80 *and* KX+	Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility: • In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention. • When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients. • In a case involving a complex surgical procedure that qualifies for more than one physician.
AS	Use when the physician assistant is not enrolled as an individual provider and provides assistance at surgery.
Sterilizations	
PM	Use to indicate post-menopausal.
PS	Use to indicate previously sterilized.
Excision of Lesions/Masses	
KX+	Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.
Injections	
AT	Use to indicate acute conditions.
JA	Administered intravenously.
JB	Administered subcutaneously.
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
76+	Use to indicate the repeated non-clinical procedure.
FP+	Use to indicate that the service was part of an annual family planning examination.
TH+	Use with external causes of injury and poisoning (E Codes) procedures and morphology of neoplasms (M Codes) procedures to specify antepartum or postpartum care.

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

Modifier	Special Instructions/Notes (if applicable)
25	Use to describe circumstances in which an office visit was provided at the same time as other separately identifiable services.
Anesthesia	
One of the following modifier combinations must be used by anesthesiologists directing non-CRNA qualified professionals.	
AA and U1	Use to indicate that the anesthesia services were performed personally by the anesthesiologist.
AD and U1 (Emergency circumstances only)	Use when directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrent requiring five or more concurrent procedures.
QK an U1	Use when directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.
QY and U1	Use when directing one procedure provided by a non-CRNA qualified professional.
One of the following modifier combinations must be used by anesthesiologists directing CRNAs.	
AD and U2 (Emergency circumstances only)	Use when directing five or more concurrent procedures involving CRNA (s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.
QK and U2	Use when directing two, three, or four concurrent procedures involving CRNAs.
QY and U2	Use when directing one procedure by a CRNA.
One of the following modifier combinations must be used by CRNAs.	
QX and U2	Use to indicate the anesthesia was medically directed by the anesthesiologist.
QZ and U1	Use to indicate the anesthesia was directed by the surgeon.
FQHC and RHC	
Services provided by a health-care professional require one of the following modifiers:	
AH	Use to indicate that the services were performed by a clinical psychologist.
AJ	Use to indicate that the services were performed by a clinical social worker.
AM	Use to indicate that the services were performed by a physician or team member service (includes clinical psychiatrist).
SA	Use to indicate that the services were performed by an advanced practice registered nurse (APRN) or CNM rendering services in collaboration with a physician.
TD	For home services performed by a RN and provided in areas with a shortage of home health agencies.
TE	For home services performed by an LVN and provided in areas with a shortage of home health agencies.
TS	Use to indicate a case management follow-up service
U1	Licensed professional counselor
U2	Licensed marriage and family therapist
U7*	Physician assistant services for other than assistant at surgery
The following modifiers may be used in addition to the modifier identifying the health-care professional that rendered the service:	
EP	Use to indicate THSteps services (FQHC only).

+ Modifier is required for accurate claims processing.

*** Description is defined by the state.**

Modifier	Special Instructions/Notes (if applicable)
FP	Use to indicate that the service was part of an annual family planning examination.
TH	Use to indicate the encounter is for antepartum care or postpartum care.
U5*	State-defined modifier for use with case management services.
Abortion	
G7	Use by performing physicians, facilities, anesthesiologists, and CRNAs (with appropriate procedure code) when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid.
Vision	
RB	Use modifier RB to indicate replacement of prosthetic or nonprosthetic eyeglasses or contact lenses.
VP+	Use when billing prosthetic eyeglasses or contact lenses with a diagnosis of aphakia.
Laboratory/Radiology	
26+	Use for laboratory interpretations and radiological procedures.
59-	Code (CCI Table) to indicate the procedure or service was independent from other services performed on the same day.
91+	Use for repeat laboratory clinical test.
76	Use for repeat laboratory nonclinical test.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used for technical radiological procedures.
Q4+	Use for lab/radiology/ultrasound interps by other than the attending physician.
Therapy	
AT+	Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.
GN	Use to indicate outpatient speech language pathology.
GO	Use to indicate outpatient occupational therapy.
GP	Use to indicate outpatient PT.
U4*	Reassessment
THSteps Medical	
AM	Physician, team member service
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	Nurse practitioner rendering service in collaboration with a physician
U5*	Intermediate oral examination with dental varnish
U7*	Physician assistant services for other than assistant at surgery
TD	Registered nurse
THSteps Exceptions to Periodicity	
SC	Medically necessary service or supply

+ Modifier is required for accurate claims processing.

*** Description is defined by the state.**

Modifier	Special Instructions/Notes (if applicable)
23	Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier *23* to the procedure code of the basic service or by use of the separate five-digit modifier code 09923
32	Mandated Services: Services related to mandated consultation or related services (e.g., peer review organization [PRO], third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure or the service may be reported by use of the five digit modifier 09932
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)
Radiology Services	
U6	CT, CTA, MRI, MRA, Cardiac Nuclear Imaging, and PET Scan studies provided in the emergency department. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay.
Durable Medical Equipment	
NU	Use to indicate purchased equipment.
RR	Use to indicate leased equipment.
Telemedicine	
GT	Use with appropriate evaluation and management codes.
+ Modifier is required for accurate claims processing. * Description is defined by the state.	

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

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

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

6.3.6 Benefit Code

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

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

Program	Benefit Code
Comprehensive Care Program (CCP)	CCP
THSteps Medical	EP1
THSteps Dental	DE1
Family Planning Agencies*	FP3
Hearing Aid Dispensers	HA1
Maternity	MA1
County Indigent Health Care Program	CA1
Early Childhood Intervention (ECI) Providers	EC1
Tuberculosis (TB) Clinics	TB1
Texas Medicaid Program Home Health DME	DM2
Case management mental retardation (MR) providers	MH2

*Agencies only—Benefit codes should not be used for individual family planning providers.

6.4 Claims Filing Instructions

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

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

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

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

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

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

6.4.1 National Correct Coding Initiative (NCCI) Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims that are submitted to TMHP be filed in accordance with the NCCI guidelines. These guidelines can be found in the NCCI Policy and Medicare Claims Processing Manuals on the CMS website at www.cms.gov/NationalCorrectCodInitEd/.

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

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

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

HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals or bulletins. Providers should refer to the CMS NCCI web page at www.cms.gov/MedicaidNCCICoding/ for correct coding guidelines and specific applicable code combinations.

When Texas Medicaid medical policy is more restrictive than NCCI MUE guidance, Texas Medicaid medical policy prevails.

6.4.1.1 NCCI Processing Categories

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

Coding Rule Category	Description
Maximum units	CMS has assigned to all procedure codes a maximum number of units that may be submitted for a client per day, regardless of the provider. The maximum number of units for each procedure code is based on the following criteria: • Procedure code description • Anatomical site • CMS sources • Clinical guidelines ***Important:*** *If the maximum number of units has been exceeded on a particular line item, the line item will be denied. The line item will not be cut back to the allowable quantity. The line item may be appealed with the appropriate quantity for consideration*

Coding Rule Category	Description
NCCI	NCCI is a collection of bundling edits created and sponsored by CMS that are separated into two major categories: Column I and Column II procedure code edits (previously referred to as "Comprehensive" and "Component") and Mutually Exclusive procedure code edits. NCCI edits are applied to services that are performed by the same provider on the same date of service only and do not apply to services that are performed within the global surgical period. Each NCCI code pair edit is associated with a policy as defined in the *National Correct Coding Initiative Policy Manual.* Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on this effective date. Termination dates also apply to code pairs in NCCI. This date represents the date when CMS removed the code pair combination from the NCCI edits. Code combinations are refreshed quarterly.

For a list of NCCI and MUEs, providers may refer to the CMS website at: www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html.

6.4.1.2 CPT and HCPCS Claims Auditing Guidelines

The following coding rule categories apply to claims submissions:

Coding Rule Category	Description
Add-on codes	Certain services are commonly carried out in addition to the rendering of the primary procedure and are associated with the primary procedures. These additional or supplemental procedures are referred to as "add-on" procedures. Add-on codes are identified in the CPT Manual with a plus mark ("+") symbol and are also listed in Appendix D of the CPT Manual. Add-on codes are always performed in addition to a primary procedure, and should never be reported as a stand-alone service. When an add-on code is submitted and the primary procedure has not been identified on either the same or different claim, then the add-on code will be denied as an inappropriately-coded procedure. If the primary procedure is denied for any reason, then the add-on code will be denied also.
Deleted HCPCS codes	Procedure codes undergo revision by the AMA and CMS on a regular basis. Revisions typically include adding new procedure codes, deleting procedure codes, and redefining the description of existing procedure codes. These revisions are normally made on an annual basis by the governing entities with occasional quarterly updates. Claims that are received with deleted procedure codes will be validated against the date of service. If the procedure code is valid for the date of service, the claim will continue processing. If the procedure code is invalid for the date of service, the invalid procedure code will be denied.

Coding Rule Category	Description
Diagnosis validity	ICD-9-CM diagnosis codes undergo revision by the Centers for Disease Control and Prevention (CDC) and CMS on a regular basis. Revisions typically include adding new diagnosis codes, deleting diagnosis codes, and redefining the description of existing diagnosis codes. These revisions are normally made on an annual basis. Claims that are received with invalid diagnosis codes will be validated against the date of service. If the diagnosis code is valid for the date of service, the claim will continue processing. If the diagnosis code is invalid for the date of service, the procedure that is referenced to the invalid diagnosis code will be denied.
Diagnosis-age	Certain diagnosis codes are age-specific. If a diagnosis code that is billed does not match the age of the client on that date of service, all services associated with that diagnosis code will be denied. For example, a newborn diagnosis must be associated with a client who is 29 days of age or younger.
Diagnosis-gender	Certain diagnosis codes are gender-specific. If the diagnosis code that is billed does not match the gender of the client, all services associated with that diagnosis code will be denied. For example, diagnosis code 60000 (benign hypertrophy of prostate) is restricted to male clients.
Duplicate claim	A duplicate claim is defined as a claim or procedure code detail that exactly matches a claim or procedure code detail that has been reimbursed to the same provider for the same client. Duplicate claims or details include the same date of service, procedure code, modifier, and number of units. Duplicate claims or procedure code details will be denied. ***Note:*** *Modifiers may be used to identify separate services.*
Evaluation and Management (E/M) services	The AMA defines new and established patients as follows: • A new patient is "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." • An established patient is "one who has received a professional service from the physician or another physician of the same specialty who belongs to the same group practice within the past three years." Only one E/M procedure code may be reimbursed for a single date of service by the same provider group and specialty, regardless of place of service. Providers may refer to subsection 8.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol.2, Provider Handbooks)* for additional information about physician E/M services.
Procedure code definition	The CPT manual assigns each procedure code a specific description or definition to describe the service that is rendered. In order to support correct coding, the procedure code definition rules will deny procedure codes based on the appropriateness of the code selection as directed by the definition and nature of the procedure code.
Procedure code guideline	The CPT manual includes specific reporting guidelines that are located throughout the manual and at the beginning of each section. In order to ensure correct coding, these guidelines provide reporting guidance and must be followed when submitting specific procedure codes.

Coding Rule Category	Description
Procedure-age	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of a specific age or age group. For example, procedure code 99382 is limited to clients who are 1 through 4 years of age.
Procedure-gender	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender. For example, hysterectomy procedure code 58150 is limited to female clients.
Total, professional interpretation, and technical services	Diagnostic tests and radiology services are procedure codes that include two components: professional interpretation and technical. The professional interpretation component describes the physician's interpretation and report services and is billed with modifier 26. The technical component describes the technical portion of a procedure, such as the use of equipment and staff needed to perform the service, and is billed with modifier TC. If the professional interpretation and technical components are rendered by the same provider, the total component may be billed using the appropriate procedure code without modifiers 26 and TC. Reimbursement of diagnostic tests and radiology services is limited to no more than the amount for the total component. Providers must refer to the appropriate Texas Medicaid fee schedules to determine payable components for diagnostic and radiology services. Procedure codes that are submitted with an inappropriate modifier will be denied.

6.4.2 Claim Form Requirements

6.4.2.1 Provider Signature on Claims

Each CMS-1500, 2006 American Dental Association (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 appear in the "Paid or Denied Claims" sections of the R&S Reports.

Refer to: Form 6.1, "Sample Letter XUB Computer Billing Service Inc" in this section.

6.4.2.2 Group Providers

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

6.4.2.3 Prior Authorization Numbers on Claims

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

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

6.4.2.4 Newborn Clients Without Medicaid Numbers

If a Medicaid eligible newborn has not been assigned a Medicaid number on the DOS, the provider must wait until a Medicaid client number is assigned to file the claim. The provider writes the number instead of "Pending." The 95-day filing period begins on the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Providers verify eligibility and add date through TexMedConnect or by calling AIS or the TMHP Contact Center at 1-800-925-9126 after the number is received.

Providers must check Medicaid eligibility regularly to file claims within the required 95-day filing deadline.

Refer to: Section 4: Client Eligibility (*Vol. 1, General Information*).

6.4.2.5 Multipage Claim Forms

6.4.2.5.1 Professional Claims

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

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

6.4.2.5.2 Institutional Claims

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

An EDI approved electronic format of the UB-04 CMS-1450 is designed to list 61 lines. C21 merges like revenue codes together to reduce the lines to 28 or less.

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

The paper UB-04 CMS-1450 is designed to list 23 lines in Block 43. If services exceed the 23-line limitation, the provider may attach additional pages. The first page of a multipage claim must contain all required billing information. On subsequent pages, the provider identifies the client's name,

diagnosis, all information required in Block 43, and the page number of the attachment (e.g., page 2 of 3) in the top right-hand corner of the form and indicate "continued" on Line 23 of Block 47. The combined total charges for all pages should be listed on the last page on Line 23 of Block 47.

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.*

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

TEFRA hospitals are required to submit all charges.

6.4.2.5.3 Inpatient Hospital Claims

Medicaid present-on-admission (POA) reporting is required for all inpatient hospital claims that are paid under prospective payment basis methodology with the exception of the following facilities that Medicare exempts or are paid for by TEFRA methodology. These facilities include:

- Critical access hospitals (CAH)
- Cancer hospitals
- Children's inpatient facilities
- State-owned teaching facilities
- RHCs
- Federally qualified health centers (FQHCs)
- Religious nonmedical health-care institutions
- Inpatient psychiatric hospitals and institutes for mental disease (IMD)
- Inpatient rehabilitation facilities (IRF)
- Military hospitals

A POA value must be submitted for each diagnosis on the claim form. Claims submitted without POA are rejected unless the facility is exempt from POA reporting.

POA values are:

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

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

6.4.2.6 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 paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services, or the TMHP Standardized MRAN form. Providers that submit paper crossover claims must submit only one of the approved MRAN formats. 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 Texas Medicaid.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

Refer to: Form MD.4, "Hysterectomy Acknowledgment Form" in *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

6.4.2.7 Clients with a Designated or Primary Care Provider

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

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

6.5 CMS-1500 Paper Claim Filing Instructions

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

Providers
Ambulance
ASC (freestanding)
Case Management for Blind and Visually Impaired Children (BVIC), Case Management for Early Childhood Intervention (ECI), and Case Management for Children and Pregnant Women
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Certified respiratory care practitioner (CRCP)
Chemical dependency treatment facilities
Chiropractor

Providers
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 the DSHS Family Planning Program
FQHC
Genetic service agency
Hearing aid
In-home total parenteral nutrition (TPN) supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental health (MH) rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/opthamologist
Orthotic and prosthetic supplier (CCP only)
Pharmacy
Physical therapist
Physician (group and individual)
Physician assistant (PA)
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology
Rural Health Clinics rendering services to THSteps clients
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical
Tuberculosis clinic

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

6.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 paper claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

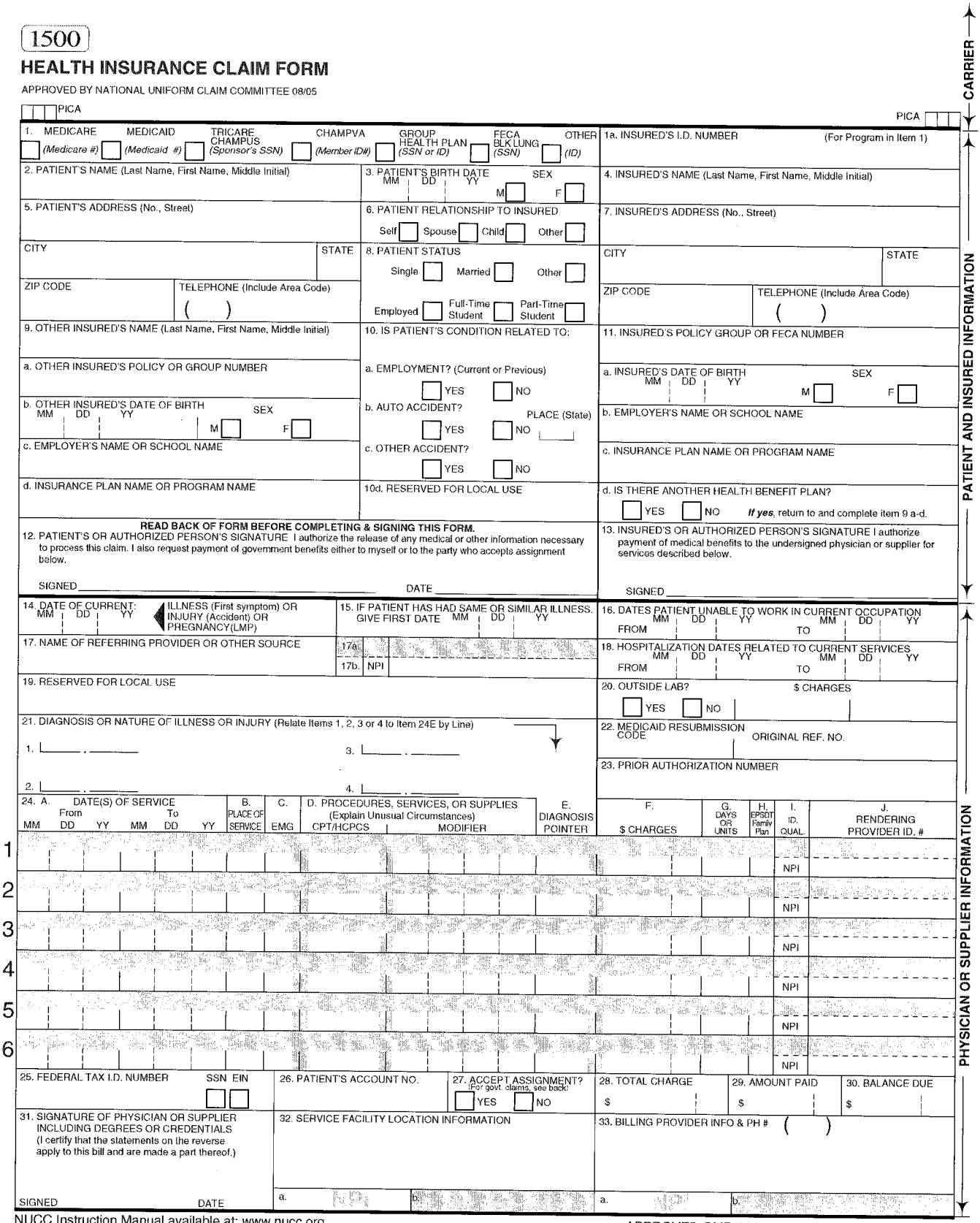
Refer to: Subsection 3.2, "Electronic Billing" in Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information about electronic billing.

6.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

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

6.5.3 CMS-1500 Blank Paper Claim Form



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)

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

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

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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. 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

6.5.4 CMS- 1500 Provider Definitions

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

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

Examples include, but are not limited to the following:

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

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

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

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

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

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

An example would be the supervision of a resident physician.

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

Examples of services include the following:

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

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

6.5.5 CMS-1500 Instruction Table

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

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit patient number from the Medicaid identification form. For other property & casualty claims: Enter the Federal Tax ID or SSN of the insured person or entity.
2	Patient's name	Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's gender by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the client's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information such as: • If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	Is patient's condition related to: a. Employment (current or previous)? b. Auto accident? c. Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. • For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.

Block No.	Description	Guidelines
14	Date of current	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.
17 17b	Name of referring physician or other source	Enter the complete name (block 17) and the NPI (block 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider. Refer to specific sections for requirements. in the following situations: **The attending physician for:** • Clinical pathology consultations to hospital inpatients or outpatients • Services provided to a client in a nursing facility (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) **The referring physician for:** • Services provided to managed care clients (must be the client's primary care provider). ***Note:*** *If there is not a referral from the primary care provider, a prior authorization number (PAN) must be on the claim.* • Consultation services • CCP services • Radiology services. • Radiation therapy services. **The ordering physician for:** • Laboratory and radiology services • Speech-language therapy • Physical therapy • Occupational therapy • In-home TPN services The designated provider for nonemergency services provided to limited clients on referral. The performing provider (surgeon) for freestanding ASCs.

Block No.	Description	Guidelines
19	Reserved for local use	**Transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other client's complete name and Medicaid number. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
20	Outside lab	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32.
21	Diagnosis or nature of illness or injury	Enter up to four ICD-9-CM diagnosis codes to the highest level of specificity available.
23	Prior authorization number	Enter the PAN issued by TMHP. For Workers Compensation and other property and casualty claims, this is required when prior authorization, referral, concurrent review, or voluntary certification was received.
24	(Various)	General notes for blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. **NDC** In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. **Example:** N400409231231 ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24b	Place of service	Select the appropriate POS code for each service from the table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section.
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. ***Refer to:*** Subsection 5.3.4, "THSteps Medical Checkups" in *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

Block No.	Description	Guidelines
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **NDC** **Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24e	Diagnosis pointer	Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can 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 clients.
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** *The maximum number of units per detail is 9,999.* **NDC** **Optional:** In the shaded area, enter the NDC unit of measurement code. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
24j	Rendering provider ID # (performing)	Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.
26	Patient's account number	**Optional:** Enter the client identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
27	Accept assignment	**Required** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*

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 by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP code of the facility where the service was provided.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the TPI number of the billing provider.

