



Children with Special Health Care Needs (CSHCN) Services Program

# PROVIDER MANUAL

February 2024



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
A STATE MEDICAID CONTRACTOR



TEXAS  
Health and Human  
Services

# **INTRODUCTION**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# INTRODUCTION

## Table of Contents

- 1.1 Program History .....3
- 1.2 About the Provider Manual .....3
- 1.3 Feedback .....4
- 1.4 TMHP-CSHCN Services Program Contact Center .....5
- 1.5 Copyright Acknowledgments .....5

## 1.1 Program History

The Children with Special Health Care Needs (CSHCN) Services Program is the oldest governmentally-administered continuous medical assistance program in Texas for low-income children with special health-care needs and people of any age with cystic fibrosis. In 1933, state legislative action initiated funding two years in advance of the first federal initiative, Title V of the *Social Security Act*.

The program currently receives part of its funding from Title V, and aligns its services with Title V objectives, such as:

- Promoting partnerships between families and providers.
- Ensuring that all children get services in the context of the medical home.
- Organizing services so that they are easy for families to access.
- Promoting the provision of services that help youth transition to adulthood.

## 1.2 About the Provider Manual

The *CSHCN Services Program Provider Manual* contains policy information about the program. This edition of the *CSHCN Services Program Provider Manual* supersedes all previous editions. Read this manual carefully.

The *CSHCN Services Program Provider Manual* is intended primarily for those providers who submit claims to the Texas Medicaid & Healthcare Partnership (TMHP); however, information is also provided for services reimbursed by the Vendor Drug Program and the Medical Transportation Program.

The *CSHCN Services Program Provider Manual* contains information to help providers submit and correct first-time claims in the Computerized Medicaid Claims Processing Assessment System, COMPASS21. This will help providers minimize resubmissions and appeals and help conserve their own and the Program's resources.

The TMHP website at [www.tmhp.com](http://www.tmhp.com) supplements the information in this manual. The website contains:

- Enrollment information.
- Complete instructions for setting up a Provider Administrator account.
- Publications (e.g., manuals and bulletins).
- Directory of regional provider relations representatives.
- TexMedConnect.
- Provider education information (e.g., computer-based training, live workshops, webinars).

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

- Online provider enrollment.
- Online Fee Lookup (OFL).
- Claim status inquiries (CSIs).
- Eligibility verification.
- Electronic Remittance and Status Reports.
- Claim and appeal submissions.
- Payment amounts search, view, and print capabilities.
- Notification of an invalid address on file for any provider's National Provider Identifier (NPI).

- Notification of pending payments because of inaccurate or incomplete provider information.

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

New provider services continue to be added to the website. Visit the TMHP website at [www.tmhp.com](http://www.tmhp.com) or call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 for the latest information about online services.

The CSHCN Services Program Provider Manual is the providers' principal source of information about the CSHCN Services Program. The manual is regularly updated to reflect the most recent policy and procedure changes. Updates are generally available the month following the effective date of the change. For advanced notification of upcoming changes, providers should monitor banner messages, which appear at the beginning of their Remittance and Status (R&S) reports, and the corresponding website articles published on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

According to the CSHCN Services Program Agreement, providers must be thoroughly familiar with the contents of the *CSHCN Services Program Provider Manual*, the provider bulletins, and the messages contained in the R&S Reports as they apply to the CSHCN Services Program.

Providers must also comply with the following:

- CSHCN Services Program policies
- Policy notification letters
- Provider manuals
- Statutes
- Rules
- Regulations

This manual includes information about correct coding for claims. The CSHCN Services Program regrets that, due to copyright limitations, *Current Procedural Terminology (CPT)*, *Current Dental Terminology (CDT)*, International Classification of Disease (ICD) code descriptions, and Healthcare Common Procedure Coding System (HCPCS) code descriptions cannot be published in CSHCN Services Program publications. Consult reference manuals published or authorized by the American Medical Association (AMA), the American Dental Association (ADA), World Health Organization (WHO), and the Centers for Medicare & Medicaid Services (CMS) for code descriptions.

Specific procedure or diagnosis codes related to program benefits and coverage are included in the manual to provide helpful information, but should not be considered all-inclusive. From time to time, codes are added, deleted, or revised.

### 1.3 Feedback

The CSHCN Services Program and TMHP welcome provider comments and suggestions concerning this publication. Providers can mail them to:

Texas Medicaid & Healthcare Partnership  
Attn: Publications  
PO Box 204270  
Austin, TX 78720-4270

## 1.4 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

## 1.5 Copyright Acknowledgments

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# **TMHP AND HHSC CONTACT INFORMATION**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# TMHP AND HHSC CONTACT INFORMATION

## Table of Contents

- 1.1 TMHP-CSHCN Services Program Contact Information.....3**
  - 1.1.1 CSHCN Services Program Telephone and Fax Communication ..... 3
  - 1.1.2 Written Communication with CSHCN Services Program..... 3
  - 1.1.3 TMHP-CSHCN Services Program Contact Center ..... 4
  - 1.1.4 TMHP-CSHCN Services Program Automated Inquiry System (AIS) ..... 4
  - 1.1.5 TMHP Regional Representatives..... 4
- 1.2 TMHP Website Information .....5**
  - 1.2.1 Publications ..... 6
- 1.3 CSHCN Services Program Central and Regional Offices .....6**
  - 1.3.1 Central Office..... 6
  - 1.3.2 Regional Offices ..... 7
    - 1.3.2.1 Region 1 ..... 7
    - 1.3.2.2 Region 2 ..... 8
    - 1.3.2.3 Region 3 ..... 8
    - 1.3.2.4 Region 4 ..... 8
    - 1.3.2.5 Region 5 North ..... 10
    - 1.3.2.6 Regions 5 South and 6 ..... 11
    - 1.3.2.7 Region 7 ..... 11
    - 1.3.2.8 Region 8 ..... 13
    - 1.3.2.9 Regions 9 and 10 ..... 13
    - 1.3.2.10 Region 11 ..... 14
- 1.4 DSHS Health Service Regions Map.....15**



## 1.1 TMHP-CSHCN Services Program Contact Information

### 1.1.1 CSHCN Services Program Telephone and Fax Communication

| Contact  | Telephone and Fax Number |
|--|--------------------------|
| TMHP-CSHCN Prior Authorization and Authorization Fax | 1-512-514-4222           |
| Provider Enrollment Fax                              | 1-512-514-4214           |
| Provider Enrollment Phone                            | 1-800-568-2413, Option 2 |
| CSHCN Services Program Helpline                      | 1-800-252-8023, Option 2 |
| TMHP Electronic Data Interchange (EDI) Help Desk     | 1-888-863-3638, Option 4 |
| TMHP EDI Help Desk Fax                               | 1-512-514-4228           |
| Third-Party Resource (TPR) Phone                     | 1-800-846-7307           |
| TPR Fax  | 1-512-514-4225           |
| Appeal Submission through AIS Line                   | 1-800-568-2413, Option 1 |
| CSHCN Services Program Complaints Unit Fax           | 1-512-776-7238           |

### 1.1.2 Written Communication with CSHCN Services Program

| Correspondence  | Address  |
|---|--|
| First-Time Claims<br>(Resubmit all “Zero Allowed, Zero Paid” claims. Resubmit claims originally denied as an “Incomplete Claim” on an R&S Report) | Texas Medicaid & Healthcare Partnership<br>Attn: CSHCN Services Program Claims<br>PO Box 200855<br>Austin, TX 78720-0855   |
| Appeals and Adjustments   | Texas Medicaid & Healthcare Partnership<br>Attn: CSHCN Services Program Appeals, MC-A11<br>12365-A Riata Trace Parkway, Suite 100<br>Austin, TX 78727                        |
| Provider Complaints   | CSHCN Services Program<br>ATTN: Complaints<br>MC-1938<br>PO Box 149030<br>Austin, TX 78714-9947  |
| Prior Authorization and Authorization   | Texas Medicaid & Healthcare Partnership<br>Attn: TMHP-CSHCN Services Program Authorizations Department, MC-A11<br>12365-A Riata Trace Parkway, Suite 100<br>Austin, TX 78727 |
| Enrollment  | Texas Medicaid & Healthcare Partnership<br>Attn: Provider Enrollment<br>PO Box 200795<br>Austin, TX 78720-0795   |
| Third-Party Resource  | Texas Medicaid & Healthcare Partnership<br>Third-Party Resource Unit<br>PO Box 202948<br>Austin, TX 78720-9981   |
| Electronic Claims and Rejected Reports<br>(Past the 95-day filing deadline)   | Texas Medicaid & Healthcare Partnership<br>PO Box 200645<br>Austin, TX 78720-0645  |

| Correspondence  | Address   |
|---|---|
| Other Correspondence<br>(Must be directed to a specific department or individual) | Texas Medicaid & Healthcare Partnership<br>Attn: CSHCN Services Program Appeals, MC-A11<br>12365-A Riata Trace Parkway, Suite 100<br>Austin, TX 78727 |

**1.1.3 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

**1.1.4 TMHP-CSHCN Services Program Automated Inquiry System (AIS)**

Dial 1-800-568-2413 (toll-free) to access the TMHP-CSHCN Services Program AIS. The call is answered automatically. Providers should follow the directions to access AIS and use the automated features to obtain information and services.

The TMHP-CSHCN Services Program AIS provides the following information and services through the use of a touch-tone telephone: claim status, client eligibility, current weekly payment amount, faxed forms, and claim appeals.

The TMHP-CSHCN Services Program AIS eligibility and claim status information is available 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 Monday through Friday from 7 a.m. until 7 p.m., Central Time. AIS offers 15 transactions per call.

***Note:** Pressing Star then Pound (\*#) repeats any information given. Pressing Star then Star (\*\*) begins again if an error was made. Pressing Zero then Pound (0#) at any time repeats the main menu.*

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

**Referto:** <https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval>

**1.1.5 TMHP Regional Representatives**

The TMHP Provider Relations Department comprises a staff of Austin-based and field-based provider relations representatives who serve the health-care community by furnishing a variety of services and activities designed to inform and educate health-care providers about the CSHCN Services Program policies and claims filing procedures.

Provider Relations activities include the following:

- *Provider education through planned events.* Provider representatives conduct a planned program of educational workshops, webinars, computer-based training (CBT), in-services, and training sessions designed to keep all actively-enrolled providers informed of the latest policies, claim processing procedures, and federal and state regulations affecting CSHCN Services Program. Technical support and training are also provided to TexMedConnect software users.
- *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 CSHCN 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 the CSHCN Services Program, the Provider Relations Department maintains a working relationship with these organizations. Also, the Provider Relations Department participates in several events sponsored by Texas health-care associations, such as conventions and conferences.

Providers must call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 to speak to a representative who can answer questions.

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.

Provider relations representatives, the area they serve and additional information, including a regional listing by county and workshop information, is available on the TMHP website at [www.tmhp.com/resources/provider-support-services](http://www.tmhp.com/resources/provider-support-services).

## 1.2 TMHP Website Information

The TMHP website at [www.tmhp.com](http://www.tmhp.com) is a valuable resource that provides:

- Information and registration for upcoming provider education and training sessions.
- A file library of publications, such as bulletins, banner messages, and provider manuals.
- Announcements of current and upcoming program changes and other important information.
- A chatbot for frequently asked questions and a live chat to speak with an agent.

Additional advanced features are available for providers that create an account. There is no charge for creating an account on the TMHP website. All enrolled providers are eligible for this service. Once an account has been created, providers have access to:

- Texas Medicaid and the CSHCN Services Program enrollment information.
- Claim Status Inquiry (CSI).
- Eligibility verification (EV).
- Electronic Remittance and Status (ER&S) Report download option.
- Complete instructions for setting up a Provider Administrator account and the use of online CSI, EV, and ER&S Reports.
- E-mail the TMHP-CSHCN Services Program Contact Center.
- Workshop registration.
- Claim submission.
- Claim appeals.
- View the new provider welcome.

New services continue to be added to the website. Visit the TMHP website at [www.tmhp.com](http://www.tmhp.com) or call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 for the latest information about online services.

**Referto:** The TMHP website at [www.tmhp.com](http://www.tmhp.com) for further details and instructions on how to submit claims on the website.

## 1.2.1 Publications

All providers have access to the publications available on the TMHP website, including:

- Banner messages—a weekly history of banner messages.
- EDI reference and connectivity guides.
- Fee schedules.
- Provider manuals.

### Search Capabilities for the CSHCN Services Program Provider Manual

The online version of the *CSHCN Services Program Provider Manual* is available in portable document format (PDF), which can be viewed in Adobe® Acrobat® or Reader®. The Bookmarks window located on the left side of the screen provides a link to each heading within the manual. Click on the heading or link to quickly access the topic of interest.

Providers can use the following instructions to search the online version of the manual by a keyword or phrase:

- 1) Click the **Search** icon (binoculars) in the toolbar located at the top of the page. The Acrobat Find window opens.
- 2) In the Find What window, enter a keyword or phrase. Choose one of the following options, if applicable to the search:
  - Whole word only
  - Case-Sensitive
  - Include Bookmarks
  - Include Comments
- 3) Click **Search**. The cursor moves to the first place within the manual where the word or phrase appears. Instances found are listed in the Results window.
- 4) To search for a different keyword or term, click the **New Search** icon and type in the keyword or term and click **Search**.

## 1.3 CSHCN Services Program Central and Regional Offices

### 1.3.1 Central Office

The central offices of the CSHCN Services Program are administratively located within the Office of Primary and Specialty Health, Health & Developmental Services section of the division for Health, Developmental & Independence Services, at the Health and Human Services Commission (HHSC).

TMHP is the claims administrator, and questions concerning provider enrollment, benefits or coverage, claims processing, and authorizations or prior authorizations should be directed to TMHP. DSHS-CSHCN Services Program welcomes provider comments and suggestions.

Providers can contact the CSHCN Services Program using the following information:

- Telephone toll-free at 1-800-252-8023 (may be used only in Texas) or the Austin local number at 1-512-776-7355
- Fax to CSHCN Services Program at 1-512-776-7162 or the Austin local number at 1-512-776-7238
- Send email to [cshcn@dshs.texas.gov](mailto:cshcn@dshs.texas.gov)

Providers of Family Support Services (e.g., respite care, home and vehicle modification) are enrolled and reimbursed by the CSHCN Services Program. Enrollment applications are available on the CSHCN Services Program website at [hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/children-special-health-care-needs-services-program/family-support-services](https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/children-special-health-care-needs-services-program/family-support-services).

Mail completed enrollment applications to the following address:

CSHCN Services Program—Provider Enrollment  
 MC-1938  
 PO Box 149030  
 Austin, TX 78714–9947  
 Fax: 1-512-776-7238

Deliveries and overnight mail to the following address:

CSHCN Services Program—Provider Enrollment  
 MC-1938  
 Health and Human Services Commission-Moreton Building  
 1100 West 49th Street  
 Austin, TX 78756–3179  
 Fax: 1-800-441-5133

Additional information about the CSHCN Services Program is available online at [www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/children-special-health-care-needs-services-program](https://www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/children-special-health-care-needs-services-program).

**1.3.2 Regional Offices**

Case management and client eligibility services are provided by a statewide network of regionally-based social service program consultants and include the following activities:

- Coordination of medical services
- Linkage to available resources
- Acting as a liaison among the client, family, and caregivers
- Management of institutional services, insurance carriers, and other services required for the improved well-being of the client and family

**Referto:** “Appendix A: Acronyms and Initialisms Dictionary” for definitions of the abbreviated academic degrees listed in the following tables.

**1.3.2.1 Region 1**

|   |  |
|---|--|
| <p><b>DSHS Health Service Region (HSR) 1</b><br/>                 3407 Pony Express Way, Amarillo, TX 79118<br/>                 Telephone: 1-806-655-7151<br/>                 Fax: 1-806-373-4757</p>   |  |
| <p><b>1L - Lubbock Regional Office</b><br/>                 Health Services Region 1<br/>                 6302 Iola Ave.<br/>                 Lubbock, TX 79424–2721<br/>                 Telephone: 1-806-744-3577 or<br/>                 1-806-783-6452<br/>                 Fax: 1-806-783-6455</p> |  |

**1.3.2.2 Region 2**

|   |  |
|---|--|
| <p><b>2A - Abilene Office</b><br/>                 Health Services Region 2<br/>                 4601 South First Street, Suite L<br/>                 Abilene, TX 79605-1466<br/>                 Telephone: 1-325-795-5847<br/>                 Fax: 1-325-795-5894</p> |  |
|---|--|

**1.3.2.3 Region 3**

|  |  |
|--|--|
| <p><b>3 - Regional Office (Arlington)</b><br/>                 Health Services Region 3<br/>                 1301 South Bowen Road, Suite 200<br/>                 Arlington, TX 76013-2262<br/>                 Telephone: 1-817-264-4634 or<br/>                 1-817-264-4619<br/>                 Fax: 1-817-264-4911</p> |  |
| <p><b>Bonham Office</b><br/>                 PO Box 605 (mailing address)<br/>                 1205-A East Sam Rayburn (physical address)<br/>                 Bonham, TX 75418<br/>                 Telephone: 1-903-486-9258<br/>                 Fax: 1-903-486-9286</p>  |  |
| <p><b>Granbury Office</b><br/>                 214 North Travis Street<br/>                 Granbury, TX 79048<br/>                 Telephone: 1-817-579-2117<br/>                 Fax: 1-817-578-3310</p>   |  |
| <p><b>Denton Office</b><br/>                 3612 East McKinney<br/>                 Denton, TX 76209<br/>                 Telephone: 1-940-320-8275<br/>                 Fax: 1-940-591-6254</p>  |  |

**1.3.2.4 Region 4**

|   |  |
|---|--|
| <p><b>4/5N - Regional Office (Tyler)</b><br/>                 Health Service Region 4/5N<br/>                 2521 West Front Street<br/>                 Tyler, TX 75702-7822<br/>                 Telephone: 1-903-533-5269<br/>                 Toll free: 1-877-340-8842<br/>                 Fax: 1-903-535-7593</p> |  |
| <p><b>Athens Office</b><br/>                 708 East Corsicana<br/>                 Athens, TX 75751<br/>                 Telephone: 1-903-675-9107<br/>                 Fax: 1-903-675-3622</p>   |  |

|  |  |
|--|--|
| <p><b>Carthage Office</b><br/>                 1430 South Adams<br/>                 Carthage, TX 75633<br/>                 Telephone: 1-903-693-9322<br/>                 Toll Free: 1-800-306-0568<br/>                 Fax: 1-903-694-2316</p>   |  |
| <p><b>Gilmer Office</b><br/>                 324 Yapaco<br/>                 Gilmer, TX 75644<br/>                 Telephone: 1-903-843-3030<br/>                 Fax: 1-903-843-4264</p>  |  |
| <p><b>Henderson Office</b><br/>                 700 Zeid Blvd.<br/>                 Henderson, TX 75652<br/>                 Telephone: 1-903-655-6256<br/>                 Toll Free: 1-800-306-0568<br/>                 Fax: 1-903-655-0104</p>   |  |
| <p><b>Linden Office</b><br/>                 213 Hwy 8 N (physical address)<br/>                 123 Kaufman (mailing address)<br/>                 PO Box 300<br/>                 Linden, TX 75563<br/>                 Telephone: 1-903-756-4807<br/>                 Fax: 1-903-756-5146</p> |  |
| <p><b>Longview Office</b><br/>                 1750 North Eastman Road<br/>                 Longview, TX 75601-3347<br/>                 Telephone: 1-903-232-3289<br/>                 Toll Free: 1-866-327-1364<br/>                 Fax: 1-903-232-3278</p>                                   |  |
| <p><b>Marshall Office</b><br/>                 4105 Victory Drive<br/>                 Marshall, TX 75670<br/>                 Telephone: 1-903-927-0218<br/>                 Toll Free: 1-866-327-1364<br/>                 Fax: 1-903-927-0290</p>   |  |
| <p><b>Mount Pleasant Office</b><br/>                 1014 North Jefferson<br/>                 Mount Pleasant, TX 75455<br/>                 Telephone: 1-903-577-1929<br/>                 Toll Free: 1-866-268-6465<br/>                 Fax: 1-903-577-8957</p>                               |  |

|   |  |
|---|--|
| <p><b>Palestine Office</b><br/>                 320 E. Spring Street, Suite D<br/>                 Palestine, TX 75801<br/>                 Telephone: 1-903-661-6089<br/>                 Fax: 1-903-729-7034</p>  |  |
| <p><b>Paris Office</b><br/>                 1460 19th Street NW<br/>                 Paris, TX 75460<br/>                 Telephone: 1-903-737-0236<br/>                 Fax: 1-903-737-0220</p>  |  |
| <p><b>Sulphur Springs Office</b><br/>                 1400 College, Suite 167<br/>                 Sulphur Springs, TX 75482<br/>                 Telephone: 1-903-439-9331<br/>                 Toll Free: 1-866-518-0601<br/>                 Fax: 1-903-439-9335</p> |  |
| <p><b>Texarkana Office</b><br/>                 3101 Summerhill Road<br/>                 Texarkana, TX 75703<br/>                 Telephone: 1-903-791-3229<br/>                 Fax: 1-903-791-3230</p>   |  |

**1.3.2.5 Region 5 North**

|  |  |
|--|--|
| <p><b>Center Office</b><br/>                 912 Nacogdoches<br/>                 Center, TX 75935<br/>                 Telephone: 1-936-598-1231<br/>                 Fax: 1-936-591-0162</p>   |  |
| <p><b>Crockett Office</b><br/>                 1034 South Fourth Street<br/>                 Crockett, TX 75835<br/>                 Telephone: 1-936-545-0360<br/>                 Fax: 1-936-544-0280</p>  |  |
| <p><b>Jasper Office</b><br/>                 Jasper-Newton County Public Health District<br/>                 130 West Lamar<br/>                 Jasper, TX 75951<br/>                 Telephone: 1-409-384-6829, Ext. 231<br/>                 Fax: 1-409-384-7861</p>       |  |
| <p><b>Kirbyville Office</b><br/>                 314 North Herndon (physical location)<br/>                 PO Box 900 (mailing address)<br/>                 Kirbyville, TX 75956<br/>                 Telephone: 1-409-423-4612<br/>                 Fax: 1-409-423-4027</p> |  |



|   |  |
|---|--|
| <p><b>Livingston Office</b><br/>                 410 East Church Street, Suite B<br/>                 Livingston, TX 77351<br/>                 Telephone: 1-936-328-8240, Ext. 232<br/>                 Toll Free: 1-888-851-4748<br/>                 Fax: 1-936-328-8249</p> |  |
| <p><b>Lufkin Office</b><br/>                 1210 South Chestnut<br/>                 Lufkin, TX 75901<br/>                 Telephone: 1-936-633-3657<br/>                 Toll Free: 1-877-340-8840<br/>                 Fax: 1-936-633-3667</p>                               |  |
| <p><b>Nacogdoches Office</b><br/>                 2614 N.W. Stallings Drive<br/>                 Nacogdoches, TX 75964-1255<br/>                 Telephone: 1-936-569-4982 or<br/>                 1-936-569-4918<br/>                 Fax: 1-936-569-4989</p>                  |  |

**1.3.2.6 Regions 5 South and 6**

|   |  |
|---|--|
| <p><b>6/5S - Regional Office (Houston)</b><br/>                 5425 Polk Avenue, Suite 460<br/>                 Houston, TX 77023-1497<br/>                 Telephone: 1-713-767-3111<br/>                 Fax: 1-713-767-3125</p>             |  |
| <p><b>Beaumont Office</b><br/>                 3105 Executive Blvd.<br/>                 Beaumont, TX 77701<br/>                 Telephone: 1-409-730-1837<br/>                 Fax: 1-409-730-1845</p>   |  |
| <p><b>Conroe Office</b><br/>                 608 North Drive Loop 336 East<br/>                 Conroe, TX 77301<br/>                 Telephone: 1-936-760-4704, 1-936-760-4750, or 1-936-760-4705<br/>                 Fax: 1-936-760-4707</p> |  |

**1.3.2.7 Region 7**

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|--|--|
| <p><b>7T - Temple Office</b><br/>                 Health Service Region 7<br/>                 2408 South 37th Street<br/>                 Temple, TX 76504-7168<br/>                 Telephone: 1-254-771-6791 or 1-800-789-2865<br/>                 Fax: 1-254-750-9372</p> |  |
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| <p><b>7A - Austin Office</b><br/>                 Health Services Region 7<br/>                 1601 Rutherford Lane, Suite C-3<br/>                 Austin, TX 78754-5119<br/>                 Telephone: 1-512-873-6308<br/>                 Toll Free: 1-800-789-2865<br/>                 Fax: 1-512-873-6345</p> |  |
| <p><b>Bastrop Office</b><br/>                 104 Loop 150 West, Suite 102<br/>                 Bastrop, TX 78602<br/>                 Telephone: 1-512-321-2465<br/>                 Fax: 1-512-321-4861</p>   |  |
| <p><b>Bryan Office</b><br/>                 3000 Villa Maria<br/>                 Bryan, TX 77803<br/>                 Telephone: 1-979-776-7489<br/>                 Fax: 1-979-731-0191</p>   |  |
| <p><b>Lockhart Office</b><br/>                 1403F Blackjack Street (physical location)<br/>                 PO Box 43 (mailing address)<br/>                 Lockhart, TX 78744<br/>                 Telephone: 1-512-376-1078<br/>                 Fax: 1-512-398-0022</p>  |  |
| <p><b>Navasota Office</b><br/>                 425 N. Lasalle (physical address)<br/>                 PO Box 1287 (mailing address)<br/>                 Navasota, TX 77868<br/>                 Telephone: 1-936-825-7586<br/>                 Fax: 1-936-825-0380</p>   |  |
| <p><b>San Saba Office</b><br/>                 421 E. Wallace<br/>                 San Saba, TX 76877<br/>                 Telephone: 1-325-372-5188 or<br/>                 1-325-372-5191<br/>                 Fax: 1-325-372-3297</p>  |  |
| <p><b>Waco Office</b><br/>                 801 Austin Avenue, Suite 820F<br/>                 Waco, TX 76701<br/>                 Telephone: 1-254-750-9339 or 1-254-750-9248<br/>                 Fax: 1-254-753-0879</p>  |  |

**1.3.2.8 Region 8**

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| <p><b>8 - San Antonio Office</b><br/>                 Health Service Region 8<br/>                 7430 Louis Pasteur Drive<br/>                 San Antonio, TX 78229-4507<br/>                 Telephone: 1-210-949-2142 or<br/>                 1-210-949-2155<br/>                 Fax: 1-210-949-2047</p> |  |
| <p><b>Uvalde Office</b><br/>                 112 Joe Carper Drive<br/>                 Uvalde, TX 78801<br/>                 Phone: 1-830-591-4388 or 1-830-591-4384<br/>                 Fax: 1-830-278-1831</p>  |  |
| <p><b>Eagle Pass Office</b><br/>                 1593 Veterans Boulevard<br/>                 Eagle Pass, TX 78852<br/>                 Telephone: 1-830-758-4252<br/>                 Fax: 1-830-773-4688</p>   |  |
| <p><b>Victoria Office</b><br/>                 2306 Leary Lane<br/>                 Victoria, TX 77901<br/>                 Telephone: 1-361-574-7421<br/>                 Fax: 1-361-574-7396</p>   |  |

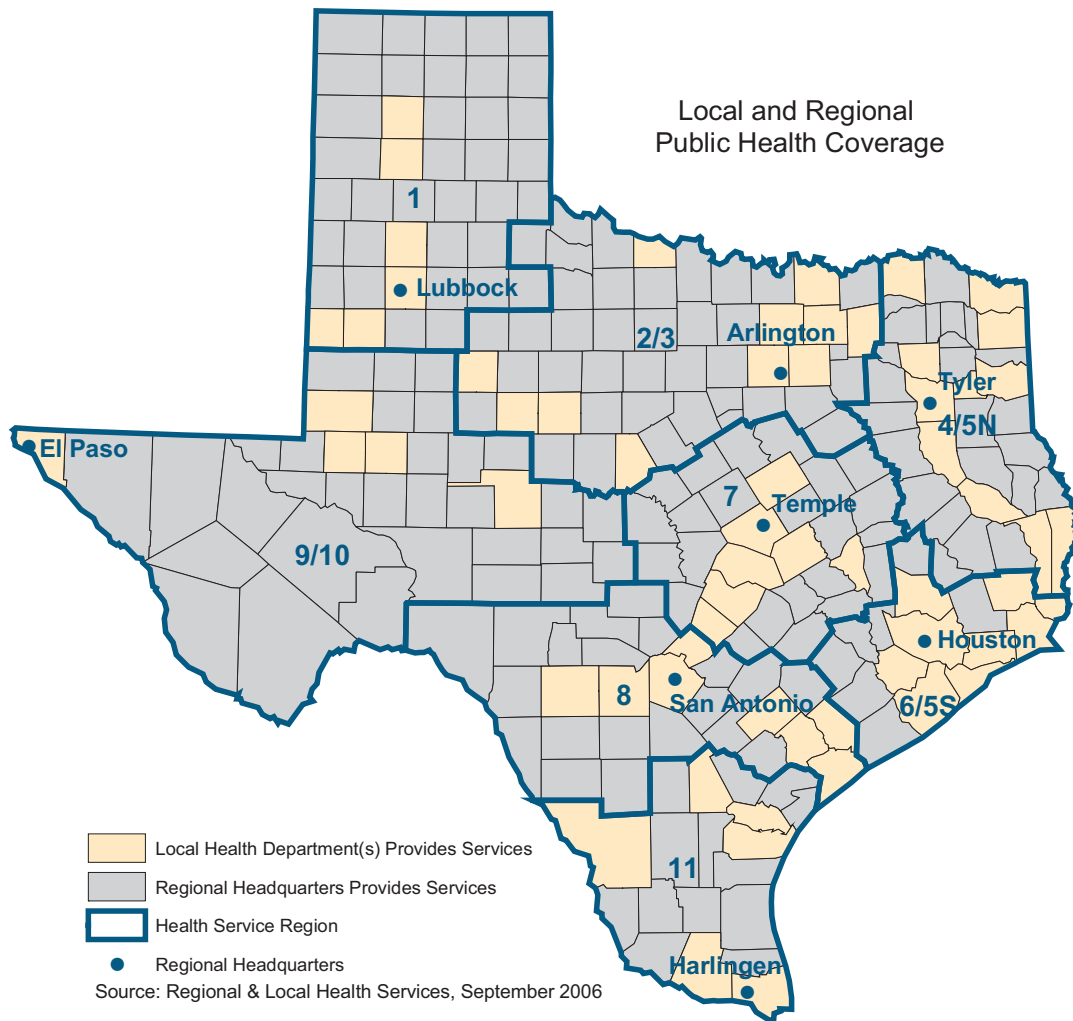
**1.3.2.9 Regions 9 and 10**

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| <p><b>9/10 - El Paso Office</b><br/>                 Health Services Region 9/10<br/>                 401 East Franklin, Suite 210<br/>                 El Paso, TX 79901-1206<br/>                 Telephone: 1-915-834-7675<br/>                 Fax: 1-915-834-7808</p> |  |
| <p><b>Midland Office</b><br/>                 2301 N Big Spring Street, Suite 300<br/>                 Midland, TX 79705<br/>                 Telephone: 1-432-683-9492<br/>                 Fax: 1-432-684-3932</p>   |  |
| <p><b>San Angelo Office</b><br/>                 622 South Oakes, Suite H<br/>                 San Angelo, TX 76903<br/>                 Telephone: 1-325-659-7853<br/>                 Fax: 1-915-655-6798</p>  |  |

**1.3.2.10 Region 11**

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| <p><b>11H - Harlingen Office</b><br/>                 Health Service Region 11<br/>                 601 West Sesame Drive<br/>                 Harlingen, TX 78550-4040<br/>                 Telephone: 1-956-423-0130<br/>                 Fax: 1-956-444-3293</p>             |  |
| <p><b>Alice Office</b><br/>                 408 N. Flournoy, Suite C<br/>                 Alice, TX 78332<br/>                 Telephone: 1-361-660-2263<br/>                 Fax: 1-361-668-4000</p>   |  |
| <p><b>11C - Corpus Christi Office</b><br/>                 Health Services Region 11<br/>                 5155 Flynn Pkwy., 4th floor<br/>                 Corpus Christi, TX 78401<br/>                 Telephone: 1-361-878-3450<br/>                 Fax: 1-361-883-9942</p> |  |
| <p><b>11L - Laredo Office</b><br/>                 1500 Arkansas Avenue, Suite 3<br/>                 Laredo, TX 78043-3049<br/>                 Telephone: 1-956-794-6385<br/>                 Fax: 1-956-729-8600</p>   |  |
| <p><b>11M - McAllen Office</b><br/>                 Health Services Region 11<br/>                 4501 West Business Hwy 83<br/>                 McAllen, TX 78501-9907<br/>                 Telephone: 1-956-971-1312<br/>                 Fax: 1-956-971-1275</p>            |  |
| <p><b>Mercedes Office</b><br/>                 Health Services Region 11<br/>                 202 West 2nd Street<br/>                 Mercedes, TX 78570<br/>                 Telephone: 1-956-825-5300<br/>                 Fax: 1-956-825-5320</p>                           |  |
| <p><b>Brownsville Office</b><br/>                 1000 W. Price Road<br/>                 Brownsville, TX 78520<br/>                 Telephone: 1-956-554-5500<br/>                 Fax: 1-956-554-5581</p>   |  |
| <p><b>Rio Grande City Office</b><br/>                 608 N. Garza<br/>                 Rio Grande City, TX 78582<br/>                 Telephone: 1-956-487-5556<br/>                 Fax: 1-956-487-8865</p>   |  |

### 1.4 DSHS Health Service Regions Map



# **PROVIDER ENROLLMENT AND RESPONSIBILITIES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# PROVIDER ENROLLMENT AND RESPONSIBILITIES

## Table of Contents

- 2.1 Provider Enrollment.....3**
- 2.1.1 Affordable Care Act of 2010 (ACA) Enrollment Requirements..... 4
  - 2.1.1.1 Medical Foods and Hospice Providers ..... 4
  - 2.1.1.2 Enrollment for Ordering and Referring-Only Providers ..... 4
- 2.1.2 Changes in Enrollment..... 4
- 2.1.3 Claim Filing ..... 5
  - 2.1.3.1 NPIs Terminated After 24 Months of No Claim Activity ..... 5
- 2.1.4 Provider Enrollment Determinations ..... 6
- 2.1.5 Provider Enrollment Application ..... 6
  - 2.1.5.1 Types of Providers ..... 6
  - 2.1.5.2 Owner/Creditor/Principal Entry and Disclosure of Ownership Form..... 7
  - 2.1.5.3 Provider Agreement ..... 7
  - 2.1.5.4 Request for Taxpayer Identification Number and Certification..... 7
  - 2.1.5.5 Franchise Tax Account Status Page..... 7
  - 2.1.5.6 Clinical Laboratory Improvement Amendments (CLIA) of 1988 ..... 8
  - 2.1.5.7 Provider’s License ..... 8
- 2.1.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)..... 9
- 2.1.7 Transplant Specialty Centers..... 9
- 2.1.8 Pharmacy Enrollment..... 9
  - 2.1.8.1 Immunizations ..... 9
- 2.1.9 Out-of-State Providers ..... 10
- 2.1.10 Substitute Physician ..... 10
- 2.1.11 Providers of Family Support Services ..... 10
- 2.2 Provider Complaints Process.....11**
- 2.3 Provider Responsibilities .....12**
- 2.3.1 Information Change Requests..... 12
- 2.3.2 Required Updates ..... 13
- 2.3.3 General Medical Record Documentation Requirements..... 13
- 2.3.4 Retention of Records ..... 14
- 2.3.5 Utilization Review: General Provisions..... 14
- 2.3.6 Release of Confidential Information ..... 15
- 2.3.7 Fraud, Waste, and Abuse..... 15
- 2.3.8 Provider Certification/Assignment ..... 16
- 2.3.9 Billing Clients..... 17
- 2.3.10 Credit Balance and Recovery Vendor ..... 18
- 2.3.11 Texas Family Code Compliance ..... 18
  - 2.3.11.1 Child Support ..... 18
  - 2.3.11.2 Abuse and Neglect Reporting Requirements..... 18
- 2.4 TMHP-CSHCN Services Program Contact Center .....18**

## 2.1 Provider Enrollment

Providers must be actively enrolled as a Texas Medicaid provider as a prerequisite to enrolling as a CSHCN Services Program provider. For information about Texas Medicaid enrollment requirements, or to complete an online enrollment, visit the TMHP website at [www.tmhp.com](http://www.tmhp.com). Providers can call the TMHP Contact Center at 1-800-925-9126 for additional information about Texas Medicaid enrollment, and call the TMHP CSHCN Services Program Contact Center at 1-800-568-2413 for additional information about CSHCN Services Program enrollment.

Providers of services not covered by Medicaid are not required to enroll as Medicaid providers, such as, family support providers for respite care, home and vehicle modifications, medical foods, and hospice services.

**Referto:** Section 26.3, “Medical Foods” in Chapter 26, “Medical Nutrition Services.”  
Chapter 39, “Transportation of Deceased Clients.”

To enroll in the CSHCN Services Program, a provider must enter into a written Provider Agreement with the CSHCN Services Program using TMHP’s Provider Enrollment and Management System (PEMS). The physical address, National Provider Identifier (NPI), and Tax ID on the CSHCN Services Program application must correspond to the Medicaid provider enrollment. The taxonomy code can be different from the taxonomy code selected for the Medicaid enrollment.

Providers can submit the following optional items if applicable using PEMS:

- Electronic Funds Transfer (EFT) Notification
- Rehabilitation Engineering and Assistive Technology Society of North American (RESNA) certification for custom DME enrollment

Providers enroll online by logging into PEMS.

Online enrollment has the following advantages:

- NPI-based enrollment
- Single application for all programs
- Single revalidation date and enrollment period
- Flexible application completion
- Alignment of effective and approval dates
- Paperless
- Consolidated provider agreement
- Email and online communication
- Online help features
- Enhanced data validation
- 45 business days to correct all deficiencies

Providers can update their demographic information online through PEMS by going to the TMHP home page and selecting “Log in to My Account.”

For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

A provider *cannot* be enrolled if his or her license is due to expire within 30 days of the date of application. TMHP verifies license information provided with the enrollment application.



If a license or certification is required by law to practice in the State of Texas, the provider must maintain the required license or certification and practice within the scope of the license, certification, registration, and any other applicable requirements. Current license information must be on file with the program or its payment contractor. If the license was submitted when enrolling with Medicaid, it does not need to be duplicated. If there are additional enrollment requirements for a specific provider type, the requirements are described in the specific provider section of this manual.

The provider's enrollment effective date will be the same day that the enrollment is completed in PEMS.

### **2.1.1 Affordable Care Act of 2010 (ACA) Enrollment Requirements**

All providers must comply with the provisions of the Affordable Care Act of 2010 (ACA). CSHCN Services Program providers who have fulfilled the ACA requirements through their Texas Medicaid enrollment are considered ACA-compliant.

**Exception:** *Medical foods providers and hospice providers are not required to enroll in Texas Medicaid as a prerequisite for CSHCN Services Program enrollment and are not required to pay a provider application fee to enroll in the CSHCN Services Program.*

**Referto:** The TMHP website at [www.tmhp.com](http://www.tmhp.com) for additional information about ACA requirements including provider types that are required to pay the application fee.

#### **2.1.1.1 Medical Foods and Hospice Providers**

CSHCN Services Program medical foods providers and hospice providers that submit a provider enrollment application for new enrollment, a new practice location, or other type of enrollment or re-enrollment will be subject to the following ACA requirements:

- Provider screening according to the provider's level of risk as determined by DSHS.
- Enrollment revalidation at least every five years during which time the provider screening will be completed.

#### **2.1.1.2 Enrollment for Ordering and Referring-Only Providers**

Providers who are not currently enrolled in the CSHCN Services Program but who order or refer services and supplies for CSHCN Services Program clients are required to enroll in Texas Medicaid as ordering or referring-only providers.

Ordering and referring providers do not submit claims to TMHP for rendered services. Although ordering and referring providers do not submit claims for reimbursement, the ordering and referring provider's National Provider Identifier (NPI) is required on claims that are submitted by the providers that render the supplies or services.

Providers can search for ordering/referring-only providers on the Online Provider Lookup (OPL) search page to help with verification of the provider that ordered or referred services is enrolled in Texas Medicaid. The search can be done by using the Basic Provider or Advanced Provider Search.

### **2.1.2 Changes in Enrollment**

When a provider has one of the following changes, a new enrollment application must be completed using PEMS:

- Ownership—The new owner must take the following actions:
  - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
  - Complete a Texas Medicaid Provider Enrollment Application.
  - Complete the CSHCN Services Program Provider Enrollment Application.

- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership).
- Supply a listing of all of the NPIs affected by the change of ownership.
- Providers who join a new group or enroll as an individual must complete and submit a CSHCN Services Program Provider Enrollment Application to request enrollment in the new group.  
*Note: Providers leaving group practices must notify TMHP within 90 days of the date of termination through PEMS. Failure to provide this information may lead to administrative action by the Department of State Health Services (DSHS).*
- Physical address—Providers must enroll with Texas Medicaid before applying with the CSHCN Services Program to enroll a new location or provider type. Alternate addresses may be added to an existing enrollment using PEMS.
- Provider type—Providers must submit a separate CSHCN Services Program Provider Enrollment Application for each provider enrollment type requested. For example, a hospital may want to enroll as an ambulatory surgical center. A second application to enroll in the CSHCN Services Program as an ambulatory surgical center would be required.

### 2.1.3 Claim Filing

New providers must follow all claims filing procedures while completing the enrollment process.

TMHP must receive all claims for services rendered to CSHCN Services Program-eligible clients within the required filing deadlines, regardless of enrollment status.

Claims for group providers must include the NPIs for the performing provider as well as for the group. To be eligible for reimbursement, both the group and the performing provider must be enrolled in the CSHCN Services Program.

When a provider has questions, the provider may call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

*Referto:* Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

#### 2.1.3.1 NPIs Terminated After 24 Months of No Claim Activity

Payment denial codes are applied to an NPI that has had no claim activity for a period of 24 months. The NPI will be considered inactive and cannot be used to submit claims.

A courtesy letter will be sent to providers whenever an NPI goes 18 months without claims activity. Providers are encouraged to use electronic claims filing, such as TexMedConnect and Electronic Data Interchange (EDI), for timely claims processing, which will help prevent an NPI from being disenrolled. The letter will inform providers that if they want to keep their NPI active, they must submit a claim within 6 months of the date of the letter using the NPI referenced in the letter. TMHP will apply a payment denial code to any NPI that has had no claims activity within 6 months of the date of the courtesy letter and will notify the provider that the NPI has been terminated because the provider has not submitted claims using the NPI for a period of 24 months or more.

If a provider is enrolled in both Medicaid and the CSHCN Services Program, the NPIs for both programs will be examined to determine whether any claims activity has occurred. When a provider’s NPI is terminated for Traditional Medicaid, the corresponding NPIs for all other Texas state health-care programs will also be terminated.

To have the status code removed from an NPI, 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

status code to be removed. If the provider has moved to a different address or joined a different group, the status code will not be removed from the old NPI. A new enrollment record for the new group will be created using the existing NPI.

## 2.1.4 Provider Enrollment Determinations

The CSHCN Services Program may approve, deny, modify, suspend, or terminate a provider's enrollment for the reasons listed in the Texas Administrative Code (TAC), CSHCN Services Program Rules §351.6(b)(1) through (2) at [www.sos.texas.gov/tac/index.shtml](http://www.sos.texas.gov/tac/index.shtml). Before taking action to deny, modify, suspend, or terminate enrollment, the CSHCN Services Program shall give the provider written notice of an opportunity to request an administrative review of the proposed action within 30 days of the notice. If the provider does not respond in writing within the 30-day period, the provider is presumed to have waived the administrative review as well as access to a fair hearing, and the CSHCN Services Program's action is final. If the provider so requests, the CSHCN Services Program will conduct an administrative review of the circumstances of the proposed denial, modification, suspension, or termination of provider program participation is based and give the provider written notice of the program decision and the supporting reasons within 30 days of receipt of the request for administrative review.

In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program and the provider if the fair hearing is requested within 20 days of receipt of the administrative review decision.

**Referto:** Chapter 7, "Appeals and Administrative Review."

Providers excluded or terminated by Medicaid will be excluded or terminated by the CSHCN Services Program.

Providers must maintain active enrollment in Medicaid to remain enrolled in the CSHCN Services Program. "Actively enrolled" providers are those that have filed claims for clients of the CSHCN Services Program or Texas Medicaid within the past 24 months, and that do not have any type of payment holds on their enrollment status.

Descriptions of required enrollment forms are provided in the following sections. Forms are available on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

## 2.1.5 Provider Enrollment Application

### 2.1.5.1 Types of Providers

There are four types of enrollment for providers in the CSHCN Services Program, 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 tax identification number of the individual. An individual may also enroll as an employee, using the tax identification number of the employer. Certain provider types must enroll as individuals, including dietitians, licensed vocational nurses (LVNs), 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 tax identification number of the legal entity.

**Note:** For any group enrollment application, 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.

- *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. Examples of facilities include hospitals, independent diagnostic testing facilities, ambulatory surgical centers, renal dialysis facilities, and hospices.

#### **2.1.5.2 Owner/Creditor/Principal Entry and Disclosure of Ownership Form**

The following forms must be completed by all providers or the owner, officer, director, or principal applying for CSHCN Services Program enrollment more than one year from their Texas Medicaid enrollment date. An Owner/Creditor/Principal Entry in PEMS must be completed by each principal of the provider enrolling in the CSHCN Services Program. 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

The Disclosure of Ownership form is submitted by all providers, excluding the performing providers of a group. This form provides the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization.