6.6 UB-04 CMS-1450 Paper Claim Filing Instructions

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

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

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

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

6.6.1 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837I 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

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

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

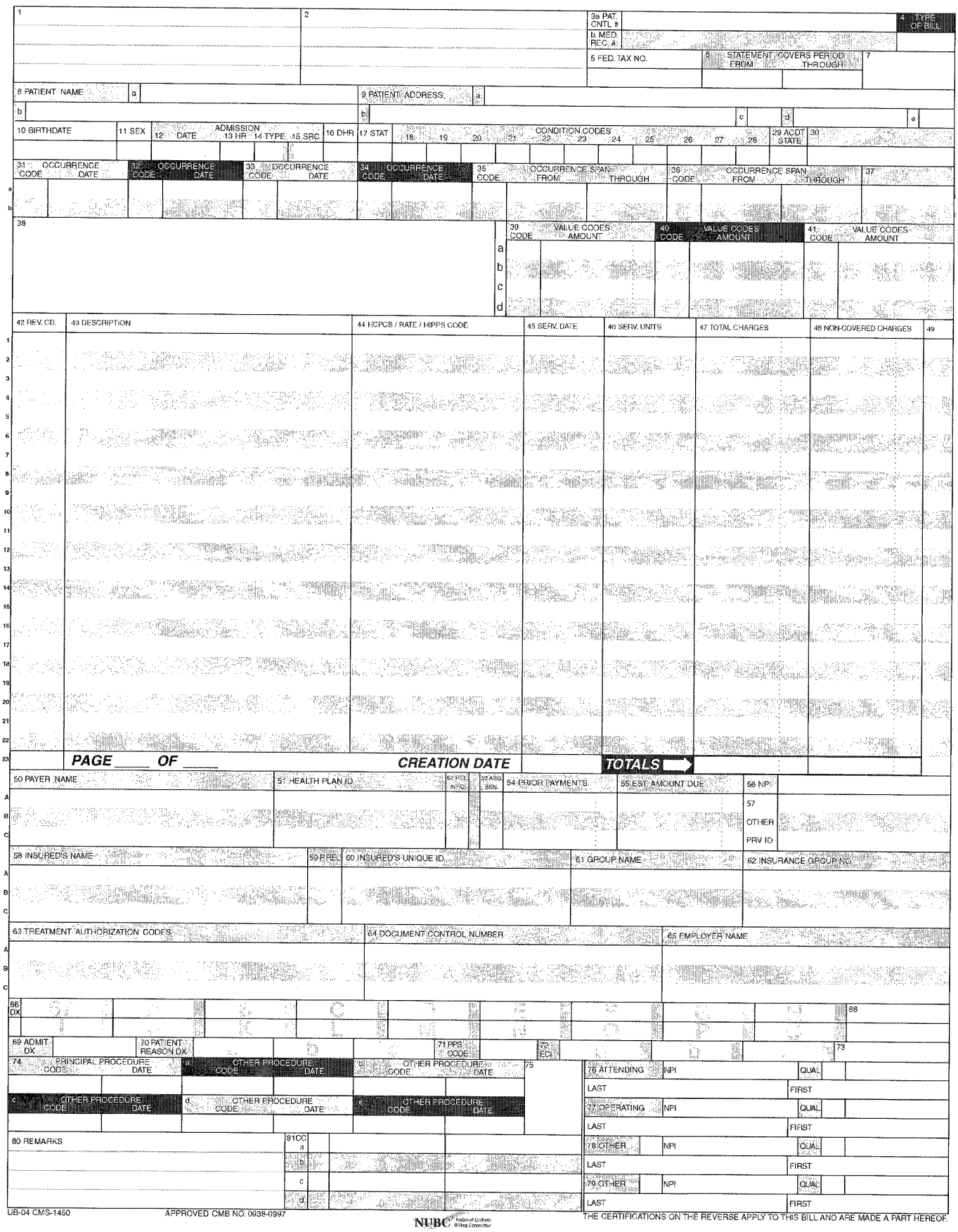
Providers obtain the UB-04 CMS-1450 paper claim forms from a vendor of their choice.

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

Completed UB-04 CMS-1450 claims must contain the billing provider's full name, address, and provider identifier. Claims *without* a provider name, address, and provider identifier *cannot* be processed.

Refer to: Subsection 6.6.4, "UB-04 CMS-1450 Instruction Table" in this section.

6.6.3 UB-04 CMS-1450 Blank Paper Claim Form



6.6.4 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 paper claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

Block No.	Description	Guidelines
1	Unlabeled	Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.
3a	Patient control number	**Optional:** Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3b	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient identifier	**Optional:** Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by providers office to identify internal patient account number.
8b	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
9a–9b	Patient address	Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).

Block No.	Description	Guidelines
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY).
11	Sex	Indicate the patient's gender by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 15.) 5 Trauma center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. **For type of admission 1, 2, 3, or 5:** 1 Physician referral 2 Clinic referral 3 Health maintenance organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room 8 Court/law enforcement 9 Information not available **For type of admission 4 (newborn):** 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank.
17	Patient Status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. ***Refer to:*** Subsection 6.6.6, "Patient Status Codes" in this section.
18–28	Condition codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a patient.
29	ACDT state	**Optional:** Accident state.
31-34	Occurrence codes and dates	Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61, 62, and 80 must also be completed as required. ***Refer to:*** Subsection 6.6.5, "Occurrence Codes" in this section.
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 patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **NDC** Enter N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). **Optional:** The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) can also be submitted but they are not required. Do not enter hyphens or spaces within this number. ***Example:*** *N400409231231GR0.025* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.
44	HCPCS/rates	**Inpatient:** Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.

Block No.	Description	Guidelines
		Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. ***Note:*** *The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.* *If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.*
45	Service date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation date	Enter the date the bill was submitted.
46	Serv. units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. ***Note:*** *For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan identification number.
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required.
56	NPI	Enter the NPI of the billing provider.
57	Other identification (ID) number	Enter the TPI number (non-NPI number) of the billing provider.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number if one was issued.
65	Employer name	Enter the name of the patient's employer if health care might be provided.

Block No.	Description	Guidelines
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. POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.5.3, "Inpatient Hospital Claims" in this section for POA values.
67A-67Q	Secondary 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 J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.* ***Note:*** *ICD-9-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing.* POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Subsection 6.4.2.5.3, "Inpatient Hospital Claims" in this section for POA values.
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 patient's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indication	**Optional:** Enter the ICD-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. ***Refer to:*** Subsection 6.4.2.5.3, "Inpatient Hospital Claims" in this section for POA values.
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. NPI number of the attending provider. Services that required an attending provider are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.
77	Operating	Enter operating provider's name (last name and first name) and NPI number of the operating provider.

Block No.	Description	Guidelines
78-79	Other	Other provider's name (last name and first name) and NPI. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure ***Note:*** *If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.*
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the patient is deceased, enter the date of death and indicate "DOD". 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. • Request for 110-day rule for a third party insurance.
81A-81D	Code code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set.

6.6.5 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.

Code	Description	Guidelines
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:*** Subsection 4.13.6, "Third Party Liability - Tort" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).
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.
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.

Code	Description	Guidelines
45	Date treatment started for speech-language pathology (SLP)	Indicate when speech language pathology services were initiated.
50	Date other insurance paid	Indicate the date the other insurance paid the claim.
51	Date claim filed with other insurance	Indicate the date the claim was file to the other insurance.
52	Date renal dialysis initiated	Indicate the date the renal dialysis is initiated.

6.6.6 Patient Status Codes

Code	Description
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)

6.6.7 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

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

Important: *Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional UB-04 CMS-1450 paper claim form and will be assigned a different claim number by TMHP. 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 paper claim form submitted with 28 or fewer items is given an internal control number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client *if all* pages contain 28 or fewer items.
- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures *must* be reflected on the face of the UB-04 CMS-1450 paper claim form. Attachments will only be used for clarification purposes.
- 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: Subsection 6.3.3, "Procedure Coding" in this section.

6.7 2006 American Dental Association (ADA) Dental Claim Filing Instructions

Providers billing for dental services and intermediate care facility for persons with mental retardation (ICF-MR) dental services may bill electronically or use the 2006 ADA claim form.

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

6.7.1 2006 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps dental claims using TexMedConnect or an approved vendor software that uses the ANSI ASC X12 837D 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

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

6.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a 2006 ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 1-800-947-4746.

Claims must contain the billing provider's complete name, address and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

6.7.3 2006 ADA Dental Claim Form

Samples of the ADA Dental Claim form can be found on the ADA website at www.ada.org/3017.aspx?currentTab=2.

6.7.4 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:*** Form CH.12, "THSteps Dental Mandatory Prior Authorization Request Form" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
2	Predetermination/Preauthorization Number	Enter prior authorization number if assigned by Medicaid.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter TMHP and the address. ***Refer to:*** "Written Communication With TMHP" in "Preliminary Information" (*Vol. 1, General Information*).
4	Other Dental or Medical Coverage?	Check No if no other dental or medical coverage (skip Blocks 5-11). Check Yes if dental or medical coverage is available other than Texas Medicaid coverage, and complete Blocks 5-11.
5-11	Other Coverage Information	General notes: • Enter the information for non-Medicaid insurance coverage. • Enter the information for the policyholder or subscriber, not necessarily the patient. May be a parent or legal guardian of the patient receiving treatment.
5	Name of Policyholder/Subscriber in # 4	Enter the policyholder/subscriber name.
6	Date of Birth (MM/DD/CCYY)	Enter policyholder/subscriber eight-digit date of birth (MM/DD/YYYY).
7	Gender	Check the appropriate box for the policyholder/subscriber gender
8	Policyholder/Subscriber ID	Enter policyholder/subscriber identifier.
9	Plan/Group Number	Enter policyholder/subscriber plan/group number.
10	Patient's Relationship to Person Named in # 5	Enter the patient's relationship to policyholder/subscriber.

ADA Block No.	ADA Description	Instructions
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Enter the contact information for the insurance company providing the non-Medicaid coverage.
12	Policy-holder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter the Medicaid patient's last name, first name, and middle initial as printed on the Medicaid identification form.
13	Date of Birth (MM/DD/CCYY)	Enter the Medicaid patient's date of birth (MM/DD/YYYY).
14	Gender	Check the appropriate box for the Medicaid patient's gender.
15	Policy-holder/Subscriber ID	Enter nine-digit patient number from the Medicaid identification form.
16	Plan/Group/Number	Enter the billing or performing provider's benefit code, if applicable.
17	Employer Name	Not applicable to Texas Medicaid.
18	Relationship to Policy-holder/ Subscriber in # 12 Above	Not applicable to Texas Medicaid.
19	Student Status	Not applicable to Texas Medicaid. For exceptions to periodicity refer to Block 35.
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
21	Date of Birth (MM/DD/CCYY)	Not applicable to Texas Medicaid.
22	Gender	Not applicable to Texas Medicaid.
23	Patient ID/Account # (Assigned by Dentist)	**Optional**: Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by dental office to identify internal patient account number.
24	Procedure Date (MM/DD/CCYY)	Enter the eight-digit date of service (MM/DD/YYYY).
25	Area of Oral Cavity	Not applicable to Texas Medicaid.
26	Tooth System	Not applicable to Texas Medicaid.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. ***Refer to:*** Subsection 4.2.9, "Tooth Identification (TID) and Surface Identification (SID) Systems" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

ADA Block No.	ADA Description	Instructions
28	Tooth Surface	Enter Surface ID as required for procedure code. ***Refer to:*** Subsection 4.2.9, "Tooth Identification (TID) and Surface Identification (SID) Systems" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).
29	Procedure Code	Use appropriate Current dental terminology (CDT) procedure code.
30	Description	Enter brief description for the CDT procedure code.
31	Fee	Enter usual and customary charges for each service listed. Charges must not be higher than the fees charged to private pay clients.
32	Other Fee(s)	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.
33	Total Fee	Enter the sum of all fees in Block 31. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
34	Place an X on each missing tooth	Place an X on the appropriate tooth number to identify each missing tooth.
35	Remarks	Use this space for:" • Explanation of exception to periodicity. • "The facility name and address if the place of treatment indicated in Block 38 is not the provider's office. • Explanation of emergency if indicated in Block 45. • To provide more information such as reports for local orthodontia codes, 999 codes, multiple supernumerary teeth, or remarks.
36	Patient/Guardian signature	Not applicable to Texas Medicaid.
37	Subscriber signature	Not applicable to Texas Medicaid.
38	Place of Treatment	Check only Provider's Office or Hospital box. Do not use ECF and Other. Check the Hospital box for services rendered in a day surgery facility.
39	Number of Enclosures	Enter the number of enclosures (attachments) accompanying the claim, if applicable. Texas Medicaid does not require radiographs with claims. **Exception:** When requested, radiographs may be submitted with appeals.
40	Is Treatment for Orthodontics?	Check Yes or No as appropriate.

ADA Block No.	ADA Description	Instructions
41	Date Appliance Placed	Not applicable to Texas Medicaid.
42	Months of Treatment Remaining	Not applicable to Texas Medicaid.
43	Replacement of Prosthesis?	Not applicable to Texas Medicaid.
44	Date Prior Placement	Not applicable to Texas Medicaid.
45	Treatment Resulting from (Check applicable box)	Providers are required to check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of Accident (MM/DD/CCYY)	Not applicable to Texas Medicaid.
47	Auto Accident State	Not applicable to Texas Medicaid.
48	Name, Address, City, State, ZIP Code	Enter the name and address of the billing group or individual provider. Do not enter the name and address of a provider employed within a group.
49	NPI	Enter the billing provider's NPI for a group or an individual. Do not enter the NPI for a provider employed within a group.
50	License Number	Not applicable to Texas Medicaid.
51	Social Security Number (SSN) or Tax Identification Number (TIN)	Not applicable to Texas Medicaid.
52	Telephone Number	Enter the area code and number for the billing group or individual Do not enter the telephone number of a provider employed within a group.
52A	Additional Provider ID	Enter the nine-digit TPI assigned to the billing dentist or dental entity. Do not enter the TPI for a provider employed within a group.
53	Signed (Treating Dentist)	Required-Signature of treating dentist or authorized personnel. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Subsection 6.4.2.1, "Provider Signature on Claims" in this section.
54	NPI	Enter the NPI for the dentist enrolled as part of a group who treated the patient. Does not apply to individual providers.
55	License Number	Not applicable to Texas Medicaid.
56	Address, City, State, ZIP Code	Not applicable to Texas Medicaid.
56A	Provider Specialty Code	This block is optional.
57	Telephone Number	Not applicable to Texas Medicaid.
58	Additional Provider ID	**Required** Enter the TPI for the dentist's enrolled as part of a group who treated the patient. Does not apply to individual providers.

6.8 Family Planning Claim Filing Instructions

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

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

6.8.1 Family Planning Electronic Billing

Electronic billers must submit family planning claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/Pages/EDI/EDI_Technical_Info.aspx. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

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

6.9 Family Planning Claim Form (Paper Billing)

Claims must contain the billing providers complete name, address, and a provider identifier. Claims without a provider name, address, and provider identifier cannot be processed.

6.9.1 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 Type of Service	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 #
1												TPI / NPI
2												TPI / NPI
3												TPI / NPI
4												TPI / NPI
5												TPI / 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.

6.9.2 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.	XIX, DSHS Family Planning Program (All)
2a	Billing provider TPI	Enter the billing provider's nine-digit TPI.	All
2b	Billing provider NPI	Enter the billing provider's NPI.	All
3	Provider name	Enter the provider's name as enrolled with TMHP.	All
4	Eligibility date (V or XX)	Enter the date (MM/DD/CCYY) this client was originally designated eligible for DSHS Family Planning Program services. If client has DSHS Family Planning Program eligibility from a previous visit, enter that eligibility date. For a DSHS Family Planning Program client, this information comes from the 2025 claim form.	DSHS Family Planning Program
5	Family planning no. (Medicaid PCN if XIX)	If previous DSHS Family Planning Program 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 DSHS Family Planning Program.	All
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	All
7a	ZIP Code	Enter the client's ZIP Code.	All
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	All
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	All
10	Sex	Indicate the client's gender by checking the appropriate box.	All
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."	All
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	All

Block No.	Description	Guidelines	Required
13	Race (code #)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	All
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	All
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	All
15	Family income (all)	DSHS Family Planning Program: 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 and older, enter the gross monthly income of all family members. For unmarried clients age 19 years and 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.	All

Block No.	Description	Guidelines	Required
15a	Family size	DSHS Family Planning Program: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	All
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	All
17	Number live births	Enter the number of live births for this client. If male, enter zero.	All
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	All
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	All
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	All
21	If no method used at end of this visit, give reason (required only if #20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from this block (a through g).	All (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.	
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
27b	Referring NPI	If a non-family planning service is being billed and the service requires a referring provider identifier, enter the referring provider's NPI.	XIX

Block No.	Description	Guidelines	Required
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 DSHS Family Planning Program funding.	DSHS Family Planning Program
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.	All
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.	All, 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, 18/2010). Electronic Billers Medicaid does not accept multiple (to–from) dates on a single-line detail. Bill only one date per line. **NDC** In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Do not enter hyphens or spaces within this number. **Example:** N400409231231 ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.	All
32B	Place of service	Enter the appropriate POS code for each service from the POS table under subsection 6.3.1.1, "Place of Service (POS) Coding" in this section. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	All

Block No.	Description	Guidelines	Required
32C	Reserved for local use	Leave this block blank. ***Note:*** *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 Section 2, "Medicaid Title XIX family planning services" in *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*). **NDC** **Optional:** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.	All
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.	All
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). **NDC** **Optional:** In the shaded area, enter the NDC unit of measurement code. ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.	All
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 Section 2, "Medicaid Title XIX family planning services" in *Gynecological and Reproductive Health and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).	All

Block No.	Description	Guidelines	Required
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 DSHS Family Planning Program 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 DSHS Family Planning Program 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
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 DSHS Family Planning Program 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 DSHS Family Planning Program 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 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 (V, X or XX)	If the client was assessed a copayment (DSHS Family Planning Program), 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 DSHS Family Planning Program patients.	DSHS Family Planning Program

Block No.	Description	Guidelines	Required
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	All
37	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on file" in place of the provider's signature if the billing service obtains and retains on file a letter signed and dated by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	All
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP Code, of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health-care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address of the outside laboratory should be entered. The laboratory should bill Texas Medicaid for the services performed.	XIX
38a	NPI	Enter the NPI of the provider where services were rendered (if other than home or office).	XIX
39	Physician's, supplier's billing name, address, ZIP Code, and telephone number	Enter the billing provider name, street, city, state, ZIP Code, and telephone number.	

6.10 Vision Claim Form

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

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

Refer to: Form VH.3, "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" in *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

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

Block No.	Description
1a	Enter the patient's nine-digit client number from the Your Texas Benefits Medicaid card.
2	Enter the patient's last name, first name, and middle initial as printed on the Your Texas Benefits Medicaid card.
3	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Enter the patient's complete address as described (street, city, state, and ZIP Code).
9 and 9a–9d	Other insurance or government benefits
10	Was condition related to: a. Patient's employment b. Auto accident c. Other accident
11	Medicare HIC number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 Name of referring physician or other source 17b NPI	Name, provider identifiers, and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis pointer
24F	Charges
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier
32	Name and address of facility where services were rendered if other than home or office
33	Telephone number
33	Physician's or supplier's name, address, city, state, and ZIP code
No longer used	Referral from screening program (THSteps)

6.11 Remittance and Status (R&S) Report

The R&S Report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electronic Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S Report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

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

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

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

6.11.1 R&S Report Delivery Options

TMHP offers two options for the delivery of the R&S Report. Although providers can choose either of the following methods, a newly-enrolled provider is initially set up to receive an PDF version of the R&S Report.

The PDF version of the R&S Report can be downloaded by registered users of the TMHP website at www.tmhp.com. The report is available each Monday morning, immediately following the weekly claims cycle. Payments associated with the R&S Report are not released until all provider payments are released on the Friday following the weekly claims cycle.

In addition to the PDF R&S Report, an 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 or third party software. The ER&S Report is also available each Monday after the completion of the claims processing cycle.

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

6.11.2 Banner Pages

Banner pages serve two purposes:

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

The title pages include the following information:

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

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

6.11.3 R&S Report Field Explanation

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

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

Program Type

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

Claim Type

Claim Type	Description
020	Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)
021	THSteps (dental)
023	Outpatient hospital, home health, RHC, FQHC
030	Physician crossovers
031	Hospital outpatient crossovers, home health crossovers, RHC crossovers
040	Inpatient hospital
050	Inpatient crossover
056	DSHS Family Planning Program
058	Family Planning Title XIX (Form 2017)

Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
030	Electronic (including TexMedConnect)
031	Electronic adjustment (including TexMedConnect)
041	AIS adjustment
051	Mass adjustment
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	State Action Request
081	State Action Request adjustment
090	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 subsection 6.3.1.1, "Place of Service (POS) Coding" in this section for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), alpha POS codes, and one-digit numeric code on the R&S Report. Providers using electronic claims submission should continue using the same POS codes.
- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.

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

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

6.11.4 R&S Report Section Explanation

6.11.4.1 Claims – Paid or Denied

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

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

- *Age.* Client's age according to TMHP records
- *Sex.* Client's sex according to TMHP records:
  M = Male, F = Female, U = Unknown
- *Pat-Stat.* Indicates the client's status at the time of discharge or the last DOS on the claim (refer to instructions for UB-04 CMS-1450 paper claim form, Block 17)
- *Proc.* ICD-9-CM code indicates the primary surgical procedure used in determining the DRG

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

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

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

6.11.4.2 Adjustments to Claims

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

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

the heading, "Financial Transactions Accounts Receivable." EOB 06065, "Account Receivable is due to the adjusted claim listed. For details, refer to your R&S Report for the date listed within the original date field."

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

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

6.11.4.3 Financial Transactions

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

6.11.4.3.1 Accounts Receivable

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

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

6.11.4.3.2 IRS Levies

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

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

6.11.4.3.3 Refunds

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

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

6.11.4.3.4 Payouts

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

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

6.11.4.3.5 Reissues

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

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

6.11.4.3.6 Voids and Stops

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

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

6.11.4.4 Claims Payment Summary

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

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

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

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

- *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.

6.11.4.5 The Following Claims are Being Processed

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

6.11.4.6 Explanation of Benefit Codes Messages

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

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

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

6.11.4.7 Explanation of Pending Status Codes Appendix

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

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

6.11.5 R&S Report Examples

See the following pages for examples of R&S Reports.

6.11.6 Banner Page R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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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 FOR MEDICAID HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.								
2008999999999	6.19		06135	22152	222.00			
2008999999999	1,442.00		06135					
TOTAL FOR MEDICAID:	$ 1,448.19							
YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.								
2008999999999	989.00		00330					
TOTAL FOR MANAGED CARE:	$ 989.00							

****

6.11.6.1 Paid or Denied Claims (Hospital) R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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.								
2008999999999	1,442.00	2010	06005					
TOTAL FOR MEDICAID:	$ 1,442.00							
A CHECK FOR MANAGED CARE HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.								
2008999999999	7,800.00	2011	06012					
TOTAL FOR MANAGED CARE:	$ 7,800.00							

****

6.11.6.2 Paid or Denied Claims (Physician) R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

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

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
********** CLAIMS - PAID OR DENIED **********											
DOE, JANE 0000	10003001020070440000000		123456789			01147					53081
01/04/2012 01/04/2012	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.

6.11.6.3 Adjustments R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

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

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 10002101120073466666666 123456789 00207
11111
01/17/2012 01/17/2012 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 01/14/2011

ORIGINAL CLAIM:
DOE, JANE 10002102020073555555555 123456789 01147
11111
01/17/2012 01/17/2012 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.

6.11.6.4 Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

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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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		123456789				00A01				78605
01/15/2012	01/15/2012	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.

6.11.6.5 System Payouts R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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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 FOR MEDICAID HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.								
2008999999999	6.19		06135	22152	222.00			
2008999999999	1,442.00		06135					
TOTAL FOR MEDICAID:	$ 1,448.19							
YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED FOR THE REASON INDICATED BELOW.								
2008999999999	989.00		00330					
TOTAL FOR MANAGED CARE:	$ 989.00							

6.11.6.6 Manual Payouts R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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.

2008999999999	1,442.00	2010	06005

TOTAL FOR MEDICAID: $ 1,442.00

A CHECK FOR MANAGED CARE HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.

2008999999999	7,800.00	2011	06012

TOTAL FOR MANAGED CARE: $ 7,800.00

****

6.11.6.7 Accounts Receivables 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: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

CONTROL NUMBER	RECOUPMENT RATE / MAXIMUM PERIODIC RECOUPMENT AMOUNT	ORIGINAL DATE / ORIGINAL AMOUNT	PRIOR DATE / PRIOR BALANCE	APPLIED AMOUNT	PROGRAM	FYE	EOB	PATIENT NAME / CLAIM NUMBER
********** FINANCIAL TRANSACTIONS **********								
ACCOUNTS RECEIVABLE								
YOUR PAYMENT WAS REDUCED BY THE APPLIED AMOUNTS SHOWN BELOW FOR THE REASONS INDICATED.								
2008299999999	50% / 67,281.00	08/01/2011 / 67,281.00	08/02/2011 / 65,417.90	926.34	MGD CARE		06022	
$1,597.00 WAS RECOVERED ON THIS ACCOUNT RECEIVABLE FROM AN AFFILIATED PROVIDER.								
2008299999999	50% / 67,281.00	08/01/2011 / 67,281.00	08/02/2011 / 64,491.56	550.29	MEDICAID		06022	
$1,597.00 WAS RECOVERED ON THIS ACCOUNT RECEIVABLE FROM AN AFFILIATED PROVIDER.								
2008299999999	25% / 2,700.00	08/15/2011 / 2,700.00	00/00/0000 / 2,700.00	137.57	MEDICAID		06022	
2008299999999	25% / 2,700.00	08/15/2011 / 2,700.00	00/00/0000 / 2,562.43	231.58	MGD CARE		06022	
2008299999999	100% / 96.98	08/15/2011 / 96.98	08/02/2011 / 96.98	96.98	MEDICAID	2008	06065	DOE, JANE / 10003103020089999999999
2008299999999	100% / 1,080.44	08/15/2011 / 1,080.44	08/02/2011 / 1,080.44	1,080.44	MGD CARE	2008	06065	DOE, JANE / 20003103020089999999999
2008299999999	100% / 126.68	08/15/2011 / 126.68	08/04/2011 / 126.68	126.68	MGD CARE	2007	06065	DOE, JANE / 20003103020079999999999
TOTAL RECOUPED:				$ 3,149.88				

6.11.6.8 Void and Stop Pay R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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********** FINANCIAL TRANSACTIONS **********

VOIDS AND STOPS FOR MEDICAID

CHECK NUMBER: 000000000 AMOUNT: 116.20 R&S NUMBER: 123456789 R&S DATE: 09/28/2011

TOTAL FOR MEDICAID: $ 116.20

VOIDS AND STOPS FOR MANAGED CARE

CHECK NUMBER: 000000000 AMOUNT: 194.79 R&S NUMBER: 123456789 R&S DATE: 09/28/2011

TOTAL FOR MANAGED CARE: $ 194.79

****

6.11.6.9 Refunds for Medicaid R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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********** FINANCIAL TRANSACTIONS **********

REFUNDS FOR MEDICAID

YOUR REFUND CHECK #999999999 DATED 01/13/2012 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
10002302120079999999999	LAST, FIRST NAME	123456789	05/31/2011	25.00	6.19	00124
					13.60	00124
Subtotal Claim Specific					$ 19.79	

NON-CLAIM-SPECIFIC:

PAYOUT CASH CONTROL NUMBER	FYE	EOB	AMOUNT APPLIED THIS CYCLE
2008999999999	0000	06067	6.19
Subtotal Non-Claim Specific			$ 6.19

TOTAL FOR MEDICAID: $ 25.98

REFUNDS FOR MANAGED CARE

6.11.6.10 Refunds for Managed Care R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

********** FINANCIAL TRANSACTIONS **********

REFUNDS FOR MANAGED CARE

YOUR REFUND CHECK #000022152 DATED 01/13/2012 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
20002302020079999999999	LAST, FIRST NAME	999999999	05/01/2011	124.33	27.02	00124
					11.00	00124
Subtotal Claim Specific					$ 38.02	

TOTAL FOR MANAGED CARE: $ 38.02

6.11.6.11 IRS Levy R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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:								
2008299999999	20%	554.00	08/02/2011	554.00	554.00	08/02/2011	.00	554.00
IRS LEVY INFORMATION FOR MANAGED CARE:								
2008999999999	20%	554.00	08/02/2011	554.00	554.00	08/02/2011	554.00	.00

PAYMENT(S) TOTALING $554.00 WERE REMITTED ON YOUR BEHALF TO THE INTERNAL REVENUE SERVICE DUE TO THE LEVY THAT IS DESCRIBED ABOVE.

****

6.11.6.12 Backup Withholding Penalty Information R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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:	2008999999999	08/02/2011	428.00
MANAGED CARE:	2008999999999	08/02/2011	935.93

6.11.6.13 Reissues R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

********** FINANCIAL TRANSACTIONS **********

REISSUES

YOUR PAYMENT FOR MEDICAID HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

CHECK NUMBER: 099999999	AMOUNT:	8,300.88	R&S NUMBER:	99999999	R&S DATE: 08/17/2011
CHECK NUMBER: 099999999	AMOUNT:	3,411.72	R&S NUMBER:	11111111	R&S DATE: 03/07/2011

TOTAL FOR MEDICAID: $ 11,712.60

YOUR PAYMENT FOR MANAGED CARE HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

CHECK NUMBER: 099999999	AMOUNT:	8,330.88	R&S NUMBER:	99999999	R&S DATE: 08/17/2011
CHECK NUMBER: 099999999	AMOUNT:	307.43	R&S NUMBER:	11111111	R&S DATE: 03/07/2011

TOTAL FOR MANAGED CARE: $ 8,638.31

****

6.11.6.14 Sub-Owner Recoupments R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

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CONTROL NUMBER	RECOUPMENT AMOUNT	PROGRAM
********** FINANCIAL TRANSACTIONS **********		
SUB-OWNER RECOUPMENTS		
RECOUPMENT IS A RESULT OF YOUR AFFILIATION WITH ANOTHER PROVIDER.		
2007999999999	10.53	MEDICAID
2007999999999	9.47	MGD CARE
TOTAL RECOUPED:	$ 20.00	

****

6.11.6.15 Summary R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727-6422

(800) 925-9126

Texas Provider
P.O. BOX 848484
Dallas, TX 75888-1234
(214) 555-4141

TPI: 1234567-01
NPI/API: 1234567890
Taxonomy: 193400000X
Benefit Code:
Report Seq. Number: 33
R&S Number: 99999999

PAYMENT SUMMARY FOR TAX ID 123456789

	*** AFFECTING PAYMENT THIS CYCLE *** AMOUNT	COUNT	*** AMOUNT AFFECTING 1099 EARNINGS *** THIS CYCLE	YEAR TO DATE
CLAIMS PAID	3,738.10	9	3,738.10	35,676.72
SYSTEM PAYOUTS	2,437.19		2,437.19	2,437.19
MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT)			9,242.00	9,242.00
AMOUNT PAID TO IRS FOR LEVIES	-554.00			
AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING	-1,363.93			
ACCOUNTS RECEIVABLE RECOUPMENTS	-3,149.88		-3,149.88	-9,314.02
AMOUNTS STOPPED/VOIDED			-310.99	-310.99
SYSTEM REISSUES	20,350.91			
CLAIM RELATED REFUNDS			-57.81	-57.81
NON-CLAIM RELATED REFUNDS			-6.19	-6.19
HELD AMOUNT	-4,291.67			
PAYMENT AMOUNT	17,166.72		11,892.42	37,666.90
PENDING CLAIMS	54,913.83			

THE AMOUNT OF $4,291.67 WAS HELD AT THE DIRECTION OF THE STATE MEDICAID AGENCY.

**********PAYMENT TOTAL FOR DIRECT DEPOSIT BY EFT 000000099999999 IN THE AMOUNT OF 17,166.72.**********

T Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 02/01/2012

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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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.

6.11.7 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 paper MRAN received from Medicare or a Medicare intermediary, the computer generated MRANs from the CMS-approved software applications MREP for professional services or PC-Print for institutional services or the TMHP Standardized MRAN form with the completed claim form.

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

- The provider can use the claim status inquiry function of TexMedConnect on the TMHP website at www.tmhp.com.
- The provider can call AIS at 1-800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of the three options above indicates that TMHP has no record of the claim, the provider can call the TMHP Contact Center at 1-800-925-9126 and speak to a TMHP contact center representative.
- 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)" in "Preliminary Information" (*Vol. 1, General Information*).

6.12 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500 paper claim form, Fields 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy number and group number
- Policyholder
- Effective date if available
- Date of disposition by other insurance resource (used to calculate filing deadline)
- Payment or specific denial information

Important: *Important: By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance or copays related to Medicaid-covered services.*

6.12.1 Unbundled Services That Are Prior Authorized and Manually Priced Procedure Codes

Providers that submit prior authorization requests and claims to TMHP must:

- Unbundle any bundled procedure codes that have been submitted to the client's other insurance company.
- Itemize the rates.

If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for the services using the MSRP that was submitted with the authorization request and the following information that is listed on the authorization letter:

- The authorization number
- The provider identifier
- The procedure codes
- The dates of service
- The types of service
- The required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter* should not *be submitted on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

6.12.2 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in Texas Medicaid. When a TPR issues a payment or partial payment to a provider, the other insurance credit *must* be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR payments correctly in the appropriate electronic field or the paper claim form block.

Claim Form	Reference
CMS-1500	Block 29, CMS-1500 Blank Claim Form (subsection 6.5.3 in this section)
UB-04 CMS-1450	Block 54, UB-04 CMS-1450 Blank Claim Form (subsection 6.6.3 in this section)
THSteps Dental	Block 31, 2006 ADA Dental Claim Form (subsection 6.7.3 in this section)

6.12.2.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the clients deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

6.12.2.2 Managed Care Organization (MCO) Copayments

TMHP processes and pays MCO copayments for private and Medicare MCOs 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 MCO or PPO has denied, if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

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

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and the Texas Medicaid Program when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 – Office	Description
CP001	Private HMO copayment—professional
CP002	Private PPO copayment—professional

POS 1 – Office	Description
CP003	Medicare HMO copayment-professional
CP004	Medicare PPO copayment-professional

POS 5 – Outpatient	Description
CP005	Private HMO copayment—outpatient
CP006	Private PPO copayment—outpatient
CP007	Medicare HMO copayment-outpatient
CP008	Medicare PPO copayment-outpatient

6.12.2.3 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPL/Tort Customer Service line at 1-800-846-7307. When calling the TPL/Tort Customer Service line and when filing claims to TMHP, the provider must have the following information before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource
- Insurance company's name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client
- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

Providers that update a client's insurance records through the TMHP TPL/Tort Customer Service line must follow the current appeal process once the other insurance information has been updated on the client's file.

6.12.2.4 110-Day Rule

When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required:

- Name and address of the TPR
- Date the TPR was billed
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's R&S Report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is *not* sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

6.12.2.5 Filing Deadlines

In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the DOS. Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.
  - The provider must appeal the claim to TMHP with complete other insurance information, which includes all EOBs and disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial.
  - If a provider submits other insurance EOBs without disposition dates, the appeal will be denied. If the other insurance disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being submitted to TMHP is on a subsequent page or pages, the provider must submit the first page that shows the disposition date and all of the pages that show the claim that is being submitted to TMHP.
- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.

Refer to: Subsection 4.13, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

6.12.3 Claims Forwarded to Other Insurance Carriers

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

TMHP forwards electronic institutional claims for clients suspected of having other insurance to a contractor. The contractor researches the claims to determine the client's possible other insurance information. If it is determined that the client has valid other insurance for the claim's date of service and the insurance carrier is listed below, the contractor will forward the claim to the selected insurance carrier. TMHP has begun forwarding claims to the major insurance carriers for Texas.

Provider will receive a denial EOB from TMHP on the R&S Report that will indicate that the claim was forwarded to the client's other insurance carrier.

If the other insurance carrier denies the claim, the provider should first exhaust all avenues to appeal the claim with the other insurance carrier. If the final disposition is a denial, the provider may appeal the claim to TMHP using the carrier's EOB showing the denial. Providers must review their R&S Reports to ensure that any follow-up action is taken within the appeal deadlines.

TMHP will not forward the following claim types to the contractor:

- Electronic institutional claims that are rejected by TMHP
- Electronic institutional Texas Medicaid fee-for-service adjustments
- Suspended or finalized claims
- Claims that are part of mass adjustments originating from TMHP

- All other electronic claim types (professional and dental)

  Note: *Other claim types (professional and dental) will be eligible for forwarding at a later date.*
- All Medicare crossover claims
- All NPI contingent claims
- All paper claims
- School Health and Related Services (SHARS) claims
- Early Childhood Intervention (ECI) claims
- CSHCN Services Program claims
- County Indigent Health Care Program (CIHCP) claims
- PCS claims
- Case Management for Children and Pregnant Women claims
- Claims that are rejected by the Contractor for HIPAA validation failures
- THSteps medical and dental claims

Refer to: Subsection 4.13, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for information about filing claims for clients with other insurance.

Section 6.12.2.5, "Filing Deadlines" in this section for information about filing deadlines for clients with other insurance.

6.13 Medicare Claims

Medicaid clients who are also eligible for Medicare Part A (inpatient coverage), Part B (medical coverage), or Part C (noncontracted Medicare Advantage Plans [MAPs]), may be covered by Medicaid as follows:

- *Qualified Medicare beneficiary (QMB).* QMB clients are covered by Medicare through Part A, B, or C coverage. Medicaid may reimburse providers for the client's Medicare coinsurance and deductible up to the Medicaid allowed amount for the service less the amount paid by Medicare.
- *Medicaid Qualified Medicare beneficiary (MQMB).* MQMB clients are covered by Medicare through Part A, B, or C coverage and receive Medicaid benefits for services that are not a benefit of Medicare or exceed Medicare benefit limitations. Medicaid also may reimburse providers for the client's Medicare coinsurance and deductible up to the Medicaid allowed amount for the service less the amount paid by Medicare.

  Note: *If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, no additional payment is made for coinsurance and deductible.*

For Medicare Part C, the above coinsurance and deductible payment guidelines apply for noncontracted MAPs only.

Claims for Medicare copayments can also be submitted to TMHP.

Refer to: Subsection 6.12.2.2, "Managed Care Organization (MCO) Copayments" in this section.

6.13.1 Coinsurance and Deductible Payment Exceptions

Some MAPs have contracted with HHSC to receive a monthly payment for each client the MAP enrolls. The payment to the MAP includes all Medicaid costs associated with rendering services to MQMB clients. TMHP does not reimburse the copayment, coinsurance, or deductible amounts for these claims. These payments are included in the capitated rate paid to the MCO and must not be billed to TMHP or the Medicaid client.

Refer to: The EDI section of the TMHP website at www.tmhp.com for a list of MAPs that are contracted with HHSC. The list will be updated as additional plans receive approved contracts.

For crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers, Texas Medicaid reimburses the Medicare coinsurance and deductible less five percent.

6.13.2 Medicare Claims Filing

When a service is a benefit of both Medicare and Medicaid, the claims must be filed to Medicare first. Providers should not file a claim with Medicaid until Medicare has dispositioned the claim.

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

6.13.3 Medicare and Medicaid Assignment and Payments

Providers must accept Medicare assignment to receive Medicaid payment for any portion of the coinsurance and deductible amounts for services rendered to QMB and MQMB clients.

If a provider has accepted a Medicare assignment, the provider may receive, on behalf of the QMB or MQMB client, the lesser of the coinsurance and deductible payment, or the amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service.

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

6.13.4 Electronic Crossover Claims

Medicare primary claims filed to Medicare Administrative Contractors (MACs) may be transferred electronically to TMHP through a Coordination of Benefits Contractor (COBC) for claims that are processed as assigned. Providers should contact their MAC for more information.

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

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

6.13.4.1 Requirement for Group Billing Providers – Professional Claims

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

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

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

6.13.5 Paper Crossovers

The following paper crossover claims may be submitted to TMHP:

- For QMB and MQMB clients, crossover claims that are not transferred to TMHP electronically through the COBC. (Providers can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration.)

- For MQMB clients, claims that are denied by Medicare because the services are not a benefit of Medicare or because Medicare benefits have been exhausted. (Providers can submit a paper claim to TMHP for coinsurance and deductible reimbursement consideration, and reimbursement consideration for the denied services. The Medicare EOB that contains the relevant claim denial must be submitted to TMHP with the completed claim from within 95 days from the Medicare disposition date and 365 days from the date of service. The denied services will be processed as Medicaid-only services.)

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

The paper submission must include all of the following:

- The Medicare Remittance Advice (RA) or Remittance Notice (RN) that is issued by Medicare
- The appropriate, completed paper CMS-1500 or UB-04 CMS-1450 paper claim form
- The appropriate TMHP Standardized Medicare and MAP Remittance Advice Notice Form (i.e., MRAN/MAP template). (The MRAN/MAP template is optional when certain conditions are met.)

6.13.5.1 TMHP Standardized Medicare and MAP Remittance Advice Notice Form

Providers that receive any of the following Medicare RAs or RNs from Medicare or a Medicare intermediary are not required to submit the MRAN/MAP template to TMHP:

- Paper RAs or RNs
- Electronic RAs or RNs using the CMS-approved software
  - MREP (professional services)
  - PC-Print (institutional services)

Providers that cannot retrieve the Medicare RA/RN from MREP or PC-Print, or who don't receive a paper Medicare RA/RN from Medicare or a Medicare intermediary, must submit the TMHP MRAN/MAP template.

Providers that submit paper crossover claims must submit only one of the following approved Medicare RA/RN formats along with a completed claim form:

- MREP
- PC-Print
- Paper Medicare RA/RN from Medicare or a Medicare intermediary
- TMHP MRAN/MAP template (if the provider cannot receive the paper Medicare RA/RN or the MREP or PC-Print electronic Medicare RA/RN)

Paper crossover claims that contain multiple Medicare RA/RN forms with conflicting information are returned to the provider or denied.

The following guidelines apply for the submission of the MRAN/MAP templates:

- The Medicare ICN must be included on the form. Claims will be denied if the Medicare internal control number (ICN) is omitted.
- For the TMHP Crossover Professional Claim Type 30 form, the performing provider NPI and TPI must be submitted on each detail line item. A detail line item will be denied if the performing provider NPI or TPI is omitted, if the performing provider NPI is not associated with the TPI according to the performing provider's enrollment information, or if the performing provider is not a member of the group billing provider.

- For the TMHP Crossover Outpatient Facility Claim Type 31 form, the detail line items are required. Claims will be denied if the details are omitted.
- The MRAN/MAP template must be submitted with a completed claim form, must be legible, and must identify only one client per page. Providers must not submit handwritten MRAN/MAP templates.

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

By submitting the MRAN/MAP templates to TMHP, the provider attests that the information included in the form matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on the crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

Refer to: Subsection 6.21, "Forms" in this section, for the MRAN/MAP templates and instructions.

Subsection 2.6, "Medicare Crossover Claim Reimbursement"in Section 2, "Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

6.13.5.2 Crossover Claims Filing Deadlines

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

6.13.5.3 Filing a Medicare-Adjusted Claim

Providers may also submit Medicare-adjusted claims by submitting the adjusted Medicare RA/RNs (paper or electronic) and the appropriate TMHP MRAN/MAP template. The information on the Medicare RA/RN must exactly match the information submitted on the TMHP MRAN template.

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

6.14 Filing Medicare Primary Paper Claims

Providers are allowed to file Medicare primary paper claims to TMHP for payment of coinsurance or deductible for claims that fail to cross over from Medicare electronically.

Providers that receive paper MRANs from Medicare or a Medicare intermediary or MRANs using the CMS-approved software MREP, for professional services, or PC-Print, for institutional services, may submit these MRAN to TMHP. Providers that submit these MRANs are not required to submit the TMHP Standardized MRAN Form.

Providers that cannot retrieve the MRAN from MREP or PC-Print, or who don't receive a paper MRAN from Medicare or a Medicare intermediary, must submit the TMHP Standardized MRAN Form.

Providers that submit paper crossover claims must submit only one of the approved MRAN formats—MREP, PC-Print, paper MRAN from Medicare or a Medicare intermediary or TMHP Standardized MRAN form along with a completed claim form. Paper crossover claims that contain multiple MRAN forms with conflicting information are returned to the provider or denied.