These forms were designed across multiple state agencies to help meet the requirements set forth by the 75th Legislature's Senate Bill (S.B.) 30 to enhance the enrollment requirements for potential providers, meet federal requirements for enrollment, and improve the integrity of Texas State healthcare programs.

#### **2.1.5.3 Provider Agreement**

To participate in the CSHCN Services Program, all providers must complete a Provider Agreement with DSHS. The Provider Agreement must be signed by the provider applying for enrollment. If applying as a group, the Provider Agreement must be signed by an owner, officer, director, or principal. If the provider is unable to sign, a letter showing Power of Attorney must be attached to the Provider Enrollment Application. By signing the Provider Agreement, the provider agrees to abide by CSHCN Services Program rules, policies, and procedures as a condition for participation. This form is included in the enrollment application.

#### **2.1.5.4 Request for Taxpayer Identification Number and Certification**

The Internal Revenue Service (IRS) W-9 form is completed and submitted by all providers, excluding performing providers of a group.

#### **2.1.5.5 Franchise Tax Account Status Page**

When enrolling as a "Corporation" type of entity, providers must submit a Franchise Tax Account Status Page. This information can be obtained from the Texas State Comptroller's Office website at <https://comptroller.texas.gov/taxes/franchise/>.

Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit the Franchise Tax Account Status Page.

### 2.1.5.6 Clinical Laboratory Improvement Amendments (CLIA) of 1988

To be eligible for reimbursement by the CSHCN Services Program, all providers performing laboratory tests must be CLIA certified.

**Referto:** Section 25.1.1, “Clinical Laboratory Improvement Amendments (CLIA) of 1988” in Chapter 25, “Laboratory Services.”

### 2.1.5.7 Provider’s License

Evidence of current licensure or certification is required to participate in the CSHCN Services Program. Not abiding by this license and certification requirement will adversely impact a provider’s qualification for continued participation in the CSHCN Services Program.

An enrolling provider submits professional license information in the enrollment form. A copy of the license does not need to be sent with the enrollment application for those providers licensed by one of the boards listed below, unless the licensing board experiences technical difficulties and cannot provide the license information to TMHP. TMHP verifies this information with the appropriate licensing board. A provider cannot be enrolled if his or her license is due to expire within 30 days of the date of application.

Once enrolled in the CSHCN Services Program, a reminder letter will be automatically generated and sent to providers whose license will expire in 60 days. The letter will notify providers that they must keep their licensure current to continue their enrollment with Texas state health-care programs. When the license is renewed, providers licensed by the boards listed below will not need to contact TMHP with renewal information as TMHP receives licensure information from these licensing boards.

- Texas Medical Board
- Texas State Board of Dental Examiners

Only licenses for registered nurses (RNs) are auto-renewed. Certified registered nurse anesthetists (CRNAs) must submit a paper copy of their license when it is renewed to maintain a current record.

Providers cannot enroll in the CSHCN Services Program if their license is due to expire within 30 days. During the enrollment process, TMHP verifies licensure using available resources. If TMHP cannot verify a license at the time of enrollment, it is the provider’s responsibility to provide a copy of the active license to TMHP. Psychologists and facilities must submit a copy of their license since these licenses cannot be verified online.

TMHP will notify the provider by letter if a copy has not been submitted and the license cannot be verified.

Once a provider is enrolled in the CSHCN Services Program the license or certification must be kept current. A reminder letter for renewal will be sent to the provider 60 days before the provider’s license expires.

TMHP directly obtains licensure information from the following licensing boards:

- Texas Medical Board (TMB) (for physicians only)
- Texas Board of Nursing (BON) (for RNs only, not APRNs)
- Texas State Board of Dental Examiners (TSBDE)

If the licensing board experiences technical difficulties and cannot provide the license information to TMHP, the provider must submit proof of license renewal to TMHP.

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

**Referto:** Section 14.2.6.10, “Dental Anesthesia” in Chapter 14, “Dental” for information about dental anesthesia permit levels.

Copies of licenses or certifications should be uploaded using PEMS.

If a provider's license has expired, a disenrollment letter will be sent to the provider, and all claims filed on or after the expiration date will be denied. To have claim payments resumed, providers must renew their licenses, and if necessary, provide proof of the renewal to TMHP. Payment will be considered for dates of service on or after the date of return to active license status.

### **2.1.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**

Federally qualified health centers (FQHCs), their satellite offices, FQHC look-alikes, and rural health clinics (RHC) can enroll as providers for the Children with Special Health Care Needs (CSHCN) Services Program.

*Referto:* Chapter 19, “Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).”

### **2.1.7 Transplant Specialty Centers**

Facilities enrolled in the CSHCN Services Program that perform stem cell or kidney transplants must also be a designated specialty transplant center.

A stem cell transplant facility must be a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). The program or its designee will maintain a current listing of all approved centers.

All renal transplants must be done in a Medicaid-approved, CSHCN Services Program-enrolled transplant center facility that is certified by United Network of Organ Sharing (UNOS). For more information about how to obtain Medicaid approval as a transplant center, contact TMHP at 1-800-925-9126.

### **2.1.8 Pharmacy Enrollment**

The CSHCN Services Program reimburses pharmacies for medications as prescribed by a practitioner licensed to do so if the medication is included in the CSHCN formulary, and if the dispensing pharmacy is an active provider with the Vendor Drug Program (VDP). VDP reimburses pharmacies providing medications to CSHCN clients with the exception of hemophilia blood factor products, which are reimbursed by TMHP. Claims for medications must be submitted to VDP. Pharmacies are reimbursed the same drug costs and dispensing fees allowed by VDP.

Pharmacies must enroll as durable medical equipment (DME) providers to provide expendable medical supplies, standard wheelchairs and other equipment.

*Referto:* Chapter 17, “Durable Medical Equipment (DME)” and Chapter 18, “Expendable Medical Supplies” for more information.

#### **2.1.8.1 Immunizations**

The administration of immunizations may be a benefit of the CSHCN Services Program and may be provided by a pharmacy or pharmacist. A pharmacist must obtain and provide proof of certification by the American Council on Pharmaceutical Education (ACPE) through the ACPE Certificate Program in Pharmacy-Based Immunization Delivery to enroll in the CSHCN Services Program. The Certificate must be accompanied by written proof of the awardee's current certification in Cardiopulmonary Resuscitation (CPR) or Basic Cardiac Life Support (BCLS). All providers who enroll in the CSHCN Services Program must first be enrolled in Texas Medicaid.

A pharmacy that is certified to administer immunizations and has at least one pharmacist as a performing provider can enroll in the CSHCN Services Program as a group provider.

*Referto:* Section 31.2.25, “Immunizations (Vaccines and Toxoids)” in Chapter 31, “Physician” for more information.

### 2.1.9 Out-of-State Providers

CSHCN Services Program policies and procedures apply for providers who care for program clients outside of Texas. This includes the requirement that providers maintain a corresponding enrollment as Medicaid providers. Out-of-state provider's licensure must be maintained if it is required in the respective state(s). Providers located in Arkansas, Louisiana, New Mexico, or Oklahoma, within 50 miles from the Texas border must be enrolled and are considered in-state providers.

**Note:** *This section applies only in circumstances requiring the client to travel out-of-state to receive health-care services. The limitations listed below do not apply to out-of-state providers of selected items who deliver their products to a client in Texas and for which the client does not have to travel out of state to receive the products or services (such as medical foods, augmentative communication devices, hearing amplification devices, DME supplies, reference lab services, mail order pharmacies, out-of-state interpretations of imaging, electrocardiograms, or other services provided to the client in Texas but sent out-of-state for interpretation).*

Requests for medical services provided by an out-of-state provider more than 50 miles from the Texas state border must be submitted to TMHP at the address provided in Section 2.1, "Provider Enrollment" in this chapter.

In unique circumstances, the CSHCN Services Program may approve coverage of services if they are within the scope of the program. The CSHCN Services Program may agree that:

- The out-of-state provider is the provider of choice for quality care.
- The same treatment or another treatment of equal benefit or cost is not available from CSHCN Services Program providers in Texas.
- The out-of-state treatment should result in a decrease in the total projected CSHCN Services Program cost of the client's treatment.
- Medical literature indicates that the out-of-state treatment is accepted medical practice and is expected to improve the client's quality of life.

**Referto:** Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility."

Section 5.1.8, "Claims Filing Deadlines" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

### 2.1.10 Substitute Physician

Reimbursement may be made to a physician for CSHCN Services Program-covered services that are provided by another physician who is acting as his or her substitute. Such a substitution arrangement may be either an informal reciprocal arrangement of 14 days or fewer, or a long-term arrangement (up to 90 days) involving per diem or fee-for-time compensation. The arrangement may be extended for a continuous period longer than 90 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the Armed Forces.

Substitute physicians are required to enroll with the CSHCN Services Program.

Substitute physicians are also required to enroll with Texas Medicaid before enrolling in the CSHCN Services Program and cannot be on the Texas Medicaid provider exclusion list.

**Referto:** Section 31.1.3, "Substitute Physician" in Chapter 31, "Physician."

### 2.1.11 Providers of Family Support Services

Providers of Family Support Services (e.g., respite care, home and vehicle modification) are enrolled and reimbursed by the CSHCN Services Program. Enrollment applications are available in PEMS and can be submitted using PEMS.

## 2.2 Provider Complaints Process

The CSHCN Services Program takes each provider complaint seriously. Depending on the level and nature of the complaint, the CSHCN Services Program works with the provider to resolve the issue.

The CSHCN Services Program provides due process for resolving all provider complaints. A complaint is defined as any dissatisfaction expressed by telephone or in writing by a provider, or on behalf of a provider, concerning the CSHCN Services Program. 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 complaint process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint. Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.

The TMHP Complaints Resolution Department handles all provider complaints for the CSHCN Services Program. Providers may submit their complaints by email, telephone, mail, or fax. Providers will receive an acknowledgment letter from TMHP within 5 business days of receipt of the complaint.

Provide the following information when reporting the complaint:

- Point of contact name and phone number or email address
- Provider name
- Provider NPI
- Description of the complaint situation
- Client name
- Client PCN
- Date of service

Providers and clients can report complaints to TMHP by using the following methods:

- By using the Email Us button on the TMHP Contact web page
- By calling the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 or the TMHP-CSHCN Services Program Client Line at 1-877-888-2350
- 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-CSHCN Services Program Contact Center at 1-800-568-2413.



Providers who believe they did not receive due process regarding the complaint from TMHP may submit a request for an administrative review to the CSHCN Services Program in writing or by fax to:

CSHCN Services Program  
ATTN: Administrative Review  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238 or 512-776-7162

The appeals and administrative review processes are covered in greater detail in the following sections of this manual:

- Chapter 4, “Prior Authorizations and Authorizations”
- Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement”
- Chapter 7, “Appeals and Administrative Review”
- Section 2.1.4, “Provider Enrollment Determinations” in this chapter.

## 2.3 Provider Responsibilities

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are responsible not only for knowledge of the adopted CSHCN Services Program agency rules published in 26 TAC, Part 1, Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371. TAC rules can be found at [www.sos.texas.gov/tac/index.shtml](http://www.sos.texas.gov/tac/index.shtml).

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC, Part 1, §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to clients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

### 2.3.1 Information Change Requests

Providers must promptly advise TMHP Provider Enrollment of address changes (office or accounting), name changes, and federal tax identification number changes. Changes to provider information may be made online using PEMS. A W-9 is required if the provider is changing the mailing or accounting address by written communication sent to TMHP.

CSHCN Services Program providers are able to make information changes using PEMS.

The OPL is used primarily by clients to search for providers.

The following functions are available in the OPL:

- Clients are able to search for providers by county.
- Doing business as (DBA) names appear for providers or provider groups.

- Providers can indicate practice limitations, such as gender and age of patient.
- Providers can indicate whether or not they are accepting new patients.

The Medicaid and CSHCN Services Program provider agreements require providers to keep their correct physical address on file with TMHP. The physical address is also displayed in the OPL so that clients can locate providers. Providers who practice at multiple locations are required to enroll each location at which health-care services will be rendered. It is important that each location’s correct physical address and telephone number are available on the OPL.

Providers should verify that the physical address for their NPI is correct on the OPL. Providers can confirm and update the address and other demographic information on the TMHP website at [www.tmhp.com](http://www.tmhp.com). To locate the OPL information, providers can sign into the My Account page and choose the option to Change/verify address information.

Providers that have a moderate or high risk category cannot render or submit claims for services at a new practice location until it has been approved and added to the enrollment record. Providers are encouraged to check PEMS for verification that the practice location has been approved prior to rendering or submitting claims for services.

**Referto:** The Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions on the TMHP website at [www.tmhp.com/sites/default/files/file-library/topics/provider-enrollment/provider-enrollment-frequently-asked-questions.pdf](http://www.tmhp.com/sites/default/files/file-library/topics/provider-enrollment/provider-enrollment-frequently-asked-questions.pdf) for more information on risk category screening requirements.

Providers who have an e-mail address on file with TMHP will receive a confirmation e-mail from TMHP when a physical address has been updated. Providers can make other demographic changes online using a PEMS Maintenance request or Existing Enrollment request.

### 2.3.2 Required Updates

Certain providers are required to verify and update key demographic information every six months to ensure that their information is correct in the OPL. Affected provider types include physicians, nurses, dentists, and durable medical equipment (DME) providers.

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

### 2.3.3 General Medical Record Documentation Requirements

TMHP routinely performs a retrospective review of all providers. This review may include 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.*

| Requirement  | Mandatory/<br>Desirable |
|--|-------------------------|
| All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider. | Mandatory               |
| Each page of the medical record documents the client’s name and CSHCN Services Program client identification number.               | Mandatory               |
| Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.                            | Mandatory               |

| Requirement  | Mandatory/<br>Desirable |
|--|-------------------------|
| The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. Providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS, when selecting the level of service provided. | Mandatory               |
| Necessary follow-up visits specify the time of return by at least the week or month.   | Mandatory               |
| The history and physical documents the presenting complaint with appropriate subjective and objective information, e.g., medical and surgical history, current medications and supplements, family history, social history, diet, pertinent physical examination measurements and findings, etc.               | Mandatory               |
| The services provided are clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need for the services.  | Mandatory               |
| Medically necessary diagnostic lab and X-ray results are included in the medical record, and abnormal findings include an explicit notation of follow-up plans.  | Mandatory               |
| Unresolved problems are noted in the record.   | Mandatory               |
| Immunizations are noted in the record as complete or up-to-date.   | Mandatory               |
| Personal data includes the parent, guardian, or caretaker's address, employer, home and work telephone numbers, sex, marital status, and emergency contacts.   | Desirable               |

### 2.3.4 Retention of Records

The provider must maintain and retain all necessary records and claims to fully document the services and supplies provided to a client, for full disclosure to the CSHCN Services Program or its designee. These records and claims must be retained for a period of 5 years from the date of service, until the client's 21st birthday, or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever occurs last.

Upon request, these records must be made available promptly by submitting copies of such records, at no cost, to TMHP and representatives of the Office of Inspector General (OIG) or DSHS.

If the provider places the required information in records that are in the custody of another legal entity, such as a hospital, the provider is responsible for obtaining a copy of such records at no cost, for use by TMHP and representatives of the Office of Inspector General (OIG) or DSHS during any investigation or study of the appropriateness of the claims submitted by the provider.

### 2.3.5 Utilization Review: General Provisions

Utilization review activities required by the CSHCN Services Program are accomplished through a series of monitoring systems developed to ensure that services are necessary and of the optimum quality and quantity. Both clients and providers are subject to utilization review monitoring. Utilization review procedures safeguard against unnecessary care and services, monitor quality, and ensure that payments are appropriate according to the payment standards defined by the CSHCN Services Program.

One goal of utilization review is to identify the provider whose practice patterns are not consistent with the CSHCN Services Program requirements and the scope of benefits.

Educating the provider is the principal approach to resolution of inappropriate use. This education must include either a provider representative visit or letter to assist with the technical aspects of the program or a physician visit, telephone call, or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service. The purpose of the letter or the visit is to discuss the inappropriate practices so that the provider may institute measures to remedy the problem.

Depending on the intensity of the identified problem, the letter or visit may result in review of claims before payment. Medical staff develops parameters for prepayment review according to the identified problem. The purpose of the review is to provide additional information enabling the provider to under-

stand the scope of benefits by correlating billing practices and medical policy as billing occurs. As part of the prepayment review process, providers may be required to submit documentation. The documentation is used to ascertain the medical necessity of the services rendered. Prepayment review occurs for a minimum of 6 months. Services not consistent with medical policy are adjudicated in accordance with the established policies.

Recoupment of excess payments for intensity of service not supported by the medical documentation may occur at any phase in the review process.

A provider is removed from prepayment review after achieving compliance with the established medical policy. A follow-up review is performed to monitor continued appropriate utilization of resources.

When the provider is consistently noncompliant with policies, the provider history is provided to the CSHCN Services Program for possible administrative sanctions.

### **2.3.6 Release of Confidential Information**

The *Health Insurance Portability and Accountability Act* (HIPAA) Privacy Regulations are intended to protect individually identifiable health information by restricting disclosure of protected health information (PHI).

Information concerning the diagnosis, evaluation, or treatment of a client by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical disorder is normally confidential information that the provider must disclose only to authorized persons. The client's signature is not required on the claim form for payment of a claim; however, TMHP strongly recommends that the provider obtain written authorization from the client before releasing confidential medical information. The client's authorization for release of such information is not required when the release is requested by and made to the CSHCN Services Program or TMHP.

### **2.3.7 Fraud, Waste, and Abuse**

DSHS is responsible for minimizing the opportunity for provider fraud and abuse. DSHS takes appropriate action to protect clients and the CSHCN Services Program when providers of services are suspected of committing fraud, waste, and abuse. DSHS is responsible for establishing criteria to identify cases of possible fraud, waste, and abuse and recouping all overpayments to a provider. Some circumstances may result in referring a provider for legal evaluation and possible prosecution while other circumstances may result in administrative sanctions.

Providers are responsible for the delivery of health-care items and services to CSHCN Services Program clients in full accordance with all applicable licensure and certification requirements, and in full accordance with accepted medical community standards and standards that govern occupations. Such standards include, without limitation, those related to medical record and claims filing practices, documentation requirements, and records maintenance. The requirement to follow all such standards in the CSHCN Services Program is incorporated by reference to the program's requirements, in 1 TAC section 371.1659.

Accepted medical community standards and standards that govern occupations include standards for coding and billing. CSHCN Services Program providers must follow the coding and billing requirements in the *CSHCN Services Program Provider Manual*. However, if coding and billing requirements for the particular service are not addressed in the provider manual, and if coding and billing requirements are not otherwise specified in program policy (such as in the provider bulletins or banner messages), then providers must follow the most current coding guidelines. These include the following:

- Current Procedural Terminology (CPT) as set forth in the American Medical Association's (AMA) most recently published CPT books, *CPT Assistant* monthly newsletters, and other publications resulting from the collaborative efforts of the AMA with 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 CMS, and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations (pairs of procedure codes) 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 the use of modifiers, some of which are not currently recognized by the CSHCN Services Program.*

**Referto:** Section 5.6.2.6, “Modifiers” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

- *Current Dental Terminology (CDT)* as published by the American Dental Association (ADA).
- *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*
- *Current Diagnostic and Statistical Manual of Mental Disorders.*

To the extent that the above authorities do not conflict with any specific requirement stated in CSHCN Services Program policy, the requirements of these authorities are incorporated by reference into CSHCN Services Program policy. Failure to comply with these authorities may result in a provider or person being found to have engaged in one or more program violations, as identified in this section and also set forth in 1 TAC, Chapter 371.

### 2.3.8 Provider Certification/Assignment

Providers of the CSHCN Services Program are required to certify compliance with, or agreement to, various provisions of state laws and regulations. Upon submitting a signed claim to TMHP, the provider certifies that the following provisions were upheld:

- Services were personally rendered by the *billing provider* or under the personal supervision of the billing provider.

**Exception:** *As allowed under substitute physician and telemedicine services rulings.*

**Referto:** Section 38.2.2, “Telemedicine Services” in Chapter 38, “Telecommunication Services.”  
Section 31.1.3, “Substitute Physician” in Chapter 31, “Physician.”

- The information contained on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the diagnosis or treatment of the client.
- Medical records document all services billed.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees that are charged to private pay clients.
- Services were provided without regard to race, color, sex, national origin, age, disability, political beliefs, or religion.
- Before providing services, providers should always discuss with, and inform clients and their families of their liability for services not a benefit of the CSHCN Services Program.
- The provider of medical care and services files a claim with the CSHCN Services Program, agreeing to accept CSHCN Services Program reimbursement as payment in full for services that are a benefit of the CSHCN Services Program. The CSHCN Services Program client, or others on the client’s behalf, must not be billed for amounts above the amount the CSHCN Services Program 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. The client may be billed for services that are not a CSHCN Services Program benefit.

- The provider understands that endorsing or depositing a CSHCN Services Program check is accepting money from state or federal funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under state or federal laws.

Payment for services is made on behalf of clients to the provider of the service by TMHP in accordance with the limitations and procedures of the program.

If the claim is prepared by a billing service or printed by data processing equipment physically removed from the provider's office, it is permissible to print "Signature on File" in place of the provider's signature. The billing service must obtain and retain a letter on file signed by the provider authorizing the submission of his or her claims. Providers delegating signatory 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.

### **2.3.9 Billing Clients**

CSHCN Services Program clients, parents, or guardians of children eligible for CSHCN Services Program benefits must not be billed for CSHCN Services Program covered services. CSHCN Services Program providers must agree to accept the CSHCN Services Program allowed amount of payment (regardless of payer) as payment in full for covered services provide to CSHCN Services Program clients. Providers may collect allowable insurance or health maintenance organization co-payment, in accordance with those plan provisions.

CSHCN Services Program providers must agree to accept the CSHCN Services Program allowed amount of payment (regardless of payer) as payment in full for covered services provided to CSHCN Services Program clients. A provider must not require a down payment, bill, or take recourse against an eligible client for a denied or reduced claim for services that are within the amount, duration, and scope of benefits of the CSHCN Services Program when the action is the result of any of the following provider errors:

- Failure to submit a claim, including claims not received by TMHP.
- Failure to submit a complete authorization or prior authorization request, on a program-approved form, within the established deadlines.
- Failure to submit a claim within the 95-day filing deadline.
- Filing an incorrect claim.
- Failure to resubmit a corrected claim or to appeal a claim within the 120-day correction and resubmission period.
- Errors made in claims preparation, claims submission, or in the correction and resubmission (appeal) process.
- Failure to submit a request for Administrative Review to the CSHCN Services Program within 30 days of the date of the resubmission (appeal) denial.

A provider attempting to bill or recover money from a client is in violation of the above conditions and may be subject to termination from the CSHCN Services Program.

A provider may bill the client for:

- Any service that is not a benefit of the CSHCN Services Program, such as obstetrical care.
- All services incurred on noncovered days due to eligibility or inpatient hospital or inpatient rehabilitation day-limitations. Total client liability must be determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered day.

Each provider must furnish services to eligible CSHCN Services Program clients in the same manner, to the same extent, and of the same quality as services provided to other clients. Services made available to other clients must be made available to CSHCN Services Program clients when the services are benefits of the CSHCN Services Program.

Clients must not be billed for the completion of a claim form, even when it is a provider's office policy to do so.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations."

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

Chapter 7, "Appeals and Administrative Review."

### **2.3.10 Credit Balance and Recovery Vendor**

Trend Health Partners helps Texas Medicaid resolve credit balances and recover overpayments. Trend Health Partners reviews the credit balances of all current accounts with claims that received a primary or secondary payment from both TMHP and a health insurance carrier, but the health insurance carrier was liable for payment before Medicaid.

### **2.3.11 Texas Family Code Compliance**

#### **2.3.11.1 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 or agreements with governmental entities or nonprofit corporations.

The law also requires that payments be stopped when notified that the contractor or provider is more than 30 days delinquent in paying child support. CSHCN Services Program payments are placed on hold upon notification that a provider is delinquent in child support payments. A provider application may also be denied or a provider agreement terminated when the provider is delinquent in paying child support.

#### **2.3.11.2 Abuse and Neglect Reporting Requirements**

The CSHCN Services Program expects providers to comply with the provisions of state law as set forth in Chapter 261, Texas Family Code, related to the reporting of child abuse and neglect.

**Note:** *A professional may not delegate to or rely on another person to make the report of abuse or neglect.*

## **2.4 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **CLIENT BENEFITS AND ELIGIBILITY**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**





# CLIENT BENEFITS AND ELIGIBILITY

## Table of Contents

- 3.1 Client Benefits ..... 3**
  - 3.1.1 Prescription Drug Benefits ..... 4
  - 3.1.2 Respiratory Syncytial Virus (RSV) Prophylaxis ..... 5
  - 3.1.3 Medical Transportation Program (MTP) Benefits ..... 5
  - 3.1.4 Services Provided Outside of Texas..... 5
  - 3.1.5 CSHCN Services Program Services and Supplies Limitations and Exclusions..... 5
- 3.2 Client Eligibility ..... 7**
  - 3.2.1 CSHCN Services Program Application Criteria..... 7
  - 3.2.2 Eligibility Criteria ..... 8
  - 3.2.3 Prematurity ..... 8
  - 3.2.4 Program Applicants and Clients Residing in Long-Term Care ..... 8
  - 3.2.5 Program Applicants and Clients That Are Incarcerated ..... 9
  - 3.2.6 Sporadic Medicaid, MBIC, MBI, or CHIP Coverage ..... 9
  - 3.2.7 Eligibility Date for Program Health Care Benefits..... 9
  - 3.2.8 Financial Eligibility Criteria ..... 10
  - 3.2.9 Medical Eligibility Criteria and the Physician/Dentist Assessment Form (PAF) ..... 10
    - 3.2.9.1 Medical Certification Definition ..... 10
    - 3.2.9.2 Primary and Secondary Diagnoses ..... 11
    - 3.2.9.3 Important Considerations When Completing the PAF ..... 11
- 3.3 CSHCN Services Program Notice of Eligibility ..... 12**
  - 3.3.1 Eligibility Restrictions..... 13
  - 3.3.2 CSHCN Services Program Notice of Eligibility Sample ..... 14
- 3.4 Clients Eligible for Medicaid and CSHCN Services Program Benefits ..... 15**
- 3.5 Clients Eligible for CHIP and CSHCN Services Program Benefits..... 15**
- 3.6 Clients Eligible for Medicaid and Comprehensive Care Program (CCP) Benefits ..... 15**
- 3.7 Medically Needy Program (MNP) ..... 16**
  - 3.7.1 MNP Spend Down Processing..... 16
  - 3.7.2 Provider Assistance to Clients with Spend Down..... 17
  - 3.7.3 Claims Filing Involving a Medicaid Spend Down ..... 18
- 3.8 Renal Dialysis ..... 18**
- 3.9 Waiting List Information..... 19**
- 3.10 TMHP-CSHCN Services Program Contact Center ..... 20**

### 3.1 Client Benefits

The CSHCN Services Program is a comprehensive health-care program. Clients must see providers who are enrolled in the CSHCN Services Program, and they can go to specialists without a referral. Benefits include, but are not limited to, the items in the list below. Consult the specific chapter or section for more details about coverage and authorization requirements.

- Ambulance
- Ambulatory or day surgery
- Augmentative communication devices (ACDs)
- Behavioral health
- Dental and orthodontia
- Drug copayments (except Children's Health Insurance Program [CHIP] drug copayments)
- Durable medical equipment and expendable medical supplies
- Eye prostheses
- Gastrostomy devices
- Genetic services
- Hearing services
- Hemophilia blood factor products
- Home health services
- Hospice care
- Inpatient services
- Laboratory services
- Insurance Premium Payment Assistance (IPPA) (reimburses health insurance premiums)
- Medical foods and nutritional services
- Orthotics and prosthetics
- Outpatient services
- Physical and occupational therapy (outpatient only)
- Physical medicine
- Prescription drugs
- Primary and preventive care
- Physician services, including services performed by advanced practice registered nurses (APRNs)
- Podiatry
- Prescription shoes
- Radiology and radiation therapy services
- Rehabilitation (inpatient and outpatient)
- Renal dialysis
- Renal transplants
- Respiratory care and equipment

- Speech-language pathology (outpatient only)
- Sleep studies
- Stem cell transplants (\$200,000 maximum)
- Surgery
- Telemedicine
- Vision care

### **3.1.1 Prescription Drug Benefits**

Prior Authorization requests for prescription drug claims are submitted to the CSHCN Services Program and approved internally by CSHCN.

Providers do not need prior authorization for the following drugs and products:

- Insulin/insulin syringes
- Medications for home use

For the CSHCN Services Program, providers must obtain prior authorization for the following drugs and products by submitting the specified form:

- Aerosolized tobramycin (TOBI) (HHS Form 1143)
- Cayston (HHS Form 1143)
- Kalydeco (HHS Form 1143)
- Pulmozyme (HHS Form 1143)
- Growth hormone products (HHS Form 1312)
- Synagis (HHS Form 1055)

Prior authorization request forms are available on the CSHCN Services Program Prior Authorization Forms page of the Texas Vendor Drug Program website at [www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-18-forms/prior-authorization-requests-cshcn-services-program](http://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-18-forms/prior-authorization-requests-cshcn-services-program). The forms must be faxed to 1-512-776-7238.

An approved prescribing physician must submit a completed and signed CSHCN Authorization Request Form to certify that the client continues to require these medications. The CSHCN Services Program generally grants authorizations for one year. Regardless of how long the authorization lasts, the client must be eligible for and enrolled in the CSHCN Services Program.

Pulmozyme and Kalydeco may not require an annual review if initial prior authorization criteria is established. Kalydeco will be approved for clients with cystic fibrosis who meet current CF Foundation and FDA indications and prescribing guidelines.

Coordination with primary payer insurance must be used when applicable.

Providers must obtain approval from the CSHCN Services Program for HIV products, family planning, and pulmonary hypertension drugs.

To obtain approval, the prescribing physician must compose a letter of medical necessity on office stationery and fax it to the CSHCN Services Program at 1-512-776-7238. The CSHCN Services Program generally grants approval for one year. Regardless of how long the approval lasts, the client must be eligible for and enrolled in the CSHCN Services Program.

HIV/AIDS drugs are a benefit of the CSHCN Services Program for 60 days. The CSHCN Services Program can extend the benefit beyond 60 days if the provider submits a denial from the Texas HIV Medicaid program or any other third-party payer.

The CSHCN Services Program does not reimburse providers for drug waste.

### **3.1.2 Respiratory Syncytial Virus (RSV) Prophylaxis**

Prior authorization for the RSV prophylaxis drug Palivizumab (Synagis) must be obtained through the CSHCN Services Program.

To request prior authorization, a completed Children with Special Health Care Needs (CSHCN) Services Program Synagis® (Palivizumab) Prior Authorization Request & Prescription Form 1055 must be faxed to the CSHCN Services Program at 1-512-776-7238.

Providers may refer to the Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at <https://www.txvendordrug.com/sites/default/files/docs/1325.pdf> for a copy of the prior authorization form and more information about obtaining palivizumab for CSHCN Services Program clients.

For additional information about RSV criteria, refer to Section 31.2.25.13, “Respiratory Syncytial Virus (RSV) Prophylaxis” in Chapter 31, “Physician.”

### **3.1.3 Medical Transportation Program (MTP) Benefits**

The MTP makes travel arrangements for CSHCN Services Program clients to get to their medical or dental appointments, or to the pharmacy. Clients must call MTP in advance to request travel assistance. To contact MTP, call 1-877-633-8747.

### **3.1.4 Services Provided Outside of Texas**

CSHCN Services Program policies and procedures apply to all enrolled providers outside of the state of Texas. Out-of-state providers must be enrolled and remain enrolled as Title XIX Medicaid providers for to claims to be considered for reimbursement by the CSHCN Services Program.

*Referto:* Section 2.1.9, “Out-of-State Providers” in Chapter 2, “Provider Enrollment and Responsibilities.”

### **3.1.5 CSHCN Services Program Services and Supplies Limitations and Exclusions**

The following are not CSHCN Services Program benefits (this list is not all-inclusive):

- Abortions
- Allergy treatment services, except antibiotic desensitization
- Ambulatory blood pressure monitoring
- Attendant care services
- Augmentation mammoplasty or breast reconstruction (except following a medically necessary mastectomy)
- Autopsies
- Neurofeedback (i.e., EEG biofeedback)
- Care and treatment related to any condition for which benefits are provided or available under worker’s compensation laws
- Chemolase injection (chymodiactin and chymopapain)
- Chiropractic treatment
- Circumcisions (routine)
- Color vision and dark adaption exams
- Craniotomy for lobotomy

- Custodial care
- Dermabrasion or chemical peels
- Donor search for kidney transplants
- Donor search for stem cell transplants
- Dressings and supplies billed in physician's office
- Ear piercing or repair of ear piercing
- Experimental or investigational procedures
- Extracorporeal membrane oxygenation (ECMO)
- Extracorporeal photophoresis
- Fees for completing or filing a CSHCN Services Program claim form, the [CSHCN Services Program Physician/Dentist Assessment Form](#), or other documentation
- Fertility services
- Fetal medical and surgical services
- Implantation of anti-esophageal reflux device
- More than 60 days of inpatient hospitalization per calendar year

**Note:** *An additional 60-day hospital stay begins on the date of hospital admission for an approved stem cell transplant (refer to Section 24.3.1.6, "Transplants - Nonsolid Organ" in Chapter 24, "Hospital").*

- Inpatient rehabilitation of more than 90 days per calendar year
- Intermittent positive pressure breathing (IPPB) (physician services)
- Intersex surgery (except to repair or treat congenital defects)
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
- Lipectomies and rhytidectomies
- Manipulation of chest wall, including percussion
- Newborn services (routine)
- Obsolete diagnostic tests
- Obstetrical tests
- Outpatient cardiac rehabilitation
- Penile plethysmography or nocturnal tumescence test
- Peripheral and thermal angioplasty
- Portable X-ray services
- Prostate treatment (massage and surgery)
- Recreational therapy
- Routine blood drawing for specimens
- Salivary gland and duct diversion or ligation
- Services or supplies:
  - For which benefits are available under any other contract, policy, or insurance

- For which claims were not submitted within the filing deadline
- That are not reasonable and necessary for diagnosis or treatment
- That are not specifically a benefit of the CSHCN Services Program
- Provided before or after the eligibility time period of the client
- Provided to clients on the CSHCN Services Program waiting list
- Provided to a client after a finding was made during utilization review procedures that these services or supplies were not medically necessary
- Payable by any health, accident, or other insurance coverage; by any private or other governmental benefit system; or by any legally liable third party
- Provided by ineligible, suspended, or excluded providers
- Silicone or collagen injections (cosmetic)
- Single photon emission computerized tomography (SPECT) imaging
- Social and educational counseling
- Speech prosthesis insertion
- Sterilizations, sterilization reversals, infertility, obstetrics, and family-planning services
- Substance use treatment
- Tattooing
- Telephone calls, computer calculations, reports, and medical testimony
- Transplants of the heart, intestines, liver, lung or pancreas
- Travel allowance for specimen collection for homebound clients

## **3.2 Client Eligibility**

### **3.2.1 CSHCN Services Program Application Criteria**

Applicants who may be eligible for coverage under Medicare, Medicaid, Medicaid Buy-In (MBI), Medicaid Buy-In for Children (MBIC), or CHIP by reason of citizenship, residency status, age, or medical condition must apply for coverage. A written Medicaid and CHIP determination must be sent with the application for the CSHCN Services Program. Applicants who are not citizens or legal residents of the United States or who are currently enrolled in CHIP or Texas Medicaid are exempt from this requirement. Proof of exempt status must be sent with the application for the CSHCN Services Program.

If the CSHCN Services Program does not receive the Medicaid or CHIP determination or evidence of exemption from this requirement with the application, the applicant is given 60 days to submit the requested information. During this 60-day period, the applicant may send in any additional information that the CSHCN Services Program requires to process the application. If all information is received before the end of the 60 days, the CSHCN Services Program may grant eligibility for CSHCN Services Program health-care benefits or place the client on the waiting list. The eligibility effective date will be established as the date the application was made complete.

If the client or applicant has submitted all of the documentation required to approve his or her case for CSHCN Services Program health-care benefits, except for the Medicaid and CHIP determinations, the program may approve the case for 60 days until the Medicaid and CHIP determinations are received. Services are suspended if the Medicaid or CHIP determinations are not received on or before the end of 60 days. The suspension remains until the requested information is received. Once all of the required information is received, eligibility is granted. Eligibility is suspended between the 60-day cutoff date and the date on which the requested information is received.

An extension of 30 days may be granted for exceptional circumstances when requested.

The CSHCN Services Program does not pay for any services until the client's application is approved and the client is eligible to receive CSHCN Services Program health-care benefits.

If the CSHCN Services Program denies eligibility to a program applicant, the program shall give the applicant written notice of the denial and of the applicant's right to request an administrative review of the denial within 30 days of the date of the notification.

If the CSHCN Services Program proposes to modify, suspend, or terminate a client's eligibility for health-care benefits (unless such program actions are authorized by the CSHCN Services Program Rules Title 26 Part I TAC §351.16 relating to Procedures to Address Program Budget Alignment), the CSHCN Services Program shall give the client written notice of the proposed action and of the client's right to request an administrative review of the proposed action within 30 days of the date of notification.

Any questions concerning a client's eligibility for benefits of the CSHCN Services Program must be directed to the CSHCN Services Program Central Office at 1-800-252-8023.

### **3.2.2 Eligibility Criteria**

A person may be eligible for health-care benefits under the CSHCN Services Program if the following conditions are met:

- The applicant must be a Texas resident.
- The applicant is 20 years of age or younger. Persons diagnosed with cystic fibrosis are exempt from this requirement.
- The applicant's family meets the CSHCN Services Program financial eligibility criteria.
- The applicant's physician or dentist attests to the program's medical certification definition and provides a diagnosis that meets the definition on the [CSHCN Services Program Physician/Dentist Assessment Form](#) located in the CSHCN Services Program Application.

The applicant must be eligible for medical assistance at the time the service is provided. Having an application for CSHCN Services Program eligibility in process is not a guarantee that the applicant can become eligible. Services and supplies are not paid by the CSHCN Services Program if they are provided to a client before the effective date of his or her eligibility or after the effective date of his or her denial of eligibility.

### **3.2.3 Prematurity**

Applicants who meet the definition of prematurity are not medically eligible for CSHCN Services Program health care benefits until they have been discharged from the hospital and remain out of the hospital for at least 14 consecutive days.

### **3.2.4 Program Applicants and Clients Residing in Long-Term Care**

Applicants and clients who are residing in skilled nursing facilities (SNF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), state hospitals (court-ordered and not considered a public institution), or community group homes may apply for CSHCN Services Program health care benefits.

Long-term care services provided by the facilities described above are not a covered health care benefit. If an ongoing CSHCN Services Program client is admitted to any of the above-mentioned facilities, his or her eligibility for covered health care benefits remains unchanged; however, the client may qualify for Medicaid or CHIP services and must maintain that coverage to continue eligibility for covered CSHCN Services Program health care benefits.

### 3.2.5 Program Applicants and Clients That Are Incarcerated

If an applicant or client meets the financial, medical, age, residency, and other criteria for eligibility for CSHCN Services Program health care benefits, eligibility may be granted; however, the applicant or client is not eligible for CSHCN Services Program health care benefits until released from custody. Services provided while the client is in the custody of, or incarcerated by, any municipal, county, state, or federal governmental entity are not covered.

**Exception:** *Case management or prior-approved FSS not provided by the governmental entity, that are needed during the time when a client is making a transition from custody or incarceration into a community-living setting, may be covered*

### 3.2.6 Sporadic Medicaid, MBIC, MBI, or CHIP Coverage

If the CSHCN Services Program client loses Medicaid coverage for longer than one month, reapplication to Medicaid is required. The client is notified that reapplication is required and is given 60 days to submit the Medicaid determination. CSHCN Services Program coverage for health care benefits may be granted during the 60 day period. If the determination is not received within the 60 day period the client's eligibility may be suspended. The CSHCN Services Program may grant a 30-day extension, at the client's request, to obtain the determination for Medicaid.

If a client is disenrolled by MBIC or MBI during the coverage period, the client or family must submit written notification to the CSHCN Services Program stating the reason for disenrollment.

Acceptable reasons to end MBIC or MBI coverage include, but are not limited to:

- Age limitations
- Has Medicaid coverage
- Lost private insurance coverage
- Found not to be a U. S. citizen

### 3.2.7 Eligibility Date for Program Health Care Benefits

The effective date of eligibility for CSHCN Services Program health care benefits is the date of receipt of the application, except in the following circumstances:

- *Newborn.* The effective date of eligibility for newborns that are not born prematurely is the date of birth. Newborn means a child 30 days old or younger.
- *Spend down.* The effective date of eligibility for applicants with spend down is the day after the earliest DOS on which the cumulative bills are sufficient to meet the spend-down amount. Only medical bills having a DOS within the 12 months prior to the date of receipt of the application denial date may be included to satisfy spend-down requirements. Medical bills from any member of the household for which the applicant, parents, guardian, or managing conservator of the applicant is responsible and that are not payable by another entity may be included. All spend-down documentation must be received within 60 days of receipt of the application denial. Medical bills that are used to meet spend down are not payable by the CSHCN Services Program.
- *Waiting List Exception.* If an ongoing client (not on the waiting list) reapplies on or before the day that CSHCN Services Program financial and medical eligibility expires and the income is over scale, his or her name is not placed on the waiting list. Eligibility is denied until bills are received that are sufficient to meet spend down. Eligibility then begins according to the spend-down criteria above.
- *Prematurity.* The effective date of eligibility for an applicant that is born prematurely is the day after the applicant has been out of the hospital for 14 consecutive days.
- *Trauma.* The effective date of eligibility following traumatic injury is the day after the acute phase of the treatment ends, the date of transfer to the rehabilitation facility, or the date discharged to home.



- The Trauma and Accident Section of the CSHCN Services Program Physician and Dentist Assessment Form in the CSHCN Services Program Application must be completed for all first time applicants. Applicants who are currently ongoing clients and are reapplying to establish continuing eligibility, or applicants who have had CSHCN Services Program eligibility in the past are exempt from this requirement. This exemption pertains even if the returning applicant has sustained a traumatic injury or accident during any time following the submission of an original application that included this information.
- The received date is the date the application is received by the CSHCN Services Program.

### **3.2.8 Financial Eligibility Criteria**

Prospective CSHCN Services Program clients must meet financial eligibility requirements. Additional information about CSHCN Services Program financial eligibility is available at the toll free CSHCN Services Program Inquiry Line at 1-800-252-8023 or online at [www.dshs.texas.gov](http://www.dshs.texas.gov). CSHCN Services Program inquiries may also be mailed to:

CSHCN Services Program  
MC 1938  
PO Box 149030  
Austin, TX 78714-9947

**Important:** *All client eligibility information must be kept up to date. CSHCN Services Program financial eligibility must be updated annually. Medical eligibility must be updated annually; however, medical information may be updated whenever there is a change in the client's condition.*

### **3.2.9 Medical Eligibility Criteria and the Physician/Dentist Assessment Form (PAF)**

An important element of determining client eligibility is the [CSHCN Services Program Physician/Dentist Assessment Form](#). The PAF provides the CSHCN Services Program with vital information about the client's medical condition, qualifies the client as medically eligible for benefits, and is used when clients are considered for removal from the waiting list. The PAF also provides a medical certification for a diagnosis that meets the CSHCN Services Program's definition of a child with special health-care needs and also allows for identification and explanation of an urgent need for medical care.

CSHCN Services Program applicants and clients are required to submit proof of their medical condition with the initial application, notify the CSHCN Services Program of any changes in the client's condition, and certify at least once annually that the client is medically eligible. This information is completed and submitted on the [CSHCN Services Program Physician/Dentist Assessment Form](#).

Copies of the form are included with the application packet, and clients or their families must ensure that a physician or dentist provides the information necessary to meet the medical eligibility requirements of the CSHCN Services Program.

#### **3.2.9.1 Medical Certification Definition**

The CSHCN Services Program rules state that the following medical criteria should be used when referring clients to the program:

- A chronic developmental condition must include physical manifest and may not be solely a delay in intellectual, mental, behavioral, or emotional development.

CSHCN Services Program rules state the following for a chronic physical condition:

- Such a condition may exist with accompanying developmental, mental, behavioral, or emotional conditions, but is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition.

A diagnosis of intellectual disability, autism, or attention deficit hyperactivity disorder (ADHD) does not indicate a physical disability by itself. If the client also has cerebral palsy or another condition causing physical disability, use that diagnosis on the PAF to expedite the processing of the application.

The physician or dentist who completes the PAF must also certify that the applicant meets the CSHCN Services Program's definition of a person with special health-care needs outlined below:

- 21 years of age or younger
- Must have a chronic physical or developmental condition that will last or is expected to last for at least 12 months and may result in limits to one or more major life activities or result in death if not treated
- Must have a chronic physical or developmental condition that requires health and related services of a type or amount beyond those generally required by children
- Must have a physical (body, bodily tissue, or organ) manifestation
- May have an accompanying developmental, mental, behavioral, or emotional condition(s) that is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition
- A person of any age who has cystic fibrosis

### **3.2.9.2 Primary and Secondary Diagnoses**

The CSHCN Services Program is not diagnosis-restricted; however, a valid *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM) code, or its successor, that indicates an applicant's chronic physical condition is required on the PAF. This information is important for program data purposes and to ensure that the applicant meets the program's definition of a child with special health-care needs.