6.14.1 Crossover Claim Type 30 TMHP Standardized MRAN Form

Crossover Professional Claim Type 30

TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form

1 Billing Provider NPI/API:	2 Billing Provider TPI:
3 Billing Provider Name:	4 Billing Provider Medicare ID:
5 Medicaid Client Number:	6 Medicare Paid Date:
7 Client Last Name:	8 Client First Name:
9 Medicare ICN:	10 Client HIC Number:

11 Detail(s) Information

Dtl #	a. Perf Prov TPI / b. Perf Prov NPI	c. From DOS	d. To DOS	e. POS	f. Units	g. CPT	h. Mods	i. Charges	j. Allow	k. Ded	l. Coins	m. Paid	n. Reason Code
1													
2													
3													
4													
5													
6													
7													

12 Totals Information	a. Charges	b. Allow	c. Ded	d. Coins	e. Paid	f. Total Pages
						__ of __

13 Medicare Prev Paid	

Important: By submitting these forms to TMHP, the provider attests that the information included in the form exactly matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on this crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

Save As

Effective 01012012 / Revised 0206012

6.14.2 Crossover Claim Type 30 Instructions

Crossover Professional Claim Type 30

TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form Instructions

Providers that bill professional services on the CMS-1500 paper claim form may submit the Crossover Professional Claim Type 30 template with a copy of a completed claim form. The Remittance Advice (RA) or Remittance Notice (RN) from Medicare, the CMS-approved software Medicare Remit Easy Print (MREP), or the MAP is required when submitting the Crossover Professional Claim Type 30 template. All fields (excluding Medicaid information fields) on the form must be completed using the RA or RN that was received from Medicare or the MAP.

Important: *All details from the Medicare or MAP RA or RN must be included in the template even if a deductible or coinsurance is not due.*

The TMHP Standardized MRAN Submission Form must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Professional Claim Type 30 template:

#	Field Description	Guidelines
1	Billing Provider NPI/API	Enter the National Provider Identifier (NPI) for the billing provider.
2	Billing Provider TPI	Enter the Medicaid Texas Provider Identifier (TPI) number of the billing provider.
3	Billing Provider Name	Enter the billing provider's name.
4	Billing Provider Medicare ID	Enter the Medicare Provider ID number of the billing provider listed on the Medicare or MAP RA/RN.
5	Medicaid Client Number	Enter the client's nine-digit Medicaid number from the Medicaid identification form.
6	Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare or MAP RA/RN.
7	Client Last Name	Enter the client's last name listed on the Medicare or MAP RA/RN.
8	Client First Name	Enter the client's first name listed on the Medicare or MAP RA/RN.
9	Medicare ICN	Enter the Medicare Internal Control Number (ICN) listed on the Medicare or MAP RA/RN.
10	Client HIC Number	Enter the client's identification number listed on the Medicare or MAP RA/RN.
11	Details Information	
11a	Perf Prov NPI/API	Enter the National Provider Identifier (NPI) for the performing provider
11b	Perf Prov TPI	Enter the Texas Provider Identifier (TPI) number of the performing provider
11c	From DOS	Enter the first date of service (DOS) for each procedure in a MM/DD/YYYY format.
11d	To DOS	Enter the last DOS for each procedure in a MM/DD/YYYY format.
11e	POS	Enter the place of service (POS) listed on the MAP Remittance Advice/Remittance Notice.
11f	Units	Enter the number of units (quantity billed) from the Medicare or MAP RA/RN.
11g	CPT	Enter the appropriate Current Procedural Terminology (CPT) procedure code for each procedure/service listed on the Medicare or MAP RA/RN ***Note:*** *The procedure code listed on the Standardized MRAN Template may not match the procedure code listed on the claim form attached.*
11h	Mods	Enter the modifier (when applicable) listed on the Medicare or MAP RA/RN for each detail.
11i	Charges	Enter the Medicare charges (billed amount) listed on the Medicare or MAP RA/RN for each detail.
11j	Allow	Enter the Medicare allowed amount listed on the Medicare or MAP RA/RN for each detail.
11k	Ded	Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN for each detail.
11l	Coins	Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN for each detail.
11m	Paid	Enter the Medicare paid amount listed on the Medicare or MAP RA/RN for each detail.

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Crossover Professional Claim Type 30

TMHP Standardized Medicare and Medicare Advantage Plan (MAP)

Remittance Advice Notice Form Instructions

11n	Reason Code	Enter Medicare's reason code listed on the Medicare or MAP RA/RN for each detail.
12	Totals Information	
12a	Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare or MAP RA/RN. ***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.*
12b	Total Allow	Enter the Medicare total allowed amount listed on the Medicare or MAP RA/RN.
12c	Total Ded	Enter the Medicare total deductible amount listed on the Medicare or MAP RA/RN.
12d	Total Coins	Enter the Medicare total coinsurance amount listed on the Medicare or MAP RA/RN.
12e	Total Paid	Enter the Medicare total paid amount listed on the Medicare or MAP RA/RN.
12f	Total Pages	If the crossover claim contains more than 7 detail line items, use multiple pages to identify up to 28 detail line items for the claim as necessary. Add the number of the page in the first blank line and the total page count in the second blank line (e.g., "1 of 3", "2 of 3", "3 of 3"). This field is only required if multiple pages are necessary to capture all billed detail line items. If multiple pages are necessary, Boxes 1-10 must be completed on each page submitted.
13	Medicare Prev Paid	Enter the Medicare previous paid amount listed on the Medicare or MAP RA/RN.

6.14.3 Crossover Claim Type 31

Crossover Outpatient Facility Claim Type 31

TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form

1 Medicare Paid Date:										
2 Provider Name:		3 NPI/API:		4 TPI:			5 Medicare ID:			
6 Street Address:										
City:		State:					Zip:			
7 Bill Type:		8 From DOS:		9 Through DOS:						
10 Client Last Name:				11 Client First Name:						
12 Medicare HIC:				13 Medicare ICN:						
14 Total Charges:		15 Covered Charges:		16 Non Covered Charges/Reason Code:						
17 Deductible:		18 Blood Deductible:		19 Coinsurance:			20 Paid Amount Medicare:			
21 Detail(s) Information										
a. Rev Cd	b. CPT/Mods	d. From DOS	e. Units	f. Charges	g. Allow	h. Ded	i. Coins	j. Blood Ded	k. Paid	l. Reason Code
22 Totals Information				a. Charges	b. Allow	c. Ded	d. Coins	e. Blood Ded	f. Paid	g. Total Pages
										___ of ___

Important: By submitting these forms to TMHP, the provider attests that the information included in the form exactly matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on this crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

Save As

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6.14.4 Crossover Claim Type 31 Instructions

Crossover Outpatient Facility Claim Type 31

TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form Instructions

Providers that bill outpatient crossover claims on the UB-04 CMS-1450 paper claim form may submit the Crossover Outpatient Facility Claim Type 31 template with a copy of a completed claim form. The Remittance Advice (RA) or Remittance Notice (RN) from Medicare, the CMS-approved software PC-Print, or the MAP is required when submitting the Crossover Outpatient Facility Claim Type 31 template. All fields (excluding Medicaid information fields) on the form must be completed using the RA or RN that was received from Medicare or the MAP.

Important: *All details from the Medicare or MAP RA or RN must be included in the template even if a deductible or coinsurance is not due.*

The TMHP Standardized MRAN Submission Form must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Outpatient Facility Claim Type 31 template:

#	Field Description	Guidelines
1	Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare RA/RN.
2	Provider Name	Enter the billing provider's name.
3	NPI/API	Enter the National Provider Identifier (NPI)/Atypical Provider Identifier (API) for the billing providers.
4	TPI	Enter the Texas Provider Identifier (TPI) for the billing provider.
5	Medicare ID	Enter the Medicare Provider ID of the billing provider number listed on the Medicare or MAP RA/RN.
6	Street Address, City, State, ZIP	Enter the billing provider's street address, city, state, and ZIP code in the appropriate fields.
7	Bill Type	Enter the Medicare Bill Type listed on the Medicare or MAP RA/RN. ***Note:*** *The Medicare Bill Type may not match the type of bill (TOB) listed on the claim form.*
8	From DOS	Enter the first date of service (DOS) for all procedures in a MM/DD/YYYY format.
9	Through DOS	Enter the last DOS for all procedures in a MM/DD/YYYY format.
10	Client Last Name	Enter the patient's last name listed on the Medicare or MAP RA/RN.
11	Client First Name	Enter the patient's first name listed on the Medicare or MAP RA/RN.
12	Medicare HIC	Enter the patient's Medicare Health Insurance Claim (HIC) number (Medicare Identification number) listed on the Medicare or MAP RA/RN.
13	Medicare ICN	Enter the Medicare Internal Control Number (ICN) listed on the Medicare or MAP RA/RN.
14	Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare or MAP RA/RN.
15	Covered Charges	Enter the covered charges listed on the Medicare or MAP RA/RN.
16	Non Covered Charges/Reason Code	Enter the noncovered charges listed on the MAP RA/RN followed by the reason code listed on the Medicare RA/RN.
17	Deductible	Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN.
18	Blood Deductible	Enter the blood deductible listed on the Medicare or MAP RA/RN for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a blood deductible amount.*
19	Coinsurance	Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN.
20	Medicare Paid Amount	Enter the Medicare paid amount listed on the Medicare or MAP RA/RN.
21	Detail(s) Information	
21a	Rev Cd	
21b	CPT	Enter the appropriate Current Procedural Terminology (CPT) procedure code for each

Crossover Outpatient Facility Claim Type 31

TMHP Standardized Medicare and Medicare Advantage Plan (MAP) Remittance Advice Notice Form Instructions

		procedure/service listed on the Medicare or MAP RA/RN ***Note:*** *The procedure code listed on the Standardized MRAN Template may not match the procedure code listed on the claim form attached.*
21c	Mods	Enter the modifier (when applicable) listed on the Medicare or MAP RA/RN for each detail.
21d	From DOS	Enter the first date of service (DOS) for each procedure in a MM/DD/YYYY format.
21e	Units	Enter the number of units (quantity billed) from the Medicare or MAP RA/RN.
21f	Charges	Enter the Medicare charges (billed amount) listed on the Medicare or MAP RA/RN for each detail.
21g	Allow	Enter the Medicare allowed amount listed on the Medicare or MAP RA/RN for each detail.
21h	Ded	Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN for each detail.
21i	Coins	Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN for each detail.
21j	Blood Ded	Enter the Medicare blood deductible amount listed on the Medicare or MAP RA/RN for each detail.
21k	Paid	Enter the Medicare paid amount listed on the Medicare or MAP RA/RN for each detail.
21l	Reason Code	Enter Medicare's reason code listed on the Medicare or MAP RA/RN for each detail.
22	Totals Information	
22a	Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare or MAP RA/RN. ***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.*
22b	Total Allow	Enter the Medicare total allowed amount listed on the Medicare or MAP RA/RN.
22c	Total Ded	Enter the Medicare total deductible amount listed on the Medicare or MAP RA/RN.
22d	Total Coins	Enter the Medicare total coinsurance amount listed on the Medicare or MAP RA/RN.
22e	Total Blood Ded	Enter the Medicare total blood deductible amount listed on the Medicare or MAP RA/RN.
22f	Total Paid	Enter the Medicare total paid amount listed on the Medicare or MAP RA/RN.
22g	Total Pages	If the crossover claim contains more than 10 detail line items, use multiple pages to identify up to 28 detail line items for the claim as necessary. Add the number of the page in the first blank line and the total page count in the second blank line (e.g., "1 of 3", "2 of 3", "3 of 3". This field is only required if multiple pages are necessary to capture all billed detail line items. If multiple pages are necessary, Boxes 1-6 must be completed on each page submitted.

6.14.5 Crossover Claim Type 50

Crossover Inpatient Hospital Claim Type 50

TMHP Standardized Medicare and Medicare Advantage Plan (MAP)

Remittance Advice Notice Form

1	Medicare Paid Date:			
2	Provider Name:	NPI/API:	TPI:	Medicare ID:
3	Street Address:			
4	City:	State:	Zip:	

5	Bill Type	
6	From DOS	
7	Through DOS	
8	Client Last Name	
9	Client First Name	
10	Medicare HIC	
11	Medicare ICN	
12	Total Charges	
13	Covered Charges	
14	Non Covered Charges/Reason Code	
15	DRG Amount	
16	Deductible	
17	Blood Deductible	
18	Coinsurance	
19	Medicare Paid Amount	
20	DRG Code	

Important: By submitting these forms to TMHP, the provider attests that the information included in the form exactly matches the Medicare RA or RN that was received from Medicare or the MAP. If the information on this crossover claim type form does not exactly match the information on the RA or RN, the claim may be denied.

Save As

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6.14.6 Crossover Claim Type 50 Instructions

Crossover Inpatient Hospital Claim Type 50

TMHP Standardized Medicare and Medicare Advantage Plan (MAP)

Remittance Advice Notice Form Instructions

Providers that bill inpatient crossover claims on the UB-04 CMS-1450 paper claim form may submit the Crossover Inpatient Hospital Claim Type 50 template with a copy of a completed claim form. The Remittance Advice (RA) or Remittance Notice (RN) from Medicare, the CMS-approved software PC-Print, or the MAP is required when submitting the Crossover Inpatient Hospital Claim Type 50 template. All fields (excluding Medicaid information fields) on the form must be completed using the RA or RN that was received from Medicare or the MAP.

Important: *All details from the Medicare or MAP RA or RN must be included in the template even if a deductible or coinsurance is not due.*

The TMHP Standardized MRAN Submission Form must be typed or computer-generated. Handwritten forms will not be accepted and will be returned to the provider.

The following are the requirements for the Crossover Inpatient Hospital Claim Type 50 template:

#	Field Description	Guidelines
1	Medicare Paid Date	Enter the Medicare Paid Date listed on the Medicare RA/RN.
2	Provider Name	Enter the billing provider's name.
	NPI/API/TPI	Enter the National Provider Identifier (NPI)/Atypical Provider Identifier (API)/Texas Provider Identifier (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 or MAP RA/RN.
3	Street Address	Enter the billing provider's street address.
4	City	Enter the billing provider's city.
	State	Enter the billing provider's state.
	ZIP	Enter the billing provider's ZIP code.
5	Bill Type	Enter the Medicare Bill Type listed on the Medicare or MAP RA/RN. ***Note:*** *The Medicare Bill Type may not match the type of bill (TOB) listed on the claim form.*
6	From DOS	Enter the first date of service (DOS) for all procedures in a MM/DD/YYYY format.
7	Through DOS	Enter the last DOS for all procedures in a MM/DD/YYYY format.
8	Client Last Name	Enter the patient's last name listed on the Medicare or MAP RA/RN.
9	Client First Name	Enter the patient's first name listed on the Medicare or MAP RA/RN.
10	Medicare HIC	Enter the patient's Medicare Health Insurance Claim (HIC) number (Medicare Identification number) listed on the Medicare or MAP RA/RN.
11	Medicare ICN	Enter the Medicare Internal Control Number (ICN) listed on the Medicare or MAP RA/RN.
12	Total Charges	Enter the Medicare total charges (billed amount) listed on the Medicare or MAP RA/RN.
13	Covered Charges	Enter the covered charges listed on the Medicare or MAP RA/RN.
14	Non Covered Charges/Reason Code	Enter the noncovered charges listed on the MAP RA/RN followed by the reason code listed on the Medicare RA/RN.
15	DRG Amount	Enter the diagnosis-related group (DRG) amount listed on the Medicare or MAP RA/RN for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a DRG amount.*
16	Deductible	Enter the Medicare deductible amount listed on the Medicare or MAP RA/RN.
17	Blood Deductible	Enter the blood deductible listed on the Medicare or MAP RA/RN for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a blood deductible amount.*
18	Coinsurance	Enter the Medicare coinsurance amount listed on the Medicare or MAP RA/RN.
19	Medicare Paid Amount	Enter the Medicare paid amount listed on the Medicare or MAP RA/RN.
20	DRG Code	Enter the DRG code listed on the Medicare or MAP RA/RN for inpatient claims, if applicable. ***Note:*** *Outpatient claims do not require a DRG code.*

6.15 Medically Needy Claims Filing

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

The client's payment responsibilities are as follows:

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

When eligibility has been established, a TP 55 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 30 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under Emergency medical condition is defined under Subsection 4.4.2.2, "Exceptions to Limited Status" in Section 4, "Client Eligibility" (*Vol. 1, General Information*).

6.16 Claims Filing for Consumer-Directed Services (CDS)

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

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

- If a client is only using the CDS option for Texas Medicaid PCS, a case manager will submit a prior authorization request to TMHP that approves the U8 modifier and either the U7 or UB modifier. In this case, the provider authorization notification letter will include the U8 modifier and the U7 or UB modifier.

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

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

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

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

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

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

Refer to: Subsection 4.4.3, "Hospice Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for more information related to Medicaid hospice client benefits and eligibility.

6.17.1 Medical Services When Client is Discharged From Hospice

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

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

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

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

Mail paper claims to the following address:

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

Appeal claims by writing to the following address:

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

6.17.3 Lab and X-Ray

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

6.18 Claims for Texas Medicaid and CSHCN Services Program Eligible Clients

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

6.18.1 New Claim Submissions

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

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

6.18.2 CSHCN Services Program Claims Reprocessing for Retroactive Texas Medicaid Eligibility

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

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

6.19 Claims for State Supported Living Center Residents (SSLC)

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

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

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

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

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

For women with income at or below 185 percent FPL:

- Hospital facility charges are paid through Emergency Medicaid and processed by TMHP.

- Professional service charges are paid through the CHIP Perinatal Program and processed through CHIP.

  Note: *Delivery-related professional services claims denied by the CHIP Perinatal health plan will be considered for reimbursement through Emergency Medicaid and will require the CHIP Perinatal health plan denial notice. These claims should be submitted through the existing Medicaid appeals process within 95 days from the date of the CHIP Perinatal Health plan denial notice. The provider must provide a copy of the complete explanation of benefits that includes the complete description of the reason for denial.*

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

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

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

6.20.1 CHIP Perinatal Newborn Transfer Hospital Claims

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

The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This change applies only to CHIP Perinatal newborns with a family income at or below 185 percent of the FPL.

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

6.21 Forms

6.1 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

Effective Date_01152008/Revised Date_08082007

SECTION 7: APPEALS

7.1 Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use three methods to appeal Medicaid fee-for-service and carve-out service claims to Texas Medicaid & Healthcare Partnership (TMHP): electronic, Automated Inquiry System (AIS), or paper.

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days from the date of disposition of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Standard administrative requests and medical appeals must be sent first to TMHP or the claims processing entity as a first-level appeal. After the provider has exhausted all aspects of the appeals process for the entire claim, the provider may submit a second-level appeal to HHSC.

1) A first-level appeal is a provider's initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.
2) A second-level appeal is a provider's final medical or standard administrative appeal to HHSC of a claim that meets *all* of the following requirements:
   - It has been denied or adjusted by TMHP.
   - It has been appealed as a first-level appeal to TMHP.
   - It has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO BOX 204077
Austin, Texas 78720-4077

TMHP is not responsible for managing appeals resulting from utilization review (UR) decisions by the HHSC Office of Inspector General (OIG) UR Unit. These must be submitted to HHSC Medical and UR Appeals.

Note: *Appeals for managed care claims must be submitted to the managed care organization (MCO) or dental plan that administers the client's managed care benefits. The only managed care appeals administered by TMHP are those for carve-out services.*

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

Medicaid Managed Care Handbook (*Vol. 2, Provider Handbooks*) for additional information about managed care appeals.

7.1.1 Electronic Appeal Submission

Electronic appeal submission is a method of submitting appeals using a personal computer. The electronic appeals feature can be accessed by a business organization (e.g., billing agents) interfacing directly with the TMHP Electronic Data Interchange (EDI) Gateway or through TexMedConnect, the free web-based application available from TMHP.

The Health Insurance Portability and Accountability Act (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

7.1.1.1 Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Maintained audit trails through print and download capabilities.
- Appeal submission windows can be automatically filled in with electronic R&S (ER&S) Report information, thereby reducing data entry time.

7.1.1.2 Disallowed Electronic Appeals

The following claims may *not* be appealed electronically:

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays).
- Diagnosis-related group (DRG) assignment.
- Medicare crossovers.
- Claims listed as *pending* or *in process* with explanation of pending status (EOPS) messages.
- Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply.
- Claims denied as *past the payment deadline.*
- Claims with additional quantity billed changes in the claims details.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions in Form GN.5, "Hysterectomy Acknowledgement Form" in the* Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

7.1.2 Resubmission of TMHP Electronic Data Interchange (EDI) Rejections

TMHP EDI transactions that fail HIPAA edits are rejected, and the submitter receives a TMHP EDI Rejected Transaction Report. The Rejected Transaction Report lists activity by submitter, provider, and payer. Each rejection report includes member identifier, patient last name and first initial, patient control number (PCN), document control number (DCN), type of bill or place of service, charge, transaction from and to dates, receipt date, rejection code, and rejection description.

Providers who receive TMHP EDI Rejected Transaction Reports may resubmit an electronic claim within 95 days of the date of service. A paper appeal may also be submitted with a copy of the transaction rejection report within 120 days of the transaction rejection report to meet the filing deadline. A copy of the Rejected Transaction Report must accompany each corrected claim that is submitted on paper.

7.1.3 Automated Inquiry System (AIS) Appeals

The following appeals may be submitted using AIS:

- *Client eligibility.* The client's correct Medicaid number, name, and date of birth are required.
- *Provider information (excluding Medicare crossovers).* The correct provider identifier is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
- *Claim corrections.* Providers may correct the 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 (DOS)
- 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 that require supporting documentation
- Third party liability (TPL)/other insurance

Providers may appeal these denials either electronically or on paper.

Refer to: Subsection 7.1.1.2, "Disallowed Electronic Appeals" in this section to determine whether these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed if the requested form has been faxed according to the instructions under subsection 5.10, "Hysterectomy Services" in the* Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

7.1.4 Automated Inquiry System Automated Appeals Guide

To access the AIS automated appeals guide, providers can call 1-800-925-9126. Providers may submit up to three fields per claim and 15 appeals per call. If during any step invalid information is entered three times, the call transfers to the TMHP Contact Center for assistance.

7.1.5 Paper Appeals

Claim appeal requests that cannot be appealed electronically or by using AIS may be appealed on paper. Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the attached R&S Report the information that is being appealed and identify the claim being appealed.

If a provider determines that a claim cannot be appealed electronically or through AIS, the claim may be appealed on paper by completing the following:

1) Submit a copy of the R&S Report page on which the claim is paid or denied. A copy of other official notification from TMHP may also be submitted.
2) Submit one copy of the R&S Report for each claim appealed.
3) Circle only one claim per R&S Report page.
4) Identify the reason for the appeal.
5) If applicable, indicate the incorrect information and provide the corrected information that should be used to appeal the claim.
6) Attach a copy of any supporting medical documentation that is required or has been requested by TMHP. Supporting documentation must be on a separate page and not copied on the opposite side of the R&S Report.

Note: *It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If a certified receipt is provided as proof, the certified receipt number must be indicated on the detailed listing along with the Medicaid number, billed amount, date of service (DOS), and a signed claim copy. The provider may need to keep such proof regarding multiple claims submissions if the provider identifier is pending.*

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment *must* be submitted on paper with the appropriate documentation.

Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

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

Exception: *Hospitals appealing HHSC OIG UR Unit final technical denials, admission denials, DRG revisions, continued-stay denials for Tax Equity and Fiscal Responsibility Act (of 1982) (TEFRA) Hospitals, or cost/day outliers must appeal to HHSC at the following address:*

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

All other provider fields on the claim forms (referring, facility, admitting, operating, and other) require only an NPI.

Providers that choose to appeal the claim with NPI information must continue submitting both a TPI and an NPI until the claim is finalized.

7.1.5.1 Texas Medicaid Fee-for-Service DRG Adjustment Appeal

Texas Medicaid fee-for-service hospital providers who are appealing a DRG adjustment (higher weight DRG) must provide the original and revised UB-04 CMS-1450 paper claim form, the complete medical record, and a statement defining the reason for the requested change. Hospitals have 120 days from the

date of the R&S Report to request an addition of a diagnosis or procedure resulting in a DRG adjustment. Providers appealing a DRG that has not been revised by the OIG Utilization Review Unit should appeal to TMHP.

Refer to: Subsection 7.3.3, "Utilization Review Appeals" in this section.

7.1.5.2 Medical Necessity Denial Appeals

Appeals of denials relating to medical necessity decisions made for all medical services with the exception of HHSC Inpatient UR cases may be submitted for further review if providers find denials are inappropriate. All necessary documentation must accompany the request for review. Incomplete appeals and adjustment requests are denied by TMHP with an explanation of benefits (EOB) code requesting additional information.

TMHP reviews each appeal (DRG adjustment and medical necessity) and forwards written notice of final action in the form of a letter or an adjustment transaction on the R&S Report.

7.1.5.3 Other Insurance Appeals

To appeal a claim denial due to other insurance coverage, the provider must submit complete other insurance information including the disposition date. The disposition date indicates when the other insurance company processed the payment or denial. An appeal submitted without this information will be denied.

If submitting a paper appeal the provider must submit EOBs containing disposition dates. If the disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being appealed is on a subsequent page, the provider must also include the first page of the EOB that shows the disposition date.

7.1.6 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.

7.2 Refunds to TMHP

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when any of the following occur: overpayment, duplicate payment, payment to incorrect providers, and overlapping payments by Medicaid and a third party resource (TPR).

Providers have the option of refunding payments by issuing a check to TMHP or requesting a recoupment through the paper appeal process. The paper appeal process does not require a provider to issue a check because the refund amount is reduced on the R&S Report. To accurately process claim refunds, the TMHP Cash Reimbursement Unit requests that the refund check be accompanied by Form 7.2, "Texas Medicaid Refund Information Form" in this section, with the following information:

- Refunding provider's name and provider identifier.
- Client's name and Medicaid ID number.
- Date of service.
- A copy of the R&S Report showing the claim to which the refund is being applied.
- The specific reason for the refund.

- Name and address of the attorney or casualty insurance company (including the policy and claim number).
- TPR subscriber information.
- Amount of insurance payment.

To request the forms, contact the TMHP Contact Center at 1-800-925-9126, or write to the following address:

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

Refer to: Subsection 4.13, "Third Party Liability (TPL)" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) for additional TPL information.

7.2.1 Refunds Resulting from Other Insurance Payments

Providers are prohibited from receiving payment from Medicaid, billing a TPR, and then refunding the lesser of the two payments to Medicaid.

Refunds owed to TMHP must not be held until the end of an accounting year. If within 12 months of the date of service a provider identifies a TPR and wants to submit a claim for payment, the provider must refund any amounts previously paid by TMHP before submitting the claim to the third party.

If private insurance paid for the services submitted on the claim, the provider must provide the exact amount paid, the insurance company's name and address, and the client's policy number and group number.

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

- A claim for payment has been paid by TMHP.
- The provider failed to refund the payment to TMHP before submitting a claim for payment to a third party as outlined above.

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

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

In accordance with Title 1 Texas Administrative Code (TAC) §§354.2321 [g] and 354.2322 [i], providers that do not follow TPR rules "may be referred for investigation and prosecution for violations of state or federal Medicaid or false claims laws." Providers should refer to the full text of these rules for a full description of payment requirements.

7.3 Appeals to HHSC Texas Medicaid Fee-for-Service

7.3.1 Administrative Claim Appeals

An administrative appeal is a request for review of (not a hearing on) claims that are denied by TMHP or claims processing entity for technical and nonmedical reasons. There are *two types* of administrative appeals:

- *Exception requests to the 95-day filing deadline or 120-day appeal deadline.* A provider's formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day filing deadline or 120-day appeal deadline. Exception requests to the 95-day filing deadline should meet one of the five exceptions in subsection 7.3.1.2, "Exceptions to the 95-Day Filing Deadline" in this section. Exceptions to the 120-day appeal deadline should meet one of the situations in subsection 7.3.1.3, "Exceptions to the 120-day Appeal Deadline" in this section.
- *Standard Administrative Appeal.* A provider's formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical or non-medical reasons.

An administrative claims appeal is a request for a review as defined in Title 1 TAC §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator 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 or ticket numbers from the TMHP Contact Center when pertinent (cannot be used as proof of timely filing).
  - Memos from HHSC, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
  - Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, if relevant to the appeals. Receipts can be helpful when the issue is late filing.
- Received by HHSC Claims Administrator Contract Management within 120 days from the date of disposition by TMHP or the claims processing entity as evidenced by the weekly R&S Report.

Providers who have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP assigned batch ID. In addition, this report must include the individual claim that is being appealed. The claim information on the batch report, including date of service and billed amount, must match the information on the claim that is being appealed. This required information constitutes proof of timely filing.

Note: *Only reports accepted or rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TexMedConnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.*

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the DOS. All claims must be paid within 24 months from the DOS as outlined in 1 TAC §354.1003.

Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator 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.

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

7.3.1.1 Requirements for Exception Requests

HHSC Claims Administrator Contract Management makes the final decision on whether claims fall within one of the exceptions to the 95-day or 120-day filing deadlines.

Providers must submit the following documentation for all exception requests:

- Exception requests must be in writing and mailed directly to HHSC.
- Adequate back-up documentation must accompany the exception request. Failure to provide adequate documentation results in the case being closed. Providers are notified of the reason for denial.
- All claims that are to be considered for an exception must accompany the request. HHSC will consider only the claims that are attached to the request.
- Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims must be submitted as a separate request and must include all required documentation. Information from a previous request will not be linked by HHSC to process additional claims.

- All exception requests must include an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.
- Multiple requests submitted simultaneously must be sorted by provider identifier first, and then alphabetically by client name. The orderly submission of exception requests facilitates the review process. Exception requests are returned to the provider if not submitted in the required format.

HHSC may request additional information which must be received within 21 calendar days from the date of the letter from HHSC. If the information is not received within 21 calendar days, the case will remain closed.

HHSC notifies providers about the outcome of the case upon completion of an exception request review.

7.3.1.2 Exceptions to the 95-Day Filing Deadline

HHSC Claims Administrator Contract Management is responsible for reviewing requests for exceptions to the 95-day filing deadline for Texas Medicaid fee-for-service. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are *not* accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC will only consider exceptions to the 95-day filing deadline for claims that are submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.

Exceptions to the filing deadline are considered when one of the following situations exists:

- Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including, but not limited to, fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the control of the provider, including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when the intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent.

  Providers requesting an exception for catastrophic events must include independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

- Delay or error in the eligibility determination of a client, or delay due to erroneous written information from HHSC, its designee, or another state agency.

  Providers requesting an exception for the delay or error in the eligibility determination of a client or delay due to erroneous written information from HHSC, its designee, or another state agency must include the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

- Delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers.

  Providers requesting an exception for the delay due to electronic claim or system implementation problems experienced by HHSC, its designee, or Texas Medicaid providers must include the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems.

The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

If the provider is requesting an exception based upon an electronic claim or system implementation problem experienced by HHSC or its designee, the provider must submit a written statement outlining the details of the electronic claim or system implementation problems experienced by HHSC or its designee that caused the delay in the submission of claims by the provider, any steps taken to notify the state or its designee of the problem, and a verification that the delay was not caused by the neglect, indifference, or lack of diligence on the part of the provider or its employees or agents.

- Submission of claims occurred within the 365-day federal filing deadline, but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and an effective date for the new benefit was applied retroactively.

  Providers requesting an exception for claims that were submitted within the 365-day federal filing deadline, but were not filed within the 95-days of the date of service because the service was determined to be a benefit of Texas Medicaid and an effective date for the new benefit was applied retroactively, must include a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.

- Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

  Providers requesting an exception for client eligibility determined retroactively and the provider is not notified of retroactive coverage must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

7.3.1.3 Exceptions to the 120-day Appeal Deadline

HHSC must receive a written exception request within 120 days of TMHP's final action. HHSC shall consider exceptions to the 120-day appeal deadline for the situations listed below. This is a one-time exception request; therefore, all claims that are to be considered within the request for an exception must accompany the request. Claims submitted after HHSC's determination has been made for the exception will be denied consideration because they were not included in the original request.

- An exception request must be received by HHSC within 18 months from the date of service to be considered. This requirement will be waived for the exceptions listed in the following bullets (b) and (c), as well as the situation listed under "Exceptions to the 24-month deadline."
- The following exceptions to the 120-day appeal deadline are considered if the criteria in the previous bullet is met and there is evidence to support one of the bullets below:
  - (a) Errors made by a third party payor that were outside the control of the provider. The provider must submit a statement outlining the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider, the provider's employee, or agent. This affidavit or statement should be made by the person with personal knowledge of the facts. In lieu of the above affidavit or statement from the provider, the provider may obtain an affidavit or statement from the third party payor including the same information, and provide this to HHSC as part of the request for appeal.
  - (b) Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit a statement from the original payor outlining the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence on the part of the provider, the provider's employee, or

agent. In lieu of the above reimbursement entity's statement, the provider may submit a statement including the same information and provide this to HHSC as part of the request for appeal.

- (c) Claims were adjudicated, but an error in the claim's processing was identified after the 120-day appeal deadline. The error is not the fault of the provider. An error occurred in the claims processing system that is identified after the 120-day appeal deadline has passed.

7.3.1.4 Exceptions to the 24-Month Payment Deadline

HHSC shall consider exceptions to the 24-month claims payment deadline for the situations listed below, as identified in 42 CFR §447.272. The final decision about whether a claim falls within one of the following exceptions will be made by HHSC.

- Claims for providers with retroactive adjustments who are reimbursed under a retrospective payment system.
- Claims paid within six months from the Medicare paid date.
- Claims from providers under investigation for fraud or abuse.
- Claims paid at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

Mail exception requests to HHSC at the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

7.3.2 Medical Necessity Appeals

Medical necessity appeals are defined as disputes regarding medical necessity of services. Providers must appeal to TMHP and exhaust the appeal/grievance process before submitting an appeal to HHSC.

Medical necessity appeals related to UR decisions made by the HHSC OIG UR Unit *must* be appealed to HHSC *not* TMHP.

When filing appeals to HHSC, providers must submit copies of all supporting documentation, including information sent to TMHP.

Refer to: Subsection 7.1.5.1, "Texas Medicaid Fee-for-Service DRG Adjustment Appeal" in this section for additional information.

7.3.3 Utilization Review Appeals

Hospitals may appeal adverse UR decisions made by the HHSC OIG UR Unit to the HHSC Medical and UR Appeals Unit. The written appeal request, with complete medical record and approved affidavit in section 6.5 of this handbook, 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 that follow.

Hospitals may appeal adverse HHSC OIG UR Unit determinations to the following address:

Texas Health and Human Services Commission
Medical and UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

7.3.3.1 Admission Denials, Continued Stay Denials for TEFRA Hospitals, DRG Revisions, and Cost/Day Outlier Denials

If a hospital is dissatisfied with the original retrospective review conducted by the HHSC OIG UR Unit, it may submit a written request for an appeal to the HHSC Medical and Utilization Review Appeals Unit. The HHSC Medical and UR Appeals Unit is responsible for conducting an independent review in response to a provider's appeal. The professional staff uses only the documentation submitted in the medical record to determine whether an inpatient admission was appropriate and whether the diagnoses and procedures were correct. The HHSC UR and Medical Appeals physician performs a complete review for the medical necessity of inpatient admission, DRG validation, quality of care, continued stay medical necessity, and ancillary charges (TEFRA cases) using the medical record documentation submitted on appeal. After completion of the review, the physician 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 subsection 4.2.4, "Outpatient Observation Room Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

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: Form 7.1, "Business Records Affidavit Form" in this section.

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 displeased with the appeals decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Medical and UR Appeals physician. The educational conference is held by telephone between the physician and the hospital medical director or attending physician. This is an opportunity for the physicians to discuss the deciding factors in the case and any hospital billing processes that may have affected the adjudication of the case. The educational conference will not alter the previous appeal decision.

The HHSC Medical and Utilization Review Unit recognizes that hospital staff may use guidelines, such as the *American Hospital Association's Coding Clinic,* to assist them in identifying diagnoses or procedures for statistical and billing purposes. However, the HHSC Medical and Utilization Review Appeals Unit determines the appropriate diagnoses or procedures for reimbursement purposes using the documentation in the medical record (submitted on appeal) and the following guidelines:

- *Principal diagnosis assignment.* The diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during the admission to the hospital.

- *Secondary diagnosis assignment.* Conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care or monitoring, or, in the case of a newborn (birth through 28 days of age), which the physician deems to have clinically significant implications for future health care needs. Normal newborn conditions or routine procedures should not be considered as complications or comorbidities for DRG assignment.

If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, not sequenced correctly, or have been omitted, the codes may be changed, added, or deleted by the HHSC Medical and UR Appeals physician. When it is determined the diagnoses or procedures are substantiated and sequenced correctly, a final DRG assignment is made.

7.3.3.2 Final Technical Denials

Hospitals may submit a request for a written appeal to HHSC Medical and UR Appeals only if the hospital has evidence that the HHSC OIG UR Unit issued a final technical denial in error, or did not provide proper notification of the preliminary technical denial. The request must include a letter explaining the reasons why the HHSC OIG UR decision is incorrect and a copy of the HHSC OIG UR decision letter.

The written appeal request must be received by HHSC Medical and UR Appeals within 120 days of the date of the original HHSC OIG UR decision letter. If the request is not received within the 120 days, the appeal is not conducted and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request.

If the appeal time frame is met, the HHSC Medical and UR Appeals Unit reviews all the documentation and renders a final decision on the case. If it is determined the technical denial was issued correctly by the HHSC OIG UR Unit, HHSC's decision is upheld. The hospital is notified in writing of the decision. This decision is the final decision.

If it is determined that the final technical denial decision should be overturned, the HHSC Medical and UR Appeals Unit will request a copy of the complete medical record and an original, properly completed, notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. The HHSC Medical and UR Appeals physician performs a complete review for the medical necessity of the admission, DRG validation, quality of care or continued stay, and ancillary charges (for TEFRA Hospitals) using only the medical record documentation. After completion of the review, the physician renders a final decision on the case. The hospital is notified in writing of the final decision.

If the requested documentation is not received within the required 21-day time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered final.

7.3.4 Provider Complaints

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

Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. Complaints to TMHP may be submitted using the following methods:

- By telephone at 1-800-925-9126
- By fax to 1-888-235-8399
- In writing to:

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

Questions regarding the complaint process or the status of a complaint should be directed to the TMHP Contact Center at 1-800-925-9126.

7.3.4.1 Provider Complaint Policy

TMHP takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, TMHP works with the provider to resolve the issue or directs the complaint to the appropriate department.

The Medical Affairs Division handles complaints that relate to utilization of services (including ER use), denial of continued stay, and all clinical and access issues. This includes provider's appeal of an adverse authorization decision.

If the complaint relates to a medical issue, the Medical Affairs Division staff may assist in resolving the complaint. The provider complaints process applies only to the resolution of disputes within the control of Texas Medicaid, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other Texas Medicaid providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC.

7.3.4.2 Provider Complaint Process

The TMHP Complaints Resolution Department Unit handles all provider complaints. The processing of a provider's complaint is described as follows:

- Providers must submit their complaint by telephone or in writing (mail or fax). All requests to remove clients from panel reports must be submitted in writing.
- Providers will receive a written acknowledgement letter from TMHP within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.
- If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint.

Providers who believe they did not receive due process regarding their complaint from TMHP may file a complaint with HHSC. Providers are encouraged to utilize the appeals and grievance process with TMHP before filing a complaint with HHSC.

7.3.4.3 Complaints to HHSC—Texas Medicaid Fee-for-Service

Texas Medicaid fee-for-service providers may file complaints to the HHSC Claims Administrator Contract Management if they find they did not receive full due process from TMHP in the management of their appeal. Texas Medicaid fee-for-service providers must exhaust the appeals and grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Contract Management.

Refer to: Subsection 7.3, "Appeals to HHSC Texas Medicaid Fee-for-Service" in this section for information about submission of an appeal to HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning Texas Medicaid. The term *complaint* does not include the following:

- A misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.
- A provider's oral or written dissatisfaction with an adverse determination.

Under the complaint process, the HHSC Claims Administrator 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 and services in question, if applicable.
- Provider's original claim or billing record, electronic or manual, if applicable.
- Provider's internal notes and logs when pertinent.
- Memos from HHSC or TMHP indicating any problems, policy changes, or claims' processing discrepancies that may be relevant to the complaint.
- Other documents, such as certified mail receipts, original date-stamped envelopes, in-service notes, or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

7.4 Cost Report Settlement Appeal Process

A provider who is dissatisfied with the determination contained in the Notice of Program Reimbursement (NPR) from TMHP Medicaid Audit may request an appeal as follows:

- The request for appeal must be in writing.
- The request for appeal must be filed within 180 calendar days from the date of receipt of the NPR.
- If the amount in controversy is at least $1,000, the request for the appeal must be filed with TMHP Medicaid Audit.
- If the NPR shows that the provider is indebted to Texas Medicaid, TMHP must take the necessary action to recover the overpayment, including a suspension of interim payments. This process will take place even if an appeal has been requested.

7.4.1 Appeals to TMHP Medicaid Audit

A provider's request to appeal his or her NPR must include the following:

- Identify specific individual items in TMHP Medicaid Audit's determination with which the provider disagrees.
- Give the reasons the provider believes these are incorrect.
- Identify the amount in controversy for each item and provide a calculation of that amount.

The appeal may include any materials the provider believes will support its position.

TMHP Medicaid Audit completes a desk review of the appeal within six months of the date of receipt of complete documentation supporting the appeal. TMHP does the following:

- Reviews the materials submitted by the provider.
- Informs the provider if it appears that the request for an appeal was not timely or the amount of controversy is not at least $1,000.
- Reviews the record that formed the basis for the determination of the total payment due to the provider.
- Attempts to resolve as many points in controversy as possible with the provider and inform him or her in writing the issues that have been resolved and those that the provider may appeal to HHSC.
- Ensures all available documentation in support of the provider or TMHP Medicaid Audit is part of the record.

To appeal to TMHP Medicaid Audit, send the written notice within 120 days of receipt of the NPR letter to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit Operations Director
PO Box 200345
Austin, TX 78720-0345

7.5 Forms

7.1 Business Records Affidavit Form

BUSINESS RECORDS AFFIDAVIT

THE STATE OF TEXAS

COUNTY OF _____

I, _____, Custodian of Records for
(Custodian of Records Printed Name)

_____, _____,
(Provider or Facility Printed Name) (Provider or Facility Printed Address)

_____, Texas, do hereby certify that I am of sound mind,
(Provider or Facility Printed City)

capable of making this affidavit, and personally acquainted with the facts stated herein.

Attached hereto are _____ pages of records from the above listed provider or facility. The said pages were kept by the above listed provider or facility in the regular course of business, and it was the regular course of business for me and any employee or representative of the above listed provider or facility 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 exact duplicate of the original and no other documents exist on the file for _____,
(Printed Patient Name)

Medicaid recipient # :_____ for the time period _____.
(PCN) (Admission and Discharge Date)

_____
(Affiant's Signature)

SWORN TO AND SUBSCRIBED before me on this the _____ day of _____, 20____.

_____
(Notary Public, State of Texas)

SEAL

_____
(Notary's printed name)

My commission expires: _____

7.2 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

7.3 Credit Balance Refund Worksheet

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

APPENDIX A: STATE AND FEDERAL OFFICES COMMUNICATION GUIDE

A.1 Texas Health and Human Services Commission (HHSC) and Texas Department of State Health Services (DSHS) Office Addresses

Use the following address for general inquiries or for any group that is not listed in the table below:

Texas Health and Human Services Commission
PO Box 13247
Austin, TX 78711-3247

Note: *Remember to use the four-digit addition to the ZIP code.*

Use the following address for the HHSC Inspector General:

Texas Health and Human Services Commission
Office of Inspector General
PO Box 85200
Austin, TX 78708-5200

Note: *Remember to use the four-digit addition to the ZIP code.*

For the following groups, use the corresponding address and include the group name on the second line of the address.