The primary diagnosis on the PAF must be medical in nature and meet CSHCN Services Program criteria. Any additional diagnoses may be listed in the Other Diagnoses section located below the Primary Diagnosis line.

For example, if a CSHCN Services Program client has a diagnosis of autism and cerebral palsy, use cerebral palsy as the primary diagnosis because it indicates a physical disability, and autism does not.

To facilitate applications to the CSHCN Services Program for certain applicants, the CSHCN Services Program medical director may accept written documentation of medical criteria certification submitted by a physician or dentist who is licensed to practice in a state or jurisdiction of the United States of America other than Texas.

The CSHCN Services Program does not reimburse providers for written documentation of medical criteria certification. In addition, providers may not request or accept payment from the client or applicant, or the client or applicant's family, for completing any CSHCN Services Program forms.

### **3.2.9.3 Important Considerations When Completing the PAF**

- Use as the primary diagnosis, a medical diagnosis that indicates the client's chronic condition that meets the CSHCN Services Program's definition of a child with special health-care needs, and/or identifies the urgent need for care.
- Use the full diagnosis code, including any suffixes (e.g., "D51.2" rather than "D51").
- If YES is noted in the Determination of Urgent Need for Services section, an explanation must be entered to justify the YES answer. If this section is incomplete, the PAF will be rejected.

- A physician or dentist must complete the Physician/Dentist Data section of the form, sign it, and date it. The signature must be an original signature. Electronic or stamped signatures are not accepted. The form can only be signed by a physician (doctor of medicine [MD], doctor of osteopathy [DO], doctor of dental surgery [DDS], or doctor of dental medicine [DMD]) who has seen the client in the previous 12 months.
- An original signature is required. Electronic or stamped signatures are not accepted.
- Instructions for updating the PAF are also available on the Texas Health and Human Services website.
- The [CSHCN Services Program Physician/Dentist Assessment Form](#) instructions

**Important:** Providers can photocopy this form but should retain the original for future use.

### 3.3 CSHCN Services Program Notice of Eligibility

The CSHCN Services Program Notice of Eligibility gives clients, parents, and providers a quick way to verify CSHCN Services Program eligibility. The Notice is designed to convey all of the information necessary to document identification information.

**Referto:** Section 3.3.2, “CSHCN Services Program Notice of Eligibility Sample” in this chapter.

CSHCN Services Program Notices of Eligibility are valid for a 12-month coverage period. Clients must reapply for CSHCN Services Program health-care benefits annually. A new application and all proof of financial eligibility must be submitted each time a client reapplies for the CSHCN Services Program. This notice is one way to verify client eligibility.

The client’s notice of eligibility shows:

- The client’s case number (also called the client ID number). The case number for the CSHCN Services Program will always begin with a 9 and end with 00.
- The client’s name, date of birth, and gender.
- The 12 months of the client’s eligibility.

Providers should ask for the notice when scheduling a client for an appointment. Under certain circumstances, the notice may not be valid at the time the provider sees the client.

Providers can also verify client eligibility by using the following options:

- CSHCN Services Program Automated Inquiry System (AIS) at 1-800-568-2413.
- CSHCN Services Program at 1-800-252-8023.
- TMHP Electronic Data Interchange (EDI) Gateway.
- TMHP website at [www.tmhp.com](http://www.tmhp.com).

If the client is not eligible when they arrive for an appointment, the provider must advise the client that they are being accepted as a private-pay client at the time the service is provided. The client will be responsible for paying for all services received. Providers are encouraged to ensure that the client signs written notification indicating that the client is being accepted as a private-pay client.

**Referto:** The “Client Eligibility” computer-based training on [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program Notice of Eligibility provides the reapplication deadlines that are specific to each client. It identifies the date on which they can start the reapplication process and lets them know that they must submit a renewal application before their eligibility ends.

Approximately 60 days before the eligibility renewal date, the CSHCN Services Program mails a letter and a reapplication packet containing the CSHCN Services Program Application (T-3) to clients. Clients who have not received the packet within 30 days prior to the renewal date can request one from their local CSHCN Services Program Regional Office (refer to the listing in Section 1.3.2, “Regional Offices” in Chapter 1, “TMHP and HHSC Contact Information” of this manual), or by calling the CSHCN Services Program Central Office at 1-800-252-8023, or downloading the booklet from the CSHCN Services Program website at [www.dshs.texas.gov/cshcn/clapplforms.shtm](http://www.dshs.texas.gov/cshcn/clapplforms.shtm).

### **3.3.1 Eligibility Restrictions**

Under certain circumstances, the client eligibility notice may not be valid at the time of the client’s appointment. For example, restrictions are sometimes placed on clients’ cases after they receive their eligibility notice. Some reasons for restrictions are:

- The CSHCN Services Program needs a Medicaid or CHIP determination.
- The client or family has moved.
- The family circumstances have changed, possibly making the client ineligible for the CSHCN Services Program.
- The client or family must apply to the Medically Needy Program.

The restriction period usually lasts 60 days. A 30-day extension may be granted when requested.

The client can continue to receive CSHCN Services Program benefits while there is a pending restriction on the case. However, there are a few important conditions to keep in mind.

- If the CSHCN Services Program receives the requested information or documentation before the end of the 60-day restriction period, the restriction ends, and there is no lapse in the client’s eligibility.
- If the CSHCN Services Program receives the information or documentation after the end of the 60-day period (and the added 30-day extension, if requested), but before the end of the client’s eligibility, their eligibility will lapse from the time the restriction period deadline until the time the CSHCN Services Program received the information.
- If the CSHCN Services Program receives the information after the client’s eligibility expires, the client’s name is placed on the program’s waiting list. Clients on the waiting list are not eligible for health benefits.

**3.3.2 CSHCN Services Program Notice of Eligibility Sample**



**TEXAS**  
Health and Human  
Services

**Charles Smith**  
Executive Commissioner

**Children with Special Health Care Needs (CSHCN) Services Program**  
**Notice of Eligibility**

John Client  
123 Texas Street  
City, TX 12345-0001

**Client:** John Client  
**Client ID:** 123456789

This is your CSHCN Services Program Notice of Eligibility. Your Notice cannot be used for anyone else and can only be used for services between the current approval periods: **12/11/2017 - 12/10/2018**. Please bring this Notice with you when you visit your program providers. You are eligible for benefits as shown below.

| <b>Benefit Category</b>                     | <b>Approved</b> | <b>Start Date</b> | <b>End Date</b> |
|---|-----------------|-------------------|-----------------|
| Drugs                                       | Yes             | 12/11/2017        | 12/10/2018      |
| Medical/Dental                              | Yes             | 12/11/2017        | 12/10/2018      |
| Medical Transportation                      | Yes             | 12/11/2017        | 12/10/2018      |
| Insurance Premium Payment Assistance (IPPA) | No              |                   |                 |
| Family Support Services (FSS)               | Yes*            | 12/11/2017        | 12/10/2018      |

***\*FSS requires prior authorization. This means that the program must make sure that you are eligible for each service before approving it. To learn more, please refer to your Client Handbook or call your case manager at your local health services regional office.***

To apply to continue receiving services after the Benefit End Date, the program must receive your new application no later than **12/10/2018**, but not sooner than **10/11/2018**.

To request a new copy of this Notice, get a new application, contact Eligibility Services, or for any other questions, please call **1-800-252-8023** or visit **dshs.texas.gov/cshcn**.

CSHCN Services Program • MC 1938 • PO Box 149347 • Austin, Texas 78714-9347  
1-800-252-8023 • dshs.texas.gov/cshcn

### 3.4 Clients Eligible for Medicaid and CSHCN Services Program Benefits

The CSHCN Services Program requires all applicants to apply for Medicaid and include the determination or exemption letter in their program application. The CSHCN Services Program will not pay for services until the client's Medicaid eligibility is determined. The CSHCN Services Program also does not pay for services provided to children who are also eligible for Medicaid, with the exception of the transportation of a deceased client's body.

If the CSHCN Services Program pays benefits that also were paid by Medicaid, providers are responsible for refunding the full CSHCN Services Program payment. Providers must make the refund check payable to TMHP and send it to the attention of the TMHP Financial Unit. Send the refund check along with the [CHSCN Services Program Refund Information Form](#) to the following address:

Texas Medicaid & Healthcare Partnership  
Attn: Financial Unit  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727

Include the following information:

- Client name and CSHCN Services Program client number
- Copies of the Remittance and Status (R&S) Reports from both Texas Medicaid and the CSHCN Services Program that show the claims were paid
- Date of service
- Provider name
- National Provider Identifier (NPI)

**Note:** *If the Medicaid claims administrator (TMHP) denies a claim with the explanation of benefits (EOB) code 00182 (client not eligible), but the family has evidence that the client is eligible for Medicaid, providers must appeal or resubmit the claim to TMHP. Client Medicaid eligibility information may not have been available at the time of the first claim submission.*

### 3.5 Clients Eligible for CHIP and CSHCN Services Program Benefits

CHIP offers comprehensive health-care coverage to thousands of Texas children who are uninsured. CHIP provides services such as physician care, medications, medical equipment, therapies, hospitalization, and much more.

Many children in the CSHCN Services Program are eligible for CHIP. Children may receive CHIP and CSHCN Services Program benefits at the same time. The CSHCN Services Program may pay for meals, transportation, lodging, other services not available from CHIP, or services beyond the CHIP maximum benefit. The CSHCN Services Program is the payer of last resort for medical services.

CHIP benefits apply to all children in the family, including the child who is also eligible for the CSHCN Services Program. For more information about CHIP (children and perinatal coverage), contact CHIP/Children's Medicaid at 1-877-KIDS-NOW (1-877-543-7669) or visit the CHIP website at [www.insurekidsnow.gov](http://www.insurekidsnow.gov).

### 3.6 Clients Eligible for Medicaid and Comprehensive Care Program (CCP) Benefits

The Texas Comprehensive Care Program (CCP) and Texas Medicaid (Title XIX) Home Health Services cover medically necessary services for enrolled clients who are 20 years of age or younger.

The CSHCN Services Program does not pay claims for its clients who are eligible for CCP and whose claims were denied by Medicaid for any reason, including late filing, limited client, duplicate services, incorrect claim form, or additional information required.

Additional information about CCP is available toll free at 1-800-846-7470, Monday through Friday, from 7 a.m. to 7 p.m, Central Time.

### **3.7 Medically Needy Program (MNP)**

MNP provides access to Medicaid benefits for children who are 18 years of age or younger and whose family income exceeds the eligibility limits under Temporary Assistance to Needy Families (TANF) or one of the medical-assistance-only programs for children, but whose income and assets are not sufficient to meet their medical expenses.

The CSHCN Services Program requires all applicants to include a Medicaid determination or exemption along with their application. No services are paid by the CSHCN Services Program until Medicaid eligibility is determined.

Once eligibility is established, the client can receive the same care and services available to all other Medicaid clients.

The CSHCN Services Program may ask clients to apply to MNP if \$2,000 or more in medical bills were paid or are expected to be paid by the CSHCN Services Program. Clients are given 60 days to apply to MNP and send the determination to the CSHCN Services Program.

CSHCN Services Program client benefits are not limited during this 60-day period; however, the Program will suspend a client's eligibility if he or she does not comply with the request to apply to MNP.

#### **3.7.1 MNP Spend Down Processing**

MNP applicants must meet basic TANF eligibility requirements. Eligibility may be determined with or without spend down (the difference between the applicant's net income and the MNP income limits). When the applicant is eligible without spend down (income is below MNP income limits), the applicant is certified to be Medicaid-eligible.

Prospective MNP clients who do not qualify for Medicaid must participate in the "Spend Down" program which is based on income and health-care expenses. The spend-down amount and duration of Medicaid coverage is determined by HHSC. The client is issued a Medical Bills Transmittal (Form H1120 or H1122) that indicates the spend-down amount and the months of potential coverage (limited to the month of application and any of the 3 months before the application month).

During spend down, program participants are responsible for paying a portion of their health-care bills and submitting those bills or completed claim forms, also referred to as invoices, to the Medically Needy Clearinghouse (MNC). All medical bills (for all family members) must be submitted to the TMHP-MNC, along with the Form H1120 or H1122 for application toward the spend-down amount.

Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse  
PO Box 202947  
Austin, TX 78720-2947

Charges from the bills are applied in date-of-service order to the spend-down amount. The spend down is met when the accumulated charges equal the spend-down amount.

Once the client has met the total spend-down amount and becomes eligible for Medicaid, MNC will return the invoices to the client, and the client will receive a Medicaid Identification form. Spend down program participants are required to notify their providers once their Medicaid eligibility has been

established. Providers are expected to submit claims to Medicaid for those clients after that time. MNC will also mail notification letters to providers who have not yet submitted claims for clients who have become eligible for Medicaid by meeting their spend-down amount.

**Note:** *Providers must include the CSHCN Services Program client number and the CSHCN Services Program client name on all of the documentation sent to the CSHCN Services Program or TMHP-MNC.*

The CSHCN Services Program can assist with the submission of medical bills to apply for Medicaid coverage through the spend down process. TMHP MNC accepts paid or unpaid medical bills from the CSHCN Services Program for application toward the spend-down amount regardless of the date of service. This process enables TMHP MNC to expedite the conclusion of the case and inform DSHS when the spend down is met.

When the spend down is met and the client is certified as Medicaid-eligible, the CSHCN Services Program may consider whether any of the services used to meet the spend-down amount (client liability) may be considered for CSHCN Services Program health-care benefits coverage.

### **3.7.2 Provider Assistance to Clients with Spend Down**

Providers may assist clients in meeting their spend-down amount by:

- Submitting bills to TMHP MNC for the CSHCN Services Program client that are not payable by the program.
- Submitting bills to TMHP MNC for services provided to any other member of the family.
- Providing clients and families with current itemized statements.
- Encouraging clients to submit all of the medical bills they incurred from all of their providers.

Only medical bills having a date of service (DOS) within the 12 months preceding the date of receipt of the application denial date may be included to satisfy spend-down requirements. Medical bills from any member of the household for which the applicant, parents, foster parents, guardian, or managing conservator of the CSHCN Services Program applicant is responsible and which are not payable by another entity may be included. All spend-down documentation must be received within 60 days of receipt of the application denial. Medical bills used to meet spend down are not payable by the CSHCN Services Program.

Submitted bills must be itemized and must show the provider's name, client's name, CSHCN Services Program client number, MNP client number, dates of service, services provided, charge for each service, total charges, amounts of payments, dates of payments, and total due.

Bills for past accounts must be itemized statements dated in the last 60 days from the provider and must verify the outstanding status of the account and the current balance due. Accounts with payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's EOB or a Medicare Summary Notice (formerly known as a Medicare Explanation of Benefits) that shows the specific services covered and amounts paid.

When additional information is requested by TMHP MNC, the applicant has 30 days from the date of the letter to respond. The provider may assist the client by furnishing the additional information to the applicant or sending it directly to TMHP MNC in a timely manner.

**Note:** *TMHP MNC does not pay bills; it only applies the charges toward the spend-down amount. The provider must file a Medicaid claim after the client's Medicaid eligibility is established so that Medicaid can consider the claim. During the spend-down period, the client does not have Medicaid coverage, and providers cannot send claims to Medicaid. Any claim filed at that time is denied due to client ineligibility.*



Providers may make inquiries regarding status, months of potential eligibility, Medicaid or case number, and general client information by contacting the TMHP Contact Center at 1-800-925-9126, from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

### 3.7.3 Claims Filing Involving a Medicaid Spend Down

TMHP MNC will mail notification letters to providers whenever clients meet spend down and TMHP has not yet received any claim for the client's bills. The notification letter will state 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 also responsible for informing their medical providers of their Medicaid eligibility and making arrangements to pay the charges used to meet the spend-down amount. For CSHCN Services Program clients, the CSHCN Services Program may consider paying the charges used to meet the spend down for covered services.

TMHP MNC notifies the client of:

- Bills or charges that were used to meet the spend down.
- Bills or charges that the client is financially responsible to pay.
- Bills or charges that the provider should submit to Texas Medicaid for consideration of payment.

Bills or charges not applied toward spend down or not previously submitted to the CSHCN Services Program, must be received by TMHP for Medicaid consideration. These claims must be received within 95 days from the date the client's eligibility was added to the TMHP file (add date) and must be on the appropriate claim form (such as CMS-1500 and UB-04 CMS-1450).

The client's payment responsibilities are as follows:

- When a portion of the entire bill was used to meet spend down, the client is responsible for the payment of the specific portion or the entire bill. For CSHCN Services Program clients, submit the bill to the CSHCN Services Program for payment consideration.

Claims are subject to the following:

- The claim must show the total billed amount for the services provided. Charges for ineligible days or spend-down amounts must not be deducted or included on the claim.
- A client's payment toward spend down must not be reflected on the claim submitted to TMHP.

*Note: Payments made by the client for services that were not used in the spend down but that were incurred during an eligible period must be reimbursed to the client before the provider files a claim with TMHP.*

Once eligibility is established, the client is eligible to receive the same care and services available to all other Medicaid clients.

## 3.8 Renal Dialysis

Eligibility for clients needing renal dialysis begins with the initial date of eligibility or the first dialysis treatment date, whichever is later, and may continue for a period of three months. All CSHCN Services Program clients who need dialysis due to end-stage renal disease (ESRD) are referred to the Kidney Health Care (KHC) program and to Medicare for coverage. These clients are notified that they must apply to KHC and Medicare and are given 60 days to submit the determinations to the CSHCN Services Program. Coverage for health care benefits continues for ongoing clients and waiting list clients may receive eligibility during the 60-day period. A 30-day extension may be granted to obtain the determinations. If the client is not eligible for KHC or Medicare, eligibility for CSHCN Services Program coverage continues.

### 3.9 Waiting List Information

The CSHCN Services Program may establish a waiting list when budgetary limitations exist. The waiting list is maintained continually from one fiscal year to the next.

Clients are placed on the waiting list for one of two reasons:

- 1) They are new applicants to the program.
- 2) They are current clients who did not renew on time.

Clients placed on the waiting list are notified of their status. The CSHCN Services Program periodically contacts waiting list clients to confirm their eligibility for CSHCN Services Program services.

Clients on the waiting list do not receive a CSHCN Services Program Notice of Eligibility Form. The CSHCN Services Program sends information about the waiting list process to adult clients, the parent, guardian, caretaker, or managing conservator of a minor child, the DSHS Regional Office, and the client's physician or dentist. Applicants are not placed on the waiting list until it is determined that they meet all of the eligibility criteria for the program.

If all of the documentation necessary to complete the application has been received except the Medicaid or CHIP determinations, the client is placed on the waiting list. The Medicaid or CHIP determinations must be received before the client is removed from the waiting list.

Each month the CSHCN Services Program reviews its funds to see if it can take people off the list. The Program can only take a group of clients off the list and does not take one person off at a time. Clients are removed from the list when funds become available.

Funding decisions concerning the waiting list are based both on the amount of program funds available and the anticipated amounts required to provide health-care benefits. The order in which clients are removed is not purely sequential; it depends on a combination of factors, including the urgent medical need of the condition as reported by a physician or dentist on the [CSHCN Services Program Physician/Dentist Assessment Form](#), the availability of other health insurance, the client's age, and the date and time of the latest uninterrupted eligibility period.

When a client is removed from the waiting list, the client receives a new program approval letter and a CSHCN Services Program Notice of Eligibility Form with the active eligibility dates and information regarding the range of services. If there is a change in the client's condition, the client's medical information must be updated. It is important that all client eligibility information is current.

Clients' placement on the waiting list is also based on the date and time their application is processed and approved for the program. Clients must maintain program eligibility to remain on the waiting list. A lapse in eligibility changes their placement on the waiting list.

Waiting list clients who wish to remain eligible to be considered for program health-care benefits must reapply for eligibility before their eligibility is scheduled to end. The eligibility coverage period is 12 months (i.e., 365 days from the first day of the client's current eligibility period, or 366 days during a Leap Year). Clients are notified of program deadlines to re-establish eligibility. Within 60 days of the client's eligibility end date, the CSHCN Services Program mails the client a CSHCN Services Program Application and a letter advising that it is time to reapply.

If a waiting list client submits an application without all of the required documentation, the application is considered incomplete, and the client is given 60 days to complete it. If the reapplication process is not completed within the 60-day period, the client's place on the waiting list is forfeited. When the CSHCN Services Program receives a complete reapplication after the 60-day period, the client is placed at the end of the waiting list according to the approval date of his or her complete application.

### **3.10 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **PRIOR AUTHORIZATIONS AND AUTHORIZATIONS**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# PRIOR AUTHORIZATIONS AND AUTHORIZATIONS

## Table of Contents

- 4.1 General Information ..... 3**
- 4.2 Extension of Filing Deadlines for Holidays ..... 3**
  - 4.2.1 Limitations ..... 3
  - 4.2.2 Signature Requirements ..... 3
    - 4.2.2.1 Electronic Signatures ..... 4
      - 4.2.2.1.1 Authority and Definitions ..... 4
      - 4.2.2.1.2 Electronic Signature Requirements ..... 5
  - 4.2.3 Requests for Procedures That Are Pending a Rate Hearing ..... 5
  - 4.2.4 Requests for Procedures That Are Manually Priced ..... 6
  - 4.2.5 Clients with Third Party Resources ..... 6
- 4.3 Authorizations ..... 7**
  - 4.3.1 Services that Require Authorization ..... 7
  - 4.3.2 How To Submit an Authorization Request ..... 9
- 4.4 Prior Authorizations ..... 9**
  - 4.4.1 Services that Require Prior Authorization ..... 10
  - 4.4.2 Prior Authorization for Inpatient Admission After Business Hours ..... 14
  - 4.4.3 Specialty Team or Center Services ..... 14
  - 4.4.4 Retroactive Prior Authorizations ..... 14
  - 4.4.5 How to Submit a Prior Authorization Request ..... 15
  - 4.4.6 Prior Authorization Electronic Submissions through the TMHP Prior Authorization (PA) on the Portal ..... 16
  - 4.4.7 Browser Compatibility and System Requirements ..... 18
  - 4.4.8 Electronic Attachments ..... 18
  - 4.4.9 Maintaining Complete Documentation ..... 18
  - 4.4.10 Sending Prior Authorization Requests via Fax ..... 19
- 4.5 Authorization and Prior Authorization Denials ..... 19**
  - 4.5.1 Denied Authorization and Prior Authorization Requests Resubmission ..... 20
  - 4.5.2 Closing a Prior Authorization ..... 20
  - 4.5.3 Administrative Review for Authorization and Prior Authorization Denials ..... 20
  - 4.5.4 Fair Hearing ..... 21
- 4.6 TMHP-CSHCN Contact Center ..... 21**

## 4.1 General Information

Some services require authorization or prior authorization as a condition for reimbursement. Authorization or prior authorization is not a guarantee of payment.

- Authorization must be obtained no later than 95 days after the date of service.
- Prior authorization must be obtained before the service is provided.
- Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization or prior authorization submission.

TMHP sends a notification to providers and clients when it approves, denies, or modifies an authorization or prior authorization request. It is strongly recommended that providers maintain a list that details the authorizations, including:

- Client name
- CSHCN Services Program client number
- Date of service
- Provider number
- Items submitted

Providers will need this information if they request an administrative review after an authorization or prior authorization is denied. In addition, providers should keep a copy of the request for authorization and the response received from TMHP.

*Referto:* [2023 Authorization and Filing Deadline Calendar](#)  
[2024 Authorization and Filing Deadline Calendar](#)

Providers should allow three business days to receive a response to an authorization or prior authorization request.

## 4.2 Extension of Filing Deadlines for Holidays

For holidays that extend the filing deadline, please refer to Section 5.1.8, “Claims Filing Deadlines” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

### 4.2.1 Limitations

Authorization and prior authorization requests will be denied if the provider is not actively enrolled with the CSHCN Services Program. “Actively enrolled” providers are those that have filed claims for clients of the CSHCN Services Program or Texas Medicaid within the past 24 months, and that do not have any type of payment holds on their enrollment status.

*Referto:* Chapter 2, “Provider Enrollment and Responsibilities” for more information on becoming a CSHCN Services Program provider.

- Providers are responsible for verifying client eligibility before providing services. If the client is not eligible at the time of the authorization or prior authorization request, the request will be denied. If the client becomes eligible at a later date, providers can submit a new authorization or prior authorization request form.
- Any services provided beyond the limitations of the CSHCN Services Program are not reimbursed.

### 4.2.2 Signature Requirements

Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the client’s medical provider, dental provider, or medical supplier. If indicated on the form, an authorized representative’s signature is acceptable.

### 4.2.2.1 Electronic Signatures

#### 4.2.2.1.1 Authority and Definitions

Texas Government Code §531.0055(m) requires the Health and Human Services Commission (HHSC) to establish standards for the use of electronic signatures in accordance with the Uniform Electronic Transactions Act (Chapter 322, Business and Commerce Code), with respect to any transaction, as defined by Section 322.003, Business and Commerce Code, in connection with the administration of health and human services programs.

The following definitions apply for the policy information outlined in this section:

| Term                            | Definition  |
|---------------------------------|---|
| Asymmetric cryptosystem         | A computer-based system that employs two different but mathematically related keys with the following characteristics: <ul style="list-style-type: none"> <li>• One key encrypts a given message;</li> <li>• One key decrypts a given message; and</li> <li>• The keys have the property that, knowing one key, it is computationally infeasible to discover the other key.</li> </ul>  |
| Certificate                     | A message, as defined in 1 TAC §203.1(2), which: <ul style="list-style-type: none"> <li>• Identifies the certification authority issuing it;</li> <li>• Names or identifies its subscriber;</li> <li>• Contains the subscriber’s public key;</li> <li>• Identifies its operational period;</li> <li>• Is digitally signed by the certification authority issuing it; and</li> <li>• Conforms to ISO X.509 Version 3 standards.</li> </ul> |
| Certification authority         | A person who issues a certificate.  |
| Digital signature               | An electronic identifier intended by the person using it to have the same force and effect as the use of a manual signature, and that complies with the requirements of 1 TAC §203.23.  |
| Digitized signature             | An image of pen-to-paper.   |
| Electronic record               | A record created, generated, sent, communicated, received, or stored by electronic means.   |
| Electronic signature            | An electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.   |
| Prior authorization             | A request submitted to the program, or its designated contractor, to provide a service the program ultimately considers for reimbursement. (Prior authorization must be obtained before the delivery or date of service.)   |
| Program                         | The Children with Special Health Care Needs Services Program.   |
| Public key                      | The public part of an asymmetric key pair that is used to verify signatures or encrypt data.  |
| Texas Administrative Code (TAC) | A compilation of all state agency rules in Texas.   |

#### 4.2.2.1.2 Electronic Signature Requirements

The CSHCN Services Program complies with 1 TAC, Chapter 203, Guidelines for the Management of Electronic Transactions and Signed Records, which details the requirements for state agencies that send and accept electronic records and electronic signatures or otherwise create, generate, communicate, store, process, use, or rely upon electronic records and electronic signatures.

The program, or its designated contractor, may accept electronic signatures on authorization or prior authorization requests and supporting documentation transmitted by mail, fax, or through the online prior authorization portal, if the electronic signature technology meets all applicable federal and state statutes and administrative rules.

Electronic signatures, also known as digital signatures, that comply with the Texas Department of Information Resources (DIR) rules at 1 TAC §203.24 will be considered to have the same legal effect as a handwritten signature.

Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable.

Electronically-signed documents must have an electronic date on the same page as the signature.

Providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules.

Electronically-signed transactions and electronically-signed documents must be kept in the client's medical record, and a paper copy must be available upon request.

All fax transmissions must reflect the date, time, and fax number of origination, and the original document must be maintained by the provider.

All documentation submitted with a handwritten provider's signature must have a handwritten date next to the signature and must be kept in the client's medical record.

Any signature (electronic or handwritten) on a submitted document certifies, to the best of the provider's knowledge, that the information in the document is true, accurate, and complete.

The provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method have the responsibility for the authenticity of the information being certified for which the authentication is provided.

The provider must exercise reasonable care to retain control of their electronic signature and prevent its disclosure to any person not authorized to create the electronic signature, as described in 1 TAC §203.24(c)(3).

The provider and the provider's representative understand and agree that systems and software products must include protections against modification and bear responsibility for ensuring administrative safeguards are in place.

Stamped signatures and signatures that have been typed in a document without using an electronic identifier will not be accepted.

Digitized signatures will not be accepted. (Examples include scanned images of handwritten signatures or signatures on a signature pad. Handwritten signatures on faxed documents are not digitized signatures.)

#### 4.2.3 Requests for Procedures That Are Pending a Rate Hearing

Some procedure codes that require authorization or prior authorization may be pending a rate hearing. In these cases, providers must follow the established authorization or prior authorization processes for these procedure codes and must not wait until the procedure codes have gone through the rate hearing process to request authorization or prior authorization.



Providers are responsible for meeting all filing deadlines and for ensuring that the authorization or prior authorization number appears on the claim the first time it is submitted.

TMHP will deny the affected procedure codes as pending a rate hearing until the rates are adopted and implemented. Once the rates are adopted and implemented, TMHP will automatically reprocess the claims. However, if the required authorization or prior authorization number is not on the claim at the time of reprocessing, the claim will be denied as lacking authorization or prior authorization.

**Referto:** Section 5.6.2.3, “Determining Reimbursement Rates for New HCPCS Procedure Codes” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for more information.

#### **4.2.4 Requests for Procedures That Are Manually Priced**

Certain procedure codes do not have an established fee and must be priced manually by the TMHP-CSHCN Services Program medical staff. The medical staff determines the reimbursement amount by comparing the services to other services that require a similar amount of skill and resources.

If an item requires manual pricing, providers must submit with the prior authorization request or the claim the appropriate procedure codes and documentation of one of the following, as applicable:

- The manufacturers suggested retail price (MSRP) or average wholesale price (AWP)
- The provider’s documented invoice cost if a published MSRP or AWP is not available

**Note:** *The AWP is for nutritional products only.*

For appropriate processing and payment, providers should bill the applicable MSRP or AWP rate instead of the calculated manual pricing rate. The calculated rate or the Pay Price that is indicated on the authorization letter for prior authorized services should not be billed on the claim.

Claims for authorized procedure codes that are manually priced must list the claims detail information in the same order as itemized on the authorization letter.

#### **4.2.5 Clients with Third Party Resources**

If a client has other coverage from a third-party resource (TPR), prior authorization and authorization requests will be approved or denied according to the CSHCN Services Program prior authorization and authorization guidelines. The approved services will be considered for payment:

- If the TPR does not pay because of co-insurance or deductible amounts.
- When the total amount paid (including all payers) to the provider does not exceed the amount allowed by the program for the covered service.
- If the provider submits an explanation of benefits (EOB) from the TPR with a valid claim.

If clients have dual coverage with the Children’s Health Insurance Program (CHIP), prior authorization and authorization requests will be approved or denied according to CSHCN Services Program prior authorization and authorization guidelines. The approved services will be considered for payment as follows:

- Dental services and durable medical equipment may be reimbursed after the CHIP cap has been met.
- Orthodontic services not covered under the CHIP medical plan may be reimbursed.
- Other covered program benefits specifically excluded from or capped by the CHIP benefit plan may be reimbursed.
- The provider submits an explanation of benefits (EOB) from the TPR with a valid claim.

### 4.3 Authorizations

Providers must submit authorization requests on a CSHCN Services Program-approved form. Requests with insufficient information will be denied and providers will receive notification of the reason for denial. If a form is not available for a specific service, providers must submit the request using the [CSHCN Services Program Authorization and Prior Authorization Request form](#) and follow the guidelines and requirements listed in the chapter for that service.

Authorization requests must be submitted and approved no later than 95 days after the date of service and may be submitted before the service is provided. If the service has already been provided, the authorization form may be submitted before the claim, or attached to the paper claim form. Claims for services requiring authorization are denied if the authorization number is not indicated on the claim or if the authorization and all required documentation is not attached to the claim.

The 95-day deadline applies to all services requiring authorization, including extensions and emergency situations. Fax transmittal confirmations and postal registered mail receipts are not accepted as proof of timely authorization submission. Authorization requests are reconsidered only when resubmitted, received, and approved within 95-days of the date of service.

**Important:** *No extensions beyond the 95-day initial deadline are given.*

Providers can correct and resubmit requests for authorization. Questions, concerns, or requests for clarification may be included in authorization resubmissions. The TMHP-CSHCN Services Program Authorization Department will respond to questions, concerns, or requests for clarification by phone, fax, or mail. Corrected requests must meet authorization and prior authorization submission deadlines. Requests that do not meet the deadlines will be denied.

Providers must mail or fax written authorization requests and all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership  
 TMHP-CSHCN Services Program Authorization Department  
 12365-A Riata Trace Parkway, Suite 100  
 Austin, TX 78727  
 Fax: 1-512-514-4222

#### 4.3.1 Services that Require Authorization

The following is a list of many of the services that require authorization. The list below is not all-inclusive. Information about specific authorization requirements for each of the services that is a benefit of the CSHCN Services Program is included in the chapter for each service.

Most outpatient surgery services no longer require authorization or prior authorization unless otherwise indicated in the specific sections of the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual. All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are available on [Forms page of the TMHP website](#). This form must be used when indicated for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

Refer to the specific provider sections in this manual or call TMHP at 1-800-568-2413 for more information.

| Blood Pressure Devices, In Specific Instances |  |
|---|--|
| Refer to:                                     | Chapter 11, “Blood Pressure Monitoring and Devices”  |
| Use:  | <a href="#">The CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| <b>Botulinum Toxin (Type A and B)</b> |  |
|---------------------------------------|--|
| Refer to:                             | Section 31.2.26.9, “Botulinum Toxin (Type A and Type B)” in Chapter 31, “Physician”  |
| Use:                                  | The <a href="#">CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions</a> |

| <b>Clinician-Directed Care Coordination Services</b> |  |
|--|--|
| Refer to:  | Section 31.2.12, “Clinician-Directed Care Coordination Services” in Chapter 31, “Physician”  |
| Use:   | The <a href="#">CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services form</a> |

| <b>Durable Medical Equipment (DME)</b> |  |
|--|--|
| Refer to:                              | Chapter 17, “Durable Medical Equipment (DME)”  |
| Use:                                   | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |
| Exception:                             | Custom DME and more complex equipment requires prior authorization.  |

| <b>Hemophilia Blood Factor Products</b> |   |
|---|---|
| Refer to:                               | Section 31.2.9, “Bone Growth Stimulators” in Chapter 31, “Physician”  |
| Use:                                    | The <a href="#">CSHCN Services Program Authorization and Prior Authorization Request for Hemophilia Blood Factor Products</a> |

| <b>Home Health (Skilled Nursing Only) Up to 200 Hours Per Calendar Year</b> |  |
|---|--|
| Refer to:   | Chapter 22, “Home Health (Skilled Nursing) Care”   |
| Use:  | The <a href="#">CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form</a> |

| <b>Nebulizers, In Specific Instances</b> |  |
|--|--|
| Refer to:                                | Section 36.2.5, “Nebulizers” in Chapter 36, “Respiratory Equipment and Supplies”   |
| Use:                                     | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| <b>Outpatient Dental Surgical Procedures</b> |  |
|--|--|
| Refer to:                                    | Section 14.2.7, “Dental Treatment in Hospitals and ASCs” in Chapter 14, “Dental”   |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions</a> |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services</a>  |
| Use:   | The <a href="#">CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia</a>  |

| <b>Telecommunication Services</b> |   |
|-----------------------------------|---|
| Refer to:                         | Section 38.2.4, “Telemonitoring Services” in Chapter 38, “Telecommunication Services” |
| Use:                              | The <a href="#">Home Telemonitoring Services Prior Authorization Request Form</a>     |

### 4.3.2 How To Submit an Authorization Request

Providers must mail or fax written authorization requests and all applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership  
TMHP-CSHCN Services Program Authorization Department  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727  
Fax: 1-512-514-4222

### 4.4 Prior Authorizations

Providers must submit prior authorization requests on a CSHCN Services Program-approved form. If a form is not available for a specific service, providers must submit the request using the [CSHCN Services Program Authorization and Prior Authorization Request form](#) and follow the guidelines and requirements listed in the chapter for that service. Only complete prior authorization requests will be considered. Incomplete requests are denied.

Prior authorization requests must be submitted and approved before the service is provided. However, if the service is provided after business hours (business hours are Monday through Friday, from 8 a.m. to 5 p.m., Central Time), on a weekend, or on a holiday then the prior authorization request may be submitted on the next business day.

**Referto:** Section 5.1.8, “Claims Filing Deadlines” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

Providers should allow three business days to receive a response to an authorization or prior authorization request.

The TMHP Contact Center receives calls from CSHCN Services Program providers with inquiries related to prior authorization. Contact Center agents make every attempt to answer the provider’s questions and/or resolve the provider’s concerns. If a provider requires a call back from a Prior Authorization (PA) clinician and the request for call back is not related to urgent/emergent services, the provider should submit a call back request via fax to 1-512-514-4222.

All inpatient admissions must be prior authorized. The [CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission](#)—For Use by Facilities Only must be submitted to the claims contractor for review and approval before the date of service, or the entire hospital stay will be denied.

**Note:** *Partial approvals for a hospital stay will not be granted.*

Requests for emergency hospital admissions must be received by the next working day after admission date for the coverage of the entire hospital stay. Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

If the initial prior authorization request meets the deadline requirements and is denied for incomplete or inaccurate information, the provider may correct and resubmit the prior authorization request. The corrected request is a one-time resubmission only and must be received by the next business day following the denial of the initial request. If the corrected request is received by the next business day but still contains incomplete or inaccurate information, then the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after the next business day following the initial denial will be denied for the entire hospital stay.

**Referto:** Section 24.3.1.2, “Emergency Inpatient Hospital Admissions” in Chapter 24, “Hospital” for detailed information on prior authorization requirements.

If a client requires a service that exceeds policy limitations, providers may request prior authorization with documentation of medical necessity.

If a client requires a service that has diagnosis restrictions, providers may request prior authorization with documentation of medical necessity for diagnoses not listed in the policy.

Claims submissions must include the prior authorization number in the appropriate field.

**Referto:** Section 5.7, “Claims Filing Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for claims filing instruction details.

**Important:** *The Program does not grant extensions to these deadlines to allow providers to complete or correct and resubmit their prior authorization requests.*

**4.4.1 Services that Require Prior Authorization**

The following is a list of many of the services that require prior authorization. The list below is not all-inclusive. Information about specific prior authorization requirements for each service that is a benefit of the CSHCN Services Program is included in the chapter for each service.

Most outpatient surgery services no longer require authorization or prior authorization unless otherwise indicated in the specific sections of the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual. All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are located on the [Forms page of the TMHP website](#). This form must be used when indicated for procedures as outlined in specific sections of the CSHCN Services Program Provider Manual.

Providers must fill out all sections of the prior authorization form. Providers should refer to the Instructions page for each request form.

Refer to the specific provider sections in this manual or call TMHP at 1-800-568-2413 for more information.

| <b>Augmentative Communication Devices (ACDs)</b> |  |
|--|--|
| Refer to:  | Chapter 10, “Augmentative Communication Devices (ACDs)”  |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs)</a> |

| <b>Stem Cell Transplants (initial and one subsequent transplant)</b> |  |
|--|--|
| Refer to:  | Section 31.2.42.2, “Transplants - Nonsolid Organ” in Chapter 31, “Physician”                             |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant</a> |

| <b>Certified Respiratory Care Practitioner</b> |  |
|--|--|
| Refer to:                                      | Chapter 13, “Certified Respiratory Care Practitioner (CRCP)”   |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioner (CRCP)</a> |

| <b>Cleft/Craniofacial Surgical Procedures</b> |  |
|---|--|
| Refer to:                                     | Section 31.2.39.11, “Cleft/Craniofacial Procedures” in Chapter 31, “Physician”   |
| Use:  | The <a href="#">CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only</a>   |
| Use:  | The <a href="#">CSHCN Services Program Prior Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons Form and Instructions</a> |

| <b>Cranial Molding Devices (Dynamic Orthotic Cranioplasty [DOC™] only)</b> |  |
|--|--|
| Refer to:  | Section 28.2.2, “Orthoses and Prostheses (Not All-Inclusive)” in Chapter 28, “Orthotic and Prosthetic Devices”               |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| <b>Dental Procedures (some), Including Inpatient Admissions for Dental Surgical Procedures</b> |  |
|--|--|
| Refer to:  | Chapter 14, “Dental”   |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services</a>                          |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only</a> |

| <b>Diapers, Liners, and Pull-ups (or any combinations of these supplies)</b> |   |
|--|---|
| Require prior authorization for quantities that exceed 240 per month.        |   |
| Refer to:  | Chapter 18, “Expendable Medical Supplies”   |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Diapers, Pull-ups, Briefs, or Liners</a> |

| <b>Home Health (Skilled Nursing) Services Over 200 Hours per Calendar Year</b> |  |
|--|--|
| Refer to:  | Chapter 22, “Home Health (Skilled Nursing) Care”   |
| Use:   | The <a href="#">CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form</a> |

| <b>Home Health Services</b> |  |
|-----------------------------|--|
| Refer to:                   | Chapter 21, “Home Health Services”   |
| Use:                        | The <a href="#">CSHCN Services Program Authorization and Prior Authorization Request</a> |

| <b>Hospice Services</b> |   |
|-------------------------|---|
| Refer to:               | Chapter 23, “Hospice”   |
| Use:                    | The <a href="#">CSHCN Services Program Prior Authorization Request for Hospice Services</a> |

| <b>Inpatient Admissions</b> |  |
|-----------------------------|--|
| Refer to:                   | Section 24.3, “Inpatient Services” in Chapter 24, “Hospital”   |
| Use:                        | The <a href="#">CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only</a> |

| <b>Inpatient Rehabilitation Admissions</b> |   |
|--|---|
| Refer to:                                  | Section 24.3.1.4, “Inpatient Rehabilitation Services” in Chapter 24, “Hospital”                               |
| Use:                                       | The <a href="#">CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission</a> |

| <b>Medical Foods, In Specific Instances</b> |  |
|---|--|
| Refer to:                                   | Section 26.3, “Medical Foods” in Chapter 26, “Medical Nutrition Services”                |
| Use:  | The <a href="#">CSHCN Services Program Prior Authorization Request for Medical Foods</a> |

| <b>More Than One Hour (Four Units) of Nutritional Assessments and Intervention per Rolling Year and More Than Two Nutritional Counseling Visits per Rolling Year</b> |   |
|--|---|
| Refer to:  | Section 26.4, “Medical Nutritional Counseling Services” in Chapter 26, “Medical Nutrition Services”     |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Medical Nutritional Products</a> |

| <b>Non-Emergency Ambulance Transports</b> |  |
|---|--|
| Refer to:                                 | Section 9.4, “Nonemergency Ambulance Transports” in Chapter 9, “Ambulance”   |
| Use:                                      | <p>The <a href="#">Non-emergency Ambulance Prior Authorization Request</a></p> <p>The <a href="#">Texas Medicaid and CSHCN Services Program Nonemergency Exception Form and Instructions</a></p> <p><i>Note: CSHCN Services Program providers must not complete any portion of the Non-emergency Ambulance Prior Authorization Request form to ensure the integrity of the request form. Prior Authorization must be obtained by the facility or the physician’s staff for all non-emergency transports. The Non-emergency Ambulance Prior Authorization Request form must be filled out and faxed or mailed to TMHP by the facility or the physician’s staff that is most familiar with the client’s condition. The CSHCN Services Program ambulance provider must not assist in completing or submitting any portion of this form.</i></p> |

| <b>Orthodontia (except for the initial orthodontic visit)</b> |   |
|---|---|
| Refer to:   | Section 14.2.4, “Orthodontia Services” in Chapter 14, “Dental”  |
| Use:  | The <a href="#">CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services</a> |

| <b>Orthotics and Prosthetics</b> |  |
|----------------------------------|--|
| Refer to:                        | Chapter 28, “Orthotic and Prosthetic Devices”  |
| Use:                             | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| <b>Outpatient Physical Therapy and Occupational Therapy Services</b> |  |
|--|--|
| Refer to:  | Section 30.2.2, “Physical Therapy (PT), and Occupational Therapy (OT)” in Chapter 30, “Physical Medicine and Rehabilitation” |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1)</a>                  |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2)</a>             |

| <b>Outpatient Speech-Language Pathology Services (all services except initial evaluations)</b> |  |
|--|--|
| Refer to:  | Chapter 37, “Speech-Language Pathology (SLP) Services”   |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1)</a>      |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2)</a> |

| <b>Pediatric Hospital Cribs and Tops</b> |  |
|--|--|
| Refer to:                                | Section 17.3.9, "Hospital Beds (Manual and Electric)" in Chapter 17, "Durable Medical Equipment (DME)"                       |
| Use:                                     | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| <b>Prescription Shoes</b> |  |
|---------------------------|--|
| Refer to:                 | Section 28.3.7.2, "Prescription Shoes" in Chapter 28, "Orthotic and Prosthetic Devices"                                      |
| Use:                      | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| <b>Radiation Therapy Services (some), Including Proton- or Neutron-Beam Treatment Delivery, Intensity Modulated Radiation Therapy, and Stereotactic Radiosurgery</b> |   |
|--|---|
| Refer to:  | Chapter 34, "Radiation Therapy Services"  |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization Request for Outpatient Surgery— For Outpatient Facilities and Surgeons Form and Instructions</a> |

| <b>Reduction Mammoplasties</b> |   |
|--------------------------------|---|
| Refer to:                      | Section 31.2.40, "Diagnostic and Surgical/Reconstructive Breast Therapies" in Chapter 31, "Physician".          |
| Use:                           | The <a href="#">CSHCN Services Program Prior Authorization Request for Inpatient Surgery— For Surgeons Only</a> |

| <b>Renal Dialysis</b> |   |
|-----------------------|---|
| Refer to:             | Chapter 35, "Renal Dialysis"  |
| Use:                  | The <a href="#">CSHCN Services Program Prior Authorization Request for Renal Dialysis Treatment</a> |

| <b>Renal Transplants</b> |  |
|--------------------------|--|
| Refer to:                | Section 31.2.42, "Transplants" in Chapter 31, "Physician"  |
| Use:                     | The <a href="#">CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant</a> |

| <b>Rhizotomies</b> |   |
|--------------------|---|
| Refer to:          | Section 31.2.40.8, "Rhizotomy" in Chapter 31, "Physician"   |
| Use:               | The <a href="#">CSHCN Services Program Prior Authorization Request for Inpatient Surgery— For Surgeons Only</a> |

| <b>Total Parental Nutrition (TPN)</b> |  |
|---------------------------------------|--|
| Refer to:                             | Section 26.6, "Total Parenteral Nutrition (TPN)" in Chapter 26, "Medical Nutrition Services" |
| Use:                                  | The <a href="#">CSHCN Services Program Authorization and Prior Authorization Request</a>     |

| <b>Ultrasonic Nebulizers, In Specific Instances</b> |  |
|---|--|
| Refer to:   | Section 36.2.5, "Nebulizers" in Chapter 36, "Respiratory Equipment and Supplies" |



| Ultrasonic Nebulizers, In Specific Instances |  |
|--|--|
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |

| Wheelchair Purchases (custom manual and standard or custom power) and Custom Seating Systems |  |
|--|--|
| Refer to:  | Section 17.3.19, “Wheelchairs” in Chapter 17, “Durable Medical Equipment (DME)”  |
| Use:   | The <a href="#">CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME)</a> |
| Use:   | The <a href="#">CSHCN Services Program Wheelchair Seating Evaluation Form</a>  |

#### 4.4.2 Prior Authorization for Inpatient Admission After Business Hours

*Tip:* Photocopy these forms and retain the originals for future use.