Address	Group Name
HHSC Medicaid CHIP–H-200 PO Box 85200 Austin, TX 78708	
HHSC Quality Review/Limited Program—1323 PO Box 85200 Austin, TX 78708	
HHSC Third Party Liability (TPL) PO Box 85200 Mail Code 1354 Austin, TX 78708-5200	
HHSC Medical and UR Appeals H-230 PO Box 85200 Austin, TX 78708	
HHSC Medicaid Vendor Drug H-630 PO Box 85200 Austin, TX 78708	
DSHS (Group Name) (Mail Code) PO Box 149347 Austin, TX 78714-9347	Children with Special Health Care Needs (CSHCN) Services Program (Mail Code 1938) Family Planning (Mail Code 1920) Genetic Services Indigent Health Care (Mail Code 2831) Texas Health Steps (THSteps) (Mail Code 1938) Case Management for Children and Pregnant Women (Mail Code 1938)

A.2 HHSC Regional Offices of Eligibility Services (OES)

Region	OES Officer	Regional Director			Administrative Assistant
01 Lubbock	Bo Platt	Beth Miller	Office:	(806) 783-6637	Shenaz Haney
	(512) 206-4836	6302 Iola Avenue	FAX:	(806) 783-6630	(806) 783-6632
		Lubbock, TX 79424	Mail Code: 217-1		
		Amarillo: (806) 356-3151	Toll Free:	1-888-440-5688	
02/09 Abilene	Bo Platt	Jerry Flores	Office:	(325) 795-5526	Gayle Armstrong
	(512) 206-4836	4601 South First Street	FAX:	(325) 795-5523	(325) 795-5522
		Abilene, TX 79604	Mail Code: 001-1		
		PO Box 521 Abilene, TX 79604	Toll Free:	1-866-480-2553	
03 Grand Prairie	Kathy Cox	Tracy Hays	Office:	(972) 337-6171	Sharon Schwalm
	(512) 206-5656	801 South State Hwy 161	FAX:	(972) 337-6298	(972) 337-6198
		Grand Prairie, TX 75051	Mail Code: 012-5		Michelle McNeil
		PO Box 532089 Grand Prairie, TX 75053-2089	Toll Free:	1-877-236-6500	(972) 337-6173
04 Tyler	Patrick Oyelola	Fay Booker	Office:	(903) 509-5142	Charlotte Wade
	(512) 206-5250	302 East Rieck Road	FAX:	(903) 509-5133	(903) 509-5125
		Tyler, TX 75703	Mail Code: 313-5		
			Toll Free:	1-866-480-2554	
05 Beaumont	Patrick Oyelola	Stephanie Semien	Office:	(409) 951-3425	Michelle Slugher
	(512) 206-5250	285 Liberty, 11th Floor	FAX:	(409) 951-3449	(409) 951-3413
		Beaumont, TX 77701	Mail Code: 028-1		
			Toll Free:	1-866-480-2555	
06 Houston	Cheryl Evans	Gwen Robinson	Office:	(713) 767-2417	Rosie Molano
	(512) 206-5135	5425 Polk Street, Suite 240D	FAX:	(713) 767-2323	(713) 767-2491
		Houston, TX 77023	Mail Code: 178-7		
		PO Box 16017 Houston, TX 77222-6017	Toll Free:	1-800-500-4266	
07 Austin	Kathy Cox	Sandra Dillett	Office:	(512) 832-7617	Melissa Boyd
	(512) 206-5656	4616-1 West Howard Lane, Suite 120	FAX:	(512) 832-7665	(512) 832-7692
		Austin 78728	Mail Code: 016-1		
			Toll Free:	1-866-480-2556	
08 San Antonio	Bo Platt	Grace Moser	Office:	(210) 619-8226	Bertha Ortiz
	(512) 206-4836	11307 Roszell	FAX:	(210) 619-8293	(210) 619-8019
		San Antonio, TX 78217	Mail Code: 279-4		
		PO Box 23990 San Antonio, TX 78223	Toll Free:	1-877-322-3233	

Region	OES Officer	Regional Director			Administrative Assistant
10 El Paso	Cheryl Evans	Margaret Adame	Office:	(915) 834-7580	Barbara Lopez
	(512) 206-5135	401 East Franklin	FAX:	(915) 834-7582	(915) 834-7581
		El Paso, TX 79901	Mail Code: 111-1		
		PO Box 981017 El Paso, TX 79998-1017	Toll Free:	1-866-480-2557	
11 Edinburg	Patrick Oyelola	Cynthia Pena	Office:	(956) 316-8272	Karina Tovar
	(512) 206-5250	2520 South Veterans Road	FAX:	(956) 316-8175	(956) 316-8277
		Edinburg, TX 78539	Mail Code: 108-1		Benito Narro
		PO Box 960 Edinburg, TX 78540-0960	Toll Free:	1-866-480-2558	(956) 316-8361
ART		Ramon Gamboa (Interim)	Office:	(806) 783-6626	Melissa Coates
		6302 Iola Ave	FAX:	(806) 783-6630	(281) 344-3496
		Lubbock, TX 79424	Mail Code: 270-7		
Customer Care Center	Cheryl Evans	Kelly Ford	Office:	(903) 675-9748	Barbara Wright
	(512) 206-5135	891 West Corsicana	FAX:	(903) 675-1799	(903) 675-9716
		Athens, TX 75751	Mail Code: 120-4		
		Program Includes: CBS/CPC/WHP/CCC			
Data Integrity	Monica Shepherd	Data Integrity Program Manager Vacant	Office:	(512) 706-7175	Gregory Maxwell (512) 706-7125
	(512) 206-4842	1106 Clayton Lane, Suite 450E	FAX:	(512) 706-7150	
		Austin, TX 78723	Mail Code: Y-922		
MEPD	Eric McDaniel	Cindy Fortress (Interim)	Office:	(512) 206-5560	Barbara Tejero
	(512) 506-4564	909 West 45th Street	FAX:	(512) 206-5041	(512) 206-5438
		Austin, TX 78751	Mail Code: 992-6		

OES can also be contacted by fax at (512) 206-5273. For additional office information, visit the HHSC website at www.hhsc.state.tx.us.

Refer to: Subsection A.5, "DSHS Health Service Regions Map" in this appendix to identify the regional boundaries.

A.2.1 Telephone Communication with HHSC and DSHS

Contact	Telephone Number
Assessment Utilization Services (limited program) (Option 4)	1-800-436-6184
HHSC Hearing Services for Children (HSC) (hearing aid, evaluations)	1-800-925-9126
DSHS Emergency Medical Services Division	(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
Medicaid Vendor Drug Program Pharmacy Provider Resolution Helpdesk (fee-for-service)	1-800-435-4165

A.3 Client Telephone Communication with HHSC

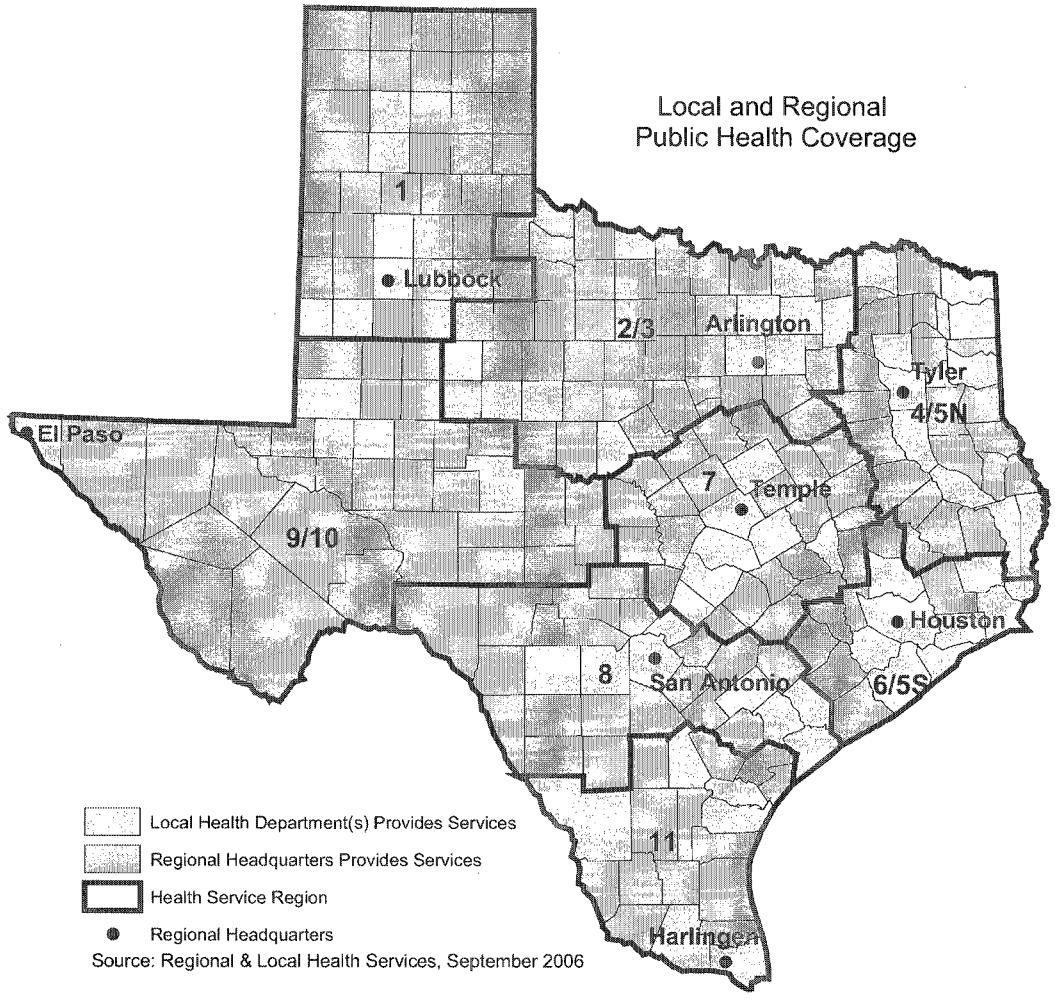
Clients can call the client toll-free number at 1-800-252-8263.

A.4 Federal and State Telephone Numbers

Telephone Number	Department/Program
1-800-CDC- INFO (1-800-232-4636)	AIDS Hotline (Nationwide, distributed by Centers for Disease Control and Prevention [CDC], Atlanta, Georgia)
1-800-299-2437	HIV/STD InfoLine
1-800-255-1090	Texas HIV Medication Program
1-800-252-5400	Child/Elder Abuse Intake (Department of Family and Protective Services [DFPS])
(512) 776-7420	Vision and Hearing Screening Program (DSHS)
(512) 834-6650, Ext. 2601	*Clinical Laboratory Improvement Amendments* (CLIA) Certification Line
1-800-458-9858	Client Abuse Hotline for Long Term Care Services and Support— Nursing Facilities (HHSC)
1-800-252-8263	Client Inquiry Hotline (HHSC) (Medicaid questions from clients with Medicaid only)
(512) 776-7745	THSteps Program (DSHS)
1-888-963-7111 ext. 7318 or (512) 776-7318 Fax: (512) 776-7294	THSteps Laboratory Services (DSHS)
1-888-963-7111 ext. 7661 or (512) 776-7661 Fax: (512) 776-7672	Laboratory Supply Orders (DSHS)
1-888-963-7111 ext. 7578 or (512) 776-7578	Report of Laboratory Test Results (DSHS)
(210) 531-4596	Adolescent Preventive Visit Pap Smear Supplies/Forms Texas Center for Infectious Disease (Women's Health Laboratories)
(512) 776-7796	DSHS Family Planning (Titles V, X, and XX only)
1-800-436-6184	Fraud or Abuse of Provider Services (HHSC Office of Inspector General)
1-800-436-6184	Fraud or Abuse/Long Term Care Services and Support—Nursing Facilities/HHSC
1-800-436-6184	Fraud or Abuse/Client/HHSC Office of the Inspector General
1-800-792-1109	Goal-Directed Therapy
(512) 438-3169 or 1-800-252-8010	Hospice Program (HHSC Policy Development division)
1-800-252-9152	Immunization Branch (DSHS)
1-800-925-9126	Medically Needy Spend Down Unit
1-800-MEDICARE or 1-800-633-4227	Medicare/Social Security Administration
1-800- 925-9126	Newborn Screening (DSHS)
1-800-925-9126	HHSC Hearing Services for Children (HSC)
1-800-628-5115	DARS Inquiries Line (for information about ECI or to refer a child.)
1-800-436-6184	Recipient Utilization Control Unit (HHSC) (for limited status review and for referrals from providers for potential client overutilization, etc.)
(512) 776-7796	Breast and Cervical Cancer Services (DSHS)
(713) 526-2559	Snellen Letter (Tumbling E Wall Chart)
1-800-435-4165	Medicaid Vendor Drug Program (HHSC) (fee-for-service) (specifically for pharmacy use)
1-877-728-3927	Medicaid Vendor Drugs Prior Authorization Center (fee-for-service)

Telephone Number	Department/Program
1-866-993-9972	Medicaid Women's Health Program Eligibility
(512) 776-7796	Cervical Cancer Screening

A.5 DSHS Health Service Regions Map



A.6 DSHS Health Service Region Contacts

Health Service Region 1 Regional Office (Lubbock)	Health Service Regions 2 & 3 Regional Office (Arlington)
DSHS/PHR 1 6302 Iola Ave. Lubbock, TX 79424 (806) 744-3577 Fax: (806) 783-6435	DSHS/PHR 2 & 3 1301 S. Bowen, Suite 200 Arlington, TX 76013 (817) 264-4500 Fax: (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

Health Service Region 1 Regional Office (Lubbock)	Health Service Regions 2 & 3 Regional Office (Arlington)
Manager of Social Work Services and Case Management Pat Greenwood, MSSW, LMSW	Manager of Social Work Services and Case Management Crystal Womack, MSSW, LMSW-AP
Communicable Disease Manager Vacant	Director of Clinic Operations Dorothy Kuhlmann, RN
Immunization Program Manager Keila Johnson	Immunization Program Manager Sonna Sanders
Tuberculosis Team Leader Melanie Lee	Communicable Disease Program Manager Gary Willett
THSteps Operations Lead Elizabeth Stanford 6302 Iola Ave Lubbock, TX 79424 Mail Code: 1899 (806) 783-6445 Fax: (806) 783-6430	Tuberculosis Team Leader Jeff Ralston Emergency Preparedness Bryan Flow, DVM
DSHS Regional Family Planning Specialist Patricia Rennie 1101 Camino La Costa Austin, TX 78752 (512) 467-9875 Fax: (512) 451-1468	THSteps Operations Lead Karen Riley 1301 S. Bowen Road #200, Mail Code 1905 Arlington, TX 76013 (817) 264-4918 Fax: (817) 264-4910
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 (817) 264-4743 Fax: (817) 264-4912	HIV/STD Program Manager Vacant
	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 (817) 264-4743 Fax: (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 (903) 595-3585 Fax: (903) 593-4187	DSHS 6 & 5 South 5425 Polk Avenue, Suite J Houston, TX 77023 (713) 767-3000 Fax: (713) 767-3049
Public Health Director Dr. Paul K. McGaha, DO, MPH	Public Health Director (acting Regional Medical Director) John G. Jordan, M.D., MPH
Deputy Regional Director Vacant	Deputy Regional Director Greta Etnyre, MS, RD
Manager of Social Work Services and Case Management Peggy Wooten, LCSW, ACSW	Manager of Social Work Services and Case Management Raymond Turner, MA, LMSW-AP
Director of Nursing Barbara Lay, RN, MSN	Director of Nursing Melinda Denson, RN, MPH

Health Service Regions 4 & 5 (North) Regional Office (Tyler)	Health Service Regions 6 & 5 (South) Regional Office (Houston)
Immunization Program Manager Toni Wright	Immunization Program Manager Angel H. Angco, MBA, RN
HIV/STD Program Manager Charles O'Brien	HIV/STD Program Manager Linda Hollins
Tuberculosis Program Manager Teresa Santiago, RN	Tuberculosis Program Manager Lewis Gonzalez, MD
THSteps Operations Lead Caleb Rackley 1517 W. Front, Mail Code 1358 Tyler, TX 75702 (903) 533-5357 Fax: (903) 595-4706	THSteps Operations Lead Sharon Hill 5425 Polk Avenue, Suite J, Mail Code 1906 Houston, TX 77023-1497 (713) 767-3105 Fax: (713) 767-3125
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 (903) 232-3292 Fax: (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 (903) 232-3292 Fax: (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 (254) 778-6744 Fax: (254) 778-4066	DSHS/PHR 8 7430 Louis Pasteur Drive San Antonio, TX 78229 (210) 949-2000 Fax: (210) 949-2015
Public Health Director Lisa Cornelius, MD, MPH	Public Health Director Sandra Guerra-Cantu, MD, MPH
Deputy Regional Director Jon Huss	Deputy Regional Director Gail Morrow, MPH
Manager of Social Work Services and Case Management Eileen Walker, MS, LBSW	Manager of Social Work Services and Case Management Sylvia Carrizales
Director of Nursing Pauline Culbert, MSN, RN	Director of Nursing Sandra Jones, MSN, CNS
Immunization Program Manager Diane Romnes	Immunization Program Manager Laurie Henefey
HIV/STD Program Manager Al Gonzales	Communicable Disease Program Manager Cherise Rohr-Allegrini, PhD
Tuberculosis Program Manager/Nurse Consultant Dana Schoepf, RN	HIV/STD Program Manager Joanna Nichols, MPH
THSteps Operations Lead Kimberly Langley 2408 S. 37th Street, Mail Code 1902 Temple, TX 76504 (254) 778-6744 Fax: (254) 773-2722	THSteps Operations Lead Velma Stille 7430 Louis Pasteur Drive, Mail Code 5716 San Antonio, TX 78229 (210) 949-2159 Fax: (210) 949-2041

Health Service Region 7 Regional Office (Temple)	Health Service Region 8 Regional Office (San Antonio)
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 (254) 778-6744 Ext. 2851 Fax: (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 (830) 372-0841 Fax: (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 (915) 834-7682 Fax: (915) 834-7808	DSHS/PHR 11 601 W. Sesame Drive Harlingen, TX 78550 (956) 423-0130 Fax: (956) 444-3293
Public Health Director James A. Zoretic, M.D., M.P.H., Interim Regional Medical Director	Public Health Director Brian Smith, MD, MPH
Deputy Regional Director Blanca Serrano, MPH, RS	Deputy Regional Director Sylvia Garces-Hobbs
Manager of Social Work Services and Case Management Donna Cordoni	Manager of Social Work Services and Case Management Vacant
Director of Nursing Sharon Lindsey, RN	Director of Nursing Darlene Farias, RN
Immunization Program Manager Jose Padilla	Immunization Program Manager Ivette Nunez
HIV/STD Program Manager Oscar Hernandez	HIV/STD Program Manager Richard Anguiano
Communicable Disease Manager Gale Morrow, MPH, CHES	Tuberculosis Program Manager Maria San Pedro, MSPHN, RN
THSteps Operations Lead Arturo Diaz, Jr. 401 E. Franklin, Suite 200, Mail Code 1903 El Paso, TX 79901 (915) 834-7735 Fax: (915) 834-7802	THSteps Operations Lead Ray Garza 601 W. Sesame Drive, Mail Code 1869 Harlingen, TX 78550 (956) 421-5563 Fax: (956) 444-3293
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 (254) 778-6744 Ext. 2852 Fax: (254) 773-2722	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Berta Cavazos 601 W. Sesame Drive Harlingen, TX 78550 (956) 423-0130 Fax: (956) 444-3299

A.7 State Participating Local Health Departments and Public Health Districts

State Participating Local Health Departments and Public Health Districts	
Abilene Public Health Department Region 2/3 Larry Johnson, Administrator PO Box 6489 (79608-6489) 850 N. 6th Street Abilene, TX 79605 (325) 692-5600 Fax: (325) 734-5370	Hidalgo County Health Department Region 11 Eduardo Olivarez, Administrator Omar Garza, MD, Director 1304 South 25th Street Edinburg, TX 78539-7205 (956) 383-6221 Fax: (956) 444-3298
Amarillo Bi-City-County Health District Department of Health Roger Smalligan, MD, Health Authority, Matt Richardson, Director for the City of Amarillo Department of Health 1000 Martin Road Amarillo, TX 79107 (806) 378-6300 Fax: (806) 378-6306	Houston Health & Human Services Department Region 6/5 S Stephen L. Williams, MD, MPH, Director 8000 North Stadium Drive Houston, TX 77054 (713) 794-9311 Fax: (713) 798-0862
Andrews City-County Health Department Region 9/10 Robert Garcia, MD, Director 208 NW 2nd street Andrews, TX 79714 (432) 524-1434 Fax: (432) 524-1461	Jackson County Health Department Region 8 Bain C. Cate, MD, Director 411 North Wells, Room 206 Edna, TX 77957 (361) 782-5221 Fax: (361) 782-7312
Angelina County & Cities Health District Region 4/5N Sharon Shaw, Administrator John Rudis, MD, Director Lufkin, TX 75904 (936) 632-1139 Fax: (936) 632-2640	Jasper-Newton County Public Health District Region 4/5 N Danny Brackin 139 West Lamar Street Jasper, TX 75951 (409) 384-6829 Fax: (409) 384-7861
Atascosa County Health Department Region 8 Gerald B. Phillips, MD, Director 1102 Campbell Avenue Jourdanton, TX 78026 (830) 769-3451 Fax: (210) 769-2349	Jefferson County Health Authority Cecil A. Walkes, MD 1295 Pearl Street Beaumont, TX 77701 (409) 835-8530 Fax: (409) 839-2353
Austin Department of Health & Human Services Region 7 Health District David Lurie, Director 7201 Levander Loop, Bldg. E Austin, TX 78744 (512) 927-5010 Fax: (512) 972-5016	Liberty County Health Authority Steven C. Ellerbe, DO 720 Travis Liberty, TX 77575 (936) 336-6439 Fax: (936) 336-6517
Beaumont City Health Department Region 5/6 S Ingrid West-Holmes, Director PO Box 3827 950 Washington Blvd Beaumont, TX 77704 (409) 832-4000 Fax: (409) 832-4270	Live Oak County Health Department Region 11 Alan Crouther, Director Drawer 670 (78022) Live Oak County Courthouse George West, TX 78022 (361) 449-2733 Fax: (361) 449-1013