For prior authorization of an inpatient admission after business hours in an emergency or when required medical services cannot be delayed, submit requests the next business day by completing the [CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission](#)—For Use by Facilities Only.

Requests for emergency admissions received after the next business day will be denied for the entire hospital stay.

Both the facility and the attending physician, surgeon, or supplier must be enrolled in the CSHCN Services Program for inpatient claims to be considered for payment.

**Referto:** Section 24.3.1.1, “Initial Inpatient Prior Authorization Requests” in Chapter 24, “Hospital” for additional information.

#### 4.4.3 Specialty Team or Center Services

In addition to requiring prior authorization, the following services have additional requirements for physicians or facilities:

- For stem cell transplant services, the facility must attest on the PA form that it is a Texas facility that is a designated Children’s Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization must be obtained by both the facility and the physician.
- For cleft/craniofacial surgical procedures, the surgeon must be a member of a comprehensive cleft/craniofacial team.

If the specialty team or center requirements are not met, all services related to the procedure are denied.

**Note:** *Anesthesiologists and assistant surgeons are not required to be enrolled as a specialty team or specialty center. An anesthesiologist may be paid if all enrollment and filing deadlines are met. However, when a procedure or admission is denied by the CSHCN Services Program because the primary surgeon or hospital is not appropriately specialty team- or center-enrolled, the assistant surgeon’s claims also are denied.*

**Referto:** Section 2.1.7, “Transplant Specialty Centers” in Chapter 2, “Provider Enrollment and Responsibilities” for more information about transplant specialty centers enrollment.

#### 4.4.4 Retroactive Prior Authorizations

Retroactive prior authorizations will be considered for clients who are eligible for the CSHCN Services Program when all of the following conditions are met:

- The service is a benefit of the CSHCN Services Program.

- A Medicaid prior authorization has been approved and issued for the requested service(s) but the client is no longer eligible for Medicaid on the date of service.
- The CSHCN Services Program prior authorization or authorization requirements have been met.
- All other billing requirements are met.

The retroactive CSHCN Services Program prior authorization request must include documentation that indicates approval of the Medicaid prior authorization request. The provider will be issued a new prior authorization number for the CSHCN Services Program prior authorization.

**Note:** *The CSHCN Services Program prior authorization request must contain the same information that was submitted to Medicaid.*

After a prior authorization has been approved by the CSHCN Services Program, the provider must resubmit the claim with the CSHCN Services Program client ID number and the approved CSHCN Services Program prior authorization number.

#### **4.4.5 How to Submit a Prior Authorization Request**

Providers must complete all essential fields on prior authorization forms submitted to TMHP to initiate the prior authorization process.

If any essential field on a prior authorization request is missing, incomplete, or completed with illegible information, TMHP will return the original request to the provider with the following message:

TMHP Prior Authorization could not process this request because the request form submitted has missing, incorrect, or illegible information in one or more essential fields. Please resubmit the request with all essential fields completed with accurate information for processing by TMHP within 14 business days from the request receipt date.

TMHP will use the date that the complete and accurate request form is received to determine the start date for services. Previous submission dates of incomplete forms returned will not be considered when determining the start date of service.

Providers have 14 business days from the request receipt date to respond to an incomplete prior authorization request. Incomplete prior authorization requests are requests received by TMHP with missing, incomplete, or illegible information.

Providers that need to update information on a prior authorization request form must strike through the incorrect information with a single line. The original content must remain legible, and the change must be initialed and dated by the original signatory or ordering physician when applicable. Changes that have been made using correction fluid (e.g., Wite-Out) will not be accepted.

Prior to denying an incomplete request, TMHP's Prior Authorization (PA) department will continue to communicate with the requesting provider in an effort to obtain the required additional information. A minimum of three attempts will be made to contact the requesting provider before a letter is sent to the client regarding the status of the request and the need for additional information.

If the additional information needed to make a prior authorization determination is not received within 14 business days from the request receipt date, the request will be denied as "incomplete." To ensure timely processing, providers should respond to requests for missing or incomplete information as quickly as possible.

CSHCN Services Program requests that do not appear to meet CSHCN medical policy, the TMHP PA Nurse will refer those requests to CSHCN Services Program for review and determination. CSHCN Services Program will complete the review within three business days of receipt of the completed prior authorization request.

**Note:** *Providers may re-submit a new, complete request after receiving an incomplete denial; however, submission requirements related to timeliness will apply.*

TMHP requires information in the essential fields. Essential fields contain information needed to process a prior authorization request and include the following:

- Client name
- Client CSHCN Services Program number
- Client date of birth
- Provider name
- National Provider Identifier (NPI)
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code
- Quantity of service units requested based on the CPT or HCPCS code requested

#### **4.4.6 Prior Authorization Electronic Submissions through the TMHP Prior Authorization (PA) on the Portal**

The TMHP Prior Authorization on the Portal (PA on the Portal) is available for CSHCN Services Program providers to submit CSHCN Services Program prior authorization requests to TMHP for consideration. The benefits of using the TMHP PA on the Portal are as follows:

- Real-time submissions.
- Robust status information available throughout the processing of the request, including the ability to quickly view and respond to pending action from providers.
- Electronic attachment capability. Providers can upload ALL information related to a request and submit online. Providers will receive immediate confirmation of receipt of information.
- The ability to save requests as a draft and update and submit at a later date.
- The ability to create templates which saves time when requesting similar prior authorizations frequently.
- Greater search capability including additional information provided in the search results and the ability to update existing requests with corrections, revisions or extensions.
- Portal availability using a variety of modern browsers.
- Pre-populated forms using information entered at the start of the request.
- Correct deficiencies or make revisions through the portal. No more mailing or faxing.

Providers can access the TMHP PA on the Portal from the TMHP Prior Authorization web page at [www.tmhp.com/topics/prior-authorization](http://www.tmhp.com/topics/prior-authorization), which can also be accessed from a topics page on the TMHP Provider Home Page. Providers will click on PA on the Portal and log on to the TMHP secure portal using their UserID and password obtained when the provider's account was activated.

**Referto:** The [TMHP Portal Security Training Manual](#) available on the TMHP website for information about creating an account, obtaining a UserID and password, and granting permissions.

**Important:** *To submit CSHCN Services Program prior authorization requests to TMHP, the requesting provider must be enrolled as a CSHCN Services Program provider, and must have registered his or her CSHCN Services Program NPI in an active TMHP portal account. The client ID submitted in the request must be the client's CSHCN Services Program client ID and the client must be currently enrolled in the CSHCN Services Program.*

The following Authorization Areas and Submission Types are available for CSHCN Services Program prior authorizations submitted through the TMHP PA on the Portal:

| Authorization Area         | Submission Type   |
|----------------------------|---|
| All CSHCN Services Program | Ambulance Prior Authorization<br>Dental or Orthodontia Services<br>Durable Medical Equipment and Supplies<br>Home Health, Hospice, and/or Telemonitoring<br>Hospital, Surgery, and/or Medical Services<br>Outpatient Therapy (PT, OT, ST) |

The provider will enter his or her provider, client, and authorization information including service details in the required fields of the Client Eligibility Pre-check screen and the Authorization Request – Service Details screen. All necessary documents, including, but not limited to, the TMHP fillable PDF of the authorization or prior authorization form, can then be electronically attached to the online authorization or prior authorization request.

The required authorization and prior authorization forms are available on the Authorization Request–Attachments screen in PA on the Portal along with a list of additional required documentation that the provider must upload as attachments. For prior authorization forms downloaded from the Authorization Request–Attachments screen in PA on the Portal, certain fields including, but not limited to, client name and client ID, will be automatically populated based on the information entered in the Client Eligibility Pre-Check and Service Details screens.

**Note:** Authorization and prior authorization forms are also available on the [TMHP Prior Authorization CSHCN PA Forms](#) web page as fillable forms into which providers can type the required information and e-sign the forms using available software. Certain fields will only be pre-populated if the prior authorization form is downloaded from the Authorization Request–Attachments screen in PA on the Portal. Forms that are downloaded from the [TMHP Prior Authorization CSHCN PA Forms](#) web page are fillable, but fields will not be pre-populated. Providers can choose to use the pre-populated forms generated from PA on the Portal or the fillable forms available on the new TMHP Prior Authorization web page.

Providers must submit to TMHP all pages of the prior authorization form, including the Prior Authorization Request Submitter Certification Statement page with “We Agree” checked, and the authorization pages completed and signed as applicable. The only pages that are not required to be submitted to TMHP are the instruction pages. Requests will be pended if the Prior Authorization Request Submitter Certification Statement page with the “We Agree” checked is not included with the submitted documents. Providers will be required to submit the Prior Authorization Request Submitter Certification Statement page, with “We Agree” checked, to TMHP before the request can be processed.

Once a prior authorization request has been submitted through PA on the Portal, providers will be able to submit corrections, revisions, and extensions to applicable prior authorization requests through PA on the Portal.

Providers can also save drafts and create templates to be used regularly as follows:

- Drafts can be saved with all uploaded attachments. Drafts created in PA on the Portal, but not submitted, will be deleted after 90 calendar days if the draft has not been submitted to TMHP. Up to 200 drafts can be saved per provider NPI and taxonomy combination.
- Attachments will not be saved as part of templates on PA on the Portal. Templates will be retained for up to 365 calendar days from the time the template was last used or modified. Up to 200 templates can be created and saved per provider NPI and taxonomy combination.

Providers can refer to the [TMHP Prior Authorization \(PA\) on the Portal Submission Guide](#) which is available on the [TMHP Prior Authorization](#) web page for detailed instructions about using the TMHP PA on the Portal.

#### 4.4.7 Browser Compatibility and System Requirements

TMHP's PA on the Portal is compatible with Internet Explorer® (IE) 11.0, Chrome®, and Mozilla Firefox®.

Providers must use Adobe Reader® Version 11.0 or higher to download and complete the authorization and prior authorization forms from PA on the Portal or from the new TMHP Prior Authorization web page.

**Reminder:** *Providers can continue to download the forms and complete them by hand if the applicable version of Adobe Reader® is not available. (Adobe Reader® is free software that can be downloaded onto the provider's computer.)*

#### 4.4.8 Electronic Attachments

TMHP's PA on the Portal will accept electronic attachments. Providers can submit the authorization or prior authorization forms as well as any other required forms or documentation as electronic attachments.

Up to ten files can be uploaded per authorization or prior authorization request, and each file cannot exceed 50 megabytes. PA on the Portal will accept electronic attachments in the following formats:

- Portable Document Format (PDF)
- Images with the following file extensions: JPG, TIF, PNG, GIF
- Microsoft (MS) Word
- MS Excel
- Rich Text Format (RTF)

Electronic attachments must be completed and electronically signed before they are uploaded to the PA on the Portal. Providers must use their own software to electronically sign forms, and those signatures must be added to the forms before they are uploaded to the PA on the Portal request. Submitters will not be able to electronically sign required forms once they are uploaded to the PA on the Portal request. Providers will be required to:

- 1) Download the authorization or prior authorization form, and save the downloaded form to their desktop or other folder.
- 2) Complete the form by typing into the fillable fields, and adding the appropriate signatures (providers can electronically sign the forms using the software of their choice).
- 3) Upload the form to the PA on the Portal request.

**Important:** *The PA on the Portal will always display the most current form that is available on the TMHP Prior Authorization web page to be used for the authorization or prior authorization request. Forms previously downloaded and saved to the providers desktop or folder may not reflect changes made to the form since the last submission. Provider should ensure the submitted form is the most recent.*

#### 4.4.9 Maintaining Complete Documentation

To best maintain accurate client and provider documentation, all forms and documentation completed electronically and e-signed must be kept in the client's medical record, including:

- Prior authorizations submitted to TMHP.
- Documents completed but not submitted to TMHP as a prior authorization request.

- A hard copy of electronic transactions and signed documents must be available upon request.

#### 4.4.10 Sending Prior Authorization Requests via Fax

Providers must include specific information when sending prior authorization requests via fax. The following information is required:

- A working fax number to receive faxed responses or correspondence from TMHP
- The last four digits of the client's CSHCN Services Program Identification number on the fax coversheet

**Note:** *This requirement applies to submissions of new prior authorization requests, resubmissions, and additional information needed to complete a request.*

**Reminder:** *Prior authorization cover sheets must not contain any protected health information (PHI) per Health Insurance Portability and Accountability Act (HIPAA). The faxed cover sheet is not meant to replace the appropriate prior authorization form. Providers cannot include information on a cover sheet that is needed to complete the review of a request.*

If a provider is faxing prior authorization requests for more than one client, each client request must be faxed individually with a separate cover sheet. Requests received with multiple clients will be returned to the provider for resubmission to ensure HIPAA compliance.

The fax number listed on the prior authorization form is the fax number used to send faxed responses or correspondences from TMHP.

Providers must mail or fax written prior authorization requests and all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership  
TMHP-CSHCN Services Program Authorization Department  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727  
Fax: 1-512-514-4222

#### 4.5 Authorization and Prior Authorization Denials

Authorization and prior authorization requests will be denied if they:

- Do not contain all of the information necessary for the Program to make a determination,
- Do not meet medical necessity criteria, or
- Exceed the benefit limitation.

Some of the most common reasons for the denial of authorizations and prior authorizations are because the request:

- Is incomplete,
- Is submitted on the wrong form,
- Lacks the necessary documentation,
- Contains inaccurate information,
- Fails to meet the submission deadline,
- Is for an ineligible client, benefit, or provider, or
- Is for a client that does not qualify for the health-care benefit requested.

Denied authorization and prior authorization requests may be corrected and resubmitted. Any alterations to the original denied request form must be made by using a single line strike-through so the original content is still legible, and the author of the alteration must initial and date the revision. Corrected requests must meet authorization and prior authorization submission deadlines to be considered.

Providers can also submit questions or requests for clarification of a denied authorization or prior authorization by fax. The TMHP-CSHCN Services Program Authorization Department will respond by phone, fax, or mail. The department will not respond by e-mail in order to comply with *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 requirements.

Providers dissatisfied with TMHP's decision to deny authorization and prior authorization of services may submit a request for an administrative review to the CSHCN Services Program.

**Referto:** Section 7.3.5, "Administrative Review for Claims" in Chapter 7, "Appeals and Administrative Review" for information about the administrative review process.

#### **4.5.1 Denied Authorization and Prior Authorization Requests Resubmission**

Providers can correct and resubmit requests for authorization and prior authorization, and can include questions, concerns, or requests for clarification. The TMHP-CSHCN Services Program Authorization Department will respond to questions, concerns, or requests for clarification by phone, fax, or mail.

To correct a denied request, the provider must strike through the error with a single line. The original content and the corrected information must be legible. The provider must initial and date the alteration.

Resubmitted requests must meet submission deadlines to be considered for approval. Requests that do not meet the deadlines will be denied.

Requests for services requiring authorization or prior authorization as a condition for reimbursement must be submitted on a CSHCN Services Program-approved form and contain all of the information that is necessary for the Program to make a decision. Requests submitted with insufficient information will be denied and providers will receive notification of the reason for denial.

#### **4.5.2 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.

If a provider submits a Change of Provider letter in the middle of an existing authorization period, the current authorization will be end-dated and the original provider will be notified. TMHP will send the new provider an authorization that begins on the next business day after the end date and lasts through the remainder of the authorization period.

#### **4.5.3 Administrative Review for Authorization and Prior Authorization Denials**

Clients and providers will receive written notice of denied authorization and prior authorization requests within 30 days of the date of the notification. A provider or a client who has received a denied authorization or prior authorization from TMHP may submit a request for an administrative review to

the CSHCN Services Program if they are dissatisfied with TMHP's decision to deny the authorization or prior authorization. A client or provider may not request an administrative review of the program's denial of a prior authorization or authorization request for program services or provider reimbursement amounts that are in accordance with established fee schedules and budget alignment methodologies authorized by the CSHCN Services Program Rules Title 26 Part 1 TAC §351.16.

All clients and providers must submit requests for an administrative review within 30 days of the date TMHP denied the authorization or prior authorization. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program—Administrative Review  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

#### **4.5.4 Fair Hearing**

After an administrative review, providers may request a fair hearing if they are dissatisfied with the CSHCN Services Program's decision and the supporting reason.

The fair hearing is the final appeal process and is described in the *Texas Administrative Code* (TAC) Title 25, Part 1, Chapter 1, Subchapter C ([www.sos.state.tx.us](http://www.sos.state.tx.us)). The fair hearing process is conducted by the Office of General Counsel at the Department of State Health Services (DSHS).

Providers may choose to represent themselves or have legal counsel or another spokesperson at the hearing. If providers are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to request a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program—Fair Hearing  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

**Referto:** Section 7.2.2, "Fair Hearing Requests for Authorizations or Prior Authorizations" in Chapter 7, "Appeals and Administrative Review."

#### **4.6 TMHP-CSHCN Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **CLAIMS FILING, THIRD-PARTY RESOURCES, AND REIMBURSEMENT**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# CLAIMS FILING, THIRD-PARTY RESOURCES, AND REIMBURSEMENT

## Table of Contents

|            |   |           |
|------------|---|-----------|
| <b>5.1</b> | <b>TMHP Claims Information</b>                                | <b>4</b>  |
| 5.1.1      | Claims Processed by TMHP                                      | 4         |
| 5.1.2      | Claims Processed by the CSHCN Services Program                | 4         |
| 5.1.3      | CPT and HCPCS Claims Auditing Guidelines                      | 5         |
| 5.1.4      | CMS NCCI and MUE Guidelines for All Claims                    | 5         |
| 5.1.5      | TMHP Processing Procedures                                    | 5         |
| 5.1.6      | Claims Processed by Date of Service                           | 6         |
| 5.1.7      | Inactive Provider Termination                                 | 6         |
| 5.1.8      | Claims Filing Deadlines                                       | 6         |
| 5.1.9      | Exception to Claim Filing Deadline                            | 7         |
| 5.1.10     | Fiscal Agent Payment Deadline                                 | 9         |
| <b>5.2</b> | <b>Third-Party Resource (TPR)</b>                             | <b>9</b>  |
| 5.2.1      | Health Maintenance Organization (HMO)                         | 10        |
| 5.2.2      | CSHCN Services Program Notice of Eligibility                  | 11        |
| 5.2.3      | Claims Filing Involving a TPR                                 | 11        |
| 5.2.4      | Verbal Denials by a TPR                                       | 11        |
| 5.2.5      | Filing Deadlines Involving a TPR                              | 12        |
| 5.2.6      | Blue Cross Blue Shield (BCBS) Nonparticipating Physicians     | 12        |
| 5.2.7      | Refunds   | 13        |
| 5.2.8      | Refunds to TMHP Resulting From Other Insurance                | 13        |
| 5.2.9      | Accident-Related Claims                                       | 14        |
| 5.2.9.1    | Accident Resources and Refunds Involving Claims for Accidents | 14        |
| 5.2.9.2    | Third-Party Liability for Claims Involving Accidents          | 15        |
| <b>5.3</b> | <b>Multipage Claim Forms</b>                                  | <b>15</b> |
| <b>5.4</b> | <b>Tips on Expediting Paper Claims</b>                        | <b>17</b> |
| 5.4.1      | General requirements  | 17        |
| 5.4.2      | Data Fields   | 17        |
| 5.4.3      | Attachments   | 17        |
| <b>5.5</b> | <b>Correction and Resubmission (Appeal) Time Limits</b>       | <b>17</b> |
| 5.5.1      | Claims with Incomplete Information                            | 18        |
| 5.5.2      | Other Insurance Appeals                                       | 18        |
| 5.5.3      | Resubmission of TMHP EDI Rejections                           | 18        |
| 5.5.3.1    | TMHP EDI Batch Numbers, Julian Dates                          | 18        |
| <b>5.6</b> | <b>Coding</b>   | <b>18</b> |
| 5.6.1      | Diagnosis Coding  | 18        |
| 5.6.2      | Procedure Coding  | 19        |
| 5.6.2.1    | Healthcare Common Procedure Coding System (HCPCS)             | 19        |
| 5.6.2.2    | National Correct Coding Initiative (NCCI) Guidelines          | 20        |
| 5.6.2.3    | Determining Reimbursement Rates for New HCPCS Procedure Codes | 20        |
| 5.6.2.4    | National Drug Codes (NDC)                                     | 21        |
| 5.6.2.4.1  | <b>Paper Claim Submissions</b>                                | <b>22</b> |

|             |  |           |
|-------------|--|-----------|
| 5.6.2.5     | Drug Rebate Program.....   | 23        |
| 5.6.2.6     | Modifiers.....   | 24        |
| 5.6.2.7     | Modifier U8 and the Federal 340B Drug Pricing Program.....                                       | 24        |
| 5.6.2.8     | Type of Services (TOS).....  | 24        |
| 5.6.3       | Benefit Code.....  | 25        |
| <b>5.7</b>  | <b>Claims Filing Instructions.....</b>   | <b>25</b> |
| 5.7.1       | Claim Details.....   | 26        |
| 5.7.2       | Provider Types and Selection of Claim Forms.....   | 26        |
| 5.7.2.1     | Providers and Services Billable on CMS-1500.....   | 26        |
| 5.7.2.2     | CMS-1500 Claim Form Provider Definitions.....  | 27        |
| 5.7.2.3     | CMS-1500 Electronic Billing.....   | 28        |
| 5.7.2.4     | CMS-1500 Paper Claim Form Instructions.....  | 28        |
| 5.7.2.5     | UB-04 CMS-1450 Paper Claim Form Instructions.....  | 33        |
| 5.7.2.6     | UB-04 CMS-1450 Electronic Billing.....   | 34        |
| 5.7.2.7     | Instructions for Completing the UB-04 CMS-1450 Paper Claim Form.....                             | 34        |
| 5.7.2.8     | Client Status (for block 17).....  | 42        |
| 5.7.2.9     | Occurrence Codes (for blocks 31 through 34).....   | 43        |
| 5.7.2.10    | POA Indicators (for blocks 67 and 72).....   | 43        |
| 5.7.2.11    | Dental Claim Filing.....   | 43        |
| 5.7.2.12    | ADA Dental Claim Electronic Billing.....   | 43        |
| 5.7.2.13    | Instructions for Completing the Paper ADA Dental Claim Form.....                                 | 44        |
| 5.7.2.14    | Electronic Claims Submission.....  | 47        |
| 5.7.2.15    | Taxonomy Codes.....  | 48        |
| 5.7.2.16    | Dates on Claims.....   | 48        |
| 5.7.2.17    | Span Dates.....  | 48        |
| 5.7.2.18    | Hospital Billing.....  | 48        |
| 5.7.2.19    | Group Billing.....   | 49        |
| 5.7.3       | Supervising Physician Provider Number Required on Some Claims.....                               | 49        |
| 5.7.4       | Ordering/Referring Provider NPI.....   | 49        |
| <b>5.8</b>  | <b>Reimbursement.....</b>  | <b>49</b> |
| 5.8.1       | Electronic Funds Transfer (EFT).....   | 50        |
| 5.8.1.1     | Advantages of EFT.....   | 50        |
| 5.8.1.2     | Enrollment Procedures.....   | 50        |
| 5.8.1.3     | Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission.....       | 50        |
| 5.8.2       | Texas Medicaid Reimbursement Methodology (TMRM).....   | 51        |
| 5.8.3       | Maximum Allowable Fee Schedule.....  | 51        |
| 5.8.4       | Manual Pricing.....  | 51        |
| 5.8.5       | Physician Services in Hospital Outpatient Setting.....   | 51        |
| 5.8.6       | Inpatient Hospital Reimbursement.....  | 52        |
| 5.8.7       | Fees.....  | 53        |
| 5.8.7.1     | Provider-Specific Rates for Procedure Codes with Modifiers and Age-Range Criteria.....           | 53        |
| 5.8.8       | CSHCN Services Program Reimbursement Information for Clients.....                                | 54        |
| <b>5.9</b>  | <b>CSHCN Services Program Accounts Receivables (Using Medicaid Funds to Satisfy the AR).....</b> | <b>54</b> |
| <b>5.10</b> | <b>TMHP-CSHCN Services Program Contact Center.....</b>   | <b>54</b> |

## 5.1 TMHP Claims Information

### 5.1.1 Claims Processed by TMHP

COMPASS21 (C21) is the claims and encounters processing system currently used by the Texas Medicaid & Healthcare Partnership (TMHP) to process Children with Special Health Care Needs (CSHCN) Services Program claims. C21 is an advanced Medicaid Management Information System (MMIS) that incorporates the latest claims processing methods and offers access to data and flexibility for future program changes.

There are two ways to submit claims to C21. Providers can submit claims to TMHP through TexMed-Connect or a third party vendor. Electronic filing is the most efficient and effective way to submit claims. TMHP also accepts paper claims. Providers that file paper claims are encouraged to switch to electronic submission.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI).”

A listing of the providers and services that are paid by TMHP can be found in Chapter 3, “Client Benefits and Eligibility” of this manual.

All claims sent by mail to TMHP for the first time must be addressed to:

Texas Medicaid & Healthcare Partnership  
Attn: CSHCN Services Program Claims  
PO Box 200855  
Austin, TX 78720-0855

Claim corrections and appeals sent by mail to TMHP must be addressed to:

Texas Medicaid & Healthcare Partnership  
Attn: CSHCN Services Program Appeals  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727

All other correspondence sent by mail must be directed to a specific department or individual at the following address:

Texas Medicaid & Healthcare Partnership  
Attn: *(Department)*  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727

### 5.1.2 Claims Processed by the CSHCN Services Program

Family Support Services (FSS) can help families care for clients with special health-care needs. FSS can also help a client be more independent and able to take part in family life and community activities.

FSS includes, but is not limited to:

- Respite care to allow caretakers a short break from caring for their child.
- Specialized childcare costs above and beyond the cost for typical childcare and related to the child’s disability or medical condition.
- Vehicle modifications, such as wheelchair lifts and related modifications such as wheelchair tie-downs, a raised roof, and hand controls.
- Home modifications, such as ramps, roll-in showers, or wider doorways.
- Special equipment that is not listed as a possible benefit in the child’s health insurance plan, such as porch lifts or stair lifts, positioning equipment, or bath aids.

CSHCN Services Program case managers assist clients and their families with obtaining FSS. A list of DSHS Regional Health Service offices and contact information is provided in Chapter 1, “TMHP and HHSC Contact Information.”

### 5.1.3 CPT and HCPCS Claims Auditing Guidelines

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

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

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

### 5.1.4 CMS NCCI and MUE Guidelines for All Claims

All claims must be filed in accordance with the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) and Mutually Exclusive Edit (MUE) guidelines, including claims for services that have been prior authorized or authorized with medical necessity documentation.

The CMS NCCI and MUE guidelines can be found in the NCCI Policy and Medicare Claims Processing manuals, which are available on the [CMS NCCI web page](#).

**Note:** *Providers are required to comply with NCCI and MUE guidelines as well as the guidelines that are published in this manual, all currently-published website articles, fee schedules, and all other applicable information published on the TMHP website.*

### 5.1.5 TMHP Processing Procedures

The provider who performed the service must file an assigned claim and agree to accept the allowable charge as full payment.

Regulations prohibit providers from charging clients or TMHP a fee for completing or filing claim forms. The cost of claims filing is considered a part of the usual and customary charges for services provided to all CSHCN Services Program clients.

Claims filed with TMHP for reimbursement by the CSHCN Services Program are subject to the following procedures:

- TMHP verifies that all required information is present on the claim form.
- The claim is processed using clerical and automated procedures. Claims requiring special consideration are reviewed by medical professionals.
- All claims from the same provider that are ready for disposition at the end of each week are paid by a single check or electronic funds transfer (EFT) sent to the provider with an explanation of each payment or denial. This explanation is called the Remittance and Status (R&S) Report. If no payment is made to the provider, an R&S Report identifying denied or pending claims is sent to the provider. If there is no claim action during that time period, the provider does not receive an R&S Report that week.

**Referto:** Chapter 6, “Remittance and Status (R&S) Reports.”

### 5.1.6 Claims Processed by Date of Service

Some services, such as DME, inpatient behavioral health, and outpatient mental health services, have limits to what the CSHCN Services Program can pay. The CSHCN Services Program uses the date of service to determine whether to pay, deny, or recoup claims for services that have benefit limitations for providers.

The CSHCN Services Program may recoup claims that have been submitted and paid 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. This rule also applies to NCCI/Medically Unlikely Edit (MUE) editing.

### 5.1.7 Inactive Provider Termination

Providers are required to attest their National Provider Identifier (NPI) for each of their enrolled locations; any claim that is submitted to TMHP without an attested NPI will be rejected. Additionally, at least one claim must be submitted to TMHP every 24 months in order for the provider to remain an “active provider” in the CSHCN Services Program. If a provider is enrolled in both Medicaid and the CSHCN Services Program, the NPI and taxonomy codes for both programs will be examined to determine whether any claims activity has occurred.

TMHP will send a courtesy letter to providers when 18 months have passed with no claims activity for the provider’s NPI. The letter will inform providers that if they want to keep NPIs active, they must submit a claim within 6 months of the date of the letter using one of the NPIs referenced in the letter. TMHP will apply a payment denial code to any NPI that has had no claims activity following 6 months of the date of the courtesy letter and will notify the provider that the NPI has been inactivated because the provider has not submitted claims using the NPI for a period of 24 months or more.

To have the payment denial code removed from an NPI, providers must submit a completed application for the Medicaid and CSHCN Services Program. The information on this application must match exactly the information currently on the provider’s file for the payment denial code to be removed. If the provider has moved to a different address or joined a different group, the payment denial code will not be removed from the old NPI. Instead, a new NPI will be issued for the new address or group.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for additional information.

### 5.1.8 Claims Filing Deadlines

For claims payment to be considered, providers must adhere to the following time limits. Claims received after the following time limits are not payable because the CSHCN Services Program does not provide coverage for late claims.

- Inpatient claims filed by a hospital must be submitted to TMHP within 95 days from the discharge date. Hospitals may submit interim claims before discharge. These claims must be submitted to TMHP within 95 days from the last date of service on the claim.
- Outpatient hospital services must be submitted to TMHP within 95 days from the date of service.
- For clients receiving retroactive eligibility, TMHP must receive claims within 95 days from the date the eligibility was added to the TMHP eligibility file (add date).
- Claims for clients with other group or private health insurance coverage must be received by the CSHCN Services Program within 95 days of the date of disposition by the other third-party resource (TPR) and no later than 365 from the date of service. A copy of the disposition must be submitted with the claim and mailed to TMHP.
- TMHP must receive claims from out-of-state providers within 365 days of the date of service.

- All other claims must be submitted to TMHP within 95 days from each date of service.
- When a service is a benefit of Medicare, Medicaid, and the CSHCN Services Program, and the client is covered by all programs, the claim must be filed with Medicare first, then with Medicaid. If a Medicaid claim is denied or recouped for client ineligibility, the claim may be submitted to the CSHCN Services Program within 95 days from the date of Medicaid disposition.

When a filing deadline falls on a weekend or holiday, the filing deadline is extended to the next business day following the weekend or holiday. Holidays that may extend the deadlines in 2024 are:

| Date   | Holiday                     |
|--|-----------------------------|
| January 1, 2024  | New Year's Day              |
| January 15, 2024   | Martin Luther King, Jr. Day |
| February 19, 2024  | Presidents Day              |
| May 27, 2024   | Memorial Day                |
| July 4, 2024   | Independence Day            |
| September 2, 2024  | Labor Day                   |
| October 14, 2024   | Columbus Day                |
| November 11, 2024  | Veterans Day                |
| November 28, 2024  | Thanksgiving Day            |
| November 29, 2024  | Day after Thanksgiving      |
| December 24, 2024  | Christmas Eve Day           |
| December 25, 2024  | Christmas Day               |
| <b>*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.</b> |                             |

**Referto:** [2023 Authorization Filing Deadline Calendar](#)  
[2024 Authorization Filing Deadline Calendar](#)

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.

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.

### 5.1.9 Exception to Claim Filing Deadline

The DSHS manager with responsibility for oversight of the CSHCN Services Program, or his or her designee, considers a provider's request for an exception to the 95-day claims filing deadline and the 120-day correction and resubmission deadline, if the delay is due to one of the following reasons and is received by the program within 18 months from the date of service:

- Damage to or destruction of the provider's business office or records by a catastrophic event or natural disaster; including, but not limited to fire, flood, or earthquake that substantially interferes with normal business operations of the provider. The request for an exception to the filing deadline must include:
  - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.

- 
- The cause for the delay.
  - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's current employee or agent.
  - Any additional information requested by the CSHCN Services Program, including independent evidence of insurable loss; medical, accident or death records and a police or fire department report substantiating the damage or destruction.
  - Damage or destruction of the provider's business office or records caused by intentional acts of an employee or agent of the provider, only if the employment or agency relationship was terminated and the provider filed criminal charges against the former employee or agent. The request for an exception to the filing deadline must include:
    - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
    - The cause for the delay.
    - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent.
    - Any additional information requested by the program, including a police or fire report substantiating the damage or destruction caused by the former employee or agent's criminal activity.
  - Delay, error, or constraint imposed by the program in the eligibility determination of a client and/or in claims processing, or delay due to erroneous written information from the program, its designee, or another state agency. The request for an exception to the filing deadline must include:
    - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
    - The cause for the delay.
    - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent.
    - Any additional information requested by the program, including written documentation from the program, its designee, or another state agency containing the erroneous information or explanation of the delay, error, and/or constraint.
  - Delay due to problems with the provider's electronic claims system or other documented and verifiable problems with claims submission. The request for an exception to the filing deadline must include:
    - An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
    - The cause for the delay.
    - Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent.
    - Any additional information requested by the CSHCN Services Program, including a written repair statement or invoice; a computer or modem-generated error report indicating attempts to transmit the data failed for reasons outside the control of the provider, or an explanation for the system implementation or other claim submission programs; a detailed, written statement by the person making the repairs or installing the system concerning the relationship and impact of the computer problem or system implementation to delayed claims submission; and the reason alternative billing procedures were not initiated after the problems became known.



The DSHS manager of the unit with responsibility for oversight of the CSHCN Services Program, or his or her designee(s), considers a provider's request for an exception to claims receipt deadlines due to delays caused by entities other than the provider and the program only if the following criteria are met:

- All claims that are to be considered for the same exception accompany the request (only the claims that are attached are considered).
- The exception request is received by the program within 18 months from the date of service.
- The exception request includes an affidavit or statement from a representative of an original payer, a third-party payer, or a person who has personal knowledge of the facts, stating the requested exception, documenting the cause for the delay, and providing verification that the delay was caused by another entity and not the neglect, indifference, or lack of diligence of the provider or the provider's employees or agents.

Send requests for exceptions to claim filing deadlines to:

CSHCN Services Program  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

*Note: Correspondence greater than ten pages must be mailed.*

### **5.1.10 Fiscal Agent Payment Deadline**

The CSHCN Services Program fiscal agent is required to finalize all claims, including appeals or adjustments, within 24 months.

- Provider claims—CSHCN Services Program payments cannot be made after 24 months from the date of service or discharge date on inpatient claims.
- Retroactive SSI eligibility claims—The payment deadline is derived from the client's eligibility add date to allow 24 months from the add date for the retroactive SSI-eligible client.

Payment deadlines should not be confused with the claims filing deadlines that are in place for claim submissions and appeals.

## **5.2 Third-Party Resource (TPR)**

Federal and state laws require that the CSHCN Services Program use program funds for the payment of most medical services only after all reasonable measures were taken to use a client's TPR.

A TPR is a source of payment (other than payment from the CSHCN Services Program) for medical services. TPR includes payment from any of the following sources:

- Private health insurance
- Dental insurance plan
- Health maintenance organization (HMO)
- Home, automobile, or other liability insurance
- Preferred provider organization (PPO)
- Cause of action (lawsuit)
- Medicare
- Health-care plans of the U.S. Department of Defense or the U.S. Department of Veterans Affairs (also known as TRICARE)
- Employee welfare plan

- Union health plan
- Children's Health Insurance Program (CHIP)
- Prescription drug card
- Vision insurance plan

Even though Texas Medicaid is considered a non-TPR source, when the client is eligible for both the CSHCN Services Program and Texas Medicaid, Medicaid must be billed before billing the CSHCN Services Program. The CSHCN Services Program does not pay a provider for any services that could have been reimbursed by Texas Medicaid.

If Texas Medicaid denies or recoups a claim for client ineligibility, a copy of the Medicaid R&S Report must be submitted with the claim and received at TMHP within 95 days from the date of disposition.

A provider who furnishes services and is participating in the CSHCN Services Program must not refuse to furnish services to an eligible client because of a third party's potential liability for payment of the services.

Eligible clients must not be held responsible for billed charges in excess of the TPR payment for services that are a benefit of the CSHCN Services Program. When the TPR pays less than the program allowable amount for services that are a benefit, the provider may submit a claim to TMHP for any additional allowable amount. The program does not reimburse providers for copays or provider discounts deducted from TPR payments.

When the client has other third-party coverage, the CSHCN Services Program may pay the deductible or coinsurance for the client as long as the combination of insurance and program payment does not exceed CSHCN Services Programs fee schedule in use at the time of service.

**Exception:** *By law, the CSHCN Services Program cannot reimburse for CHIP deductibles or coinsurance.*

The CSHCN Services Program may pay for covered health-care benefits during CHIP or other health insurance enrollment waiting periods. During these periods, providers may file claims directly with the CSHCN Services Program without evidence of denial by the other insurer.

### **5.2.1 Health Maintenance Organization (HMO)**

The CSHCN Services Program does not reimburse providers for client copays.

The CSHCN Services Program considers payment for services specifically excluded or limited by HMOs, but a benefit of the CSHCN Services Program. An explanation of benefits (EOB) is required from the HMO. Payment of those services must not exceed the CSHCN Services Programs maximum allowable fees for those services.

The CSHCN Services Program does not provide assistance for:

- Supplement of payment made by HMOs to their providers, unlike other insurance.
- Services that are available through an HMO and were not provided by an HMO approved provider.
- Authorization and payment for services available through an HMO.
- Copayments to providers for services available through an HMO.

*Providers may collect copays for CSHCN Services Program clients with private insurance.* The CSHCN Services Program reimburses clients for medication copays only. Clients should call the TMHP-CSHCN Services Program Contact Center Client Line at 1-877-888-2350, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time for additional information.

### 5.2.2 CSHCN Services Program Notice of Eligibility

To report other insurance information, providers can call the TMHP Third-Party Resource (TPR) Unit at 1-800-846-7307, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time for additional information or write to the following address:

TMHP TPR Unit  
PO Box 202948  
Austin, TX 78720-2948

### 5.2.3 Claims Filing Involving a TPR

When a CSHCN Services Program client has other health insurance, that resource must be billed and providers must receive a disposition from the insurance company before submitting a claim for consideration of payment by the CSHCN Services Program. All claims for clients with other insurance coverage must reference the following information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy (identification) number and group number
- Policyholder
- Effective date, if available
- Date of disposition by other insurance resource
- Payment or specific denial information

Claims must be submitted on paper with the EOB attached.

**Referto:** Claims Information section at the end of each chapter of this manual for more information.

### 5.2.4 Verbal Denials by a TPR

When a claim is denied by TMHP because of the client's other coverage, information identifying the TPR appears on the provider's R&S Report.

A statement from the client or family member indicating that they no longer have this resource is not sufficient documentation to reprocess the claim. Providers may call the third-party insurance resource and receive a verbal denial. In these situations, the provider must indicate the following information on the R&S Report:

- Date of the telephone call
- Name and telephone number of the insurance company
- Name of the person with whom they spoke
- Policyholder and group information
- Specific reason for the denial (include client's *type of coverage* to enhance the accuracy of claims processing; for example, a policy that covers only inpatient services or only physician services)

When a provider is advised by a TPR that benefits were paid to the client, the provider must include that information 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 information listed in this section. This information enables TMHP to consider the claim for payment.

### 5.2.5 Filing Deadlines Involving a TPR

Any health insurance, including CHIP or Medicaid, that provides coverage to a CSHCN Services Program eligible client must be used before the program can consider the services for reimbursement. Claims must be received by the program or the payment contractor within 95 days of the date of the disposition by the other TPR and no later than 365 days from the date of service.

If the claim is denied, the provider may submit a claim for consideration to the program. The letter of denial must accompany the claim, or the provider must include the following information with the claim for consideration:

- Date the claim was filed with the insurance company
- Reason for the denial
- Name and telephone number of the insurance company
- Policy (identification) number
- Name of the policy holder and identification numbers for each policy covering the client
- Name of the insurance company contact who provided the denial information
- Date of the contact with the insurance company

Claims involving a TPR have the following deadlines applied:

- Claims with a valid disposition must be submitted to TMHP within 95 days from the disposition (payment or denial) date.
- In addition to the above, there is a 365-day filing deadline from the date of service. *This means that a fully documented claim must be received by TMHP within 365 days of the date of service.* However, when a TPR recoups a payment made in error on a claim, and that claim was never submitted to TMHP, the provider must send the claim for special handling to the attention of the Third-Party Resources Unit at TMHP within 95 days of the TPR action, if the 365-day filing period was exceeded.

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

Claims denied by the TPR on the basis of late filing are not considered for payment by the CSHCN Services Program.

*TMHP does not have the authority to waive state or federal mandates, such as filing deadlines.*

**Note:** *Providers may request an administrative review of any claim denied by the CSHCN Services Program payment contractor. Refer to Section 7.3.5, “Administrative Review for Claims” in Chapter 7, “Appeals and Administrative Review” for more information.*

### 5.2.6 Blue Cross Blue Shield (BCBS) Nonparticipating Physicians

BCBS currently has procedures in place to pay assigned claims directly to nonparticipating providers. A nonparticipating provider is eligible to receive direct reimbursement from BCBS, when assignment is accepted. However, only payment dispositions are sent to the provider. An EOB regarding denials is sent only to the client.

Be aware that by accepting assignment on a claim when the client also has the CSHCN Services Program coverage, providers are agreeing to accept payment made by insurance carriers and the CSHCN Services Program, when appropriate, as payment in full. *The CSHCN Services Program client must not be held liable for any balance related to CSHCN Services Program-covered services.*

Physicians who treat CSHCN Services Program clients with BCBS private insurance and who are nonparticipating with BCBS must follow the instructions and procedures as follows:

- Do not provide the CSHCN Services Program client with a bill or anything the client could use as a bill. An informational statement may be given. To avoid confusion, write “Information only” clearly on the copy of the statement.
- Bill BCBS directly, accepting assignment. When payment from BCBS is received, the claim may be filed with TMHP to seek additional payment up to the CSHCN Services Program allowable amount.

A claim must be filed with TMHP-CSHCN Services Program within 365 days of the date of service.

### 5.2.7 Refunds

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments that are a result of overpayment, duplicate payment, payment to incorrect providers, returned equipment, and overpayments due to overlapping payments by the CSHCN Services Program and another source. An overpayment must be refunded to the CSHCN Services Program.

Providers must reimburse the CSHCN Services Program refund account by lump sum payment. At the discretion of the Program, refunds may be made in monthly installments or out of current claims due to be paid the provider. To process refunds accurately, refund checks should be accompanied by a [CSHCN Services Program Refund Information Form](#) and include the following information:

- Refunding provider’s name and NPI
- Client’s name and client number
- The date on which the medical service was rendered
- A copy of the R&S Report that shows the claim to which the refund is being applied
- The specific reason for the refund
- Private insurance paid on the claim. The provider must refund the lower of the amount paid by the primary insurance or CSHCN Services Program. The provider should include the exact amount paid and the insurance company’s name, address, policy number, and group number.

Refund requests must be submitted to:

Texas Medicaid & Healthcare Partnership  
Financial Department  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727

### 5.2.8 Refunds to TMHP Resulting From Other Insurance

If the CSHCN Services Program makes payment for a claim and payment is received from another resource for the same services, the provider must refund the CSHCN Services Program the lesser of the amount paid by the TPR or the amount paid by the program. These refunds must not be held until the end of an accounting year. Providers must accept assignment; therefore, they must accept the CSHCN Services Program payment as payment in full for services that are a benefit and must not use payment by another TPR to make up the difference between the amount billed and the CSHCN Services Program payment.

Providers must use the following guidelines to determine the amount to be refunded to the CSHCN Services Program:

- When the CSHCN Services Program pays more than the other resource pays, the amount of the other payment is due as a refund to the CSHCN Services Program. For example:

|              |       |
|--------------|-------|
| Total billed | \$300 |
|--------------|-------|

|                                |       |
|--------------------------------|-------|
| CSHCN Services Program payment | \$200 |
| Other resource payment         | \$150 |
| Amount to be refunded to TMHP  | \$150 |

- When the CSHCN Services Program pays less than the other resource, the amount paid by the Program is due as a refund. For example:

|                                |       |
|--------------------------------|-------|
| Total billed                   | \$300 |
| CSHCN Services Program payment | \$200 |
| Other resource payment         | \$250 |
| Amount to be refunded to TMHP  | \$200 |

### 5.2.9 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of the CSHCN Services Program clients. Providers are required to ask clients whether the medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers must indicate this information in the appropriate fields on the electronic claim form, in Block 10 of the CMS-1500 paper claim form, or Blocks 31 through 34 on the UB-04 CMS-1450 paper claim form.

If payment is available from a known third party, such as personal injury protection automobile insurance, that responsible party must be billed before the CSHCN Services Program. If the third-party payment is substantially delayed due to 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.

The following information must be included on these claims:

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

#### 5.2.9.1 Accident Resources and Refunds Involving Claims for Accidents

Acting on behalf of the CSHCN Services Program, TMHP has the authority to recover payments from any settlement, court judgment, or other resources awarded to a CSHCN Services Program client. In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for program payments. If a provider receives a portion of a settlement for which the program has made payment, the provider must refund the CSHCN Services Program. Any provider filing a lien for the entire billed amount must contact the Third-Party Resources Unit at TMHP to coordinate program postpayment activities. Providers may contact the TMHP Tort Contact Center by calling 1-800-846-7307, which is available Monday through Friday, from 8 a.m. to 5 p.m., Central Time.

A provider who receives an attorney's request for an itemized statement, claim copies, or both, should contact the TMHP Third-Party Resources Unit, if the CSHCN Services Program was billed for any services relating to the request. The provider must furnish TMHP with the client's name and CSHCN Services Program ID number, dates of service involved, and the name and address of the attorney or casualty insurance company. This information enables TMHP to pursue reimbursement from any settlement.

### 5.2.9.2 Third-Party Liability for Claims Involving Accidents

DSHS contracts with TMHP to administer third-party liability cases. To ensure that the CSHCN Services Program is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases.

TMHP also identifies and recovers CSHCN Services Program expenditures in casualty cases involving CSHCN Services Program clients.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, CSHCN Services Program clients, and state agencies.

Referrals should be submitted on the [Tort Response Form](#) to the following address:

TMHP Tort Department  
PO Box 202948  
Austin, TX, 78720-2948  
Fax: 1-512-514-4225

TMHP releases CSHCN Services Program claims information when a [Department of State Health Services Form to Release CSHCN Services Program Claims History](#) is submitted. This form is available in both [English](#) and [Spanish](#). The form must be signed by the CSHCN Services Program client, parent, or guardian. Referrals are processed within ten business days.

An attorney or other person who represents a CSHCN Services Program client in a third-party claim or action for damages for personal injuries must send written notice of representation to the TMHP Tort department at the address listed above. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the CSHCN Services Program client or from the date on which a potential third party is identified.

The following information must be included:

- The CSHCN Services Program 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, filed for injuries to the CSHCN Services Program client
- The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the CSHCN Services Program client for which a third party may be liable for payment, whether or not the claim was submitted to, or paid by, TMHP

Providers should indicate when information is unknown when the initial notice is filed. Revisions must be submitted when the information becomes available.

If the attorney or representative requests claim information about the CSHCN Services Program client, an authorization form must be included as part of the notice and must be signed by the CSHCN Services Program client, parent, or guardian. The [Department of State Health Services Form to Release CSHCN Services Program Claims History](#) must be used.

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

For additional information, providers may contact the TMHP Tort Contact Center at 1-800-846-7307, which is available Monday through Friday, from 8 a.m. to 5 p.m., Central Time.

## 5.3 Multipage Claim Forms

### Professional (CMS-1500)

The approved electronic professional claim 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, 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.

### **Institutional (UB-04 CMS-1450)**

An approved electronic format of the UB-04 CMS-1450 is designed to list 61 lines in Block 43 or its electronic equivalent. C21 merges like revenue codes together to reduce the lines to 28 or less.

If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes. When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim. Hospitals are required to submit all charges.

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

The total number of details allowed for 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.

**Note:** Revenue codes must be submitted on the UB-04 CMS-1450 institutional paper claim form or electronic equivalent in accordance with the National Uniform Billing Committee (NUBC) standards for all inpatient and outpatient institutional claims. Providers can refer to the NUBC website at [www.nubc.org](http://www.nubc.org).

### **Revenue Codes**

Per the NUBC, revenue codes are defined as codes that identify specific accommodations, ancillary services, or unique billing calculations or arrangements. Revenue codes are four-digit codes that must be entered on claims as follows:

- Providers submitting claims through TexMedConnect will be required to enter four-digit revenue codes, including the leading zero (where appropriate) for inpatient and outpatient claim submissions.
- Providers submitting institutional claims in the 837I electronic format should continue to use four-digit revenue codes in Loop 2400, Segment SV201, to enter revenue codes.

Providers are required to adhere to national billing standards, including NUBC guidelines defining data submission requirements.

Providers may refer to the National Uniform Billing Committee website for further information.

### **Type of Bill**

Type of bill (TOB) values must be submitted on the UB-04 CMS-1450 claim form or electronic equivalent in accordance with the National Uniform Billing Committee (NUBC).

Per NUBC, TOB is defined as a code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacement, voids, etc.), with the last digit defining the frequency of the bill.



Providers that submit institutional claims in the 837I electronic format may use Loop 2300, Segment CLM05-1 through CLM05-3 to enter TOBs.

## 5.4 Tips on Expediting Paper Claims

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

### 5.4.1 General requirements

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

### 5.4.2 Data Fields

- Print claim data within defined boxes on the claim form.
- Use black ink, but not a black marker. Don't use red ink or highlighters.
- Use all capital letters.
- Print using 12 point Courier font only. Don't use fonts smaller or larger than 12 points. No other font will be accepted.
- Use a laser printer for best results. Don't use a dot matrix printer, if possible.
- Use eight digits to indicate the date (e.g., 01012013). Don't use dashes or slashes in date fields.

### 5.4.3 Attachments

- Use paper clips on claims or appeals if they include attachments. Don't use glue, tape, or staples.
- Place the claim form on top when sending new claims, followed by any medical records or other attachments.
- Number the pages when sending when sending attachments or multiple claims for the same client (e.g., 1 of 2, 2 of 2).
- Don't total the billed amount on each claim form when submitting multiple claims for the same client.
- Submit claim forms with R&S Reports.

## 5.5 Correction and Resubmission (Appeal) Time Limits

All correction and resubmission (appeals) of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition of the claim (the date of the R&S Report on which the claim appears).

*Referto:* [2022 Authorization Filing Deadline Calendar](#)  
[2023 Authorization Filing Deadline Calendar](#)

### 5.5.1 Claims with Incomplete Information

Claims lacking the information necessary for processing are listed on the R&S Report with an EOB code requesting the missing information. Providers must resubmit a signed, completed, and corrected claim with a copy of the R&S Report on which the claim appears to TMHP within 120 days from the date on the R&S Report to be considered for payment. Hospitals are not required to resubmit itemized inpatient charges if those charges were included with the original submission.

### 5.5.2 Other Insurance Appeals

Providers appealing a claim denial due to other insurance coverage must submit to TMHP the complete other-insurance information, including all EOBs with disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial. If a provider submits other-insurance EOBs without disposition dates, the appeal will be denied.

### 5.5.3 Resubmission of TMHP EDI Rejections

Providers that receive TMHP EDI rejections may resubmit an electronic claim within 95 days of the DOS. A paper appeal may also be submitted with a copy of the rejection report within 120 days of the rejection report to meet the filing deadline. A copy of the rejection report with the EDI batch ID must accompany each corrected claim that is submitted on paper.

#### 5.5.3.1 TMHP EDI Batch Numbers, Julian Dates

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

- JJJ—Julian date. The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where I = 0, J = 1, K = 2, and L = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date. For example, a Julian date of 143 would be J43.
- Y—Year. The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a “3” in this position indicates the year 2013.
- SSSS—The unique 4-character sequence number assigned by EDI to the claim filed.

*Referto:* Section 7.3.1.3, “Electronic Rejections” in Chapter 7, “Appeals and Administrative Review” for more information on electronic appeals.

## 5.6 Coding

### 5.6.1 Diagnosis Coding

The *only* diagnosis coding structure accepted by the CSHCN Services Program is the *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM). The CSHCN Services Program requires providers to provide diagnosis codes on their claims. Diagnosis codes must correspond to the highest level of specificity available. A written description of the diagnosis is not required.

If the diagnosis code submitted is a valid three- to seven-digit code, do not add additional zeroes. Claims submitted with an invalid diagnosis code are denied.

Specific diagnosis codes related to program benefits are listed in chapters that follow. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, diagnosis codes are added, deleted, or revised.

## 5.6.2 Procedure Coding

### 5.6.2.1 Healthcare Common Procedure Coding System (HCPCS)

The procedure coding system used by the CSHCN Services Program is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS is a common coding structure for determining reimbursement made available to health-care providers and third-party payers.

HCPCS is designed around a five-character numeric or alphanumeric base for all procedure codes, and is divided into two principal subsystems, referred to as level I and level II:

- **Level I:** Level I procedure codes are created by the [American Medical Associations \(AMA\)](#), and are published in the Current Procedural Terminology (CPT®) manual. CPT procedure codes are numeric codes consisting of 5-digits. Maintenance of CPT is the responsibility of the AMA (AMA updates on a yearly basis) and coordinated with CMS before distribution of modifications to third-party payers.

***Note:** Claims for anesthesia must list the CPT anesthesia procedure codes. Use of narrative descriptions or CPT surgical codes result in claim denial.*

- **Level II:** Level II procedure codes are created by CMS, and are published in the HCPCS manual. HCPCS procedure codes are alpha-numeric codes consisting of a single alpha character (A–V) followed by four numeric digits; the codes are for physician and nonphysician services that are not contained in CPT (such as ambulance, durable medical equipment [DME], prostheses, and some medical codes). Updating of HCPCS codes is the responsibility of the CMS Maintenance Task Force.

Level I CPT and Level II HCPCS procedure codes are used by all the CSHCN Services Program providers to identify the procedures they perform.

***Exception:** Inpatient facility charges submitted on a UB-04 CMS-1450 paper claim form or equivalent electronic claim format must be billed using revenue codes.*

To ensure an up-to-date coding structure, HCPCS is updated annually using the latest edition of the CPT manual (i.e., Level I coding) and nationally established CMS codes (i.e., Level II coding). The coding systems comply with *Health Insurance Portability and Accountability Act (HIPAA)* requirements.

Most added procedure codes that are not directly replacing a discontinued procedure code must go through the Texas Medicaid 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.

***Referto:** Section 5.6.2.3, “Determining Reimbursement Rates for New HCPCS Procedure Codes” in this chapter for additional information about the rate hearing process as well as claims filing and prior authorization requirements for affected procedure codes.*

Specific procedure codes related to program benefits are listed in chapters that follow. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, procedure codes are added, deleted, or revised. Benefit and coding information is updated in the *CSHCN Services Program Provider Bulletin*.

The CSHCN Services Program does not reimburse for deleted procedure codes.

Authorization and prior authorization requests must be submitted to update HCPCS procedure codes for services.

***Referto:** [The Centers for Medicare & Medicaid Services HCPCS web page](#).*

### 5.6.2.2 National Correct Coding Initiative (NCCI) Guidelines

The *Patient Protection and Affordable Care Act* (PPACA) mandates that all claims submitted on or after October 1, 2010, must be filed in accordance with the NCCI guidelines. NCCI was developed by CMS to promote the correct coding of health-care services by providers. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported.

NCCI consists of two types of edits:

- NCCI procedure-to-procedure edits that define pairs of procedure codes that should not be reported together for a variety of reasons.
- MUE are units-of-service edits that define the number of units of service beyond which the reported number of units of service is unlikely to be correct.

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.

NCCI edits are applied to services that are performed by the same provider on the same date of service only. Providers may refer to the [CMS NCCI web page](#) for the *NCCI Policy* and *Medicare Claims Processing* manuals that contain the NCCI rules, relationships, and general information.

Providers are encouraged to monitor CMS for updates to the NCCI rules and guidelines. A link to the CMS NCCI website is also available through the TMHP website at [www.tmhp.com](http://www.tmhp.com) on the Code Updates - NCCI Compliance web page. In instances where the CSHCN Services Program implements exceptions to the NCCI relationships, providers will be informed through the standard provider notification process.

The HCPCS and CPT codes included in the *Children with Special Health Care Needs Services Program Provider Manual* and the *CSHCN Services Program Provider Bulletins* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. In instances when CSHCN Services Program medical policy is more restrictive than NCCI MUE guidance, CSHCN Services Program medical policy prevails.

#### NCCI Appeals

Claims or procedure codes that have been denied based on NCCI guidelines may be appealed with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be appealed with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service. Providers must follow the current standard appeals process when appealing claims to TMHP.

**Referto:** Section 7.3, “Claim Appeals” in Chapter 7, “Appeals and Administrative Review” for additional information about appealing claims.

### 5.6.2.3 Determining Reimbursement Rates for New HCPCS Procedure Codes

The CSHCN Services Program adopts the new codes that are direct replacements of discontinued codes at the discontinued codes reimbursement rate. The new HCPCS procedure codes that are not directly replacing discontinued codes require a rate hearing to determine an appropriate Texas Medicaid reimbursement rate. The 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. After the rate hearings are complete for each procedure code, the CSHCN Services Program makes the determination to adopt the Texas Medicaid rate established through the rate hearing process or to adopt the rate of a similar discontinued code.

As indicated in the *HCPCS Special Bulletin* that is published at the beginning of each year, claims for procedure codes that require a rate hearing must be submitted within the initial 95 day filing deadline. The most appropriate procedure code for the service provided must be submitted. Services provided are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted.

Once the Medicaid reimbursement rate has been determined through the rate hearing process, the CSHCN Services Program will evaluate the proposed rate to determine whether alignment with the Medicaid rate is fiscally feasible. Once reimbursement rates are established in the rate hearing, evaluated by the CSHCN Services Program, and applied, TMHP will reprocess the claim. No action on the part of the provider is necessary. Providers are notified of the implementation date and reprocessing efforts. The client cannot be billed for these services.

For those procedures that require authorization or prior authorization, providers must follow the processes detailed in Chapter 4, “Prior Authorizations and Authorizations” of the current *CSHCN Services Program Provider Manual*. Providers must not wait until new codes have completed the rate hearing process to request an authorization or prior authorization.

#### **5.6.2.4 National Drug Codes (NDC)**

All CSHCN Services Program providers must submit an NDC for professional or outpatient electronic and paper claims submitted with physician-administered prescription drug procedure codes.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

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

The valid units of measurement codes are:

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

**Note:** *Unit quantities must be submitted, and are required.*

### 5.6.2.4.1 Paper Claim Submissions

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 | <p>This block should include the following elements in the following order:</p> <ul style="list-style-type: none"> <li>NDC qualifier of N4 (e.g., N4)</li> <li>The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231)</li> <li>The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME. (e.g., GR)</li> <li>The unit quantity with a floating decimal for fractional units (limited to 3 digits). (e.g., 0.025)</li> </ul> <p><b>Example:</b> N400409231231GR0.025</p> |

#### CMS-1500

| Block No. | Description                       | Guidelines  |
|-----------|-----------------------------------|---|
| 24A       | Date(s) of service                | <p>In the shaded area, enter:</p> <ul style="list-style-type: none"> <li>NDC qualifier N4 (e.g., N4)</li> <li>The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter spaces or hyphens within this number. (e.g., 00409231231)</li> </ul> <p><b>Example:</b> N400409231231</p> |
| 24D       | Procedures, services, or supplies | <p>In the shaded area, enter NDC quantity of units administered (up to 12 digits including the decimal point). A decimal point must be used for fractions of a unit (e.g., 0.025).</p>  |
| 24G       | Days or units                     | <p>In the shaded area, enter the NDC unit of measurement code (e.g., GR).</p> <p>There are 5 allowed values: F2, GR, ML, UN or ME.</p>  |

#### 2017 Claim Form

| Block No. | Description        | Guidelines   |
|-----------|--------------------|--|
| 32A       | Date(s) of service | <p>In the shaded area, enter :</p> <ul style="list-style-type: none"> <li>NDC qualifier N4 (e.g., N4)</li> <li>The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter spaces or hyphens within this number. (e.g., 00409231231)</li> </ul> <p><b>Example:</b> N400409231231</p> |

| Block No. | Description  | Guidelines  |
|-----------|--|---|
| 32D       | Procedures, services, or supplies Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Modifier | In the shaded area, enter the NDC quantity of units administered (up to 12 digits including the decimal point). A decimal point must be used for fractions of a unit (e.g., 0.025). |
| 32F       | Days or units  | In the shaded area, enter the NDC unit of measurement code (e.g., GR).<br>There are 5 allowed values: F2, GR, ML, UN or ME.   |

**National Drug Unit:** Claims will be edited for the value submitted in the NDC quantity field. In order to convert the HCPCS units submitted into the NDC quantity; use the Texas NDC-to-HCPCS Crosswalk to review the “HCPCS Description” and the “NDC Label” description to identify the quantity.

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

Texas Supplemental NDC File lists 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.

#### 5.6.2.5 Drug Rebate Program

The CSHCN Services Program will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the CMS Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered.

CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the [CMS website](#). TMHP will republish this list quarterly in a more accessible format. Providers will be notified when the first formatted file from TMHP is available.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code (NDC) of the administered drug as indicated on the drug packaging.

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

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

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

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

TMHP has created a Rebateable National Drug Codes web page to display the quarterly lists published by CMS. Every quarter, after CMS publishes an updated list of rebateable NDCs, TMHP will produce a formatted list with the unnecessary details removed and will add the new list to the web page.

**Note:** CSHCN Services Program does not pay for drug wastage.

### 5.6.2.6 Modifiers

Modifiers further describe and qualify services provided. A modifier is placed after the five-digit procedure code. Refer to the service-specific sections for additional modifier requirements. Providers must maintain documentation in the client's medical record that supports the medical necessity of the services that are billed using a modifier. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records. On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed. Modifiers and their descriptions are available in current issues of CPT and HCPCS coding resources.

*Note: Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of a service and any modifier used to bill the claim.*

### 5.6.2.7 Modifier U8 and the Federal 340B Drug Pricing Program

All eligible organizations and covered entities that are enrolled in the federal 340B Drug Pricing Program to purchase 340B discounted drugs must use modifier U8 when submitting claims for 340B clinician-administered drugs.

Non-compliance with this new requirement to use modifier U8 on all claims submitted for 340B clinician-administered drugs may jeopardize a covered entity's 340B status with the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

*Note: Providers can refer to the HRSA website at [www.hrsa.gov/opa/index.html](http://www.hrsa.gov/opa/index.html) for more information about the 340B Drug Pricing Program.*

### 5.6.2.8 Type of Services (TOS)

The TOS identifies the specific field or specialty of services provided. TOS codes are not required for billing, but they do appear on the provider's Remittance and Status (R&S) Reports.

For procedure codes that require a modifier to assign a TOS, providers can refer to the appropriate specific section for information on modifier requirements for claim submissions.

| TOS | Description   |
|-----|---|
| 0   | Blood   |
| 1   | Medical Services  |
| 2   | Surgery   |
| 3   | Consultations   |
| 4   | Radiology (total component)   |
| 5   | Laboratory (total component)  |
| 6   | Radiation Therapy (total component)   |
| 7   | Anesthesia  |
| 8   | Assistant surgery   |
| 9   | Other medical items or services   |
| C   | Home health services  |
| 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  |



| TOS | Description   |
|-----|---|
| L   | DME rental  |
| R   | Hearing aid   |
| T   | Technical component for radiology, laboratory, or radiation therapy |
| W   | Dental  |

**Place of Service (POS) Coding**

The POS identifies where services are performed. Indicate the POS by using the appropriate numeric code for each service listed on the claim. The following POS codes must be used:

| Place of Service         | Two-Digit Numeric Codes (Electronic Billers)               | One-Digit Numeric Codes (Paper Billers) |
|--------------------------|--|---|
| Office                   | 02, 10, 11, 15, 17, 20, 49, 50, 60, 65, 71, 72             | 1                                       |
| Home                     | 12   | 2                                       |
| Inpatient hospital       | 21, 51, 52, 56, 61   | 3                                       |
| Outpatient hospital      | 19, 22, 23, 24, 55, 56, 57, 62                             | 5                                       |
| Other location           | 01, 03, 04, 05, 06, 07, 08, 16, 18, 26, 34, 41, 42, 53, 99 | 9                                       |
| Independent lab          | 81   | 6                                       |
| Destination of ambulance | Indicate destination using above codes                     | Indicate destination using above codes  |

**5.6.3 Benefit Code**

A benefit code is an additional data element used to identify state programs. Providers participating in the CSHCN Services Program must use benefit code CSN and DM3 when submitting claims and authorizations to TMHP. Additional codes may be added as necessary.

| Benefit Code | Program   |
|--------------|---|
| CSN          | CSHCN Services Program                          |
| DM3          | CSHCN Services Program home health DME services |

**Important:** The appropriate benefit code must be included on each CSHCN Services Program claim that is submitted to TMHP. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions about TexMedConnect to the TMHP EDI Help Desk at 1-888-863-3638.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for more information about electronic billing.

**5.7 Claims Filing Instructions**

Providers must read the instructions in this section carefully and supply all the requested information on the claim form.

Claim forms must contain:

- The billing provider’s:
  - Complete name.
  - Physical address.

- ZIP + 4 code.
- NPI.
- Taxonomy code.
- Benefit code (if applicable).
- The signature of the provider or an authorized representative or a “signature on file” statement.

Claim forms prepared by computer billing services may have “Signature on File” printed in the signature block if the billing service retains a letter on file from the provider authorizing the service.

Claim forms must contain the following or the claim cannot be processed:

- The billing provider’s:
  - Complete name.
  - Physical address.
  - ZIP + 4 code.
  - NPI.
  - Taxonomy code.
  - Benefit code (if applicable).
- The signature of the provider or an authorized representative or a “signature on file” statement.

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted to TMHP must be filed in accordance with NCCI guidelines. The guidelines can be found in the NCCI Policy and *Medicare Claims Processing Manuals*, which are available on the CMS website.

### **5.7.1 Claim Details**

The maximum number of units on a claim detail can not exceed 9,999 units. 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.

### **5.7.2 Provider Types and Selection of Claim Forms**

#### **5.7.2.1 Providers and Services Billable on CMS-1500**

Claims for the following provider types or services must be billed on a CMS-1500 paper claim form or approved electronic format when requesting payment for medical services and supplies under the CSHCN Services Program:

- Advanced practice registered nurse (APRN), such as pediatric nurse practitioner (PNP), clinical nurse specialist (CNS), and family nurse practitioner (FNP)
- Ambulance
- Anesthesiologist assistants
- Augmentative communication devices (ACDs)
- Certified respiratory care practitioner (CRCP)
- Certified registered nurse anesthetists (CRNA)
- Durable medical equipment (DME)
- Freestanding ambulatory surgery center
- Gastrostomy devices

- Genetic services
- Independent laboratory, radiology, and radiation therapy
- Medical foods
- Medical nutritional products and services
- Orthosis and prosthesis
- Outpatient behavioral health services
- Outpatient therapy (physical therapy [PT], occupational therapy [OT], and speech-language pathology [SLP])
- Pharmacy
- Physician (doctor of medicine [MD] and doctor of osteopathy [DO])
- Podiatry
- Total parenteral nutrition (TPN)
- Vision services
- Any other authorized provider of medical services and supplies not specifically required to use a different claim form when submitting claims to TMHP

**Referto:** The [Professional Paper Claim Form \(CMS-1500\) page](#) of the CMS website at [www.cms.gov](http://www.cms.gov) for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

### **5.7.2.2 CMS-1500 Claim Form Provider Definitions**

#### **CMS-1500 Claim Form Provider Definitions**

The following definitions apply to the provider terms used on the CMS-1500 Claim Form:

#### **Referring Provider**

The Referring Provider is the individual who directed the patient for care to the provider rendering the services being submitted on the claim form.

Examples include, but are not limited to, a primary care provider referring to a specialist; an orthodontist referring to an oral and maxillofacial surgeon; a physician referring to a physical therapist; and 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 claim form.

Examples include, but are not limited to, a provider ordering diagnostic tests and 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 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:

- 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 anti-markup rule.

In the case where a substitute provider is used, that individual is not considered a Purchased Service Provider.

### **5.7.2.3 CMS-1500 Electronic Billing**

Electronic billers must submit CMS-1500 claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at [www.tmhp.com/topics/edi](http://www.tmhp.com/topics/edi).

Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for more information about electronic billing. All CSHCN Services Program claims must be submitted with the appropriate benefit code.

Section 5.6.3, "Benefit Code" in this chapter for information about using the appropriate benefit code to file CSHCN Services Program electronic claims.

### **5.7.2.4 CMS-1500 Paper Claim Form Instructions**

The following instructions describe the information that 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.

**Referto:** The [Professional Paper Claim Form \(CMS-1500\) page](http://www.cms.gov) of the CMS website at [www.cms.gov](http://www.cms.gov) for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

| <b>Block No.</b> | <b>Description</b>  | <b>Guidelines</b>   |
|------------------|---|---|
| 1a               | Insured's ID No. (for program checked above, include all letters) | Enter the client's nine-digit CSHCN Services Program client number.<br>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 CSHCN Services Program identification form.<br>If the insured uses a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name. |

| Block No.         | Description   | Guidelines   |
|-------------------|---|--|
| 3                 | Patient's date of birth<br>Patient's sex  | Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's sex by checking the appropriate box.<br>Only one box can be marked.   |
| 5                 | Patient's address   | Enter the client's complete address as described (street, city, state, and ZIP+4 Code).  |
| 8                 | Benefit code  | Enter the benefit code (if applicable) for the billing provider.   |
| 9                 | Other insured's name  | For special situations, use this space to provide additional information such as: <ul style="list-style-type: none"> <li>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.</li> </ul>   |
| 10a<br>10b<br>10c | Is the patient's condition related to:<br>a) Employment (current or previous)?<br>b) Auto accident?<br>c) Other accident? | Check the appropriate box. If other insurance is available, enter appropriate information in Blocks 11, 11a, and 11b.  |
| 11<br>11a<br>11b  | Other health insurance coverage   | <ul style="list-style-type: none"> <li>If another insurance resource has made payment or denied a claim, enter the name and information of the insurance company. The other insurance EOB or denial letter must be attached to the claim form.</li> <li>If the client is enrolled in Medicare attach a copy of the Medicare Remittance Notice to the claim form.</li> <li>For Workers' Compensation and Other Property &amp; Casualty Claims: Required if known. Enter Workers' Compensation or Property &amp; Casualty Claim Number assigned by the payer.</li> </ul> |
| 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).<br>TMHP will process the claim without the signature of the client.   |
| 14                | Date of current   | If the client has chronic renal disease, enter the date of onset of dialysis treatments.<br>Indicate the date of treatments for PT and OT.   |

| Block No. | Description                                 | Guidelines   |
|-----------|---|--|
| 17<br>17b | Name of referring physician or other source | <p>Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order:</p> <ul style="list-style-type: none"> <li>• Referring Provider</li> <li>• Ordering Provider</li> <li>• Supervising Provider</li> </ul> <p>Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported.</p> <p>DN = Referring Provider<br/>DK = Ordering Provider<br/>DQ = Supervising Provider</p> <p>The NPI must be entered in block 17b.</p> <p><b>Supervising Physician for Referring Physicians:</b><br/>If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.</p> |
| 19        | Additional claim information                | <p><b>Ambulance transfers of multiple clients</b><br/>If the claim is part of a multiple transfer, indicate the other client’s complete name and CSHCN Services Program number, or indicate “Not a CSHCN Services Program client.”</p> <p><b>Ambulance Hospital-to-Hospital Transfers</b><br/>Indicate the services required from the second facility and unavailable at the first facility</p> <p><b>Supervising Physician for Referring Physicians</b><br/>If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.</p>  |
| 20        | Outside lab                                 | <p>Check the appropriate box. The information may be requested for retrospective review.</p> <p>If “yes,” enter the name and address or provider identifier of the facility that performed the service in Block 32.</p> <p><i>Note: The CSHCN Services Program regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider’s office must be billed by the performing laboratory or radiology center.</i></p>  |

| Block No. | Description                              | Guidelines  |
|-----------|--|---|
| 21        | Diagnosis or nature of illness or injury | <p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>0 = ICD-10-CM</p> <p>Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes.</p> <p>Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p> <p>Do not provide narrative description in this field.</p>  |
| 23        | Prior authorization number               | <p>Enter the PAN issued by TMHP, if applicable.</p> <p>For Workers' Compensation and Other Property &amp; Casualty Claims: Required when prior authorization, referral, concurrent review, or voluntary certification was received.</p>   |
| 24        | (Various)                                | <p>General notes for Blocks 24a through 24j:</p> <ul style="list-style-type: none"> <li>Unless otherwise specified, all required information should be entered in the unshaded portion.</li> <li>If more than 6-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.</li> <li>For multipage 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.</li> </ul>  |
| 24a       | Date(s) of service                       | <p>Enter the date of service for each procedure provided in a MM/DD/YYYY format.</p> <p>Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24g.</p> <p>If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line.</p> <p>National Drug Code (NDC)</p> <p>In the shaded area, enter:</p> <ul style="list-style-type: none"> <li>NDC qualifier N4 (e.g., N4)</li> <li>The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter spaces or hyphens within this number (e.g., 00409231231)</li> </ul> <p><b>Example:</b> N400409231231</p> <p><b>Referto:</b> Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter.</p> |
| 24b       | Place of service                         | <p>Select the appropriate POS code for each service from the table under Section , "Place of Service (POS) Coding" in this chapter.</p>   |

| Block No. | Description  | Guidelines  |
|-----------|--|---|
| 24d       | Fully describe procedures, medical services, or supplies furnished for each date given | <p>Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description.</p> <p><b>Note:</b> ASC providers should enter only one CPT procedure code for the inclusive global fee.</p> <p>In the shaded area, enter an NDC quantity of units administered, up to 12 digits including the decimal point (e.g., 0.025).</p> <p><b>Referto:</b> Section 5.6.2.4, “National Drug Codes (NDC)” in this chapter.</p>  |
| 24e       | Diagnosis pointer  | <p>In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow.</p> <p>The reference letter(s) should be A-L or multiple letters as applicable.</p> <p>Diagnosis codes must be entered in Form Field 21 only. Do not enter diagnosis codes in Form Field 24E.</p> |
| 24f       | Charges  | <p>Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.</p>   |
| 24g       | Days or units  | <p>If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).</p> <p><b>Note:</b> The maximum number of units per detail is 9,999.</p> <p>In the shaded area, enter the NDC unit of measurement code (e.g., GR).</p> <p>There are 5 allowed values: F2, GR, ML, UN or ME.</p> <p><b>Referto:</b> Section 5.6.2.4, “National Drug Codes (NDC)” in this chapter.</p> <p>Enter the number of blood factor units provided.</p>   |
| 24j       | Rendering provider taxonomy code (performing)  | <p>Enter the taxonomy code of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Do not enter the performing identifier in Block 33.</p> <p>Enter the taxonomy code in the shaded area of the field.</p> <p>Enter the NPI in the unshaded area of the field.</p>   |
| 26        | Patient’s account number   | <p>Optional</p> <p>Any alphanumeric characters (up to 15) in this block are referenced on the Remittance and Status (R&amp;S) Report.</p>   |
| 27        | Accept assignment  | <p>Required</p> <p>All providers of the CSHCN Services Program Services must accept assignment to receive payment by checking Yes.</p>  |



| Block No. | Description                           | Guidelines  |
|-----------|---------------------------------------|---|
| 28        | Total charge                          | Enter the total charges.<br>For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim.<br><br><i>Note:</i> Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.  |
| 29        | Amount paid                           | Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.   |
| 30        | Balance due                           | If appropriate, subtract Block 29 from Block 28 and enter the balance.  |
| 31        | Signature of physician or supplier    | The physician, supplier or an authorized representative must sign and date the claim.<br>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.<br><br><i>Referto:</i> Section 5.7, “Claims Filing Instructions” in this chapter |
| 32        | Service facility location information | If services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and ZIP+4 Code of the facility where the service was provided.   |
| 32A       | NPI                                   | Enter the NPI of the service facility location.   |
| 33        | Billing provider info & PH #          | Enter the billing provider’s name, physical address, city, state, ZIP+4 Code, and telephone number.   |
| 33A       | NPI                                   | Enter the NPI of the billing provider.  |
| 33B       | Other ID #                            | Enter the taxonomy code of the billing provider.  |

### 5.7.2.5 UB-04 CMS-1450 Paper Claim Form Instructions

The following services must be billed using the UB-04 CMS-1450 paper claim form or electronic claim format when requesting payment:

- Hospital ambulatory surgical center (HASC)
- Home health (skilled nursing service)
- Hospice services
- Inpatient hospital
- Inpatient rehabilitation
- Outpatient hospital
- Renal dialysis facility

*Referto:* The [Institutional paper claim form \(CMS-1450\)](#) CMS website at [www.cms.gov](http://www.cms.gov) for more information about the CMS-1450 paper claim form. Providers can purchase CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

### 5.7.2.6 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.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for more information about electronic billing.

### 5.7.2.7 Instructions for Completing the UB-04 CMS-1450 Paper Claim Form

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

| Block No. | Description            | Guidelines   |
|-----------|------------------------|--|
| 1         | Unlabeled              | Enter the hospital name, street, city, state, ZIP+4 Code, and benefit code (if applicable).              |
| 3a        | Patient control number | Optional<br>Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report. |
| 3b        | Medical record number  | Enter the client’s medical record number (limited to ten digits) assigned by the hospital.               |

| Block No. | Description             | Guidelines   |
|-----------|-------------------------|--|
| 4         | Type of bill (TOB)      | <p>Enter a TOB code.</p> <p>First Digit—Type of Facility:</p> <p>1 Hospital<br/>3 Home health agency<br/>7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC])<br/>8 Special facility</p> <p>Second Digit—Bill Classification (except clinics and special facilities):</p> <p>1 Inpatient (including Medicare Part A)<br/>2 Inpatient (Medicare Part B only)<br/>3 Outpatient<br/>4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays)</p> <p>Third Digit—Frequency:</p> <p>0 Nonpayment/zero claim<br/>1 Admit through discharge<br/>2 Interim-first claim<br/>3 Interim-continuing claim<br/>4 Interim-last claim<br/>5 Late charges-only claim<br/>6 Adjustment of prior claim<br/>7 Replacement of prior claim</p> |
| 6         | Statement covers period | Enter the beginning and ending dates of service billed.  |
| 8a        | Patient identifier      | Optional<br>Enter the client identification number if it is different than the Subscriber and insured's identification number.   |
| 8b        | Patient name            | Enter the client's last name, first name, and middle initial.  |
| 9a-9b     | Patient address         | Starting in 9a, enter the client's complete address as described (street, city, state, and ZIP+4 Code).  |
| 10        | Birthdate               | Enter the client's date of birth (MM/DD/YYYY).   |
| 11        | Sex                     | Indicate the client's sex by entering an "M" or "F."   |
| 12        | Admission date          | Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims.   |
| 13        | Admission hour          | Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.  |

| Block No. | Description                | Guidelines   |
|-----------|----------------------------|--|
| 14        | Type of admission          | Enter the appropriate type of admission code for inpatient claims:<br>1 Emergency<br>2 Urgent<br>3 Elective<br>4 Newborn (This code requires the use of special source of admission code in Block 15.)<br>5 Trauma center  |
| 15        | Source of admission        | Enter the appropriate source of admission code for inpatient claims.<br>For type of admission 1, 2, 3, or 5:<br>1 Physician referral<br>2 Clinic referral<br>3 Health maintenance organization (HMO) referral<br>4 Transfer from a hospital<br>5 Transfer from skilled nursing facility (SNF)<br>6 Transfer from another health-care facility<br>7 Emergency room<br>8 Court/law enforcement<br>9 Information not available<br><br>For type of admission 4 (newborn):<br>1 Normal delivery<br>2 Premature delivery<br>3 Sick baby<br>4 Extramural birth<br>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 (client status of "30"), leave the block blank.  |
| 17        | Patient Status             | For inpatient claims, enter the appropriate two-digit code to indicate the client's status as of the statement "through" date.<br><br><b>Referto:</b> Section 5.7.2.8, "Client Status (for block 17)" in this chapter.   |
| 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 client.  |
| 29        | ACDT state                 | Optional<br>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.<br><br><b>Referto:</b> Section 5.7.2.9, "Occurrence Codes (for blocks 31 through 34)" in this chapter.   |

| Block No. | Description                     | Guidelines  |
|-----------|---------------------------------|---|
| 35-36     | Occurrence span codes and dates | For inpatient claims, enter code “71” if this hospital admission is a readmission within 7 days of a previous stay. Enter the dates of the previous stay.   |
| 39-41     | Value codes                     | <p>Accident hour—For inpatient claims, if the client was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.</p> <p>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.</p> <p>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.</p>  |
| 42-43     | Revenue codes and description   | <p>For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided.</p> <p>List accommodations in the order of occurrence.</p> <p>List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate.</p> <p>National Drug Code</p> <p>Enter N4</p> <p>Enter the 11-digit NDC number (number on package or container from which medication was administered). Do not enter hyphens or spaces within this number (e.g., 00409231231).</p> <p>The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) must also be submitted (e.g., 0.025).</p> <p><b>Example:</b> N400409231231GR0.025</p> <p><b>Referto:</b> Section 5.6.2.4, “National Drug Codes (NDC)” in this chapter.</p> |

| Block No.    | Description   | Guidelines  |
|--------------|---------------|---|
| 44           | HCPCS/rates   | <p>Inpatient</p> <p>Enter the accommodation rate per day.</p> <p>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.</p> <p>Each service and supply must be itemized on the claim form.</p> <p>Outpatient</p> <p>Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.</p> <p>Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement.</p> <p><b>Note:</b> <i>The UB-04 CMS-1450 claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.</i></p> <p>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.</p> <p><b>Note:</b> <i>HASC providers should enter only one CPT procedure code for the inclusive global fee.</i></p> |
| 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   | <p>Provide units of service, if applicable.</p> <p>For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood.</p> <p>When billing for observation room services, the units indicated in this block should always represent hours spent in observation.</p> <p>Enter the number of blood factor units provided.</p>  |
| 47           | Total charges | Enter the total charges for each service provided.  |
| 47 (line 23) | Totals        | <p>Enter the total charges for the entire claim.</p> <p><b>Note:</b> <i>For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</i></p>  |

| Block No. | Description  | Guidelines  |
|-----------|--|---|
| 48        | Noncovered charges   | Enter the amount of the total noncovered charges.   |
| 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 31, 61, 62, and 80 as required.  |
| 56        | NPI  | Enter the NPI of the billing provider.<br>HASC facilities should use the HASC provider identifier for scheduled outpatient day surgeries. Claims for emergency, unscheduled outpatient surgical procedures should be using the hospital's outpatient provider identifier.   |
| 57        | Code Code (CC)   | Optional<br>Area to capture additional information necessary to adjudicate the claims. Required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.  |
| 58        | Insured's name   | If other health insurance is involved, enter the insured's name.  |
| 60        | Insured's Unique ID  | Enter the client's nine-digit CSHCN Services Program 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 client's employer if health care might be provided.   |
| 66        | Diagnosis/Procedure Code Qualifier                                     | Enter the applicable ICD indicator to identify which version of ICD codes is being reported:<br>0 = ICD-10-CM   |
| 67        | Principal diagnosis (DX) code and present on admission (POA) indicator | Enter the diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available.<br>Required<br>POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.<br>HASC providers are not required to enter a diagnosis code.<br><b>Referto:</b> Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)" in this chapter. |

| Block No. | Description                                      | Guidelines  |
|-----------|--|---|
| 67A-67Q   | Other DX codes and POA indicator                 | <p>Enter the diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis.</p> <p>Enter one diagnosis per block, using Blocks A through J only.</p> <p>A diagnosis is not required for clinical laboratory services provided for nonpatients (TOB “141”).</p> <p><b>Exception:</b> A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.</p> <p><b>Note:</b> Diagnosis codes entered in 67K-67Q are not required for systematic claims processing.</p> <p>Required</p> <p>POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.</p> <p><b>Referto:</b> Section 5.7.2.10, “POA Indicators (for blocks 67 and 72)” in this chapter.</p> |
| 69        | Admit DX code                                    | <p>Enter the diagnosis code indicating the cause of admission or include a narrative.</p> <p><b>Note:</b> The admitting diagnosis is only for inpatient claims.</p>   |
| 70a-70c   | Patient’s reason DX                              | <p>Optional</p> <p>New block indicating the client’s reason for visit on unscheduled outpatient claims.</p>   |
| 71        | Prospective Payment System (PPS) code            | <p>Optional</p> <p>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.</p>  |
| 72a-72c   | External cause of injury (ECI) and POA indicator | <p>Required</p> <p>Enter the diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis.</p> <p>POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.</p> <p><b>Referto:</b> Section 5.7.2.10, “POA Indicators (for blocks 67 and 72)” in this chapter.</p>  |
| 74        | Principal procedure code and date                | <p>Enter the HCPCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</p> <p><b>Note:</b> HASC providers enter only one CPT procedure code for the inclusive global fee.</p>  |
| 74a-74e   | Other procedure codes and dates                  | <p>Enter the HCPCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</p>   |



| Block No. | Description        | Guidelines  |
|-----------|--------------------|---|
| 76        | Attending provider | <p>Enter the attending provider name and identifiers.<br/>NPI number of the attending provider.</p> <p>For inpatient claims enter the NPI of the provider who perform the service or procedure or is responsible for the treatment and plan of care (POC).</p> <p>For outpatient claims enter the NPI of the physician who referred the client to the hospital.</p>   |
| 77        | Operating          | <p>Enter name (last name and first name) and NPI number of the operating provider (the individual with the primary responsibility for performing the surgical procedures).</p> <p>Required when a surgical procedure codes is listed on the claim.</p>  |
| 78-79     | Other provider     | <p>Other provider's name (last name and first name) and NPI.</p> <p>Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved.</p> <p>Designated physician—For a limited client when the physician performed or authorized nonemergency care.</p> <p>Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure.</p> <p><b>Note:</b> <i>If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.</i></p> |

| Block No. | Description                      | Guidelines  |
|-----------|----------------------------------|---|
| 80        | Remarks                          | <p>This block is used to explain special situations such as the following:</p> <ul style="list-style-type: none"> <li>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.</li> <li>If a client stays beyond dismissal time, indicate the medical reason if additional charge is made.</li> <li>If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician.</li> <li>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.</li> <li>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.</li> <li>If the services resulted from a family planning provider's referral, write "family planning referral."</li> <li>If services were provided at another facility, indicate the name and address of the facility where the services were rendered.</li> </ul> |
| 81A-81D   | Other identification (ID) number | Enter the CSHCN Services Program taxonomy code (non-NPI number) of the billing provider.  |

### 5.7.2.8 Client Status (for block 17)

| Code | Description   |
|------|---|
| 1    | Routine discharge   |
| 2    | Discharged to another short-term general hospital   |
| 3    | Discharged to SNF   |
| 4    | Discharged to intermediate care facility (ICF)  |
| 5    | Discharged to another type of institution   |
| 6    | Discharged to care of home health service organization  |
| 7    | Left against medical advice   |
| 8    | Discharged or transferred to home under care of a Home IV provider  |
| 9    | Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)   |
| 20   | Expired   |
| 30   | Still client (To be used only when the client has been in the facility for 30 consecutive days and payment is based on diagnosis-related group [DRG]) |
| 40   | Expired at home (hospice use only)  |
| 41   | Expired in a medical facility (hospice use only)  |
| 42   | Expired - place unknown (hospice use only)  |

| Code | Description   |
|------|---|
| 43   | Discharged or transferred to a federal hospital (such as a Veterans Administration [VA] hospital)                                   |
| 50   | Hospice-Home  |
| 51   | Hospice-Medical facility  |
| 61   | Discharged or transferred within this institution to a hospital-based Medicare approved swing bed                                   |
| 62   | Discharged or 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 or transferred to a nursing facility certified under Medicaid, but not certified under Medicare                          |
| 65   | Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital                                 |
| 66   | Discharged or transferred to a critical access hospital (CAH)   |
| 71   | Discharged to another institution of outpatient (OP) services   |
| 72   | Discharged to another institution   |

### 5.7.2.9 Occurrence Codes (for blocks 31 through 34)

Providers can refer to the National Uniform Billing Code website at [www.nubc.org](http://www.nubc.org) for the current list of occurrence codes.