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 (254) 773-4457 Fax: (254) 773-7535	Lubbock City Health Department Region 1 Nancy Haney, Director PO Box 2548 (79408) 1902 Texas Avenue Lubbock, TX 79405 (806) 775-2899 Fax: (806) 775-3209
Brazoria County Health Department Region 6/5 S Leo D. O'Gorman, MD, MPH, Director 432 East Mulberry Angleton, TX 77515 (979) 864-1484 Fax: (979) 756-1456	Maverick County Health Department Region 8 Arturo Batres, MD, Director 490 S. Bibb Eagle Pass, TX 78852 (830) 773-9438 Fax: (830) 773-6450
Brazos County Health Department Region 7 Ken Bost, Executive Director 201 North Texas Avenue Bryan, TX 77803-5317 (979) 361-4440 Fax: (409) 823-6993	Marshall-Harrison County Health District Region 4/5 N Robert Palmer, MD, Director 805 Lindsey Drive Marshall, TX 75670 (903) 938-8338 Fax: (903) 938-8330
Brownwood-Brown County Health Department Region 2/3 Russ Skinner, MD, Director PO Box 1389 Brownwood, TX 76804 (325) 646-0554 Fax: (325) 643-8157	Medina County Health Department Region 8 John W. Meyer, MD, Director 3103 Avenue G Hondo, TX 78861 (830) 741-6191 Fax: (830) 426-4202
Calhoun County Health Department Region 8 Bain C. Cate, Director 117 West Ash Port Lavaca, TX 77979 (361) 552-9721 Fax: (361) 552-9722	Midland County Health Department Region 9/10 Celestino Garcia, RS, Administrator James M. Humphreys, Jr., MD, Director Mailing address: PO Box 4905 Midland, TX 79704 Physical address: 3303 West Illinois St., Space 22 Midland, TX 79703 (432) 681-7613 Fax: (432) 681-7634
Cameron County Health Department Region 11 Yvette Salinas, Administrator 1390 W. Ex. 83 San Benito, Tx. 78586 (956) 247-3685 Fax: (956) 361-8280	Milam County Health Department Region 7 Patsy Gaines, Director PO Box 469 (76520) 209 South Houston Street Cameron, TX 76520 (254) 697-7039 Fax: (254) 697-4809
Cass County Health Department Region 4/5 N R. Bruce LeGrow, MD, Director PO Box 310 (75563) South Kaufman and Rush Linden, TX 75563 (903) 756-7051 Fax: (214) 796-3976	Montgomery County Health Department Region 6/5 S Vickie Modeland, Director 701 E. Davis, Ste. A Conroe, Tx. 77301 (936) 525-2800 Fax: (936) 539-4668

State Participating Local Health Departments and Public Health Districts	
Chambers County Health Department Region 6/5 S William Clay Brown, Director PO Box 670 (77514) 1222 Main Street Anahuac, TX 77514 (409) 267-8356 Fax: (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 (409) 883-6119 Fax: (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 (903) 683-4688 Fax: (903) 683-4899	Paris-Lamar County Health Department Region 4/5 N Anthony Bethel, Director PO Box 938 (75460) 740 South West 6th Street Paris, TX 75460 (903) 785-4561 Fax: (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 (214) 670-5711 Fax: (214) 670-3863	Plainview-Hale County Health District Region 1 John Castro, Director 111 East 10th Plainview, TX 79072 (806) 293-1359 Fax: (806) 293-5741
City of Laredo Health Department Region 11 Hector Gonzalez, Director PO Box 2337 (78044) 2600 Cedar Street Laredo, TX 78040 (956) 723-2051 Fax: (956) 726-2632	Port Arthur City Health Department Region 6/5 S Yoshi Alexander, Director 449 Austin Avenue Port Arthur, TX 77640 (409) 983-8800 Fax: (409) 983-8870
Collin County Health Care Services Region 2/3 Candy Blair, Director 825 North McDonald Street, Suite 130 McKinney, TX 75069 (972) 548-5500 Fax: (972) 548-7221	San Angelo-Tom Green County Health Department Region 9/10 Sandra Villarreal, Director Mailing address: PO Box 1751 (76902) Physical address: 106 S. Chadburne San Angelo, TX 76903 (325) 657-4493 Fax: (325) 657-4553
Colorado County Health Authority Raymond R. Thomas, MD 610 S. Austin Road Eagle Lake, TX 77434 (979) 234-2551 Fax: (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 (210) 207-8730 Fax: (210) 207-8999
Corpus Christi-Nueces County Public Health District/Region W Annette Rodriguez, Interim Director PO Box 9727 (78469) 1702 Horne Road Corpus Christi, TX 78416 (361) 851-7200 Fax: (361) 851-7295	San Patricio County Health Department Region 11 Josie Michael, Director James Mobley, MD, Director 313 North Rachal Sinton, TX 78387 (361) 364-6208 Fax: (361) 364-6117

State Participating Local Health Departments and Public Health Districts	
Corsicana-Navarro County Public Health District Region 2/3 Kent Rogers, MD, Director 618 North Main Corsicana, TX 75110 (903) 874-6731 Fax: (903) 872-7215	Scurry County Health Department Region 2/3 Cindy Wright, Director 911 26th Street Snyder, TX 79549 (325) 573-3508 Fax: (325) 573-0380
Cuero-DeWitt County Health Department Region 8 Bain C. Cate, MD, Director 106 North Gonzales Street Cuero, TX 77954 (361) 275-3461 Fax: (361) 275-5732	Smith County Public Health District Region 4/5 N George T. Roberts, Jr., F.A.C.H.E., Director 815 North Broadway Tyler, TX 75702-4507 (903) 535-0036 Fax: (903) 535-0052
Dallas County Health Department Region 2/3 Zachary S.Thompson, Director 2377 Stemmons Freeway Dallas, TX 75207-2710 (214) 819-6070 Fax: (214) 819-6022	South Plains Public Health District Region 1 Morris S. Knox, MD, Director 919 East Main Street Brownfield, TX 79316 (806) 637-2164 Fax: (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 (830) 774-7570 Fax:(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 (915) 235-5463 Fax: (915) 236-6856
Denton County Health Department Region 2/3 Bing Burton, Administrator 306 N. Loop 288, Suite 183 Denton, TX 76209 (940) 349-2900 Fax: (940) 349-2905	Texarkana-Bowie County Family Health Center Region 4/5 N Kathy Moore, Administrator 902 West 12th Texarkana, TX 75501 (903) 798-3255 Fax: (903) 793-2289
Ector County Health Department Region 9/10 Gino Solla, Director Nathan Galloway, MD, Director 221 North Texas Odessa, TX 79761 (432) 498-4141 Fax: (432) 498-4143	Uvalde City-County Health Department Region 8 Liz Barrett, RN, Director 1021 Garnerfield Road Uvalde, TX 78801 (830) 278-1705 Fax: (830) 278-1881
El Paso City-County Health and Environmental District/Region 9/10 Jorge Magaña, MD, Director 1148 Airway Blvd El Paso, TX 79925-3692 (915) 771-5701 Fax: (915) 543-3541	Victoria County Health Department Region 8 Bain C. Cate, MD, Director PO Box 2350 (77902) 2805 N. Navarro Victoria, Tx 77901 (361) 578-6281 Fax: (361) 578-7046

State Participating Local Health Departments and Public Health Districts	
Fort Bend County Health Department Region 6/5 S Jean Galloway, MD, Director PO Box 668 (77471) 4520 Reading Road, Suite A Rosenberg, TX 77471 (281) 342-6414 Fax: (281) 342-7371	Waco-McLennan County Public Health District Region 7 Roger Barker, MBA, Director 225 West Waco Drive Waco, TX 76707 (254) 750-5450 Fax: (254) 750-5452
Fort Worth-Tarrant County Department of Public Health Region 2/3 Daniel B. Reimer, Director Nick Curry, MD, Director 1800 University Drive Fort Worth, TX 76107 (817) 871-7201 Fax: (817) 871-7335	Walker County Health Authority Region 6/5 S M. Gebre-Selassie, MD 2804 Lake Road, #4 Huntsville, TX 77340 (936) 291-9600 Fax: (936) 291-1625
Galveston County Health District Region 6/5 S H. Mark Guidry, MD, MPH, Director PO Box 939 (77568) 1207 Oak Street La Marque, TX 77568 (409) 938-2401 Fax: (409) 938-2243 rmorris@gchd.org	Wichita Falls-Wichita County Public Health District Region 2/3 Lou Franklin, RN, BSN, Director Tom Edmonson, Administrator 1700 Third Street Wichita Falls, TX 76301 (940) 761-7805 Fax: (940) 767-5242
Grayson County Health Department Region 2/3 Wayne Bell 515 North Walnut Sherman, TX 75090 (903) 893-0131 Fax: (903) 892-3776	Williamson County and Cities Public Health District Region 7 W.S. Riggins, Jr., MD, MPH, Director PO Box 570 (78627) 100 W. 3rd Street Georgetown, TX 78626 (512) 943-3600 Fax: (512) 943-1499
Greenville-Hunt County Health Department Region 2/3 Mark Memahan, DO, Director Henry Underwood, DO, Director 4815 King Street, Ste. B Greenville, TX 75401 (903) 455-4433 Fax: (903) 455-4956	Wilson County Health Department Region 8 Edwin Baker, Director PO Box 396 (78114) Wilson County Courthouse Floresville, TX 78114 (830) 393-8503 Fax: (830) 393-6031
Hardin County Health Department Region 6/5 S Mary Pastor, Director PO Box 820 (77625) 440 W. Monroe Kountze, TX 77625 (409) 246-5188 Fax: (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 (903) 763-5406 Fax: (903) 763-2902
Harris County Health Department Region 6/5 S 2223 W. Loop South Houston, TX 77027 (713) 439-6016 Fax: (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 (210) 374-3010 Fax: (210) 374-3007

State Participating Local Health Departments and Public Health Districts	
Hays County Health Department Region N Larry Birdwell, DO, Director 401-A Broadway Drive San Marcos, TX 78666 (512) 353-4353 Fax: (512) 396-4656	

A.8 Department of Assistive and Rehabilitative Services (DARS), Blind Services

DARS, Blind Services	
Central Office Administrative Building 4800 North Lamar Administrative Building #110 Austin, TX 78756 1-800-628-5115 1-800-252-5204 (voice or TDD) Fax: (512) 377-0468	Laredo 313 West Village Blvd., Suite 112 Laredo, TX 78041-2275 (956) 523-8050 1-800-687-7030 Fax: (956) 523-8088
Abilene 4601 S. 1st Street, Suite M Abilene, TX 79605-1463 (325) 795-5840 1-800-687-7009 Fax: (325) 795-5850	Lubbock Corporate Center 5121 69th Street, Suite A-5 Lubbock, TX 79424-1631 (806) 783-2930 1-800-687-7032 Fax: (806) 783-2950
Amarillo 7120 I-40 West, Suite 100 Amarillo, TX 79106-2500 (806) 351-3870 1-800-687-7010 Fax: (806) 351-3885	Lufkin 3201 South Medford, #5 Lufkin, TX 75901-5796 (936) 630-3960 1-800-687-7033 Fax: (936) 630-3978
Austin 7517 Cameron Road #120 Austin, TX 78752-2053 (512) 533-7100 1-800-687-7008 Fax: (512) 459-0200	McAllen 801 Nolana, Suite 115 McAllen, TX 78504-3023 (956) 661-0930 1-800-687-7037 Fax: (956) 661-0940
Beaumont 550 Eastex Freeway, Suite D Beaumont, TX 77708 (409) 898-8490 1-800-687-7013 Fax: (409) 924-7360	Odessa 3016 Kermit Hwy., Suite A Odessa, TX 79764 (432) 334-5650 1-800-687-7034 Fax: (432) 332-3183
Bryan-College Station 1115-A Welsh College Station, TX 77840-4267 (979) 680-5290 1-800-687-7014 Fax: (979) 680-5287	San Angelo State of Texas Services Center 622 South Oakes, Suite D San Angelo, TX 76903-7035 (325) 659-7920 1-800-687-7038 Fax: (325) 659-7929

DARS, Blind Services	
Corpus Christi 410 S. Padre Island Drive, #103 Corpus Christi, TX 78405-4122 (361) 289-8710 1-800-687-7015 Fax: (361) 289-8737	San Antonio Trinity Building 4204 Woodcock Drive, #274 San Antonio, TX 78228-1324 (210) 785-2750 1-800-687-7039 Fax: (210) 785-2790
Dallas 6500 Greenville Ave., Suite 250 Dallas, TX 75206-1010 (214) 378-2600 1-800-687-7017 Fax: (214) 378-2630	Southeast 10060 Fuqua Houston, TX 77089-1337 (713) 948-7960 1-800-687-7036 Fax: (713) 948-7993
El Paso 401.E. Franklin, Suite #240 El Paso, TX 79901-1210 (915) 834-7004 1-800-687-7020 Fax: (915) 834-7072	Texarkana 410 Baylor, Suite C Texarkana, TX 75501-3290 (903) 255-3200 1-800-687-7040 Fax: (903) 255-3209
Fort Worth 4200 South Freeway, #307 Fort Worth, TX 76115-1404 (817) 759-3500 1-800-687-7023 Fax: (817) 759-3532	Tyler Woodgate Office Park, Building 1 1121 ESE Loop 323, Bldg. 1, #106 Tyler, TX 75701-9660 (903) 279-0970 1-800-687-7042 Fax: (903) 279-0992
Harlingen 1812 West Jefferson Harlingen, TX 78550-5247 (956) 336-3600 1-800-687-7025 Fax: (956) 366-3614	Victoria Town Plaza Mall 4102 N. Navarro Street, D-2 Victoria, TX 77901-2600 (361) 580-5700 1-800-687-7043 Fax: (361) 580-5737
Houston 427 West 20th, #407 Heights Medical Tower Houston, TX 77008-2430 (713) 802-3100 1-800-687-7028 Fax: (713) 802-3132	Waco 801 Austin Street, Suite 710 Waco, TX 76701-1937 (254) 753-1552 1-800-687-7044 Fax: (254) 753-1343
	Wichita Falls 3709 Gregory Street, Suite 102 Wichita Falls, TX 76308-1624 (940) 689-2740 1-800-687-7045 Fax: (940) 689-2749

APPENDIX B: VENDOR DRUG PROGRAM

Note: *The information in this section is effective on or after March 1, 2012.*

B.1 Vendor Drug Program

The Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs to those pharmacy providers contracted with the VDP. In-state pharmacies licensed as Class A or C by the Texas State Board of Pharmacy are eligible for enrollment in the VDP. Out-of-state pharmacies and pharmacies holding any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis, relative to the benefits made available to a client eligible for Texas Medicaid. Contracts are not granted to applicants unless additional benefits to the recipient are established.

VDP provides statewide access to prescription drugs as prescribed by treating physician or other health-care provider for clients eligible for:

- Medicaid fee-for-service
- Children's Health Insurance Program (CHIP)
- Children with Special Health Care Needs (CSHCN) Services Program
- Kidney Health Care (KHC)

S.B. 7. 82nd Legislature, First Called Session, 2011, requires the Texas Health and Human Services Commission (HHSC) to transition pharmacy benefits to the managed care service delivery model for most clients who are enrolled in Texas Medicaid and Children's Health Insurance Program (CHIP) statewide. By March 2012, the majority of Texas Medicaid and CHIP clients will receive their pharmacy benefits from a managed care plan. Vendor Drug will remain responsible as claims processor for Medicaid fee-for-service (FFS) clients.

Note: *Pharmacy services rendered to Medicaid managed care clients are administered by the clients' managed care organizations (MCOs).*

Refer to: *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care prescription drug and pharmacy benefits.

B.1.1 VDP Benefits for Medicaid Fee-for-Service (FFS) Clients

The Medicaid drug benefit for Medicaid FFS clients is limited to three prescriptions per month with the following exceptions that have unlimited prescriptions:

- Clients enrolled in waiver programs such as Community Living Assistance (CLASS) and Community-Based Alternatives (CBA)
- Texas Health Steps (THSteps)-eligible clients (clients who are 20 years of age and younger)
- Clients in skilled nursing facilities

Note: *Prescriptions for family planning drugs and supplies are not subject to the three-prescription limit.*

The following categories of drugs do not count against the three prescription per month limit:

- Family planning drugs
- Smoking cessation drugs
- Insulin syringes

FFS clients can be "locked-in" or "limited" to a specific pharmacy. FFS clients who are "locked-in" to a primary-care pharmacy have "LIMITED" printed on their Your Texas Benefits Medicaid card. Clients who are not "locked-in" to a specific pharmacy may obtain their drugs or supplies from any contracted Medicaid provider of pharmaceutical services.

Refer to: Subsection 4.4.2, "Client Limited Program" in Section 4, "Client Eligibility" (*Vol. 1, General Information*) 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 and are not subject to the three-prescription limit:

- Diaphragms
- Oral contraceptives
- Jellies, creams, foams, suppositories, vaginal contraceptive film, and contraceptive sponge
- Medication for treatment of vaginal/cervical/genital infections (subject to the three-prescription limit)

The VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment other than insulin syringes.

B.1.2 VDP Formulary Information

VDP drug formulary information is available to health-care providers to help their clients efficiently get their medications. Information includes which state health-care program covers the drug, whether a drug is on the Medicaid Preferred Drug List (PDL), whether a Medicaid non-preferred prior authorization or clinical prior authorization is required, and other important drug information. VDP drug formulary information is available:

- Online at www.txvendordrug.com (All state health-care program formulary information with prior authorization type (PDL or clinical) required indicator)
- Online at www.txvendordrug.com/formulary/enhanced-form-search.shtml. Here providers can find Medicaid drug formulary and PDL information with links attached to selected non-preferred drugs that will guide providers to the preferred drugs in that therapeutic class.
- Through Epocrates, a free drug information service that can be downloaded to your Palm, BlackBerry, Windows Mobile phone, or iPhone. In addition to listing a drug's preferred status, Epocrates includes drug monographs, dosing information, and warnings. For more information, go to www.epocrates.com. All providers are also eligible to register for Epocrates.

B.1.3 Obtaining Outpatient Prescribed Drug Prior Authorization for FFS Clients

To obtain prior authorization for any VDP medication for FFS clients, prescribing providers or their representatives should call the Texas Prior Authorization Hotline at 1-877-PA-TEXAS (1-877-728-3927). The Hotline is available Monday through Friday, 7:30 a.m. to 6:30 p.m. Central Time. To submit an online VDP prior authorization request for non-preferred drugs, prescribing providers must first register online at https://paxpress.txpa.hidinc.com. For Synagis prior authorization, see subsection B.3, "Palivizumab (Synagis) Available Through the VDP" in this appendix.

> ***Note:*** *Pharmacists cannot obtain prior authorization for medications. If the client arrives at the pharmacy without prior authorization for a non-preferred drug, the pharmacist will alert the provider's office and ask the provider to get prior authorization.*

B.1.4 Dispensing Life of Prescriptions

Medicaid prescriptions for noncontrolled substances are valid one year and up to 11 refills if authorized by prescriber.

Medicaid prescriptions for controlled substances in drug classes C3-C5 are valid for six months and up to 5 refills if authorized by prescriber provider.

Medicaid prescriptions controlled substances in C2 drug class have no refills and must be dispensed within 21 days of the date on which the prescription was written.

Refer to: VDP *Pharmacy Provider Procedure Manual* at txvendordrug.com/downloads/index.asp.

Texas State Board of Pharmacy website at www.tsbp.state.tx.us/rules/for rules about issuance of identical sets of C2 prescriptions.

B.1.5 VDP Contact Information

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	(512) 491-1429
Policy	(512) 491-1157
Administration	(817) 321-8092
Drug formulary (Texas listing of national drug codes)	(512) 491-1157
Texas Prior Authorization Center Hotline	1-877-728-3927

B.1.6 72-Hour Emergency Supply

Federal and Texas law requires that a 72-hour emergency supply of a prescribed drug be provided when a medication is needed without delay and prior authorization is not available. This rule applies to non-preferred drugs on the Preferred Drug List (PDL) and any drug that is affected by a clinical or therapeutic prior authorization edit and needs the prescriber's prior approval.

Refer to: VDP website at www.txvendordrug.com/pdl/72hour.shtml.

B.1.7 Cost Avoidance Coordination of Benefits

Cost avoidance coordination of benefits (COB) for pharmacy claims ensures compliance with the Centers for Medicare & Medicaid Services (CMS) regulations. Under federal rules, Medicaid agencies must be the payer of last resort. The cost avoidance model checks for other known insurance at the point of sale, preventing Medicaid from paying a claim until the pharmacy attempts to obtain payment from the client's third party insurance.

Refer to: VDP *Pharmacy Provider Procedure Manual* at txvendordrug.com/downloads/index.asp.

B.1.8 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the VDP were written on a compliant tamper resistant pad.

CMS has stated that special copy-resistant paper is not a requirement for electronic medical records (EMRs) or ePrescribing-generated prescriptions. These prescriptions may be printed on plain paper and will be fully compliant if they contain at least one feature from each of the following three categories:

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

Two features that can be incorporated into computer-generated prescriptions printed on plain paper to prevent passing a copied prescription as an original prescription are as follows:

- Use a very small font that is readable when viewed at 5x magnification or greater and illegible when copied.

- Use a "void" pantograph accompanied by a reverse "Rx," which causes a word such as "Void" to appear when the prescription is photocopied.

Refer to: *VDP Pharmacy Provider Procedure Manual* at txvendordrug.com/downloads/index.asp.

B.1.9 Schedule II Controlled Substances (CII) through Schedule V Controlled Substances (CV)

Effective September 1, 2008, pharmacies must report all CIII, CIV, and CV prescriptions to the Texas Department of Public Safety (DPS) in addition to the CII prescriptions that are already being reported. This DPS process requires reporting by the DPS registration number of the practitioner issuing the prescription. The prescription forms for Schedule CII controlled substances that are issued by the Texas Department of Public Safety (DPS) under the Texas Prescription Program meet the baseline standards set forth above.

Refer to: The DPS website at www.txdps.state.tx.us/RegulatoryServices/narcotics/narccsr.htm.

B.1.10 Free Delivery of Medicaid Prescriptions for FFS Clients

Many Medicaid pharmacies across the state offer free delivery of prescriptions to Medicaid FFS clients. To find out which pharmacies offer home delivery, refer FFS clients to the HHSC website at www.txvendordrug.com/delivery-pharmacies.pdf. Contracted Medicaid pharmacy providers are reimbursed a delivery fee that is included in the medication dispensing fee formula. The delivery fee is paid to HHSC-approved pharmacy providers that have certified that delivery services meet minimum conditions for payment of the delivery fee.

The conditions include:

- Making deliveries to individuals rather than to institutions, such as nursing homes.
- Offering no-charge prescription delivery to all Medicaid clients who request it in the same manner as to the general public.
- Displaying publicly the availability of prescription delivery services at no charge in a prominent place in the pharmacy store (window or door).
- Providing the delivery service without requiring retention of the Your Texas Benefits Medicaid card.