### 5.7.2.10 POA Indicators (for blocks 67 and 72)

| Code  | Description             | Guidelines   |
|-------|-------------------------|--|
| Y     | Yes                     | Diagnosis was present at the time of admission.  |
| N     | No                      | Diagnosis was not present at the time of admission.  |
| U     | Unknown                 | Documentation is insufficient to determine if condition is present at time of inpatient admission.       |
| W     | Clinically undetermined | Provider is unable to clinically determine whether condition was present at time of inpatient admission. |
| Blank | Unreported/Not used     | Exempt from POA reporting.   |

### 5.7.2.11 Dental Claim Filing

Dental and orthodontia services must be billed using the American Dental Association (ADA) Dental Paper Claim Form or equivalent electronic format when requesting payment.

Providers are responsible for obtaining these forms from a supplier of their choice.

*Referto:* The ADA website at [www.ada.org](http://www.ada.org) for a sample of the ADA Dental Claim Form.

### 5.7.2.12 ADA Dental Claim Electronic Billing

Electronic billers must submit 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.

*Referto:* Chapter 41, “TMHP Electronic Data Interchange (EDI)” for more information about electronic billing.

### 5.7.2.13 Instructions for Completing the Paper ADA Dental Claim Form

The instructions describe the information that must be entered in each of the block numbers of the paper ADA Dental Claim Form. Thoroughly complete the dental claim form according to the instructions below to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

| Block No. | ADA Description  | Instructions   |
|-----------|--|--|
| 1         | Type of Transaction (Mark all applicable boxes)  | For the CSHCN Services Program, check Statement of Actual Services Box. The other two boxes are not applicable.  |
| 2         | Predetermination/Preauthorization Number   | Enter PAN if assigned by the CSHCN Services Program.   |
| 3         | Company/Plan Name, Address, City, State, ZIP Code  | Enter name and address of CSHCN Services Program Contractor payer where the claim is to be sent.   |
| 4         | Other Dental or Medical Coverage   | Check applicable box<br><br>If both Dental and Medical are marked, complete blocks 5-11 for dental only  |
| 5         | Name of Policyholder/Subscriber in #4  | This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.  |
| 6         | Date of Birth (MM/DD/CCYY)   | Enter insureds eight-digit date of birth (MM/DD/CCYY). This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment. |
| 7         | Gender   | Check insureds correct gender. This line refers to the insured and is not necessarily the client. May be parent or legal guardian of client receiving treatment.                               |
| 8         | Policyholder/Subscriber ID (SSN or ID#)  | Enter insureds subscriber identifier. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.                  |
| 9         | Plan/Group Number  | Enter insureds plan/group number. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.                      |
| 10        | Client's Relationship to Person Named in #5  | Enter insureds relationship to primary subscriber. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.     |
| 11        | Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, ZIP Code                  | Information on other insurance carrier, if applicable.   |
| 12        | Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code | Enter client's last name, first name, and middle initial exactly as written on the CSHCN Services Program Eligibility Form.  |
| 13        | Date of Birth (MM/DD/CCYY)   | Enter client's eight-digit date of birth (MM/DD/CCYY).   |
| 14        | Gender   | Check client's gender.   |
| 15        | Policyholder/Subscriber ID (SSN or ID#)  | Enter client's CSHCN Services Program number.  |
| 16        | Plan/Group Number  | Enter the benefit code, if applicable, of the billing provider.  |

| Block No. | ADA Description  | Instructions  |
|-----------|--|---|
| 17        | Employer Name  | Not applicable for the CSHCN Services Program.  |
| 18        | Relationship to Policyholder/Subscriber in #12 Above                       | Not applicable for the CSHCN Services Program.  |
| 19        | Reserved for Local Use   | Leave blank and skip to Item 20. (Field was previously used to report "Student Status")<br>Include the appropriate modifier.  |
| 20        | Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code | Must put client name information, same as in Block 12.  |
| 21        | Date of Birth (MM/DD/CCYY)   | Must put client's eight-digit date of birth information, same as in Block 13.   |
| 22        | Gender   | Must put client gender information, same as in Block 14.  |
| 23        | Client ID/Account # (Assigned by Dentist)                                  | <b>Optional</b> —Used by dental office to identify internal client account number. This block is not required to process the claim.   |
| 24        | Procedure Date (MM/DD/CCYY)  | Enter eight-digit date of service (MM/DD/CCYY).   |
| 25        | Area of Oral Cavity  | Not applicable for the CSHCN Services Program.  |
| 26        | Tooth System   | Not applicable for the CSHCN Services Program.  |
| 27        | Tooth Number(s) or Letter(s)   | Enter the Tooth ID as required for procedure code. Select the appropriate tooth number for permanent teeth (01–32 or the appropriate letter for primary teeth 0A through 0T).   |
| 28        | Tooth Surface  | Enter the Surface ID as required for procedure code using M (Mesial); F (Facial); B (Buccal or Labial); O (Occlusal); L (Lingual or Cingulum); D (Distal); and/or I (Incisal).  |
| 29        | Procedure Code   | Use appropriate <i>Current Dental Terminology</i> (CDT) procedure code.   |
| 29a       | Diagnosis Code Pointer   | Enter the letter(s) from Box 34 that identified the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.   |
| 29b       | Procedure Quantity   | Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in item 24. The default value is "01."   |
| 30        | Description  | Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).  |
| 31        | Fee  | Enter usual and customary charges for each line of service used. Charges must not be higher than the fees charged to private pay clients.   |
| 31a       | Other Fee(s)   | When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies. Identify the source of each payment date in Block 11.<br><br>If the client makes a payment, the reason for the payment must be identified in Block 11. |

| Block No. | ADA Description                    | Instructions   |
|-----------|------------------------------------|--|
| 32        | Total Fee                          | Enter the sum of all fees in Block 31. For multipage claims, enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim.<br><b>Note:</b> <i>Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.</i>   |
| 33        | Missing Teeth Information          | Mark an "X" on the number of the missing tooth. (For identifying missing permanent dentition only.)<br>Report missing teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant services procedures on a particular claim.  |
| 34        | Diagnosis Code List Qualifier      | Enter the appropriate code to identify the diagnosis code source:<br>Enter "AB= ICD-10" to identify the diagnosis code source.   |
| 34a       | Diagnosis Code(s)                  | Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".   |
| 35        | Remarks                            | Use the Remarks space for local orthodontia codes, a narrative explanation for exception to periodicity (Block 19), a facility name, address, and NPI if the place of treatment (Block 38) is not a provider's office, an emergency narrative (Block 45), or additional information, such as reports for 999 codes or multiple supernumerary teeth, or remarks codes.  |
| 36        | Client/Guardian signature          | Not applicable for the CSHCN Services Program.   |
| 37        | Subscriber signature               | Not applicable for the CSHCN Services Program.   |
| 38        | Place of Treatment                 | Enter the 2-digit place of service (POS) code for professional claims, which is a <i>Health Insurance Portability and Accountability Act</i> (HIPAA) standard.<br>Frequently used POS codes include the following: <ul style="list-style-type: none"> <li>• 11=Office</li> <li>• 12=Home</li> <li>• 21=Inpatient hospital</li> <li>• 22= Outpatient hospital</li> <li>• 31=Skilled nursing facility</li> <li>• 32= Nursing facility</li> </ul> <b>Note:</b> <i>All current POS codes are available online from the Centers for Medicare &amp; Medicaid Services (CMS).</i> |
| 39        | Enclosures                         | Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).<br>Field changed to report Yes/No instead of types and quantities of enclosures.  |
| 40        | Is Treatment For Orthodontics?     | Check <b>Yes</b> or <b>No</b> as appropriate.  |
| 41        | Date Appliance Placed (MM/DD/CCYY) | Not applicable for the CSHCN Services Program.   |

| Block No. | ADA Description                      | Instructions  |
|-----------|--------------------------------------|---|
| 42        | Months of Treatment Remaining        | Not applicable for the CSHCN Services Program.  |
| 43        | Replacement of Prosthesis?           | Not applicable for the CSHCN Services Program.  |
| 44        | Date Prior Placement (MM/DD/CCYY)    | Not applicable for the CSHCN Services Program.  |
| 45        | Treatment Resulting from             | Providers are required to check Other Accident box for emergency claim reimbursement. If Other Accident box is checked, information about the emergency must be provided in Block 35. |
| 46        | Date of Accident (MM/DD/CCYY)        | Not applicable for the CSHCN Services Program.  |
| 47        | Auto Accident State                  | Not applicable for the CSHCN Services Program.  |
| 48        | Name, Address, City, State, ZIP Code | Name and physical address of the billing group or individual provider (not the name and address of a provider employed within a group).   |
| 49        | NPI                                  | Enter required billing dentist's NPI for a group or an individual (not the NPI for a provider employed within a group).   |
| 50        | License Number                       | Not applicable for the CSHCN Services Program.  |
| 51        | SSN or TIN                           | Not applicable for the CSHCN Services Program.  |
| 52        | Telephone Number                     | Enter area code and telephone number of billing group or individual (not the telephone number of a provider employed within a group).   |
| 52A       | Additional Provider ID               | Enter the taxonomy code assigned to the billing dentist or dental entity (not the CSHCN Services Program employed within a group).  |
| 53        | Signed (Treating Dentist)            | Required signature of treating dentist or authorized personnel.   |
| 54        | NPI                                  | Enter the performing dentist's (provider who treated the client).   |
| 55        | License Number                       | Not applicable for the CSHCN Services Program.  |
| 56        | Address, City, State, ZIP Code       | Not applicable for the CSHCN Services Program.  |
| 56A       | Provider Speciality Code             | This block is optional.   |
| 57        | Telephone Number                     | Not applicable for the CSHCN Services Program.  |
| 58        | Additional Provider ID               | Required information—must enter taxonomy code for the performing dentist (provider who treated the client).   |

### 5.7.2.14 Electronic Claims Submission

TMHP uses the HIPAA-compliant 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](http://www.tmhp.com) or through billing agents who interface directly with the TMHP Electronic Data Interchange (EDI) Gateway. 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.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for more information about electronic claims submission.

### 5.7.2.15 Taxonomy Codes

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.

Group billing providers are no longer required to submit the taxonomy code on electronic claims. Group billing providers can submit the taxonomy code to assist with the NPI crosswalk.

### 5.7.2.16 Dates on Claims

All dates (such as date of birth and date of service) entered on the claim (electronic and paper) must be eight digits in MMDDYYYY format.

**Example:** August 6, 2019, is entered as 08062019.

### 5.7.2.17 Span Dates

Providers currently submitting paper claims and that have provided services on consecutive days may bill multiple consecutive days per claim detail as long as the dates are in the same month and year. Providers must indicate (in the quantity billed) the number of dates they are billing.

**Example:** Services were provided each day from August 6, 2019, to August 16, 2019. When submitting the paper claim, enter the from date of service as 08062019 and the to date of service as 08162019. The quantity is 11.

**Note:** Claims submitted with a quantity billed not equal to the number of days indicated in the date of service blocks are denied. When the claim is processed, the system creates multiple details consisting of four consecutive days each so that the claim appears on the provider’s R&S Report with one detail for each 4 days billed. Using the example above, there are three details as illustrated below.

If the number of details created during this process is greater than 28, the claim is denied for exceeding the maximum details per claim, and the provider must resubmit the claim, dividing the dates of service into multiple claims, to convey complete billing information.

| Detail | From DOS | To DOS   | Qty Billed |
|--------|----------|----------|------------|
| 1      | 08062019 | 08092019 | 4          |
| 2      | 08102019 | 08132019 | 4          |
| 3      | 08142019 | 08162019 | 3          |

### 5.7.2.18 Hospital Billing

Hospitals submitting inpatient claims on paper may submit up to 61 service lines per claim. When the claim is submitted, the system performs a merge function that combines like revenue codes to reduce the number of service lines to 28 or less. Because of the merge function, it is important to understand that when the claim appears on the R&S Report the provider does not see the 61 service lines submitted, but rather the results of merged details. If the merge function is unable to merge the number of service lines to 28, the claim is denied for exceeding the maximum details per claim, and the claim needs to be subdivided and resubmitted as multiple claims.

For more information on electronic claim submission, contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.



### 5.7.2.19 Group Billing

Providers billing as a group must give the NPI and taxonomy code of the individual rendering the services on their claims as well as the group provider NPI. To be eligible for reimbursement, both the group and the performing provider must be enrolled in the CSHCN Services Program.

### 5.7.3 Supervising Physician Provider Number Required on Some Claims

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

If a referral or order for services is based on a client evaluation that was performed by the supervised provider, the claim from the performing provider must include the names and National Provider Identifiers (NPIs) of both the ordering provider and the supervising provider for Children with Special Health Care Needs (CSHCN) Services Program clients. The performing provider will need to obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

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

### 5.7.4 Ordering/Referring Provider NPI

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

- If the ordering or referring provider is enrolled in the CSHCN Services Program as a billing or performing provider, the billing or performing provider NPI can be used.
- If the ordering or referring provider is not currently enrolled in the CSHCN Services Program as a billing or performing provider, the provider can enroll to receive an ordering or referring-only NPI. The provider will receive one NPI that can be used for orders and referrals for both Texas Medicaid clients and CSHCN Services Program clients.

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

Claims that are submitted without the ordering or referring provider's NPI may be subject to retrospective review and denial if the NPI is not included on the claim.

## 5.8 Reimbursement

CSHCN Services Program reimbursements are available to all actively enrolled providers either by check or electronic funds transfer (EFT). Through EFT, TMHP deposits reimbursements directly into a provider's bank account. Active providers do not have any type of payment holds on their enrollment status.

The CSHCN Services Program reimburses hospitals, physicians, and other suppliers of service. Each section of this manual gives more detail concerning the methods used to reimburse each provider specialty for claims processed by TMHP. The following information is provided as an overview of the CSHCN Services Program reimbursement methodology.

The CSHCN Services Program implemented rate reductions for certain services. The Online Fee Lookup (OFL) includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## **5.8.1 Electronic Funds Transfer (EFT)**

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

### **5.8.1.1 Advantages of EFT**

The advantages of EFT are:

- Stop payments are no longer necessary because no paper is involved in the transaction process.
- Payment theft is less likely to occur because the process is handled electronically rather than by paper.
- Deposited funds are available for withdrawal within a few days after completion of the TMHP financial cycle.
- Upon deposit, the bank considers the transaction immediately collected. No float is attached to EFT deposits for CSHCN Services Program funds.
- TMHP includes provider and R&S Report numbers with each transaction submitted. If the banks processing software captures and displays the information, both numbers would appear on the banking statement.

### **5.8.1.2 Enrollment Procedures**

Providers are strongly encouraged to participate in EFT. EFT does not require special software, and providers can enroll immediately. To enroll in EFT, complete the Electronic Funds Transfer (EFT) Maintenance Request through the TMHP Provider Enrollment and Management System (PEMS).

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 begins to receive EFT transactions with the third cycle following the enrollment form processing. The provider continues to receive paper checks until they begin to receive EFT transactions.

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

### **5.8.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission**

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

**Referto:** Section 24.3.7, “Payment Window Reimbursement Guidelines” in Chapter 24, “Hospital” for additional information about the payment window reimbursement guidelines for inpatient admission.

### **5.8.2 Texas Medicaid Reimbursement Methodology (TMRM)**

The CSHCN Services Program reimburses physicians based on the TMRM. This methodology is used to reimburse the following services and tests:

- Physician services
- Services incidental to physician’s services
- Diagnostic tests (other than clinical laboratory)
- Radiology services

TMRM is based on Medicare’s resource-based relative value scale (RBRVS) with Medicaid modifications.

Refer to individual provider chapters for specific information about reimbursement.

### **5.8.3 Maximum Allowable Fee Schedule**

Physicians/supplier services that are not reimbursed according to TMRM or reasonable charge may be reimbursed according to a maximum fee schedule. Maximum fee schedules are determined by state and federal regulations.

### **5.8.4 Manual Pricing**

Certain procedure codes do not have an established fee and must be priced manually by the TMHP-CSHCN Services Program medical staff. The medical staff determines the reimbursement amount by comparing the services to other services that require a similar amount of skill and resources.

If an item requires manual pricing, providers must submit with the prior authorization request or the claim, the appropriate procedure codes and documentation of one of the following, as applicable:

- The manufacturer’s suggested retail price (MSRP) or average wholesale price (AWP)
- The provider’s documented invoice cost if a published MSRP or AWP is not available

**Note:** *The AWP is for nutritional products only. For appropriate processing and payment, providers should bill the applicable MSRP or AWP rate instead of the calculated manual pricing rate. The calculated rate or the Pay Price that is indicated on the authorization letter for prior authorized services should not be billed on the claim.*

Claims for authorized procedure codes that are manually priced must list the claims detail information in the same order as itemized on the authorization letter.

### **5.8.5 Physician Services in Hospital Outpatient Setting**

Section 104 of the *Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)* requires the CSHCN Services Program to limit reimbursement of physician services furnished in a hospital outpatient setting that are also ordinarily furnished in a physician’s office. The limit for each service is determined by establishing a charge base for each professional service and multiplying the charge base by 0.60. The charge base for a service is the TMRM fee for similar services furnished in the office.

This provision applies to those procedures performed in the outpatient department of the hospital, such as in clinics and emergency departments. When the eligible client is seen in the outpatient department of the hospital in an emergency situation, the condition that created the emergency must be documented on the claim form.

The following services are excluded from this limitation:

- Surgical services that are covered by ambulatory surgical center (ASC) 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 may be reasonably expected to result in one of the following outcomes:
  - Serious jeopardy to the client's health
  - Serious impairment to bodily functions
  - Serious dysfunction of any body organ or part

### **5.8.6 Inpatient Hospital Reimbursement**

The reimbursement methodology for many CSHCN Services Program facilities that are reimbursed based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) has changed to the prospective payment methodology based on All Patient Refined Diagnosis Related Groups (APR-DRG) payment system.

Hospitals that are enrolled in the CSHCN Services program must first be enrolled in Texas Medicaid. The CSHCN Services Program reimbursement methodology has changed from TEFRA to APR-DRG. The reimbursement methodology for hospitals that are reimbursed by Texas Medicaid using APR-DRG also applies for the CSHCN Services Program. This reimbursement methodology applies to all hospitals except for state-owned teaching hospitals and inpatient psychiatric facilities.

The reimbursement method will not affect inpatient benefits and limitations. Inpatient admissions will continue to require prior authorization.

**Note:** *The 20-percent payment reduction that is currently applied to inpatient claims by the CSHCN Services Program will remain in effect.*

**Referto:** Section 24.3.2, "Hospital Reimbursement" in Chapter 24, "Hospital" for more information about hospital reimbursement.

#### **Prospective Payment Methodology**

The prospective payment methodology is based on a DRG payment system. Reimbursement based on DRG includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. Claims may not be submitted for technical services.

The CSHCN Services Program does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, providers may submit only one claim for each inpatient stay. The claim must include appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form or electronic equivalent, to be considered for payment.

The number of days of care charged for a client for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a client returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a client begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to \$200,000 per client, per benefit year (January 1 through December 31) for clients who are 21 years of age and older. Claims may be subject to retrospective review, which may result in recoupment.

### **5.8.7 Fees**

Providers can now access the online fee lookup (OFL) function on the TMHP website at [www.tmhp.com](http://www.tmhp.com) and do the following:

- Retrieve fee schedule information in real time
- Search for procedure code reimbursement rates individually, in a list, or in a range
- Search and review their contracted rates
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period
- Perform an online, interactive search of benefit information that has been published within the past 18 months for up to ten procedure codes.

#### **5.8.7.1 Provider-Specific Rates for Procedure Codes with Modifiers and Age-Range Criteria**

Providers with contracted rates may also use the OFL on the TMHP website to view provider-specific rates for procedure codes that have modifiers and age range criteria.

Providers may view their provider-specific rates for procedure codes with modifiers and age range criteria by completing the following steps:

- 1) Access the secure portion of the TMHP website at [www.tmhp.com](http://www.tmhp.com)
- 2) Click **Resources**
- 3) Click **Online Fee Lookup**
- 4) Click **Fee Search**
- 5) Select or Enter the following:
  - a) NPA/API/Taxonomy/Address/ZIP+4/ Benefit Code
  - b) Program Code
  - c) Procedure Code
  - d) Date of Service
  - e) Modifier 1 (if applicable)
  - f) Modifier 2 (if applicable)
  - g) Modifier 3 (if applicable)
  - h) Modifier 4 (if applicable)
  - i) From Age, in years (if applicable)
  - j) To Age, in years (if applicable)
- 6) Click **Submit**

The Contracted Rate Search results page features a display of contracted rate search criteria and additional columns and rows to display search results. The Contracted Rate Search results page displays the following:

- Rate Type
- Rate
- Start Date
- End Date (if end-dated)
- Modifiers (if applicable)
- Client From and To Age (if applicable)

### **5.8.8 CSHCN Services Program Reimbursement Information for Clients**

The CSHCN Services Program may reimburse clients for drug copays and transportation of remains when there is an accompanying parent or other responsible person.

Clients may call TMHP at 1-877-888-2350, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for additional information.

Clients may also receive reimbursement for insurance premiums through the Insurance Premium Payment Assistance (IPPA) program. For additional information, clients may call the TMHP-IPPA toll-free client help line at 1-800-440-0493, Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

### **5.9 CSHCN Services Program Accounts Receivables (Using Medicaid Funds to Satisfy the AR)**

A service that is rendered to a CSHCN Services Program client who receives retroactive Medicaid eligibility may be reimbursed by the CSHCN Services Program or by Medicaid, but not by both.

The CSHCN Services Program is the payer of last resort. The CSHCN Services Program does not supplement a client's Medicaid benefits. However, services that are not a benefit of Medicaid may be covered by the CSHCN Services Program. If dual Medicaid and CSHCN Services Program eligibility is determined, claims that have already been paid by the CSHCN Services Program will be reprocessed under the appropriate program.

An accounts receivable (AR) is created for each CSHCN Services Program claim that is reprocessed and subsequently reimbursed under Medicaid so that the amount the CSHCN Services Program originally reimbursed can be returned to the CSHCN Services Program.

If the CSHCN Services Program payout during the week's financial cycle in which the claim was reprocessed is not sufficient to satisfy the AR, the provider's Medicaid claim payouts will be used to satisfy the CSHCN Services Program AR.

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

If the CSHCN Services Program AR is not satisfied within 45 days, TMHP will send the provider a notice that requests repayment to the CSHCN Services Program for the remaining AR balance.

### **5.10 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# REMITTANCE AND STATUS (R&S) REPORTS

CSHCN SERVICES PROGRAM PROVIDER MANUAL

FEBRUARY 2024



# REMITTANCE AND STATUS (R&S) REPORTS

## Table of Contents

|            |  |           |
|------------|--|-----------|
| <b>6.1</b> | <b>R&amp;S Report Information</b>                                | <b>3</b>  |
| 6.1.1      | Electronic Remittance and Status (ER&S) Reports                  | 3         |
| 6.1.2      | Banner Pages   | 4         |
| 6.1.3      | Explanation of R&S Report Row Headings                           | 4         |
| 6.1.4      | Explanation of R&S Report Section Headings                       | 6         |
| 6.1.4.1    | Claims—Paid or Denied  | 6         |
| 6.1.4.2    | Adjustments to Claims  | 7         |
| 6.1.4.3    | Financial Transactions   | 7         |
| 6.1.4.3.1  | Accounts Receivable  | 7         |
| 6.1.4.3.2  | IRS Levies   | 8         |
| 6.1.4.3.3  | Payouts  | 9         |
| 6.1.4.3.4  | Claim Reissues   | 9         |
| 6.1.4.3.5  | Claim Voids  | 9         |
| 6.1.4.3.6  | Claim Refunds  | 9         |
| 6.1.4.4    | Financial Transactions/Void and Stop—“Stale-Dated Checks”        | 10        |
| 6.1.5      | Claims Payment Summary   | 10        |
| 6.1.5.1    | Claims In Process  | 11        |
| 6.1.5.2    | EOB and EOPS Codes Section                                       | 11        |
| 6.1.6      | R&S Report Examples  | 12        |
| 6.1.6.1    | Physician R&S Report Example: Banner Page                        | 13        |
| 6.1.6.2    | Physician R&S Report Example: Blank Page                         | 14        |
| 6.1.6.3    | Physician R&S Report Example: Claims – Paid or Denied            | 15        |
| 6.1.6.4    | Physician R&S Report Example: Blank Page                         | 16        |
| 6.1.6.5    | Physician R&S Report Example: Payment Summary Page               | 17        |
| 6.1.6.6    | Physician R&S Report Example: Explanation of Benefits (EOB) Page | 18        |
| 6.1.6.7    | Ambulatory Surgical Center (ASC) R&S Report Example: Banner Page | 19        |
| 6.1.6.8    | ASC R&S Report Example: Adjustments R&S Report                   | 20        |
| 6.1.6.9    | ASC R&S Report Example: Blank Page                               | 21        |
| 6.1.6.10   | ASC R&S Report Example: Adjustments R&S Report                   | 22        |
| 6.1.6.11   | ASC R&S Report Example: Adjustments R&S Report                   | 23        |
| 6.1.6.12   | ASC R&S Report Example: Adjustments R&S Report                   | 24        |
| 6.1.6.13   | ASC R&S Report Example: Blank Page                               | 25        |
| 6.1.6.14   | ASC R&S Report Example: Claims in Process R&S Report             | 26        |
| 6.1.6.15   | ASC R&S Report Example: Claims in Process R&S Report             | 27        |
| 6.1.6.16   | ASC R&S Report Example: Payment Summary Page                     | 28        |
| 6.1.6.17   | ASC R&S Report Example: Explanation of Benefits (EOB) Page       | 29        |
| <b>6.2</b> | <b>TMHP-CSHCN Services Program Contact Center</b>                | <b>30</b> |



## 6.1 R&S Report Information

The R&S Report provides information on pending, paid, denied, adjusted, and incomplete claims. TMHP provides R&S Reports to give providers detailed information about the status of claims submitted to TMHP. The R&S Report also identifies receivables resulting from inappropriate payments. These receivables are recouped from payments of subsequent claim submissions.

Providers receive an R&S Report for each National Provider Identifier (NPI) with claim activity.

Providers can determine the program associated with the R&S Report by looking at the top center of the R&S Report. The line below Texas Medicaid & Healthcare Partnership identifies the program associated with the R&S Report.

Online R&S Reports are available as a PDF every Monday morning at 6 a.m., Central Time, following the claims processing cycle. Providers must have a provider administrator account on the TMHP website at [www.tmhp.com](http://www.tmhp.com) to receive online R&S Reports.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic billing.

Providers must retain copies of all R&S Reports for a minimum of 5 years. Do not send original R&S Reports back to TMHP; instead, submit copies of the R&S Reports when submitting a corrected claim or when resubmitting a previously incomplete claim.

Samples of the R&S Report are provided at the end of this chapter. The R&S Report provides information using the following general formatting guidelines:

- Information is displayed in rows rather than columns
- Incomplete claims appear in the “Claims — Paid or Denied” section
- Explanation of benefits (EOB) and explanation of pending status (EOPS) codes are five characters in length (up to four messages can be displayed at the claim level and up to five at the detail level)
- Descriptions of EOBs and EOPS are in an appendix at the end of the R&S Report
- Financial transactions appear in one of the following categories: accounts receivable, Internal Revenue Service (IRS) levies, claim refunds, payouts (system and manual), claim reissues, and claim voids
- The internal control number (ICN) is 24 digits
- The primary diagnosis submitted on the claim appears with the claim header information

### 6.1.1 Electronic Remittance and Status (ER&S) Reports

Using *Health Information Portability and Accountability Act (HIPAA)*-compliant Electronic Data Interchange (EDI) standards, the ER&S Report can be downloaded through the TMHP-EDI Gateway using TexMedConnect or third-party software. ER&S Reports contain the same information as a paper R&S Report and can be downloaded in any format.

ER&S Reports are available on the Monday following the weekly claims processing cycle. To obtain an ER&S Report, providers must complete and submit an ER&S Agreement. The ER&S Agreement is located in the Forms section of the EDI page on the TMHP Provider home page at [www.tmhp.com](http://www.tmhp.com) and can be submitted to the TMHP-EDI help desk by mail or by fax to 1-512-514-4228.

Additional information about ER&S Reports can be accessed via the EDI companion guide ANSI ASC X12N 835. Companion guides are available in the Technical Information section of the EDI Provider home page on the TMHP website.

### 6.1.2 Banner Pages

Banner pages are used to inform providers of changes in policies, claims, and procedures. The title pages include the following information:

- TMHP address for submitting paper copies of corrected and resubmitted claims
- Provider's name, address, and telephone number
- Unique R&S Report number specific to each report
- NPIs
- Report sequence number (a cumulative number of R&S Reports the provider has received for the calendar year)
- Date of the week reported on the R&S Report
- Federal tax identification number
- Page number (the R&S Report begins with page 1)
- Automated Inquiry System (AIS) telephone number for AIS inquiry calls
- Taxonomy code
- Benefit code

### 6.1.3 Explanation of R&S Report Row Headings

| Row Heading/Section | Explanation   |
|---------------------|---|
| Patient name        | Lists the client's last name and first name as indicated on the provider's claim. This field is truncated to display 13 characters. |

| Row Heading/Section                                 | Explanation   |
|---|---|
| Claim number  | <p>The 24-digit ICN assigned by TMHP for a specific claim. The format for the TMHP claim number is <b>PPCCMMYYJJBBBBSS</b>.</p> <p><b>PPP:</b> COMPASS21 Program<br/>                     400: CSHCN Services Program Code<br/> <b>CCC:</b> Claim Type<br/>                     020: Physician supplier/Genetics<br/>                     021: Dental<br/>                     023: Outpatient hospital/Home Health Agency (HHA)<br/>                     040: Inpatient hospital<br/>                     060: Medical Transportation Program<br/> <b>MMM:</b> Media Source (Region)<br/>                     010: Paper<br/>                     011: Paper adjustment<br/>                     020: TDHconnect<br/>                     021: TDHconnect adjustment<br/>                     030: Electronic (including TexMedConnect)<br/>                     031: Electronic adjustment (including TexMedConnect)<br/>                     041: AIS adjustment<br/>                     051: Mass adjustment<br/>                     071: Retroactive eligibility adjustment<br/>                     080: State action request<br/>                     081: State action request adjustment<br/>                     110: Postal mail<br/>                     990: Default media type<br/>                     991: Default/summary for all adjustments<br/>                     999: Default/summary for all media regions<br/> <b>YYYY:</b> Year in which the claim was received<br/> <b>JJJ:</b> Julian date on which the claim was received<br/> <b>BBBBB:</b> TMHP internal batch number<br/> <b>SSS:</b> TMHP internal claim sequence within the batch</p> |
| Benefit code  | These codes are submitted by the provider to identify state programs.   |
| CSHCN number  | The client’s CSHCN Services Program number.   |
| Medical record number                               | If a medical record number is used on the provider’s claim, that number appears here.   |
| EOB   | Any EOB code that applies to the entire claim (header level) prints here. Up to four EOB codes display at the header level.   |
| Diagnosis   | The primary diagnosis listed on the provider’s claim.   |
| Patient account number                              | If a client’s account number is used on the provider’s claim, that number appears here.   |
| Service dates                                       | Format MMDDYYYY (month, day, year) in <i>From</i> and <i>To</i> dates of service.   |
| Type of Service (TOS)/ Procedure/Accommodation Code | Indicates by code the specific service provided to the client. The two-digit TOS appears first, followed by a Healthcare Common Procedure Coding System (HCPCS) procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code.   |

| Row Heading/Section           | Explanation   |
|-------------------------------|---|
| Billed quantity               | Indicates the quantity billed per claim detail.   |
| Billed charge                 | Indicates the charge billed per claim detail.   |
| Allowed quantity              | Indicates the quantity allowed per claim detail.  |
| Allowed charge                | Indicates the charges allowed per claim detail.   |
| Place of service (POS) column | Includes the POS to the left of the Paid Amount. A two-digit numeric code identifying the POS is indicated in this field.   |
| Paid amount                   | The final amount allowed for payment per claim detail. Also appearing in this field is the amount paid by another insurance resource. The other insurance (OI) amount is preceded by a minus (-) symbol, and this amount is subtracted from the total of the paid amounts appearing in this field. The total paid amount for the claim appears on the claim total line. |
| EOB codes                     | These codes explain the payment or denial of the provider's claim. EOB codes are printed next to and directly below the claim. An explanation of all EOBs appearing on the R&S Report are printed in the appendix at the end of the R&S Report.   |
| EOPS code                     | The EOPS codes appear only in the "Claims In Process" section of the R&S Report. The codes explain the status of pending claims and are not an actual denial or final disposition.  |
| MOD                           | Modifiers describe and qualify the services that were provided. For dental services, two modifiers are printed. The first is the tooth identification (TID) and the second is the surface identification (SID).   |

## 6.1.4 Explanation of R&S Report Section Headings

### 6.1.4.1 Claims—Paid or Denied

The title, "Claims — Paid or Denied," is centered on the top of each page in this section. Claims in this section are finalized the week before preparation of the R&S Report. The claims are listed by claim status, claim type, and in client name order. The reported status of each claim does not change unless the provider, CSHCN Services Program, or TMHP initiates further action. TMHP *cannot* process incomplete claims.

Only paper claims are denied as incomplete. Incomplete claims may be submitted as original claims only if the resubmission is received by TMHP within the original filing deadline. Otherwise, the claim must be received within 120 days of the date on the R&S Report.

If a provider determines that a claim cannot be appealed electronically or through the Automated Inquiry System (AIS), the claim may be appealed on paper by completing the following steps:

- Submit a copy of the R&S Report page on which the claim is paid or denied. A copy of any other official notification from TMHP may also be submitted.
- Submit one copy of the R&S Report for each claim appealed.
- Circle only one claim per R&S Report page.
- Identify the reason for the appeal.
- If applicable, indicate the incorrect information and provide the correct information that should be used to appeal the claim.
- 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.

**Referto:** Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

Chapter 7, “Appeals and Administrative Review.”

Claims filed electronically without required information are *rejected*. Users are required to retrieve the response file to determine the reason for rejections. Providers receiving TMHP EDI rejections may resubmit an electronic claim within 95 days from the date of service.

A paper appeal may also be submitted with a copy of the rejection report. Appeals must be received by TMHP within 120 days of the rejection report date to be considered. A copy of the rejection report must accompany each corrected claim submitted on paper.

#### **6.1.4.2 Adjustments to Claims**

The title, “Adjustments to Claims,” is centered at the top of each page in this section. Adjustments are listed by claim type, client name, and CSHCN Services Program client number. Media types 011, 021, 031, 041, 051, 071, and 081 appear in this section. An adjustment is printed 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. The dollar amounts on the original claim are followed by a minus (-) symbol indicating the original payment is voided.

The net adjustment amount is the difference between the claim total for the original claim and the claim total for the adjusted claim. If the total amount of money to be recouped is not available on the current R&S Report, it is taken from future payments.

EOB 00601 prints the following message below the claim indicating the amount is to be recouped later: “A receivable has been established in the amount of the original payment: \$\_\_\_\_\_. Future payments will be withheld or reduced until such amount is paid in full.”

When an adjustment is set up (EOB 00601) and enough money is available on the next R&S Report, EOB 00097 prints, “Payment adjusted on following client.” The original ICN and R&S Report date appears. The dollar amount to be recouped is listed in the Original Amount column. The amount changes until all money is recouped.

In the “Adjustments to Claims” section, the amount identifying the net difference (difference between the original claim payment and the adjusted claim payment) appears below the prior claim payment. If the net difference is a positive amount, the amount is added to the amount of the current check. If the net difference is a negative amount, a minus sign appears before the dollar amount, and that amount is deducted from the amount of the current check.

#### **6.1.4.3 Financial Transactions**

All accounts receivables, IRS levies, payouts, refunds, reissues, and voids appear in this section of the R&S Report. The financial transactions section does not use the R&S Report form column headings. Additional subheadings are printed to identify the financial transactions. References to fiscal year end (FYE) represent the provider’s FYE based on cost report information and does not apply to all providers. The following are descriptions of the six types of financial transactions.

##### **6.1.4.3.1 Accounts Receivable**

Accounts receivable identifies money that was subtracted from the provider’s current payment because it is owed to the CSHCN Services Program. Specific claim data is not given on the R&S Report unless the accounts receivable setup is claim-specific. An accounts receivable control number is provided that should be referenced when corresponding with TMHP. If the withholding amount is related to a specific

claim and not an EOB 00601 (as described in Section 6.1.4.2, “Adjustments to Claims” in this chapter), a separate letter with this information is sent to the provider. Accounts receivable appears on the R&S Report in the following format:

| Row Heading/Section                | Explanation  |
|------------------------------------|--|
| Control number                     | A control number that should be referenced when corresponding with TMHP.   |
| Recoupment rate                    | The percentage of the provider’s payment 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 or month. This field is blank if the provider elects to have a percentage withheld each week or month. |
| Original date                      | The date the financial transaction was originally processed.   |
| Original amount                    | The total amount owed to the CSHCN Services Program.   |
| Prior date                         | The date the last transaction on the accounts receivable occurred.   |
| Prior balance                      | The amount owed from a previous R&S Report.  |
| Applied amount                     | The amount subtracted from the current R&S Report.   |
| FYE                                | The fiscal year end for cost reports.  |
| EOB                                | The EOB code that corresponds to the reason code for the accounts receivable.  |
| Patient name                       | If the accounts receivable is claim specific, the name of the client listed on the claim.  |
| Claim number                       | If the accounts receivable is claim specific, the ICN of the original claim.   |
| Balance                            | Indicates the total outstanding accounts receivable (AR) balance that remains due.   |

6.1.4.3.2 IRS Levies

If TMHP receives a notice from the IRS of a levy against a provider, payments will be withheld from the provider’s payment. These are displayed in the IRS Levies 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:

| Row Heading/Section       | Explanation  |
|---------------------------|--|
| Control number            | Control number to reference when corresponding with TMHP.  |
| Maximum recoupment rate   | The percentage of the provider’s payment withheld each week unless the provider elects to have a specific amount withheld each week. |
| Maximum recoupment amount | The amount to be withheld on a periodic basis. This field is blank if the provider elects to have a percentage withheld each week.   |
| Original date             | The date the levy was originally set up.   |
| Original amount           | The total amount owed to the CSHCN Services Program.   |
| Prior balance             | The amount owed from a previous R&S Report.  |
| Prior update              | The date the last transaction on the levy occurred.  |
| Current amount            | The amount subtracted from the current R&S Report.   |
| Remaining balance         | The amount still owed on the levy (this amount becomes the previous balance on the next R&S Report).                                 |

**6.1.4.3.3 Payouts**

Payouts are dollar amounts owed to the provider. TMHP processes two types of payouts: system payouts that increase the weekly payment amount and manual payouts or refunds that result in a separate payment issued to the provider. Specific claim data is not given on the R&S Report for payouts. If the payout is claim-related, a separate letter with this information is sent to the provider. A control number is given that should be referenced when corresponding with TMHP.

Payouts appear on the R&S Report in the following format:

| Row Heading/Section   | Explanation   |
|-----------------------|---|
| Payout control number | Control number to reference when corresponding with TMHP.       |
| Payout amount         | Amount of the payout.   |
| FYE                   | The fiscal year for which this refund is applicable.            |
| EOB                   | The EOB code that corresponds to the reason code assigned.      |
| Refund check number   | The number of the refund check issued by TMHP.                  |
| Refund check amount   | The amount of the refund check mailed to the provider.          |
| Patient name          | The name of the client (if available).                          |
| PCN                   | The CSHCN Services Program number of the client (if available). |
| DOS                   | The date of service (if available).                             |

**6.1.4.3.4 Claim Reissues**

Claim reissues are identified by EOB 00122, “This claim is a reissue of a previous claim.” For example, EOB 00122 is used if a check is lost in the mail and must be reissued to the provider. The message follows each claim that was reissued. Every claim paid on the original check is reprinted in the financial section. The claims appear on the R&S Report in the following format:

| Row Heading/Section | Explanation                            |
|---------------------|--|
| 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.   |

**6.1.4.3.5 Claim Voids**

Claim voids are identified by EOB 00134, “Voided claims – this amount has been credited to your net IRS liability.” This occurs when the TMHP check has been returned and voided. Claims originally paid on the check are listed and the amounts credited to the provider’s 1099. Claim voids are printed in the same format as claim reissues.

**6.1.4.3.6 Claim Refunds**

Claim refunds are identified by EOB 00124, “Thank you for your refund; your 1099 liability has been credited.” This message verifies that money refunded to the CSHCN Services Program for incorrect payments was 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:

| Row Heading/Section | Explanation   |
|---------------------|---|
| ICN                 | The claim number of the claim to which the refund was applied this cycle.       |
| Patient name        | The client’s first name, middle initial, and last name on the applicable claim. |

| Row Heading/Section       | Explanation  |
|---------------------------|--|
| CSHCN number              | The client’s CSHCN Services Program number.                            |
| Date of service           | The format MMDDYYYY (month, day, year) in <i>From</i> date of service. |
| Total billed              | The total billed amount of the refunded claim.                         |
| Amount applied this cycle | The refund amount applied to the claim.                                |
| EOB                       | The EOB code that corresponds to the reason code assigned.             |

**6.1.4.4 Financial Transactions/Void and Stop—“Stale-Dated Checks”**

Stale-dated checks (i.e., checks older than 180 days) that have not been cashed are voided and applied to either IRS levies or outstanding accounts receivable. Once a check has been voided, the associated claims may not be payable, and the transaction will be finalized after 24 months. Providers may submit a voided check appeal to TMHP Cash Financial at the following address:

Texas Medicaid & Healthcare Partnership  
 Attn: Cash Financial  
 12365-A Riata Trace Parkway  
 Austin, TX 78727

The CSHCN Services Program encourages providers to receive payment via electronic funds transfer (EFT) to eliminate stale-dating issues. EFT ensures that providers receive payments via direct deposit in a bank account of their designation. To enroll in EFT, use the [Electronic Funds Transfer \(EFT\) Notification](#) or call the TMHP Contact Center at 1-800-568-2413, Monday through Friday from 7 a.m. to 7 p.m., Central Time, and select Option 2.

*Referto:* Chapter 41, “TMHP Electronic Data Interchange (EDI).”

**6.1.5 Claims Payment Summary**

This section summarizes payments, adjustments, and financial transactions listed on the R&S Report. The section has two categories: one for the current weeks totals and one for the year-to-date totals.

*Example:* If the provider is receiving a payment on this particular R&S Report, the following information is given: “Payment summary for check number (check #) or (directly deposited by EFT) in the amount of (\$amount). Note that items marked with an asterisk (\*) do not affect your 1099 earnings.” The check number is also printed on the check that accompanies the R&S Report.

The Claims Payment Summary appears on the R&S Report in the following format:

| Heading                                    | Explanation  |
|--|--|
| Claims paid                                | The number of claims processed for the week, as well as the year-to-date total.                          |
| System payouts                             | The total amount of system payouts issued to the provider by TMHP.                                       |
| Manual payouts                             | The total amount of manual payouts issued to the provider by TMHP (remitted by a separate check or EFT). |
| Amount paid to IRS for levies              | The amount remitted to the IRS and withheld from the provider’s payment due to an IRS levy.              |
| Amounts paid to IRS for backup withholding | The amount paid to the IRS for backup withholding.   |
| Accounts receivable recoupment             | The total amount withheld from the provider’s payment for accounts receivable.                           |



| Heading                        | Explanation  |
|--------------------------------|--|
| Amounts stopped or voided      | The total amount of the payment that was voided or stopped with no reissuance of payment.  |
| System reissues                | The amount of the reissued payment.  |
| Claims related refunds         | The net amount allowed for the week's payment. If there are no adjustments recouping money showing negative paid amounts, the claim's amount is the total of all paid amounts on the individual claims. If there are adjustments showing negative paid amounts, the claim's amount is the total paid amount minus 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.  |
| Amount affecting 1099 earnings | The amount added for this week to the provider's earnings. This figure is the claim's amount minus any withheld or credit amounts. This column also shows weekly and year-to-date totals. The year-to-date IRS amount is the net total of reportable payments for tax purposes.  |
| Held amount                    | The total amount withheld from the provider's payment.   |
| Payment amount                 | Amount of the payout   |
| Pending claims                 | The total amount billed for claims in process beginning with the cutoff date for the report.   |

#### 6.1.5.1 Claims In Process

Claims that are in process appear in the section titled "The Following Claims are Being Processed." The R&S Report may list up to five EOPS messages per claim. The claims listed in this section are in process and *cannot* be resubmitted for any reason until they appear in either the "Claims - Paid or Denied," or "Adjustments - Paid or Denied" sections of the R&S Report. TMHP lists the pending status of these claims only for informational purposes. The pending messages should not be interpreted as a final claim disposition.

All claims and claims resubmitted for reconsideration that TMHP has in process are listed on the R&S report weekly. TMHP provides the following information on the R&S Report:

- Client name
- Claim number
- EOPS
- *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM) number
- Initial date of service
- Billed charge (total billed)

#### 6.1.5.2 EOB and EOPS Codes Section

The "Explanation of Benefits Codes Messages" section lists the descriptions of all EOBs and EOPS that appeared on the R&S Report. EOBs and EOPS appear in numerical order.

Electronic Data Interchange ANSI X12 5010 835 files will 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 will include the CARC, CAGC, and RARC explanation codes that are associated with the highest priority detail EOB to provide a clearer explanation for the denial.

### **6.1.6 R&S Report Examples**

The following pages provide examples of R&S Reports.

6.1.6.1 Physician R&S Report Example: Banner Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

Mail original claim to: TEXAS PROVIDER  
CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 848484  
P.O. Box 200855 DALLAS, TX 75888-1234  
Austin, Texas 78720-0855 (214) 555-4141

Mail all other correspondence to: TPI: 1234567-01  
CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 1234567890  
12357-B Riata Trace Parkway Taxonomy: 193400000X  
Austin, Texas 78727-6422 Benefit Code: CSN  
Report Seq. Number: 35  
(800) 568-2413 R&S Number: 2460000

Page 1 Of

BANNER PAGE

39 (03/25/11 THROUGH 04/15/11) \*\*\*\*\*ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS\*\*\*\*\*

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, NONSURGICAL VISION SERVICES PROCEDURES BENEFIT CRITERIA WILL CHANGE FOR THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS OF THESE CHANGES ARE AVAILABLE ON THE TMHP WEBSITE AT WWW.TMHP.COM.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

40 (03/25/11 THROUGH 04/15/11) \*\*\*\*\*ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS\*\*\*\*\*

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, THE REIMBURSEMENT RATES FOR SOME PHYSICIAN-ADMINISTERED DRUG PROCEDURE CODES WILL CHANGE FOR THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS ARE AVAILABLE ON THE TMHP WEBSITE.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

TEXAS PROVIDER  
PO BOX 848484  
DALLAS, TX 75888-1234  
(214) 555-4141

YOUR AIS NUMBER IS 0000000-01  
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 568-2413  
THE PROVIDER MANUAL PROVIDES DETAILS.  
PHYSICAL ADDRESS ON RECORD:  
TEXAS PROVIDER  
PO BOX 848484  
DALLAS, TX 75888-1234  
  
(214) 555-4141

6.1.6.2 Physician R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

Mail original claim to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
P.O. Box 200855  
Austin, Texas 78720-0855

TEXAS PROVIDER  
PO BOX 848484  
DALLAS, TX 75888-1234  
(214) 555-4141

Mail all other correspondence to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422

TPI: 1234567-01  
NPI/API: 1234567890  
Taxonomy: 193400000X  
Benefit Code: CSN  
Report Seq. Number: 35  
R&S Number: 2460000

(800) 568-2413

Page 2 Of

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6.1.6.3 Physician R&S Report Example: Claims – Paid or Denied

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to: TEXAS PROVIDER  
 CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 848484  
 P.O. Box 200855 DALLAS, TX 75888-1234  
 Austin, Texas 78720-0855 (214) 555-4141

Mail all other correspondence to: TPI: 1234567-01  
 CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 1234567890  
 12357-B Riata Trace Parkway Taxonomy: 193400000X  
 Austin, Texas 78727-6422 Benefit Code: CSN  
 Report Seq. Number: 35  
 (800) 568-2413 R&S Number: 2460000

Page 3 Of

| PATIENT NAME   | CLAIM NUMBER        | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE #        | EOB    | EOB | EOB      | EOB | DIAGNOSIS |     |     |     |     |
|----------------|---------------------|---------|------------------|------------------|-------------------|--------|-----|----------|-----|-----------|-----|-----|-----|-----|
| PATIENT ACCT # | ---SERVICE DATES--- |         | -----BILLED----- |                  | -----ALLOWED----- |        | POS | PAID AMT | EOB | EOB       | EOB | EOB | MOD | MOD |
|                | FROM                | TO      | TOS              | PROC             | QTY               | CHARGE | QTY | CHARGE   |     |           |     |     |     |     |

\*\*\*\*\* CLAIMS - PAID OR DENIED \*\*\*\*\*

|                   |                          |   |  |       |           |          |     |          |       |          |             |       |      |
|-------------------|--------------------------|---|--|-------|-----------|----------|-----|----------|-------|----------|-------------|-------|------|
| DOE, JANE         | 400020010200704400000000 |   |  | CSN   | 999999900 |          |     |          | 01147 |          |             |       | E119 |
| 000123456789      |                          |   |  |       |           |          |     |          |       |          |             |       |      |
| 03/22/2011        | 03/22/2011               | 1 |  | 92004 | 1.0       | 225.00   | 1.0 | 105.11   | 1     | 103.01   | 00475       | 01196 |      |
| 03/22/2011        | 03/22/2011               | 1 |  | 92015 | 1.0       | 35.00    | 1.0 | 22.91    | 1     | 22.45    | 00475       | 01196 |      |
|                   |                          |   |  |       |           | \$260.00 |     | \$128.02 |       | \$125.46 | CLAIM TOTAL |       |      |
| PAID CLAIM TOTALS |                          |   |  |       |           | \$260.00 |     | \$128.02 |       | \$125.46 |             |       |      |

\*\*\*\*\*  
 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.

6.1.6.4 Physician R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

Mail original claim to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
P.O. Box 200855  
Austin, Texas 78720-0855

TEXAS PROVIDER  
PO BOX 848484  
DALLAS, TX 75888-1234  
(214) 555-4141

Mail all other correspondence to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422

TPI: 1234567-01  
NPI/API: 1234567890  
Taxonomy: 193400000X  
Benefit Code: CSN  
Report Seq. Number: 35  
R&S Number: 2460000

(800) 568-2413

Page 4 Of

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6.1.6.5 Physician R&S Report Example: Payment Summary Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

Mail original claim to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
P.O. Box 200855  
Austin, Texas 78720-0855

TEXAS PROVIDER  
PO BOX 848484  
DALLAS, TX 75888-1234  
(214) 555-4141

Mail all other correspondence to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422  
  
(800) 568-2413

TPI: 1234567-01  
NPI/API: 1234567890  
Taxonomy: 193400000X  
Benefit Code: CSN  
Report Seq. Number: 35  
R&S Number: 2460000

PAYMENT SUMMARY FOR CSHCN FOR TAX ID 987654321

|  | *** AFFECTING PAYMENT THIS CYCLE *** |       | *** AMOUNT AFFECTING 1099 EARNINGS *** |              |
|--|--------------------------------------|-------|--|--------------|
|  | AMOUNT                               | COUNT | THIS CYCLE                             | YEAR TO DATE |
| CLAIMS PAID  | 125.46                               | 1     | 125.46                                 | 333.49       |
| SYSTEM PAYOUTS                                     |                                      |       |  |              |
| MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT) |                                      |       |  |              |
| AMOUNT PAID TO IRS FOR LEVIES                      |                                      |       |  |              |
| AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING          |                                      |       |  |              |
| ACCOUNTS RECEIVABLE RECOUPMENTS                    |                                      |       |  |              |
| AMOUNTS STOPPED/VOIDED                             |                                      |       |  |              |
| SYSTEM REISSUES                                    |                                      |       |  |              |
| CLAIM RELATED REFUNDS                              |                                      |       |  |              |
| NON-CLAIM RELATED REFUNDS                          |                                      |       |  |              |
| HELD AMOUNT  |                                      |       |  |              |
| PAYMENT AMOUNT                                     | 125.46                               |       | 125.46                                 | 333.49       |

PENDING CLAIMS

\*\*\*\*\*PAYMENT TOTAL FOR CHECK 00000012345678 IN THE AMOUNT OF 125.46\*\*\*\*\*

6.1.6.6 Physician R&S Report Example: Explanation of Benefits (EOB) Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

|   |                       |
|---|-----------------------|
| Mail original claim to:                         | TEXAS PROVIDER        |
| CSHCN / Texas Medicaid & Healthcare Partnership | PO BOX 848484         |
| P.O. Box 200855                                 | DALLAS, TX 75888-1234 |
| Austin, Texas 78720-0855                        | (214) 555-4141        |

|   |                        |
|---|------------------------|
| Mail all other correspondence to:               | TPI: 1234567-01        |
| CSHCN / Texas Medicaid & Healthcare Partnership | NPI/API: 1234567890    |
| 12357-B Riata Trace Parkway                     | Taxonomy: 193400000X   |
| Austin, Texas 78727-6422                        | Benefit Code: CSN      |
|   | Report Seq. Number: 35 |
| (800) 568-2413                                  | R&S Number: 2460000    |

Page 6 Of

EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

- 00475 PAID ACCORDING TO THE TEXAS MEDICAID REIMBURSEMENT METHODOLOGY-TMRM (RELATIVE VALUE UNIT TIMES STATEWIDE CONVERSION FACTOR)
- 01147 PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.
- 01196 THIS PAYMENT WAS REDUCED BY 2% IN ACCORDANCE WITH THE STATE'S SPENDING REDUCTION PLAN FOR CLAIMS WITH A DATE OF SERVICE ON OR AFTER FEBRUARY 1, 2011. PCS SERVICES ARE REDUCED BY 1%.

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT



6.1.6.7 Ambulatory Surgical Center (ASC) R&S Report Example: Banner Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

Mail original claim to: TEXAS ASC PROVIDER  
CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 959595  
P.O. Box 200855 HOUSTON, TX 75999-1234  
Austin, Texas 78720-0855 (214) 555-5555

Mail all other correspondence to: TPI: 7654321-02  
CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 0987654321  
12357-B Riata Trace Parkway Taxonomy: 111100000X  
Austin, Texas 78727-6422 Benefit Code: CSN  
Report Seq. Number: 13  
(800) 568-2413 R&S Number: 1230000

Page 1 Of

BANNER PAGE

39 (03/25/11 THROUGH 04/15/11) \*\*\*\*\*ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS\*\*\*\*\*

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, NONSURGICAL VISION SERVICES PROCEDURES BENEFIT CRITERIA WILL CHANGE FOR THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS OF THESE CHANGES ARE AVAILABLE ON THE TMHP WEBSITE AT WWW.TMHP.COM.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

40 (03/25/11 THROUGH 04/15/11) \*\*\*\*\*ATTENTION ALL CSHCN SERVICES PROGRAM PROVIDERS\*\*\*\*\*

EFFECTIVE FOR DATES OF SERVICE ON OR AFTER MAY 1, 2011, THE REIMBURSEMENT RATES FOR SOME PHYSICIAN-ADMINISTERED DRUG PROCEDURE CODES WILL CHANGE FOR THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM. DETAILS ARE AVAILABLE ON THE TMHP WEBSITE.

FOR MORE INFORMATION, CALL THE TMHP-CSHCN SERVICES PROGRAM CONTACT CENTER AT 1-800-568-2413.

TEXAS PROVIDER  
PO BOX 848484  
DALLAS, TX 75888-1234  
(214) 555-4141

YOUR AIS NUMBER IS 0000000-01  
FOR AIS INQUIRY CALL TOLL FREE 1-(800) 568-2413  
THE PROVIDER MANUAL PROVIDES DETAILS.  
PHYSICAL ADDRESS ON RECORD:  
TEXAS ASC PROVIDER  
PO BOX 959595  
HOUSTON, TX 75999-1234  
  
(214) 555-5555

6.1.6.8 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to: TEXAS ASC PROVIDER  
 CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 959595  
 P.O. Box 200855 HOUSTON, TX 75999-1234  
 Austin, Texas 78720-0855 (214) 555-5555

Mail all other correspondence to: TPI: 7654321-02  
 CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 0987654321  
 12357-B Riata Trace Parkway Taxonomy: 111100000X  
 Austin, Texas 78727-6422 Benefit Code: CSN  
 Report Seq. Number: 13  
 (800) 568-2413 R&S Number: 1230000

| PATIENT NAME                             | CLAIM NUMBER             | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE # | EOB               | EOB | EOB      | EOB | EOB      | EOB         | EOB   | EOB | EOB   | MOD | MOD | DIAGNOSIS |  |
|--|--------------------------|---------|------------------|------------------|------------|-------------------|-----|----------|-----|----------|-------------|-------|-----|-------|-----|-----|-----------|--|
| PATIENT ACCT #                           | ---SERVICE DATES---      |         | -----BILLED----- |                  |            | -----ALLOWED----- |     |          | POS | PAID AMT | EOB         | EOB   | EOB | EOB   | EOB | MOD | MOD       |  |
|  | FROM                     | TO      | TOS              | PROC             | QTY        | CHARGE            | QTY | CHARGE   |     |          | EOB         | EOB   | EOB | EOB   | EOB | MOD | MOD       |  |
| ***** ADJUSTMENTS - PAID OR DENIED ***** |                          |         |                  |                  |            |                   |     |          |     |          |             |       |     |       |     |     |           |  |
| DOE, JANE                                | 400023030201106000000000 |         |                  |                  |            | 111111111         |     | 2222222  |     |          | 01147       |       |     |       |     |     | M00071    |  |
| 0000000000                               |                          |         |                  |                  |            |                   |     |          |     |          |             |       |     |       |     |     |           |  |
| 02/18/2011                               | 02/18/2011               | F       |                  | 28755            | 1.0        | 10,192.39         | 1.0 | 444.95   | 5   | 436.05   | 00325       | 00058 |     | 01196 |     |     | TA        |  |
|  |                          |         |                  |                  |            | \$10,192.39       |     | \$444.95 |     | \$436.05 | CLAIM TOTAL |       |     |       |     |     |           |  |
| SMITH, JOHN                              | 400023030201106200000000 |         |                  |                  |            | 111111111         |     | 2222222  |     |          | 01147       |       |     |       |     |     | Q825      |  |
| 0000000000                               |                          |         |                  |                  |            |                   |     |          |     |          |             |       |     |       |     |     |           |  |
| 02/24/2011                               | 02/24/2011               | F       |                  | 17108            | 1.0        | 6,334.31          | 1.0 | 235.23   | 5   | 230.53   | 00325       | 00058 |     | 01196 |     |     |           |  |
|  |                          |         |                  |                  |            | \$6,334.31        |     | \$235.23 |     | \$230.53 | CLAIM TOTAL |       |     |       |     |     |           |  |
| PAID CLAIM TOTALS                        |                          |         |                  |                  |            | \$16,526.70       |     | \$680.18 |     | \$666.56 |             |       |     |       |     |     |           |  |

\*\*\*\*\*  
 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.  
 \*\*\*\*\*

6.1.6.9 ASC R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

Mail original claim to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
P.O. Box 200855  
Austin, Texas 78720-0855

TEXAS ASC PROVIDER  
PO BOX 959595  
HOUSTON, TX 75999-1234  
(214) 555-5555

Mail all other correspondence to:  
CSHCN / Texas Medicaid & Healthcare Partnership  
12357-B Riata Trace Parkway  
Austin, Texas 78727-6422

TPI: 7654321-02  
NPI/API: 0987654321  
Taxonomy: 111100000X  
Benefit Code: CSN  
Report Seq. Number: 13  
R&S Number: 1230000

(800) 568-2413

Page 3 Of

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6.1.6.10 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to: TEXAS ASC PROVIDER  
 CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 959595  
 P.O. Box 200855 HOUSTON, TX 75999-1234  
 Austin, Texas 78720-0855 (214) 555-5555

Mail all other correspondence to: TPI: 7654321-02  
 CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 0987654321  
 12357-B Riata Trace Parkway Taxonomy: 111100000X  
 Austin, Texas 78727-6422 Benefit Code: CSN  
 Report Seq. Number: 13  
 (800) 568-2413 R&S Number: 1230000

| PATIENT NAME   | CLAIM NUMBER        | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE #        | EOB    | EOB | EOB    | EOB | DIAGNOSIS |     |     |     |     |     |     |
|----------------|---------------------|---------|------------------|------------------|-------------------|--------|-----|--------|-----|-----------|-----|-----|-----|-----|-----|-----|
| PATIENT ACCT # | ---SERVICE DATES--- |         | -----BILLED----- |                  | -----ALLOWED----- |        | POS | PAID   | AMT | EOB       | EOB | EOB | EOB | EOB | MOD | MOD |
|                | FROM                | TO      | TOS              | PROC             | QTY               | CHARGE | QTY | CHARGE |     |           | EOB | EOB | EOB | EOB | EOB | MOD |

\*\*\*\*\* CLAIMS - PAID OR DENIED \*\*\*\*\*

ADJUSTMENT CLAIM:

DOE, JANE 400023031201107700000000 CSN 111111111 2222222 01147 N310  
 0000000000  
 12/22/2010 12/22/2010 F 51798 1.0 1,430.00 .0 .00 5 .00 00572 00129 00954  
 \$1,430.00 \$0.00 \$0.00 ADJUSTMENT CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 400023030201100612312345

ORIGINAL CLAIM:

DOE, JOHN 400023010201106900000000 CSN 111111111 2222222 01147 N310  
 0000000000  
 12/22/2010 12/22/2010 F 51798 1.0 1,430.00 .0 .00 5 .00 00572  
 \$1,430.00 \$0.00 \$0.00 ORIGINAL CLAIM TOTAL

ADJUSTMENT CLAIM:

DOE, JAMES 400023031201107400000000 CSN 111111111 2222222 01147 K029  
 0000000000  
 01/14/2011 01/14/2011 F 41899 1.0 6,211.15 1.0 504.00 5 498.96 00325 00149 01170 U3  
 \$6,211.15 \$504.00 \$498.96 ADJUSTMENT CLAIM TOTAL

\*\*\*\*\*

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 120 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

6.1.6.11 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to: TEXAS ASC PROVIDER  
 CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 959595  
 P.O. Box 200855 HOUSTON, TX 75999-1234  
 Austin, Texas 78720-0855 (214) 555-5555

Mail all other correspondence to: TPI: 7654321-02  
 CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 0987654321  
 12357-B Riata Trace Parkway Taxonomy: 111100000X  
 Austin, Texas 78727-6422 Benefit Code: CSN  
 Report Seq. Number: 13  
 (800) 568-2413 R&S Number: 1230000

| PATIENT NAME   | CLAIM NUMBER        | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE # | EOB               | EOB | EOB    | EOB | DIAGNOSIS |     |     |     |     |     |     |     |
|----------------|---------------------|---------|------------------|------------------|------------|-------------------|-----|--------|-----|-----------|-----|-----|-----|-----|-----|-----|-----|
| PATIENT ACCT # | ---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 \*\*\*\*\*

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 400023030201100612312345

ORIGINAL CLAIM:

DOE, JANNET 400023031201104600000000 CSN 11111111 222222 01147 K029  
 0000000000  
 01/14/2011 01/14/2011 F 41899 1.0 6,211.15 .0 .00 5 .00 0164 00R01 SG  
 \$6,211.15 \$0.00 \$0.00 ORIGINAL CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 400023030201100612312345

ADJUSTMENT CLAIM:

DOE, JOHNNY 400023010201107600000000 CSN 11111111 222222 01147 K029  
 0000000000  
 02/18/2011 02/18/2011 F 41899 1.0 6,156.53 1.0 504.00 5 493.92 00325 00149 01196 U3  
 \$6,156.53 \$504.00 \$493.92 ADJUSTMENT CLAIM TOTAL

00123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 400023030201100612312345

ORIGINAL CLAIM:

DOE, JAMMIE 400023031201105500000000 CSN 11111111 222222 01147 K029  
 0000000000  
 02/18/2011 02/18/2011 F 41899 1.0 6,156.53 .0 .00 5 .00 00958 00572 01170 EP

\*\*\*\*\*  
 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.

6.1.6.12 ASC R&S Report Example: Adjustments R&S Report

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to:  
 CSHCN / Texas Medicaid & Healthcare Partnership  
 P.O. Box 200855  
 Austin, Texas 78720-0855

TEXAS ASC PROVIDER  
 PO BOX 959595  
 HOUSTON, TX 75999-1234  
 (214) 555-5555

Mail all other correspondence to:  
 CSHCN / Texas Medicaid & Healthcare Partnership  
 12357-B Riata Trace Parkway  
 Austin, Texas 78727-6422

TPI: 7654321-02  
 NPI/API: 0987654321  
 Taxonomy: 111100000X  
 Benefit Code: CSN  
 Report Seq. Number: 13  
 R&S Number: 1230000

(800) 568-2413

Page 6 Of

| PATIENT NAME   | CLAIM NUMBER        | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE #        | EOB | EOB    | EOB      | EOB | DIAGNOSIS |     |     |     |     |     |
|----------------|---------------------|---------|------------------|------------------|-------------------|-----|--------|----------|-----|-----------|-----|-----|-----|-----|-----|
| PATIENT ACCT # | ---SERVICE DATES--- |         | -----BILLED----- |                  | -----ALLOWED----- |     | POS    | PAID AMT | EOB | EOB       | EOB | EOB | EOB | MOD | MOD |
| FROM           | TO                  | TOS     | PROC             | QTY              | CHARGE            | QTY | CHARGE |          |     |           |     |     |     |     |     |

\*\*\*\*\* ADJUSTMENTS - PAID OR DENIED \*\*\*\*\*

CONTINUED FROM PREVIOUS PAGE

DOE, JAMMIE 400023031201105500000000 CSN 111111111  
 0000000000

\$6,156.53 \$ .00 \$ .00 ORIGINAL CLAIM TOTAL

PAID CLAIM TOTALS \$13,797.68 \$1,008.00 \$992.88

\*\*\*\*\*  
 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.

6.1.6.13 ASC R&S Report Example: Blank Page

Texas Medicaid & Healthcare Partnership  
CSHCN Remittance and Status Report  
Date: 04/08/2011

|   |                        |
|---|------------------------|
| Mail original claim to:                         | TEXAS ASC PROVIDER     |
| CSHCN / Texas Medicaid & Healthcare Partnership | PO BOX 959595          |
| P.O. Box 200855                                 | HOUSTON, TX 75999-1234 |
| Austin, Texas 78720-0855                        | (214) 555-5555         |

|   |                        |
|---|------------------------|
| Mail all other correspondence to:               | TPI: 7654321-02        |
| CSHCN / Texas Medicaid & Healthcare Partnership | NPI/API: 0987654321    |
| 12357-B Riata Trace Parkway                     | Taxonomy: 111100000X   |
| Austin, Texas 78727-6422                        | Benefit Code: CSN      |
| (800) 568-2413                                  | Report Seq. Number: 13 |
|   | R&S Number: 1230000    |

Page 7 Of

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6.1.6.14 ASC R&S Report Example: Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to: TEXAS ASC PROVIDER  
 CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 959595  
 P.O. Box 200855 HOUSTON, TX 75999-1234  
 Austin, Texas 78720-0855 (214) 555-5555

Mail all other correspondence to: TPI: 7654321-02  
 CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 0987654321  
 12357-B Riata Trace Parkway Taxonomy: 111100000X  
 Austin, Texas 78727-6422 Benefit Code: CSN  
 Report Seq. Number: 13  
 (800) 568-2413 R&S Number: 1230000

Page 8 Of

| PATIENT NAME   | CLAIM NUMBER        | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE #        | EOPS   | EOPS | EOPS   | EOPS | DIAGNOSIS |      |      |      |      |      |     |     |
|----------------|---------------------|---------|------------------|------------------|-------------------|--------|------|--------|------|-----------|------|------|------|------|------|-----|-----|
| PATIENT ACCT # | ---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, JAKE<br>0000000000 | 400023030201107300000000 |   |       | 111111111 | 2222222     |  |  |  |  |       |  |  |  |  |    | J353 |
| 03/07/2011              | 03/07/2011               | F | 42820 | 1.0       | 6,878.36    |  |  |  |  | 00I03 |  |  |  |  |    |      |
|                         |                          |   |       |           | \$6,878.36  |  |  |  |  |       |  |  |  |  |    |      |
| DOE, JOE<br>0000000000  | 400023030201107300000000 |   |       | 111111111 | 2222222     |  |  |  |  |       |  |  |  |  |    | M899 |
| 02/11/2011              | 02/11/2011               | F | 29891 | 1.0       | 10,421.30   |  |  |  |  | 00I03 |  |  |  |  | RT |      |
|                         |                          |   |       |           | \$10,421.30 |  |  |  |  |       |  |  |  |  |    |      |
| DOE, DAVE<br>0000000000 | 400023030201107600000000 |   |       | 111111111 | 2222222     |  |  |  |  |       |  |  |  |  |    | R51  |
| 03/11/2011              | 03/11/2011               | F | 62270 | 1.0       | 7,690.00    |  |  |  |  | 00I03 |  |  |  |  |    |      |
|                         |                          |   |       |           | \$7,690.00  |  |  |  |  |       |  |  |  |  |    |      |

\*\*\*\*\*  
 IF YOUR CLAIM HAS NOT APPEARED ON ANY 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.



6.1.6.15 ASC R&S Report Example: Claims in Process R&S Report

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to: TEXAS ASC PROVIDER  
 CSHCN / Texas Medicaid & Healthcare Partnership PO BOX 959595  
 P.O. Box 200855 HOUSTON, TX 75999-1234  
 Austin, Texas 78720-0855 (214) 555-5555

Mail all other correspondence to: TPI: 7654321-02  
 CSHCN / Texas Medicaid & Healthcare Partnership NPI/API: 0987654321  
 12357-B Riata Trace Parkway Taxonomy: 111100000X  
 Austin, Texas 78727-6422 Benefit Code: CSN  
 Report Seq. Number: 13  
 (800) 568-2413 R&S Number: 1230000

Page 9 Of

| PATIENT NAME   | CLAIM NUMBER        | BENEFIT | CSHCN #          | MEDICAL RECORD # | MEDICARE #        | EOPS   | EOPS | EOPS   | EOPS | DIAGNOSIS |      |      |      |      |      |     |     |
|----------------|---------------------|---------|------------------|------------------|-------------------|--------|------|--------|------|-----------|------|------|------|------|------|-----|-----|
| PATIENT ACCT # | ---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.

PENDING CLAIM TOTALS \$24,989.66

\*\*\*\*\*  
 IF YOUR CLAIM HAS NOT APPEARED ON ANY 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.

6.1.6.16 ASC R&S Report Example: Payment Summary Page

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

Mail original claim to:  
 CSHCN / Texas Medicaid & Healthcare Partnership  
 P.O. Box 200855  
 Austin, Texas 78720-0855

TEXAS ASC PROVIDER  
 PO BOX 959595  
 HOUSTON, TX 75999-1234  
 (214) 555-5555

Mail all other correspondence to:  
 CSHCN / Texas Medicaid & Healthcare Partnership  
 12357-B Riata Trace Parkway  
 Austin, Texas 78727-6422

TPI: 7654321-02  
 NPI/API: 0987654321  
 Taxonomy: 111100000X  
 Benefit Code: CSN  
 Report Seq. Number: 13  
 R&S Number: 1230000

(800) 568-2413

Page 10 Of

PAYMENT SUMMARY FOR CSHCN FOR TAX ID 987654321

|  | *** AFFECTING PAYMENT THIS CYCLE *** |       | *** AMOUNT AFFECTING 1099 EARNINGS *** |              |
|--|--------------------------------------|-------|--|--------------|
|  | AMOUNT                               | COUNT | THIS CYCLE                             | YEAR TO DATE |
| CLAIMS PAID  | 1,659.46                             | 5     | 1,659.46                               | 10,718.85    |
| SYSTEM PAYOUTS                                     |                                      |       |  |              |
| MANUAL PAYOUTS (REMITTED BY SEPARATE CHECK OR EFT) |                                      |       |  |              |
| AMOUNT PAID TO IRS FOR LEVIES                      |                                      |       |  |              |
| AMOUNT PAID TO IRS FOR BACKUP WITHHOLDING          |                                      |       |  |              |
| ACCOUNTS RECEIVABLE RECOUPMENTS                    |                                      |       |  |              |
| AMOUNTS STOPPED/VOIDED                             |                                      |       |  |              |
| SYSTEM REISSUES                                    |                                      |       |  |              |
| CLAIM RELATED REFUNDS                              |                                      |       |  |              |
| NON-CLAIM RELATED REFUNDS                          |                                      |       |  |              |
| HELD AMOUNT  |                                      |       |  |              |
| PAYMENT AMOUNT                                     | 1,659.46                             |       | 1,659.46                               | 10,718.85    |
| PENDING CLAIMS                                     | 24,989.66                            |       |  |              |

\*\*\*\*\*PAYMENT TOTAL FOR CHECK 00000012345678 IN THE AMOUNT OF 1,659.46\*\*\*\*\*

**6.1.6.17 ASC R&S Report Example: Explanation of Benefits (EOB) Page**

Texas Medicaid & Healthcare Partnership  
 CSHCN Remittance and Status Report  
 Date: 04/08/2011

|   |                        |
|---|------------------------|
| Mail original claim to:                         | TEXAS ASC PROVIDER     |
| CSHCN / Texas Medicaid & Healthcare Partnership | PO BOX 959595          |
| P.O. Box 200855                                 | HOUSTON, TX 75999-1234 |
| Austin, Texas 78720-0855                        | (214) 555-5555         |

|   |                        |
|---|------------------------|
| Mail all other correspondence to:               | TPI: 7654321-02        |
| CSHCN / Texas Medicaid & Healthcare Partnership | NPI/API: 0987654321    |
| 12357-B Riata Trace Parkway                     | Taxonomy: 111100000X   |
| Austin, Texas 78727-6422                        | Benefit Code: CSN      |
| (800) 568-2413                                  | Report Seq. Number: 13 |
|   | R&S Number: 1230000    |

Page 11 Of

## EXPLANATION OF BENEFITS CODES MESSAGES

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

|       |   |
|-------|---|
| 00058 | PROCEDURE PAYMENT DETERMINED BY PROGRAM/BENEFIT PLAN, LOCALITY/SPECIALTY, DATE OF SERVICE AND BILLED AMOUNT.  |
| 00129 | PAYMENT REDUCED BY MEDICAL REVIEWER.  |
| 00149 | PROCEDURE PAYMENT BASED ON PROGRAM/BENEFIT PLAN, DATE OF SERVICE, AND A MAXIMUM PAYMENT AMOUNT SET BY HCFA OR TDH.  |
| 00164 | THESE SERVICES ARE NOT IN ACCORDANCE WITH MEDICAL POLICY.   |
| 00325 | FOR INPATIENT SERVICES, PAID AMOUNT REDUCED BY 20% EFF 9/1/94. FOR OUT PATIENT SVCS, PAID AMOUNT REDUCED BY 17.3% EFF 9/1/99 OR 20% EFF 9/1/94-8/31/99.                               |
| 00572 | IT IS MANDATORY THAT AUTHORIZATION BE OBTAINED. DUE TO LACK OF APPROVAL, THE SERVICE IS NON-PAYABLE.  |
| 00954 | THE AUTHORIZATION NUMBER USED ON THIS CLAIM IS NOT VALID FOR THE DATE OF SERVICE.   |
| 00958 | THIS IS NOT A VALID PROCEDURE CODE AND OR MODIFIER FOR THIS DATE OF SERVICE. RESUBMIT WITH A VALID PROCEDURE CODE AND OR MODIFIER.  |
| 01147 | PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.   |
| 01170 | THIS PAYMENT WAS REDUCED BY 1% IN ACCORDANCE WITH THE STATE'S SPENDING REDUCTION PLAN FOR CLAIMS WITH A DATE OF SERVICE ON OR AFTER SEPTEMBER 1, 2010.                                |
| 01196 | THIS PAYMENT WAS REDUCED BY 2% IN ACCORDANCE WITH THE STATE'S SPENDING REDUCTION PLAN FOR CLAIMS WITH A DATE OF SERVICE ON OR AFTER FEBRUARY 1, 2011. PCS SERVICES ARE REDUCED BY 1%. |

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.              |
| 00R01 | THIS CLAIM IS SUSPENDED FOR POSSIBLE CUTBACK OR MANUAL PRICING REVIEW. |

---

## **6.2 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **APPEALS AND ADMINISTRATIVE REVIEW**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# APPEALS AND ADMINISTRATIVE REVIEW

## Table of Contents

- 7.1 Appeals ..... 3**
- 7.2 Authorization and Prior Authorization Denials ..... 3**
  - 7.2.1 Administrative Review for Authorization or Prior Authorization Denials ..... 3
  - 7.2.2 Fair Hearing Requests for Authorizations or Prior Authorizations ..... 3
- 7.3 Claim Appeals ..... 4**
  - 7.3.1 Electronic Appeal Submission ..... 4
    - 7.3.1.1 Advantages of Electronic Appeal Submission ..... 4
    - 7.3.1.2 Disallowed Electronic Appeals ..... 5
    - 7.3.1.3 Electronic Rejections ..... 5
  - 7.3.2 AIS Claim Correction and Resubmission (Appeals) ..... 5
  - 7.3.3 Paper Appeals ..... 6
    - 7.3.3.1 Total Billed Amount Changes ..... 7
  - 7.3.4 Appeals Submitted Incorrectly ..... 7
  - 7.3.5 Administrative Review for Claims ..... 7
    - 7.3.5.1 Administrative Review Requirements ..... 8
  - 7.3.6 Fair Hearing for Claims ..... 9
  - 7.3.7 National Correct Coding Initiative (NCCI) Claims Appeals ..... 9
- 7.4 Provider Enrollment Appeals ..... 10**
- 7.5 TMHP-CSHCN Services Program Contact Center ..... 10**
- 7.6 Authorization and Filing Deadline Calendars ..... 10**

## 7.1 Appeals

An appeal is a request for reconsideration of a previous denial.

Providers may request an appeal if a denial is received for any of the following:

- Authorization or prior authorizations
- Claims
- Provider enrollment

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for additional information regarding the appeals process for authorization and prior authorization denials.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for additional information.

Section 2.1.4, “Provider Enrollment Determinations” in Chapter 2, “Provider Enrollment and Responsibilities” for additional information.

## 7.2 Authorization and Prior Authorization Denials

Authorization or prior authorization requests that do not contain all of the information necessary for the program to make a determination are denied.

**Referto:** Section 4.5, “Authorization and Prior Authorization Denials” in Chapter 4, “Prior Authorizations and Authorizations” for information about reasons for denials.

### 7.2.1 Administrative Review for Authorization or Prior Authorization Denials

A provider or client who has received a denied authorization or prior authorization may submit a request for an administrative review to the CSHCN Services Program if they are dissatisfied with TMHP’s decision to deny the authorization or prior authorization.

All providers and clients must submit requests for an administrative review within 30 days of the date TMHP denied the authorization or prior authorization. Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

### 7.2.2 Fair Hearing Requests for Authorizations or Prior Authorizations

After an administrative review, providers or clients may request a fair hearing if they are dissatisfied with the CSHCN Services Program’s decision and the supporting reason.

The fair hearing is the final appeal process and is described in the *Texas Administrative Code* (TAC) Title 25, Part 1, Chapter 1, Subchapter C ([www.sos.state.tx.us](http://www.sos.state.tx.us)). The fair hearing process is conducted by the Office of General Counsel at DSHS.

Providers or clients may choose to represent themselves, or have legal counsel or another spokesperson, at the hearing. If providers or clients are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers and clients who fail to request a fair hearing within the 20-day period are presumed to have waived their right to request a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

## 7.3 Claim Appeals

Providers may use three methods to appeal claims to TMHP:

- Automated Inquiry System (AIS)
- Electronic
- Paper

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days of 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.

**Referto:** [2023 Authorization Filing Deadline Calendar](#)  
[2024 Authorization Filing Deadline Calendar](#)

All appeals must be sent to TMHP as a first-level appeal. A first-level appeal is a provider's initial 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.

### 7.3.1 Electronic Appeal Submission

Providers can use TexMedConnect or vendor software to submit files directly to TMHP or they may use a billing agent (i.e., billing companies or clearinghouses) that submits files on the provider's behalf.

TMHP Electronic Data Interchange (EDI) accepts the *Health Insurance Portability and Accountability Act* (HIPAA) standard American National Standards Institute (ANSI) ASC X12 837 format.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for additional information regarding electronic transactions.

Zero-paid claims that appear in the "Claims - Paid or Denied" section of the R&S Report and the allowed charge and the paid amount are \$0, may be resubmitted as electronic appeals. Zero-paid claims that are still within the 95-day filing deadline should be submitted as new day claims, which process faster than appeals.

For more information, contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

#### 7.3.1.1 Advantages of Electronic Appeal Submission

- Increased accuracy potentially improves cash flow
- Audit trails can be maintained through print and download capabilities



- Appeal submission fields can be automatically filled in with Electronic Remittance and Status (ER&S) Report information, reducing data entry time
- Acceptance or rejection reports received for appeals submissions

### **7.3.1.2 Disallowed Electronic Appeals**

The following claims may not be appealed electronically, and providers must appeal these denials on paper:

- Claims that require supporting documentation (e.g., operative report, medical records)
- 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*
- Inpatient Hospital claims that require supporting documentation
- Third-party liability (TPL) and other insurance
- Claims billed for additional days or units not included in the original claim

### **7.3.1.3 Electronic Rejections**

TMHP EDI transactions that fail HIPAA edits are rejected, and the submitter receives a 277CA claim response file which replaced the TMHP EDI Rejected Transaction Report. The 277CA claims response file lists activity by submitter, provider, and payer.

The 277CA claims response file includes member identifier, patient last name and first initial, patient control number (PCN), type of bill or place of service, charge, transaction from and to dates, receipt date, rejection code, and rejection description.

Providers must send the batch ID, PCN, date of service, transaction from and to dates, receipt date, and rejection codes from the 277CA claims response file to TMHP when appealing denied claims.

The batch ID is located in the file name of the returned 277CA claims response, and not within the file. Providers must include the batch ID in all electronic response files submitted to TMHP for appeals to denied claims. Handwritten batch IDs are not acceptable for submission to TMHP. Providers who cannot identify or retrieve the batch ID from the 277CA claims response file name should contact the clearinghouse or vendor to have the filename included in the response document. If not, the provider must request a copy of the response file that contains the filename from the clearinghouse.

Providers who receive a rejection on the 277CA claims response file may resubmit an electronic claim within 95 days of the date of service.

A paper appeal may also be submitted with a copy of the response document within 120 days of the 277CA claims response file rejection to meet the filing deadline. A copy of the electronic response file rejection to include the batch ID must accompany each corrected claim that is submitted on paper.

## **7.3.2 AIS Claim Correction and Resubmission (Appeals)**

Telephone resubmissions or appeals may be entered through AIS using the keypad of a touch tone telephone. Providers may submit up to 3 field corrections per claim and 15 appeals per call. If invalid information is entered three times during any step, the call is transferred to a contact center representative for assistance.

For more information about how to correct and resubmit claims using AIS, providers can call 1-800-568-2413.

Providers may submit appeals through AIS to correct claims that were denied for the following:

- Beginning date of service

- Billing, performing, or referring provider identification numbers
- Client number
- Date of birth
- Date of onset
- Ending date of service
- Place of service (POS)
- Prior authorization number (PAN)
- Quantity billed
- X-ray date
- Type of service (TOS)

The following may not be appealed through AIS, and providers must appeal these denied claims on paper:

- Incomplete claims listed on the R&S Report in the “Claims - Paid or Denied” section
- Claims listed on the R&S Report with \$0 allowed and \$0 paid
- Claims that require supporting documentation (e.g., operative report, medical records)
- Procedure code, modifier, or diagnosis code
- 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*
- Inpatient hospital claims that require supporting documentation
- Third-Party Liability (TPL) and other insurance

### 7.3.3 Paper Appeals

If a claim cannot be appealed electronically or by using AIS, providers may appeal the claim on paper by completing the following:

- 1) Submit a copy of the R&S page on which the claim is paid or denied or other official notification from TMHP (i.e., TMHP letters attached to returned claims).
- 2) Submit one copy of the R&S Report page for each claim appealed.
- 3) Circle only one claim per R&S page.
- 4) Indicate the reason for the appeal.
- 5) If applicable, indicate the incorrect information and provide the correct information that should be used to appeal the claim.
- 6) Attach a copy of any supporting documentation that is necessary or requested by TMHP. Supporting documentation must be on a separate page.

**Note:** *Completed claim forms are not required to be submitted with paper appeals. Providers who submit paper appeals must clearly document on the R&S Report what information is being appealed and must identify the claim being appealed.*

**Reminder:** *Do not copy supporting documentation on the opposite side of the R&S Report.*

Paper appeals must be submitted to the following address:

Texas Medicaid & Healthcare Partnership  
Attn: CSHCN Services Program Appeals, MC-A11  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727

Providers may not request reconsideration or appeal of the following:

- Claims appearing in the “Pending Claims” section of the R&S Report. Providers cannot resubmit or appeal a claim that has not appeared as a paid or denied claim.
- Incomplete claims appearing in the “Claims - Paid or Denied” section of the R&S Report. Incomplete claims appear with one or more EOB code(s). Providers must correct the information and submit a new claim with the R&S Report within 120 days of the date on the R&S Report.

**Important:** *It is strongly recommended that providers who submit paper appeals retain a copy of the documentation they send. It also is recommended that paper documentation be sent by certified mail with a return receipt requested. This documentation and a detailed list of the claims that were enclosed provides proof that the claims were received by TMHP. This 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 list. The provider may need to keep such proof for all claims submissions, if their enrollment is pending.*

#### **7.3.3.1 Total Billed Amount Changes**

Appeals must be submitted on paper if the total billed amount is changed. Electronic appeals of this kind will be denied for timely filing if it is submitted more than 95 days after the original date of service.

To resubmit a claim with a new total billed amount, the claim may be submitted electronically as a new day claim. The new day claim must be within 95 days of the filing deadline. If a claim is submitted after the 95-day filing deadline, it will be denied for timely filing.

#### **7.3.4 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 fax) that does not clearly indicate the reason for submission is returned to the sender for clarification.

If TMHP identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

The provider may also initiate contact with a provider relations representative for assistance.

**Referto:** Section 1.1.5, “TMHP Regional Representatives” in Chapter 1, “TMHP and HHSC Contact Information” for contact information.

#### **7.3.5 Administrative Review for Claims**

To complete the TMHP appeals process:

- a) The claim must have been denied or adjusted by TMHP, and
- b) The claim must have been appealed as a first-level appeal to TMHP, and
- c) The first level appeal must have been denied again for the same reasons by TMHP.

After the TMHP appeals process has been exhausted, the provider must submit a request for administrative review within 30 days of the date TMHP denied the appeal in order for the claim to be considered for payment.

Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

TMHP may be required to gather information related to the original claim and the first-level appeal. The CSHCN Services Program is the sole adjudicator of the administrative review.

**Referto:** Section 4.5.3, “Administrative Review for Authorization and Prior Authorization Denials” in Chapter 4, “Prior Authorizations and Authorizations.”

### **7.3.5.1 Administrative Review Requirements**

An administrative review is a request for a review as defined in 26 TAC §351.10 and §351.13.

An administrative review must be:

- Submitted in writing to CSHCN Services Program Administrative Review by the provider who delivered the service or received claim reimbursement or claim denial for the service.
- Received by CSHCN Services Program Administrative Review after the appeals process with TMHP has been exhausted, and must contain evidence of appeal dispositions from TMHP:
  - All correspondence and documentation from the provider to TMHP, including copies of supporting documentation that was submitted during the appeal process.
  - All correspondence from TMHP to the provider.
- Received by CSHCN Services Program within 30 days of the date of disposition by TMHP as evidenced by the R&S sent to provider.
- Complete and contain all of the information necessary for consideration and determination by CSHCN Services Program Administrative Review, including:
  - A written explanation that specifies the reason for the request for review.
  - Supporting documentation for the request.
  - All R&S Reports that identify the claims and services in question.
  - Identification of the incorrect information and the corrected information used to appeal the claim.
  - A copy of the original claim, if it is available. Claim copies are helpful when the administrative review involves medical policy or procedure coding issues.
  - A corrected, signed claim.
  - A copy of supporting medical documentation requested by TMHP.
  - Provider’s internal notes and logs, when pertinent (cannot be used as proof of timely filing).
  - Memos from the state or TMHP indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the review.
  - Other documents, such as receipts (e.g., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, etc., if relevant. Receipts can be helpful when late filing is an issue.

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 CSHCN Services Program client 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.*

Providers must adhere to all filing and appeal deadlines for an administrative review to be considered by the CSHCN Services Program. The filing and appeal deadlines are described in 26 TAC §351.10 and §351.13 and in this manual.

**Referto:** Section 5.1.8, “Claims Filing Deadlines” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for additional information.

Additional information requested by the CSHCN Services Program must be returned to the Program within 30 calendar days of the date of the letter from the CSHCN Services Program. If the information is not received within 30 calendar days, the case is closed.

### **7.3.6 Fair Hearing for Claims**

After an administrative review, providers may request a fair hearing if they are dissatisfied with the CSHCN Services Program’s decision and the supporting reason.

The fair hearing is the final appeal process and is described in the 25 TAC, Part 1, Chapter 1, Subchapter C ([www.sos.state.tx.us](http://www.sos.state.tx.us)). The fair hearing process is conducted by the Office of General Counsel at DSHS.

Providers may choose to represent themselves or have legal counsel or another spokesperson at the hearing. If providers are unable to attend the hearing in person, they may request arrangements to attend by teleconference.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 calendar days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

**Note:** *Weekends and holidays must be included in the count to determine the 20-day deadline.*

### **7.3.7 National Correct Coding Initiative (NCCI) Claims Appeals**

Claims or procedure codes that have been denied based on NCCI guidelines may be appealed with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be appealed with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service. For guideline exceptions that may be appealed, providers may refer to the

Centers for Medicare & Medicaid Services (CMS) website at [www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals](http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals). Providers must follow the current standard appeals process when appealing claims to TMHP.

## 7.4 Provider Enrollment Appeals

The CSHCN Services Program may deny, modify, suspend, or terminate a provider's approval to participate for the reasons listed in the CSHCN Services Program Rules in 26 TAC §351.6(b)(1) through (2) at [www.sos.texas.gov/tac/index.shtml](http://www.sos.texas.gov/tac/index.shtml).