This delivery fee is not applicable for mail-order prescriptions.

For more information, call the Vendor Drug Resolution Help Desk at 1-800-435-4165 and ask for Pharmacy Contracts.

B.2 Medicaid Children's Services Comprehensive Care Program (CCP) Available for Children and Adolescents

Medically necessary drugs and supplies that are not covered by the VDP may be available to children and adolescents (birth through 20 years of age) through the CCP (i.e., some over the counter drugs, nutritional products, diapers, and disposable or expendable medical supplies).

The Prior Authorization fax number is (512) 514-4212.

Refer to: Subsection 2.4.1.1, "Pharmacies (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about pharmacy enrollment in CCP.

B.3 Palivizumab (*Synagis*) Available Through the VDP

Palivizumab is available to physicians for administering to Medicaid clients through the VDP. This option enables physicians to have palivizumab shipped directly to their office from a network pharmacy. Physicians will not need to purchase the drug. Physicians who obtain palivizumab through the VDP may not submit claims to Medicaid (TMHP) for the drug.

B.3.1 Participating Palivizumab Distribution Pharmacies

For a list of participating pharmacies, refer to the HHSC Vendor Drug website at www.txvendordrug.com.

Note: *Palivizumab forms are updated every year. Providers must use the most current version of the forms to submit prior authorization requests.*

The Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form is required if the prescribing provider purchases the drug and bills TMHP.

The Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request & Prescription Form for 2011 is required when the prescribing provider obtains the drug through VDP.

Refer to: Subsection 8.2.54.3, "Obtaining Palivizumab" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Providers can refer to the following forms:

Form MD.24, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Form MD.14, "Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request & Prescription Form for 2011" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

APPENDIX C: HIV/AIDS

C.1 CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

The revised Centers for Disease Control and Prevention (CDC) recommendations advocate routine voluntary human immunodeficiency virus (HIV) screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission. HIV screening should be offered as an opt-out test in accordance with CDC testing guidelines, which may be viewed at www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

C.2 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

C.2.1 Purpose

The purpose of this policy is to protect the employment rights and privileges of individuals infected with HIV and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Department of State Health Services (DSHS) encourages all employers to establish workplace policies concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients; however, the content and intent must remain consistent with this document and the Health and Safety Code (HSC).

C.2.2 Authority

Governance for this policy is found in Vernon's Texas Codes Annotated, HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines, developed by the DSHS HIV/Sexually Transmitted Disease (STD) Comprehensive Services Branch, as required by HSC §85.012, "Model Workplace Guidelines," and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of certain designated state agencies and organizations funded by those state agencies (HSC §85.113).

Refer to: Subsection C.2.7, "State Agencies Listed Under Health and Safety Code (HSC) §85.113" in this appendix.

These guidelines are also the standard for health-care facilities licensed by DSHS and the Department of Aging and Disability Services (DADS) as stated in HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities."

C.2.3 Who Must Use Workplace Guidelines

C.2.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should incorporate, at a minimum, the DSHS model workplace guidelines in this policy.

C.2.3.2 State Contractors

A program that involves direct client contact and that contracts with or is funded by any of the state agencies listed in subsection C.2.7, "State Agencies Listed Under Health and Safety Code (HSC) §85.113" in this appendix will adopt and carry out workplace guidelines as stated in HSC §85.113.

C.2.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact.
- Provide workers with current information about HIV risk reduction for employees and their families.
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues.
- Prevent work disruption and rejection of the infected employee by coworkers.
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety.
- Provide specific and ongoing education and equipment to employees in health-care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used.
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.

C.2.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. Use of the following statements in agency policy is encouraged:

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV-infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may also be available.
- This policy is consistent with current information from public health authorities, such as the CDC of the U.S. Public Health Service, and with state and federal laws and regulations.

While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- *Discrimination.* The Americans with Disabilities Act of 1990 prohibits discrimination against people with disabilities, which includes HIV and AIDS, in employment, public accommodations, public transportation, and other situations.
  A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. Such a statement might be, "This agency complies with the Americans with Disabilities Act protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment." Managers may want to define ways in which they will deal with discriminatory actions.
- *Desire and Ability to Work.* A workplace policy should address the infected employee's desire and need to work and the infected employee's value to the workplace. Such a statement reassures employees that the employer supports them.
  The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, "Procedures may be adapted to provide reasonable accommodation so that

people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation."

- *Performance Standards.* The Americans with Disabilities Act provides protections for disabled persons *qualified* to perform their jobs. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job, with or without the reasonable accommodation.
  One suggested statement is, "While the Americans with Disabilities Act does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."

- *Reasonable Accommodation.* The Americans with Disabilities Act requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the Americans with Disabilities Act.
  Such a policy statement might read, "The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules."

- *Confidentiality and Privacy.* Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS-related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds.
  Employees are not required to reveal their HIV status to employers. All medical information that an HIV-infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty").
  A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."

- *Coworker Concerns.* Employers need to be aware of the concerns that coworkers may have about an HIV-infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer's response to coworker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."

- *Employee Education.* Any health-care facility licensed by DSHS or DADS must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC, §85.004, "Educational Programs," DSHS developed model education program guidelines. These are available from DSHS, HIV/STD Comprehensive Services Branch, 1100 W. 49th St., Austin, TX. 78756-3199, 1-512-533-3000. Employers may also find the CDC's educational kit, *Business Responds to AIDS,* useful in developing educational courses. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers. Experience shows that educated coworkers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions.

Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids that are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning will reflect a commitment to the health and well-being of the work force and the community being served.

- *Assistance.* Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services.
  - Provide HIV/AIDS workplace training for managerial staff.
  - Serve as a liaison between management and the employer's clinical and occupational health programs.
  - Provide counseling for employees who irrationally fear coworkers or clients.

Employers who have no employee assistance program may consider working with other organizations that provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

A suggested policy statement might be: "An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits."

C.2.6 Where to Go for Help

Employees may call 2-1-1 for HIV/STD testing locations in Texas. For questions related to issues such as transmission, signs and symptoms, or other concerns about HIV or other sexually transmitted infections, employees may call 1-800-CDC-INFO (English/Español) or 1-888-232-6348 (TTY).

C.2.7 State Agencies Listed Under *Health and Safety Code* (HSC) §85.113

HSC §85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by... to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." H.B. 2292, 78th Leg., abolished 10 of the 12 existing health and human services agencies and transferred their powers and duties to three new state agencies and to HHSC, which rendered the state agency list found in HSC §85.113 obsolete. The list below reflects the state agency consolidation brought about by H.B. 2292 and identifies the state agencies to which HSC §85.113 applies.

- DADS
- Department of Assistive and Rehabilitative Services (DARS)
- DSHS
- Health and Human Services Commission (HHSC)
- Texas Department of Criminal Justice
- Texas Juvenile Probation Commission
- Texas Youth Commission

C.2.8 Routine HIV Testing Procedure Code

The following table lists the procedure codes for routine HIV testing and the corresponding modifiers that must be submitted for rapid testing. Routine HIV testing is covered as a preventative or screening benefit. Medical necessity is not required.

Procedure Code	Rapid Test Modifier
86689	
86701	92
86702	92
86703	92
87389	92
87390	
87534	
87535	
87536	
89391	

APPENDIX D: ACRONYM DICTIONARY

Term	Definition
A/EEG	Ambulatory Electroencephalogram
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
ABMG	American Board of Medical Geneticists
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Device
ACH	Automated Clearinghouse
ACIP	Advisory Committee on Immunization Practices
ACT	Assertive Community Treatment
ADA	American Dental Association
ADL	Activity of Daily Living
AFP	Abdominal Flat Plates
AHA	American Heart Association
AHI	Apnea/Hypopnea Index
AHRQ	Agency for Health Research and Quality
AI	Auditory Impairment
AIDS	Acquired Immunodeficiency Syndrome
AIS	Automated Inquiry System
ALS	Advanced Life Support
AMA	American Medical Association
ANSI	American National Standards Institute
API	Atypical Provider Identifier
APRN	Advanced Practice Registered Nurse
ARD	Admission, Review, and Dismissal
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
ASHA	American Speech-Language-Hearing Association
ASL	American Sign Language
ASP	Average Sales Price
AWP	Average Wholesale Price
BCCS	Breast and Cervical Cancer Services
BCG	Bacillus Calmette-Guérin
BCVDDP	Blind Children's Vocational Discovery and Development Program
BHO	Behavioral Health Organization

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
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
CAHPS	Consumer Assessment of Healthcare and Provider Systems
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARE	Client Assessment, Review, and Evaluation
CAT	Caries-risk Assessment Tool
CBA	Community-Based Alternatives (Program)
CBC	Complete Blood Count
CBO	Community Based Organization
CCIP	Comprehensive Care Inpatient Psychiatric (Unit)
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Call Center Representative
CDC	Centers for Disease Control and Prevention
CDT	Current Dental Terminology
CDTF	Chemical Dependency Treatment Facility
CE	Continuing Education (Hour)
CFR	*Code of Federal Regulations*
CHC	Comprehensive Health Centers
CHIP	Children's Health Insurance Program
CHS	Community Health Services
CHW	Community Health Worker
CIHCP	County Indigent Health Care Program
CLASS	Community Living Assistance and Support Services
CLIA	*Clinical Laboratory Improvement Amendments*
CLPPP	Childhood Lead Poisoning Prevention Program
CMS	Centers for Medicare & Medicaid Services

Term	Definition
CMT	Chiropractic Manipulative Treatment
CNM	Certified Nurse-Midwife
CNS	Clinical Nurse Specialist
COP	Condition of Participation
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility
COTA	Certified Occupational Therapist Assistant
CPAP	Continuous Positive Airway Pressure
CPE	Certification of Public Expenditures
CPM	Continuous Passive Motion
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRCP	Certified Respiratory Care Practitioner
CRF	Chronic Renal Failure
CRNA	Certified Registered Nurse Anesthetist
CROS	Contralateral Routing of Offside Signal
CSF	Colony Stimulating Factor
CSHCN	Children with Special Health Care Needs (Services Program)
CSI	Claim Status Inquiry
CT	Computed Tomography
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
dB	Decibel
DBS	Division for Blind Services
DC	Doctor of Chiropractic Medicine
DCN	Dorsal Column Neurostimulator
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Agency
DEFRA	*Deficit Reduction Act* (of 1984)
DFPS	Department of Family and Protective Services
DMD	Doctor of Medical Dentistry
DME	Durable Medical Equipment
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

Term	Definition
DOT	Directly Observed Therapy
DPC	Diagnostic Procedure Code
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis-Related Group
DSHS	(Texas) Department of State Health Services
DSM-IV-TR	*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision
DTaP	Diptheria and Tetanus Toxoids and Acellular Pertussis Vaccine
DU	Demographic Update (form)
E/M	Evaluation and Management (Services)
EBLL	Elevated Blood Lead Level
ECC	Early Childhood Caries
ECF	Extended Care Facility
ECG	Electrocardiogram
ECI	Early Childhood Intervention
ECMO	Extracorporeal Membrane Oxygenation
EDC	Estimated Date of Confinement
EDD	Expected Date of Delivery
EDI	Electronic Data Interchange
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGD	Esophagogastroduodenoscopy
EIN	Employer Identification Number
EKG	Electrocardiogram
EMG	Electromyography
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENT	Ear, Nose, and Throat
EOB	Explanation of Benefits
EOG	Electro-Oculogram
EOPS	Explanation of Pending Status
EPO	Erythropoietin Alfa
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ER&S	Electronic Remittance and Status Report
ECT	Electroconvulsive Therapy
ERA	Estrogen Receptor Assay
ERCP	Endoscopic Retrograde Cholangiopancreatography
eSP™	eScreener Plus

Term	Definition
ESRD	End Stage Renal Disease
FDA	(United States) Food and Drug Administration
FES	Functional Electrical Stimulation
FEV	Forced Expiratory Volume
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FIUT	Fetal Intrauterine Transfusion
FOC	Frontal Occipital Circumference
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FQS	Federally Qualified Satellite
FTA	Fluorescent Treponemal Antibody Absorbed
FY	Fiscal Year
FYE	Fiscal Year End
GAA	Alpha-Glucosidase
GAF	Global Assessment of Functioning
G-CSF	Granulocyte Colony Stimulating Factors
GED	Gastrointestinal Endoscopy
GM-CSF	Granulocyte-Macrophage Colony Stimulating Factor
GME	Graduate Medical Education
GNS	Gastric Neurostimulation
GYN	Gynecology/Gynecological
HASC	Hospital-based Ambulatory Surgical Center
H.B.	House Bill
HBOT	Hyperbaric Oxygen Therapy
HBsAG	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HCO	Health Care Organization
HCS	Home and Community-Based Services
HDL	High Density Lipoproteins
HepA	Hepatitis A
HepB	Hepatitis B
HFCWCS	High-Frequency Chest Wall Compression System
HHA	Home Health Aide
HHS	(United States Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HIC	Health Insurance Claim (Number)

Term	Definition
HIPAA	*Health Insurance Portability and Accountability Act*
HIPP	Health Insurance Premium Payment
HIV	Human Immunodeficiency Virus
HLD	Handicapping Labio-Lingual Deviations
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HPV	Human Papillomavirus
HRC	*Texas Human Resource Code*
HRSA	Health and Human Services Health Resources and Services Administration
HSC	*Texas Health and Safety Code*
HSR	Health Service Region
IADL	Instrumental Activity of Daily Living
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 Persons with Mental Retardation
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
IDEA	*Individuals with Disabilities Education Act*
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IM	Intramuscular
ImmTrac	Immunization Tracking system
IOL	Intraocular Lens
IPD	Intermittent Peritoneal Dialysis
IPIA	*Improper Payments Information Act* (of 2002)
IPPB	Intermittent Positive-Pressure Breathing
IPV	Intrapulmonary Percussive Ventilation
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
ISD	Independent School District
ISP	Internet Service Provider
IUD	Intrauterine Device
IV	Intravenous
JCIH	Joint Committee on Infant Hearing
KUB	Kidneys, Ureters, Bladder
LAIV	Live, Attenuated Influenza Vaccine
LASIK	Laser-Assisted in Situ Keratomileusis
LCDC	Licensed Chemical Dependency Counselor

Term	Definition
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
LEA	Local Education Agency
LLC	Limited Liability Company
LMFT	Licensed Marriage and Family Therapist
LMP	Last Menstrual Period
LOCM	Low Osmolar Contrast Material
LOS	Length of Stay
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LPTA	Licensed Physical Therapist Assistant
LTBI	Latent Tuberculosis Infection
LTC	Long Term Care
LTCH	Long Term Care Hospital
LTSS	Long Term Services and Supports
LVEF	Left-Ventricle Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Medical Access Card
MAO	Medical Assistance Only
MAST	Multiple Radioallergosorbent Test
MBCC	Medicaid for Breast and Cervical Cancer
MCH	Maternal and Child Health
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MD	Doctor of Medicine
MDCP	Medically Dependent Children Program
MESAV	Medicaid Eligibility Service Authorization Verification
MFADS	Medicaid Fraud and Abuse Detection System
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MMPI	Minnesota Multiphasic Personality Inventory
MMWR	Morbidity and Mortality Weekly Report
MNC	Medically Needy Clearinghouse
MNP	Medically Needy Program
MPI	Medicaid Program Integrity
MQMB	Medicaid Qualified Medicare Beneficiary
MR	Mental Retardation
MR	Mentally Retarded

Term	Definition
MRA	Magnetic Resonance Angiography
MRAN	Medicare Remittance Advice Notice
MRDA	Mental Retardation Diagnostic Assessment
MREP	Medicare Remit Easy Print
MRI	Magnetic Resonance Imaging
MRLA	Mental Retardation Local Authority
MRSA	Methicillin Resistant Staphylococcus Aureus
MRT	Magnetic Resonance Technology
MSAFP	Maternal Serum Alpha-Fetoprotein
MSC	Maternity Service Clinic
MSRP	Manufacturer's Suggested Retail Price
MTP	Medical Transportation Program
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NBS	Newborn Screen (Neonatal Screen)
NCCI	National Correct Coding Initiative
NCQA	National Committee for Quality Assurance
NCVIA	*National Childhood Vaccine Injury Act*
NDC	National Drug Code
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	Nasogastric
NIS	National Immunization Survey
NMES	Neuromuscular Electrical Stimulation
NMDP	National Marrow Donor Program
NP	Nurse Practitioner
NPPES	National Plan and Provider Enumeration System
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
NSAID	Nonsteriodal Anti-inflammatory Drugs
NTBHA	North Texas Behavioral Health Authority
NUCC	National Uniform Claim Committee
OAE	Otoacoustic Emissions
OB	Obstetrics
OB-GYN	Obstetric and Gynecology
OBRA	*Omnibus Budget Reconciliation Act*
OCR	Office of Civil Rights
OD	Doctor of Optometry
OHP	Oral Health Program

Term	Definition
OI	Other Insurance
OIG	Office of Inspector General
OMB	Office of Management and Budget
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, Occupational Therapist
OTC	Over the Counter
PA	Physician Assistant
PaCO2	Partial Pressure of Carbon Dioxide
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAN	Prior Authorization Number
PaO2	Partial Pressure of Oxygen
PASARR	Preadmission (MH/MR) Screening and Annual Resident Review
PC	Personal Computer
PCCM	Primary Care Case Management (Program)
PCN	Patient Control Number
PCS	Personal Care Services
PDA	Personal Digital Assistant
PDF	Portable Document Format
PDL	Preferred Drug List
PDN	Private Duty Nursing
PE	Presumptive Eligibility
PENS	Percutaneous Electrical Nerve Stimulator
PERM	Payment Error Rate Measurement
PET	Positron Emission Tomography
PHC	Primary Home Care
PhD	Doctor of Philosophy
PIC	Provider Information Change
PIF	Provider Information Form
PIP	Personal Injury Protection
PKU	Phenylketonuria
P.L.	Public Law
PLP	Provisionally Licensed Psychologist
POC	Plan of Care
POS	Place of Service
PPD	Purified Protein Derivative

Term	Definition
PPMP	Physician Performed Microscopy Procedure (CLIA-Certified)
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRA	Progesterone Receptor Assay
PRK	Photorefractive Keratectomy
PRN	Pro Re Nata (As Needed)
PRO	Peer Review Organization
PT	Physical Therapy, Physical Therapist
PTA	Percutaneous Transluminal Angioplasty
PVC	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QCC	Qualified Credentialed Counselor
QMB	Qualified Medicare Beneficiary
R&S	Remittance and Status Report
RAST	Radioallergosorbent Test
RBRVS	Resource-Based Relative Value Scale
RDC	Renal Dialysis Center
RDI	Respiratory Disturbance Index
RFI	Request For Information
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
RV	Residual Volume
RVU	Relative Value Unit
SA	Service Area
SADMERC	Statistical Analysis DME Regional Carrier
SAR	State Action Request
S.B.	Senate Bill
SC	Subcutaneous
SCI	Spinal Cord Injury
SCHIP	State Children's Health Insurance Program
SCID	Severe Combined Immunodeficiency
SDA	Standard Dollar Amount

Term	Definition
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
SMPA	Special Medical Prior Authorization
SNF	Skilled Nursing Facility (see also ICF and ECF)
SNS	Sacral Nerve Stimulator
SOC	Start of Care (concerning Home Health Services claims)
SQ	Subcutaneous
SRT	Speech Reception Threshold
SSA	Social Security Administration
SSI	Supplemental Security Income (Program)
SSL	Secure Socket Layer
SSN	Social Security Number
ST	Speech Therapy
STAR	State of Texas Access Reform (Program)
STD	Sexually Transmitted Disease
SVT	Supraventricular Tachycardia
TAC	*Texas Administrative Code*
TANF	Temporary Assistance for Needy Families
TAPD	Texas Academy of Pediatric Dentists
TB	Tuberculosis
TCADA	Texas Commission on Alcohol and Drug Abuse
TDA	Texas Dental Association
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
TID	Tooth Identification Number
TIN	Tax Identification Number
TLC	Total Lung Capacity
TMA	Texas Medical Association

Term	Definition
TMC	Texas Migrant Council
TMHP	Texas Medicaid & Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TMRM	Texas Medicaid Reimbursement Methodology
TMRP	Texas Medical Review Program
TNF	Tumor Necrosis Factor
TOB	Type of Bill
TOS	Type of Service
TP	Type Program
TPA	Texas Pharmacy Association
TPI	Texas Provider Identifier
TPL	Third Party Liability
TPN	Total Parenteral Nutrition
TP-PA	Treponema Pallidum Particle Agglutination
TPR	Third Party Resource
TRAM	Transverse Rectus Abdominis Myocutaneous
TRPP	Tamper-Resistant Prescription Pad
TSBDE	Texas State Board of Dental Examiners
TTY	Teletypewriter
TURP	Transurethral Resection of the Prostate
TVFC	Texas Vaccines for Children (Program)
TxHmL	Texas Home Living
UCB	University of California at Berkeley
UM	Utilization Management
UNOS	United Network for Organ Sharing
UR	Utilization Review
USC	*United States Code*
USDA	United States Department of Agriculture
VA	Veteran's Administration
VAERS	Vaccine Adverse Events Reporting System
VDP	Vendor Drug Program
VDRL	Venereal Disease Research Laboratory
VIS	Vaccine Information Statement
VNS	Vagal Nerve Stimulator
VPN	Virtual Private Network
VRE	Vancomycin-Resistant Enterococci
VSU	Vital Statistics Unit
WAIS-R	Wechsler Adult Intelligence Scale–Revised
WHP	Women's Health Program
WIC	Women, Infants, and Children (Program)

Term	Definition
YAG	Yttrium Aluminum Garnet

INDEX

AM = *Ambulance Services Handbook*
BH = *Behavioral Health, Rehabilitation, and Case Management Services Handbook*
CH = *Children's Services Handbook*
DM = *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*
GN = *Gynecological and Reproductive Health and Family Planning Services Handbook*
HS = *Inpatient and Outpatient Hospital Services Handbook*
MMC = *Medicaid Managed Care Handbook*
MTP = *Medical Transportation Program Handbook*
MD = *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*
NT = *Nursing and Therapy Services Handbook*
OP= *Clinics and Other Outpatient Facility Services Handbook*
RL = *Radiology and Laboratory Services Handbook*
VH = *Vision and Hearing Services Handbook*

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