Before taking action to deny, modify, suspend, or terminate the approval of a provider, the CSHCN Services Program shall give the provider written notice of an opportunity to request an administrative review of the proposed action.

The administrative review process is outlined in the notice sent to the provider. A written request for an administrative review must be received within 30 calendar days of the date of the notice. If a written request for an administrative review is not received by the CSHCN Services Program by this date, the program's decision is final and cannot be appealed.

Requests for an administrative review and all supporting documentation must be submitted by mail or fax to:

CSHCN Services Program–Administrative Review  
MC-1938  
PO Box 149030  
Austin, TX 78714-9947  
Fax: 1-512-776-7238

In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program and the provider.

Fair hearing requests must be submitted in writing to the CSHCN Services Program within 20 days of the date of the administrative review decision notice. The request should state the reasons for the disagreement and include any documents or other proof that help support those reasons. Providers who fail to request a fair hearing within the 20-day period are presumed to have waived their right to a fair hearing, and the CSHCN Services Program will take final action.

Mail or fax fair hearing requests to:

CSHCN Services Program-Fair Hearing  
MC-1938  
PO Box 149030  
Austin, TX 78714-99347  
Fax: 1-512-776-7238

## 7.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

## 7.6 Authorization and Filing Deadline Calendars

*Referto:* [2023 Authorization Filing Deadline Calendar](#)  
[2024 Authorization Filing Deadline Calendar](#)

# **ADVANCED PRACTICE REGISTERED NURSE (APRN [NP/CNS])**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# ADVANCED PRACTICE REGISTERED NURSE (APRN [NP/CNS])

## Table of Contents

- 8.1 Enrollment .....3
- 8.2 Benefits, Limitations, and Authorization Requirements.....3
  - 8.2.1 Authorization Requirements ..... 4
- 8.3 Claims Information.....4
- 8.4 Reimbursement.....4
- 8.5 TMHP-CSHCN Services Program Contact Center .....5



## 8.1 Enrollment

To enroll in the CSHCN Services Program, an advanced practice registered nurse (APRN) (e.g., nurse practitioner [NP], clinical nurse specialist [CNS]) must be actively enrolled in Texas Medicaid, licensed as a registered nurse, and recognized as an APRN by the Texas Board of Nursing (BON). APRNs may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). Out-of-state APRNs must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program enrollment procedures.

Certified registered nurse anesthetists (CRNAs) should refer to Chapter 12, “Certified Registered Nurse Anesthetist (CRNA)” for information specific to their practice.

## 8.2 Benefits, Limitations, and Authorization Requirements

Services provided by APRNs are benefits if the services are:

- Within the scope of practice for APRNs, as defined by Texas state law.
- Consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Benefits of the CSHCN Services Program when provided by a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]).
- Reasonable and medically necessary as determined by DSHS or its designee.

APRNs who are employed or paid by a physician, hospital, facility, or other provider must not bill the CSHCN Services Program for their services, if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician’s own National Provider Identifier (NPI) for services provided by an APRN must submit modifier SA on each claim detail if the physician does not make a decision regarding the client’s care or treatment on the same date of service as the billable medical visit.

All limitations applicable to physicians for the same service will also be applied to the APRN.

### 8.2.1 Authorization Requirements

Authorization and prior authorization requirements are listed in individual sections of this manual. Authorization requirements applied to services provided by physicians (MD or DO) also apply to services provided by APRNs.

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization and prior authorization requirements.

Section 31.2.12, “Clinician-Directed Care Coordination Services” in Chapter 31, “Physician” for information and prior authorization requirements for clinician-directed care coordination services.

## 8.3 Claims Information

APRN services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 8.4 Reimbursement

APRNs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an APRN if the physician does not make a decision regarding the client’s care or treatment on the same date of service as the billable medical visit. Exceptions to the 92 percent reimbursement methodology for APRNs and physicians include injections, laboratory services, radiology services, and immunizations.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## **8.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **AMBULANCE**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# AMBULANCE

## Table of Contents

- 9.1 Enrollment .....4**
- 9.2 General Information .....4**
  - 9.2.1 Origin and Destination Modifiers ..... 5
  - 9.2.2 Place of Service ..... 5
  - 9.2.3 Diagnosis Coding ..... 6
  - 9.2.4 General Documentation Requirements ..... 6
- 9.3 Emergency Ambulance Transports .....7**
  - 9.3.1 Emergency Triage, Treat, and Transport (ET3) ..... 7
    - 9.3.1.1 Transport to an Alternative Destination ..... 7
    - 9.3.1.2 Treatment in Place ..... 8
  - 9.3.2 Emergency Prior Authorization ..... 8
  - 9.3.3 Levels of Service ..... 8
  - 9.3.4 Emergency Medical Conditions ..... 9
- 9.4 Nonemergency Ambulance Transports .....10**
  - 9.4.1 Nonemergency Prior Authorizations ..... 10
  - 9.4.2 Nonemergency Ambulance Exception Request ..... 12
  - 9.4.3 Documentation of Medical Necessity ..... 13
    - 9.4.3.1 Run Sheets ..... 13
- 9.5 Types of Transport .....14**
  - 9.5.1 Multiple Client Transport ..... 14
  - 9.5.2 Specialty Care Transport ..... 14
  - 9.5.3 Air or Water Specialized Medical Services Vehicle Transport ..... 14
  - 9.5.4 Out-of- Locality Transport ..... 15
  - 9.5.5 Extra Attendant ..... 15
    - 9.5.5.1 Extra Attendant - Emergency Ambulance Transports ..... 15
    - 9.5.5.2 Extra Attendant - Nonemergency Ambulance Transports ..... 15
  - 9.5.6 Oxygen ..... 16
  - 9.5.7 Ambulance Disposable Supplies ..... 16
  - 9.5.8 Mileage ..... 16
  - 9.5.9 Waiting Time ..... 16
- 9.6 Relation of Service to Time of Death .....16**
- 9.7 Ambulance Transport Services That Are Not Benefits .....17**
- 9.8 Claims Filing and Reimbursement .....17**
  - 9.8.1 Claims Filing ..... 17
    - 9.8.1.1 Emergency Ambulance Claims ..... 18
      - 9.8.1.1.1 *Emergency Triage Services Billing* ..... 18
      - 9.8.1.1.2 *Transport to an Alternative Destination Billing* ..... 18
      - 9.8.1.1.3 *Treatment in Place (TIP) Billing* ..... 18
    - 9.8.1.2 Nonemergency Ambulance Claims ..... 19
    - 9.8.1.3 Billing Mileage with \$0.00 ..... 20
    - 9.8.1.4 National Correct Coding Initiative (NCCI) Guidelines ..... 20

---

|            |   |           |
|------------|---|-----------|
| 9.8.2      | Reimbursement .....                                     | 20        |
| 9.8.2.1    | One-day Payment Window Reimbursement Guidelines .....   | 20        |
| <b>9.9</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b> | <b>20</b> |

## 9.1 Enrollment

To enroll in the CSHCN Services Program, ambulance providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Providers may enroll online or download enrollment forms at [www.tmhp.com](http://www.tmhp.com).

A hospital-operated ambulance provider must enroll as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier.

Out-of-state ambulance and air ambulance providers must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

Ambulance and air ambulance providers must submit a copy of their permit or license from the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession or their facility, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 9.2 General Information

The CSHCN Services Program may reimburse emergency and nonemergency ambulance transports (ground, air, or specialized emergency medical services vehicle) when the client meets the definition of emergency medical condition or meets the requirements for nonemergency transport.

The following ambulance services procedure codes are a benefit of the CSHCN Services Program:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| A0382           | A0398 | A0420 | A0422 | A0424 | A0425 | A0426 | A0427 | A0428 | A0429 |
| A0430           | A0431 | A0433 | A0434 | A0435 | A0436 | A0999 | Q3014 |       |       |

Procedure codes A0398, A0433, A0434 and A0999 may be reimbursed as emergency or nonemergency services.

- Claims for emergency services must be submitted with the ET modifier.

- Nonemergency services must be prior authorized.

Ground and air mileage (procedure codes A0425, A0435, and A0436) is reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

The inpatient hospital stay benefit includes medically necessary emergency and nonemergency ambulance transportation of the client during an inpatient hospital stay.

Ambulance transport during a client’s inpatient hospital stay will not be reimbursed to the ambulance provider. One time ambulance transports that occur immediately after the client’s discharge may be considered for reimbursement.

**9.2.1 Origin and Destination Modifiers**

The following are the origin and destination codes accepted by the CSHCN Services Program:

| Origin and Destination Code | Description   |
|-----------------------------|---|
| D                           | Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P |
| E                           | Residential, domiciliary, or custodial facility (unskilled facility)  |
| G                           | Hospital-based dialysis facility (hospital or hospital-related)   |
| H                           | Hospital (inpatient or outpatient)  |
| I                           | Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport                     |
| J                           | Nonhospital-based dialysis facility   |
| N                           | Skilled nursing facility  |
| P                           | Physician’s office  |
| R                           | Residence (client’s home or any residence)  |
| S                           | Scene of accident or acute event  |
| X                           | Intermediate stop at physician’s office en route to the hospital (destination code only)                    |

The following are emergency Triage, Treat, and Transport (ET3) alternative destination and treatment in place (TIP) destination codes:

| Destination | Description  |
|-------------|--|
| C           | Community mental health center (including substance use disorder center) |
| F           | Federally qualified health center  |
| O           | Physician’s office   |
| U           | Urgent care facility   |
| W           | Treatment in place (in person or via telehealth)                         |

All ambulance claims must include the origin and destination modifiers on each procedure code submitted. Any procedure code submitted without the origin and destination modifiers will be denied.

**9.2.2 Place of Service**

All claims submitted must include a Place of Service (POS) code in block 24b of the CMS-1500 paper claim form.



The POS identifies where services are performed. Indicate the POS by using the appropriate numeric code for each service listed on the claim. The following POS codes must be used:

| Place of Service         | Two-Digit Numeric Codes<br>(Electronic Billers) | One-Digit Numeric Codes<br>(Paper Billers) |
|--------------------------|---|--|
| Office                   | 11, 65, 71, 72                                  | 1  |
| Home                     | 12  | 2  |
| Inpatient hospital       | 21, 51, 52, 56, 61                              | 3  |
| Outpatient hospital      | 22, 23, 24, 55, 62                              | 5  |
| Other location           | 26, 34, 53, 99                                  | 9  |
| Independent lab          | 81  | 6  |
| Destination of ambulance | Indicate destination using above codes          | Indicate destination using above codes     |

### 9.2.3 Diagnosis Coding

Medical necessity and coverage of ambulance transport services are not based solely on the presence of a specific diagnosis. The CSHCN Services Program reimbursement for ambulance transports may be made only for those clients whose condition at the time of transport is such that ambulance transport is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transport. In each of those instances, the condition of the client must be such that transport by any other means is medically contraindicated. In the case of ambulance transport, the condition necessitating transport is often that an accident or injury has occurred that gives rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

It is the requesting provider's (facility, physician, or ambulance) responsibility to supply the CSHCN Services Program contract administrator with information that describes the condition of the client that necessitated the ambulance transport. Because many ambulance personnel have only a limited ability to establish a diagnosis, the CSHCN Services Program recognizes that coding of a client's condition using International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes by ambulance transport services may be less specific than those determined by other health-care providers.

Ambulance services providers who submit ICD-10-CM diagnosis codes should choose the code that best describes the client's condition at the time of transport. When a diagnosis is not confirmed, it is better to use a symptom, finding, or injury code. Providers of ambulance services should avoid using ICD-10-CM codes to report "rule out" or "suspected" diagnoses.

When there are two responders to an emergency, the company that transports the client will be reimbursed for their services. The CSHCN Services Program does not reimburse for the return trip of an empty ambulance.

The ambulance provider does not have to submit the run sheet with the claim. This documentation may be requested upon retrospective review. A Medicare ambulance claim that has been denied must go through the appropriate Medicare claims appeal process with a decision by the administrative law judge before TMHP will process the ambulance claim.

### 9.2.4 General Documentation Requirements

Supporting documentation is required to be maintained by both the ambulance provider and the requesting provider, including a physician, health-care provider, or other responsible party.

An ambulance provider is required to maintain documentation that represents the client's medical conditions and other clinical information to substantiate medical necessity and the level of service and mode of transportation requested. This supporting documentation is limited to documents that are developed or maintained by the ambulance provider.

Physicians, health-care providers, or other responsible parties who request ambulance transport are required to maintain physician orders and the [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#) in the client's medical record. Requesting providers must also maintain documentation of medical necessity for the ambulance transport.

### 9.3 Emergency Ambulance Transports

Emergency transports are to be to the nearest medical facility. An appropriate facility includes the equipment, personnel, and capability to provide the services necessary to support the required medical care. When an emergency transport is made to a facility other than the nearest appropriate facility and the type of transport is medically necessary, reimbursement for mileage is limited to the amount that would be reimbursed to transport to the nearest appropriate facility.

Facility-to-facility transports may be considered an emergency if the emergency treatment is not available at the first facility. All other facility-to-facility transports are considered nonemergent and prior authorization will be required.

The CSHCN Services Program coverage for emergency air ambulance transport services is limited to instances in which the client's pickup point is inaccessible by ground transport or when great distance interferes with the immediate admission to a medical treatment facility appropriate for their condition.

Claims for emergency transport services, must include the following:

- ET modifier for each procedure code.
- One or more emergency medical condition codes in the Emergency Medical Condition Code table below.

Claims for emergency ambulance transport services that are submitted without an emergency medical condition code may be appealed with documentation of medical necessity that supports the definition of an emergency medical condition.

An emergency ambulance transport that is denied will not be accepted on appeal as a nonemergency transport.

#### 9.3.1 Emergency Triage, Treat, and Transport (ET3)

Emergency Triage Treat and Transport (ET3) services are designed to allow greater flexibility for enrolled ambulance providers to address clients' health care needs following a 9-1-1, fire, police, or other locally established system for emergency calls. ET3 permits emergency transportation (ground ambulance) providers to:

- Transport a client to an alternative destination, other than an emergency department; or
- Initiate and facilitate appropriate treatment in place (TIP) at the scene; or
- Initiate and facilitate appropriate TIP via telemedicine or telehealth.

##### 9.3.1.1 Transport to an Alternative Destination

An ambulance provider may transport a client to an alternative destination (such as an urgent care clinic, mental health center, FQHC, etc.) when upon evaluation:

- The client's condition is determined to be non-emergent but requires medical attention.

- An alternative destination will meet the client's level of care more appropriately than an emergency department.
- There is no other appropriate transportation available.

The alternative destination must be within or near the responding emergency transportation provider's service area. Prior to initiating ET3 transport to an alternative destination, the provider must have pre-established arrangements with alternative destination partners within their region, and have knowledge of the alternative destination's:

- Hours of operation.
- Clinical staff available.
- Services provided.

HHSC expects ambulance providers to use best practices and exercise their normal standard of care to determine the nearest most appropriate alternative destination for a client.

### **9.3.1.2 Treatment in Place**

Upon the emergency response team's arrival on the scene and their evaluation of the client, if the services required at that time are determined to be medically necessary, but not emergent, the emergency transportation provider may provide treatment to the client in accordance with the provider's scope of practice, their emergency transport service's medical direction and established protocols.

Treatment on scene may also be performed, when medically necessary, via a telemedicine or telehealth visit performed in accordance with telemedicine and telehealth services requirements outlined in the *Telecommunications Handbook*.

*Referto:* *The Telecommunications Handbook (Vol. 2 Handbooks)* for telemedicine and telehealth requirements.

### **9.3.2 Emergency Prior Authorization**

Emergency transports within the state of Texas do not require authorization. Transports within 50 miles of the Texas state border do not require authorization.

The inpatient hospital stay benefit includes medically necessary emergency and nonemergency ambulance transport of the client during an inpatient hospital stay. Ambulance transports during an inpatient hospital stay will not be authorized unless the transport is immediately after the client's discharge from the hospital.

Out-of-state (air, ground, and water) emergency transports require authorization. All out-of-state emergency transport requests will be reviewed by the CSHCN Services Program Medical Director.

### **9.3.3 Levels of Service**

Ambulance services for basic life support and advanced life support are benefits of the CSHCN Services Program. The following CMS and the Texas Health and Safety Code definitions apply for basic and advanced levels of service:

- Basic life support (BLS) is emergency care that uses noninvasive medical acts, and if allowed by the licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.
- Advanced life support, level 1 (ALS 1) is emergency care that uses invasive medical acts that include an ALS assessment or at least one ALS intervention.
- Advanced life support, level 2 (ALS 2) is emergency care that uses invasive medical acts including one of the following:
  - At least three separate administrations of one or more medications (excluding crystalloid fluids) by intravenous push/bolus or by continuous infusion

- At least one of the ALS 2 procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or intraosseous line.

### 9.3.4 Emergency Medical Conditions

An emergency is defined as a medical condition that manifests acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the client’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency behavioral health condition is defined as any condition that, in the opinion of a prudent layperson with an average knowledge of health and medicine, requires immediate intervention or medical attention regardless of the nature, without which the client would present an immediate danger to themselves or others or that renders the client incapable of controlling, knowing, or understanding the consequences of their actions.

The following table includes the valid emergency medical condition codes for emergency ambulance services:

| Emergency Medical Condition Codes |         |          |         |          |          |          |          |
|-----------------------------------|---------|----------|---------|----------|----------|----------|----------|
| B9689                             | B999    | D75A     | D8130   | D8131    | D8132    | D8139    | E869     |
| F068                              | F10929  | F19939   | F29     | G4489    | G8929    | H579     | H814     |
| I2693                             | I2694   | I469     | I4811   | I4819    | I4820    | I4821    | I499     |
| I80241                            | I80242  | I80243   | I80249  | I80251   | I80252   | I80253   | I80259   |
| I82451                            | I82452  | I82453   | I82459  | I82461   | I82462   | I82463   | I82469   |
| J9600                             | J984    | M549     | O2690   | Q7960    | Q7961    | Q7962    | Q7963    |
| Q7969                             | R002    | R0602    | R0603   | R0689    | R079     | R092     | R0989    |
| R100                              | R109    | R238     | R4182   | R4189    | R4589    | R509     | R52      |
| R55                               | R569    | R58      | R6889   | R7309    | S02121A  | S02121B  | S02121S  |
| S02122A                           | S02122B | S02122S  | S02129A | S02129B  | S02129S  | S02831A  | S02831B  |
| S02831S                           | S02832A | S02832B  | S02832S | S02839A  | S02839B  | S02839S  | S02841A  |
| S02841B                           | S02841S | S02842A  | S02842B | S02842S  | S02849A  | S02849B  | S02849S  |
| S0285XA                           | S0285XB | S0285XS  | S0590XA | T07XXXA  | T148XXXA | T1490XA  | T1491XA  |
| T17300A                           | T300    | T50904A  | T50911A | T50911S  | T50912A  | T50912S  | T50913A  |
| T50913S                           | T50914A | T50914S  | T50915A | T50915S  | T50916A  | T50916S  | T59891A  |
| T5994XA                           | T6701XA | T6701XS  | T6702XA | T6702XS  | T6709XA  | T6709XS  | T672XXXA |
| T675XXXA                          | T68XXXA | T699XXXA | T7500XA | T751XXXA | T754XXXA | T782XXXA | T7840XA  |
| T8189XA                           | T82519A | T887XXXA | Y35009A | Y35009S  | Y35019A  | Y35019S  | Y35029A  |
| Y35029S                           | Y35039A | Y35039S  | Y35049A | Y35049S  | Y35099A  | Y35099S  | Y35109A  |
| Y35109S                           | Y35119A | Y35119S  | Y35129A | Y35129S  | Y35199A  | Y35199S  | Y35209A  |
| Y35209S                           | Y35219A | Y35219S  | Y35299A | Y35299S  | Y35309A  | Y35309S  | Y35319A  |
| Y35319S                           | Y35399A | Y35399S  | Y35409A | Y35409S  | Y35419A  | Y35419S  | Y35499A  |
| Y35499S                           | Y35819A | Y35819S  | Y35831A | Y35831S  | Y35832A  | Y35832S  | Y35833A  |
| Y35833S                           | Y35839A | Y35839S  | Y3599XA | Y3599XS  | Y710     | Y828     | Z209     |

| Emergency Medical Condition Codes |      |       |       |       |
|-----------------------------------|------|-------|-------|-------|
| Z7401                             | Z779 | Z9181 | Z9981 | Z9989 |

## 9.4 Nonemergency Ambulance Transports

Nonemergency transports are provided by an ambulance provider for a client to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the client's home after discharge from a hospital. Nonemergency ambulance transports may be considered a benefit of CSHCN Services Program when alternate means of transport is contraindicated due to the client's medical or mental health condition.

*Note: In this circumstance, contraindicated means that the client cannot be transported by any other means from the origin to the destination without endangering the individual's health.*

Medical necessity must be established through prior authorization for all nonemergency ambulance transports.

Nonemergency transports of clients with conditions that do not meet medical necessity criteria are not a benefit of the CSHCN Services Program. Transports must be limited to trips in which the client not only meets the medical necessity requirements, but the transport of the client is the least costly service available.

A provider may appeal denied prior authorization requests by submitting a request for an administrative review to the CSHCN Services Program.

Providers may appeal denied payment for services when prior authorization was not obtained before the service was provided by submitting a request for an administrative review to the CSHCN Services Program.

A provider that is denied payment for rendered ambulance transport services is entitled to payment from the health-care provider or other responsible party that requested the services if:

- Payment is denied because the requesting provider did not obtain prior authorization.
- The performing provider submits a copy of the bill for which payment was denied to the health-care provider or other responsible party for payment.

Clients and/or providers may contact the Medical Transportation Program (MTP) for assistance when non-emergent transports are not approved. MTP may be contacted toll free at 1-877-633-8747 to request transportation services.

### 9.4.1 Nonemergency Prior Authorizations

Prior authorization will be required for all nonemergency ambulance transports, regardless of the type of transport (e.g., air or specialized emergency medical services vehicle). To obtain prior authorization, a completed [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#) must be submitted. The [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#) must not be modified (i.e., changing of the sequence). If altered in any way, the request may be denied.

The following nonemergency transports require prior authorization:

- Hospital to hospital
- Hospital to outpatient facilities
- Round-trip transport from the client's home to a scheduled medical appointment

A physician, health-care provider, or facility must obtain prior authorization from the TMHP/CSHCN Services Program Ambulance Department or a person authorized to act on behalf of the prior authorization department on the same day or the next business day following the day of transport when an ambulance is used to transport a client in circumstances not involving an emergency, and the request is for the authorization of the provision of transportation for only one day. If transportation occurs over the weekend or a holiday, the responsible party must obtain authorization on the following business day.

If the request is for the provision of transportation for more than one day, the prior authorization department shall require a physician, health-care provider, or other responsible party to obtain a single prior authorization before an ambulance is used to transport a client in circumstances that do not involve an emergency.

For nonemergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request with the requesting provider, which may include a physician, nursing facility, health-care provider, or other responsible party. Ambulance providers may assist in providing necessary information, such as their National Provider Identifier (NPI) number, fax number, and business address, to the requesting provider. However, the [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#) must be signed, dated, and submitted by the CSHCN Services Program-enrolled requesting provider, not the ambulance provider.

The following rules apply to all nonemergency transports:

- Authorization must be evaluated based on the client's medical needs and may be granted for a length of time appropriate to the client's medical condition.
- A response to a request for authorization will be made no later than 48 hours after receipt of the request.
- A request for authorization will be immediately granted and will be effective for a period of not more than 60 days from the date of issuance if the request includes a written statement from a physician that includes both of the following:
  - A statement that alternative means of transporting the client are contraindicated.
  - A submission date that is no earlier than 60 days before the requested date of service.

Authorization can be obtained by telephone at 1-800-540-0694 for hospital-to-hospital or hospital-to-outpatient-facilities transports. Telephone requests will be accepted only from the transferring facility. Hospital-to-hospital or hospital-to-outpatient-facilities transport information and prior authorization requests may also be faxed or mailed. The requesting hospital should fax or mail supporting documentation to the TMHP/CSHCN Ambulance Unit when requested, to assist in determining medical necessity. Requests may be faxed or mailed to:

Texas Medicaid & Healthcare Partnership  
Ambulance Prior Authorizations  
PO Box 200735  
Austin, TX 78727-0735  
Fax: 1-512-514-4205

The requesting provider must select from the following prior authorization periods on the [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#):

- **One-time, nonrepeating (1 day).** One-time requests are for those clients who require only a one-time transport.

- The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or discharge planner with knowledge of the client's condition. Stamped signatures and dates are not accepted. Without a signature and date, the form will be considered incomplete.
- **Recurring (up to 60 days).** Prior authorization requests are reserved for recurring transports are for those clients whose transportation needs are anticipated to last as long as 60 days.
  - The request must be signed and dated by a physician, PA, NP, or CNS. Stamped signatures and dates are not accepted. Without a signature and date, the form will be considered incomplete.
  - The request must include the approximate number of visits needed for the repetitive transport (i.e. dialysis, radiation therapy).
  - If a prior authorization request has been approved and additional procedure codes are needed because the client's condition has deteriorated or the need for equipment has changed, the requesting provider must submit a new [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#).

The TMHP Ambulance Unit no longer issues nonemergency long-term (61-180 day) approvals effective February 15, 2013. Existing prior authorization approvals by the CSHCN Services Program are not affected by this change.

Long-term prior authorization requests submitted after February 15, 2013 are still processed; however, the approval criteria is issued for only up to 60 days if the client meets the criteria.

The prior authorization department will render a decision within 48 hours for prior authorization requests that are 60 days duration or less. If for any reason, the client's condition deteriorates or the need for equipment changes requiring additional procedure codes to be submitted for the transport after a previous prior authorization request has been approved, the requesting provider must submit a new [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#).

#### **9.4.2 Nonemergency Ambulance Exception Request**

Clients whose physician has documented a debilitating condition and require recurring trips that will extend longer than 60 days may qualify for an exception to the 60 day prior authorization request.

To request an exception, the provider must submit all the following documentation:

- A completed [Non-emergency Ambulance Exception form](#) that is signed and dated by a physician.
  - Note: Stamped signatures and dates are not accepted. Without a physician's signature and date, the form is considered incomplete.*
- A completed [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#)
- Medical records that support the client's debilitating condition which may include, but not limited to:
  - Discharge information
  - Diagnostic images (i.e. MRI, CT, X-rays)
  - Care Plan

*Note: Documentation submitted with the statement "client has a debilitating condition" is insufficient.*

### 9.4.3 Documentation of Medical Necessity

Providers may be asked to supply additional documentation to support the client's condition. Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

Providers must document whether the client is currently an inpatient in a hospital when requesting prior authorization. Prior authorization will not be approved if the provider indicates the client is currently an inpatient in a hospital except for one time transports immediately after the client's discharge from the hospital.

The requesting provider which may include a physician, healthcare provider, or other responsible party is required to maintain the supporting documentation, physician's orders, the [Texas Medicaid and Children with Special Health Care Needs \(CSHCN\) Services Program Non-Emergency Ambulance Prior Authorization Request form](#) and, if applicable, the Non-emergency Ambulance Exception form.

The requesting provider (i.e., physician, nursing facility, health-care provider, or other responsible party) must contact the transporting ambulance provider with the prior authorization number (PAN) and the dates of service that were approved. The transporting ambulance provider will submit claims for the nonemergency ambulance transportation services, using the approved PAN provided by the requesting provider.

Documentation supporting medical necessity must include either:

- The client is bed-confined before, during and after the trip and alternate means of transport is medically contraindicated and would endanger the client's health (i.e. injury, surgery, or use of respiratory equipment); or
- The client's functional physical and/or mental limitations that have rendered him/her bed-confined must be documented.

*Note: Bed-confined is defined as a client who is unable to stand, ambulate, and sit in a chair or wheelchair.*

- The client's medical or mental health condition is such that alternate means of the transport is medically contraindicated and would endanger the client's health (i.e., injury, surgery, or the use of respiratory equipment); or
- The client is a direct threat to his/her self or others requiring the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (i.e., suicidal)

When physical restraints are needed, documentation must include, but not limited to:

- Type of restraint
- Time frame of use of the restraint
- Client's condition

*Note: The standard straps used in ambulance transport are not considered a restraint.*

#### 9.4.3.1 Run Sheets

The run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care provided, if necessary. The ambulance provider does not have to submit the run sheet with the claim.

The ambulance provider must have documentation to support the claim. Without documentation that would establish the medical necessity of a nonemergency ambulance transport, the transport may not be covered by the CSHCN Services Program.



It is the responsibility of the ambulance provider to maintain (and to furnish to the CSHCN Services Program upon request) concise and accurate documentation. The run sheet must include the client's physical assessment that explains why the client requires ambulance transportation and cannot be safely transported by an alternate mode of transport.

Coverage will not be allowed if the trip record contains an insufficient description of the client's condition at the time of transfer for the CSHCN Services Program to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the client's condition is limited to statements and/or opinions, such as the following:

- "Patient is non-ambulatory."
- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is bed-confined."
- "Patient is unable to sit, stand, or walk."

The run sheet should detail the client's condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request).

*Note: The ambulance provider may decline the transport if the client's medical or mental health condition does not meet the medical necessity requirements.*

## 9.5 Types of Transport

### 9.5.1 Multiple Client Transport

Multiple client transports are those in which more than one client is transported in the same vehicle at the same time. Claims for CSHCN Services Program clients must be submitted with the transport procedure code and the mileage procedure code with the GM modifier that indicates multiple client transport. Claims must include the names and CSHCN Services Program numbers of other CSHCN Services Program clients who shared the transfer or must indicate "Not a CSHCN Services Program client."

Payment for multiple client transports are adjusted to 80-percent reimbursement of the allowable base rate for the transport for each claim and mileage is divided equally among the clients who share the ambulance.

### 9.5.2 Specialty Care Transport

Specialty care transport (SCT) is the interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) paramedic. SCT is necessary when a client's condition requires ongoing care that must be furnished by one or more health-care professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

### 9.5.3 Air or Water Specialized Medical Services Vehicle Transport

Helicopter, fixed-wing aircraft, or specialized emergency medical services vehicle ambulance transport services (procedure codes A0430, A0431, A0435, A0436, and A0999) will be reviewed by the CSHCN Services Program Medical Director and may be reimbursed if one or more of the following conditions are met:

- The client's medical condition requires immediate and rapid ambulance transport that could not have been provided by ground ambulance.
- The point of client pick-up is inaccessible by ground vehicle.

- Great distance or other obstacles are involved in transporting the client to the nearest appropriate facility.

Emergency air or specialized emergency medical services vehicle transports that do not meet the emergency air criteria, but do meet the ground criteria, will be reimbursed at the appropriate ground rate.

Prior authorization is required for all nonemergency ambulance transports, regardless of the type of transport (e.g., air or specialized emergency medical services vehicle). All ambulance transport services that include helicopter, fixed-wing aircraft, or specialized emergency medical services vehicles will be reviewed by the Medical Director. Claims for specialized emergency medical services vehicles (i.e., boat or airboat) must be submitted using procedure code A0999.

All air ambulance transports (procedure codes A0430 and A0431) must be billed with the corresponding air mileage procedure code A0435 or A0436.

#### **9.5.4 Out-of- Locality Transport**

Out-of-locality transports may be reimbursed if a local facility is not adequately equipped to treat the condition. “Out-of-locality” refers to one-way transfers of 50 or more miles from point of pickup to point of destination.

#### **9.5.5 Extra Attendant**

The use of an additional attendant must be related to extraordinary circumstances that prevent the basic crew from transporting a client safely. The extra attendant must be certified by the Department of State Health Services (DSHS) to provide emergency medical services.

Reasons an extra attendant may be required beyond the basic crew include, but are not limited to the following:

- Necessity of additional special medical equipment or treatment en route to destination (Providers must describe what special treatment and equipment is required and why it requires an attendant.)
- Client behavior that may be a danger to the client or ambulance crew or requires or may require restraints
- Extreme obesity (Providers must specify the client’s weight and functional limitations.)

The CSHCN Services Program does not reimburse for an extra attendant based solely on an ambulance provider’s internal policy.

The use of an extra attendant for air transport is not a benefit of the CSHCN Services Program. Reimbursement for an extra attendant (procedure code A0424) will be denied if billed with air transport (procedure codes A0430 or A0431).

##### **9.5.5.1 Extra Attendant - Emergency Ambulance Transports**

Emergency transports that use an extra attendant do not require prior authorization.

The billing provider’s medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate medical necessity of the attendant. The information that supports medical necessity must be kept in the billing provider’s medical record and is subject to retrospective review.

When more than one client is transported at the same time in the same vehicle, the use of an extra attendant may be required when each client being transported requires medical attention and close monitoring.

##### **9.5.5.2 Extra Attendant - Nonemergency Ambulance Transports**

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When an extra attendant is needed for subsequent transports, the prior authorization must be updated.

The requesting provider must prove medical necessity on the prior authorization request by identifying attendant services that could not be provided by the basic crew. The information that supports medical necessity must be kept in the requesting provider's medical record and is subject to retrospective review.

### **9.5.6 Oxygen**

Reimbursement for oxygen (procedure code A0422) is limited to one procedure code per transport.

Oxygen (procedure code A0422) is reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

### **9.5.7 Ambulance Disposable Supplies**

Ambulance disposable supplies are included in the global fee for SCT transports and must not be billed separately.

Reimbursement for BLS and ALS disposable supplies (procedure codes A0382 or A0398) is separate from the established fee for BLS and ALS ambulance transports and is limited to one billable procedure code per transport.

Claims submitted for BLS or ALS supplies will be denied unless a corresponding ALS or BLS transport is billed on the same claim.

### **9.5.8 Mileage**

The CSHCN Services Program does not reimburse air or ground mileage when the client is not on board the ambulance.

Providers must calculate the number of miles traveled by using the ambulance vehicle odometer reading or an internet mapping tool. Mileage reported on the claim must be the actual number of miles traveled.

Procedure codes for ground ambulance transports (A0426, A0428, A0433, A0434, and A0999) must be submitted with mileage procedure code A0425. Emergency ground ambulance transports (procedure codes A0427 and A0429) may be billed without mileage code A0425 for ET3 TIP services. Providers must include TIP destination code W in the destination position of the origin/destination modifier combination.

A transport and mileage procedure code must be billed on the same claim to be considered for reimbursement. Transport and mileage procedure codes should never be reported as stand-alone services.

Providers may not include a mileage charge as part of the transport charge or in any other charges on the claim.

### **9.5.9 Waiting Time**

Waiting time (procedure code A0420) is reimbursed up to one hour. Waiting time may be submitted when it is the general billing practice of local ambulance companies to charge for unusual waiting time (over 30 minutes) based on the following:

- Separate charges must be billed for unusual wait times.
- The circumstances that necessitate a wait time and the exact time involved must be documented.

The amount charged for waiting time must not exceed the charge for a one-way transfer.

## **9.6 Relation of Service to Time of Death**

The CSHCN Services Program may reimburse an ambulance provider in the following circumstances related to a deceased client:

- The client dies in the ambulance while en route to the destination.

- The ambulance services to the point of pickup for the client who is pronounced dead by the physician after the ambulance is called.

## 9.7 Ambulance Transport Services That Are Not Benefits

The CSHCN Services Program does not reimburse providers for the following:

- An extra charge for a night call.
- Ambulance services performed in the skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility settings.

The CSHCN Services Program reimburses providers for ground emergency transports (procedure codes A0427 and A0429) that do not result in a transport to a facility, only as part of ET3 services when the destination modifier W indicating TIP is included on the claim. For all other transports, if a client contacts an ambulance provider, but the call does not result in a transport, the CSHCN Services Program will not reimburse the provider and the provider should have the client sign an acknowledgment statement and bill the client for services rendered.

## 9.8 Claims Filing and Reimbursement

### 9.8.1 Claims Filing

Ambulance claims must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

Ambulance claims must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Run sheets, medical records, or emergency room records are not required to be submitted with the claim submission. If, however, documentation is submitted with the claim, an emergency medical technicians signature is required on all of the documents.

**Note:** *Providers must maintain any documentation that substantiates the medical need for the transport and must ensure that the documentation is available to the CSHCN Services Program or its designee upon request.*

The ambulance provider is responsible for the integrity of the information about the client's condition necessitating the transport and the medical necessity of the transport. The ambulance provider may be sanctioned, including exclusion from the CSHCN Services Program, for completing or signing a claim form that includes a false or misleading representation of the client's condition or of the medical necessity of the transport.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

All claims submitted on paper or electronically must include the 2-letter origin and destination codes on every line detail. The origin is the first letter, and the destination is the second letter. For example, modifiers HR would indicate a hospital origin with a residence destination.

Providers must not bill CSHCN Services Program clients for ambulance services.

### 9.8.1.1 Emergency Ambulance Claims

Emergency air ambulance claims must include the appropriate procedure code(s) and all of the following additional information to be considered for reimbursement:

- Distance of transport
- Time of transport
- Acuity of client, origin or destination modifier, and relevant vital signs

Ambulance providers must use an appropriate ICD-10-CM diagnosis code in Block 21 of the CMS-1500 paper claim form or electronic equivalent to document the client's condition and the reason for the transport. If a diagnosis is not known at the time of the transport, providers must use the diagnosis code that most closely represents the client's physical signs and symptoms at the time of the transport. If the above documentation does not indicate an emergency, the claim is denied.

Providers billing electronically can enter the data supporting the necessity for the emergency transport in the Comments field or the Purpose of Stretcher field of the electronic claim. Providers using the CMS-1500 paper claim form can enter relevant vital signs and detailed narrative in Block 19 or 21 of the claim form. For ambulance transfers where the destination is a hospital, enter the name and address of the facility in Block 32.

#### 9.8.1.1.1 Emergency Triage Services Billing

To bill for ET3 services, a provider must:

- Be enrolled in the CSHCN Services Program as an ambulance provider.
- Be responding to a call initiated by an emergency response system (9-1-1 call, fire, police, or other locally established system for medical emergency calls).
- Upon arrival at the scene, the emergency team's field evaluation determines the client's needs are non-emergent but requires medical attention.
- Follow all requirements as outlined in section 9.1 Enrollment.

#### 9.8.1.1.2 Transport to an Alternative Destination Billing

When billing for transport to an alternative destination, providers shall bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the appropriate destination modifier to indicate ET3 services. Providers should also include the mileage code (A0425) in the claim as appropriate.

**Note:** *If an emergency transportation provider transports a client to an alternative destination and determines at the time that the site is either closed, or unable to provide the needed level of care, then the emergency transportation provider shall transport the client to the nearest emergency department. In these cases, the provider may not bill for two transports.*

#### 9.8.1.1.3 Treatment in Place (TIP) Billing

Treatment in place (TIP) is classified as an emergency transportation service and must be billed using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the W destination modifier to indicate TIP.

Claims must indicate TIP destination modifier W in the destination position of the origin/destination modifier combination. TIP claims without modifier W in the emergency indicator field will be denied.

Supplies (procedure codes A0382 and A0398) and oxygen (procedure code A04220) are payable, but mileage (procedure code A0425) and other ambulance transportation services (A0426 and A0428) are not payable for TIP services. Claims billed with non-payable ambulance TIP services will be denied.

The following are TIP ambulance claim modifiers:

| Modifier | Origination Site  | Destination |
|----------|---|-------------|
| DW       | Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P | TIP         |
| EW       | Residential, domiciliary, or custodial facility (unskilled facility)  | TIP         |
| JW       | Non-hospital-based dialysis facility  | TIP         |
| PW       | Physician's office  | TIP         |
| RW       | Residence (client's home or any residence)  | TIP         |
| SW       | Scene of accident or acute event  | TIP         |

If a client being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both treatment in place ambulance service and the transport to the emergency room. In this case, the ambulance provider shall bill only the emergency department transport.

For informational purposes, ambulance providers may include G2022 on ambulance transportation claims to an emergency department that met ET3 requirements, but the client refused TIP or transportation to an alternative destination.

When billing for TIP via telemedicine or telehealth, providers must bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, the W destination modifier to indicate TIP, and in addition, procedure code Q3014. The Q3014 code will be informational only used to identify TIP via telemedicine or telehealth services.

Ambulance TIP with telemedicine or telehealth encounters without a corresponding telemedicine or telehealth encounter will be denied. Claims for multiple TIP and transport claims rendered on the same date of service for the same recipient will be denied.

### 9.8.1.2 Nonemergency Ambulance Claims

All nonemergency ambulance claims must include the appropriate procedure codes and all of the following additional information to be considered for reimbursement:

- Detailed description of the client's medical condition necessitating the transport
- Distance of transport
- Time of transport
- Acuity of client, origin and destination modifier, and relevant vital signs

Providers billing electronically can enter the data supporting the necessity for the nonemergency transport in the Comments field or the Purpose of Stretcher field of the electronic claim. Providers using the CMS-1500 paper claim form can enter relevant vital signs and detailed narrative in Block 19 or 21 of the claim form. For ambulance transfers where the destination is a hospital, enter the name and address of the facility in Block 32. For transfers from hospital-to-hospital, indicate in Block 19 the services needed at the second facility that were unavailable at the first facility.

### 9.8.1.3 Billing Mileage with \$0.00

If the appropriate transport procedure code is submitted for reimbursement, claims with a billed mileage amount of \$0.00 may be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.

### 9.8.1.4 National Correct Coding Initiative (NCCI) Guidelines

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

## 9.8.2 Reimbursement

Ambulance procedure codes are reimbursed at a reasonable charge, which is the lesser of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

### 9.8.2.1 One-day Payment Window Reimbursement Guidelines

The one-day payment window reimbursement guidelines do not apply for ambulance services.

*Referto:* Section 24.3.7, “Payment Window Reimbursement Guidelines” in Chapter 24, “Hospital” for additional information about the one-day payment window reimbursement guidelines for services related to an inpatient hospital stay.

## 9.9 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **AUGMENTATIVE COMMUNICATION DEVICES (ACDs)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**





# AUGMENTATIVE COMMUNICATION DEVICES (ACDS)

## Table of Contents

|             |  |          |
|-------------|--|----------|
| <b>10.1</b> | <b>Enrollment .....</b>  | <b>3</b> |
| <b>10.2</b> | <b>Benefits, Limitations, and Authorization Requirements .....</b> | <b>3</b> |
| 10.2.1      | Purchases or Rentals .....   | 4        |
| 10.2.1.1    | Prior Authorization Requirements for Purchase or Rental .....      | 5        |
| 10.2.2      | Modifications .....  | 6        |
| 10.2.2.1    | Prior Authorization Requirements for Modifications .....           | 6        |
| 10.2.3      | Repairs .....  | 6        |
| 10.2.3.1    | Prior Authorization Requirements for ACD Repairs .....             | 6        |
| 10.2.4      | Replacement .....  | 6        |
| 10.2.4.1    | Prior Authorization Requirements for Replacement .....             | 7        |
| 10.2.5      | Excluded Items .....   | 7        |
| <b>10.3</b> | <b>Claims Information .....</b>                                    | <b>7</b> |
| <b>10.4</b> | <b>Reimbursement .....</b>   | <b>8</b> |
| <b>10.5</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b>            | <b>8</b> |

## 10.1 Enrollment

To enroll in the CSHCN Services Program, ACD providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state ACD providers may enroll and must meet all these conditions and be approved by the Department of State Health Services (DSHS).

ACD providers may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the TMHP website at [www.tmhp.com](http://www.tmhp.com).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, “Services Provided Outside of Texas” in Chapter 3, “Client Benefits and Eligibility” for more detailed information.

## 10.2 Benefits, Limitations, and Authorization Requirements

An ACD system is also known as an augmentative and alternative communication (AAC) device system. Benefits are limited to the purchase, rental, replacement, modification, and repair of ACDs that function independently of any other technology (i.e., may not rely on a computer in any way) for program-eligible clients when a documented need exists.

The following procedure codes must be used to request prior authorization or submit claims for the purchase or rental of ACDs. Only one of the procedure codes for rental of ACDs will be reimbursed per calendar month, by any provider.

| Procedure Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| E2500           | E2502 | E2504 | E2506 | E2508 | E2510 | E2512 | E2599 |

Claims for the purchase of a carrying case (procedure code E2599) must be submitted with modifier U1. The prior authorization request for a carrying case must include the make, model, and purchase date of the ACD system.

Items that are included in the reimbursement for an ACD system and are not reimbursed separately include, but are not limited to, the following:

- Applicable software (except for software purchased specifically to enable a client-owned computer or a personal digital assistant [PDA] to function as an ACD system)
- Batteries
- Battery charger
- Power supplies
- Interface cables
- Interconnects
- Sensors
- Moisture guard
- A/C or other electrical adapters
- Adequate memory to allow for system expansion within a 3-year time frame
- All training necessary to instruct the client, family, and caregivers in the use of the ACD system
- Any extended warranty

Prior authorization is mandatory for:

- All ACD rentals or purchases.
- ACD modifications.
- All accessories, including a carrying case.
- Replacement of ACDs or components.
- Repairs.

ACDs may be prior-authorized if the following criteria are met:

- They are prescribed by the client's treating physician.
- Clinical documentation supports medical necessity and appropriateness (refer to individual sections in this chapter for specific documentation requirements).

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

**Referto:** The [CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices \(ACDs\) Form](#).

### 10.2.1 Purchases or Rentals

Requests for ACD purchases should take into account all projected changes in the client's communication abilities for a minimum of 2 years. An ACD is not approved for purchase unless the client has used the requested ACD for a trial period of at least 30 days but not more than 60 days. Prior authorization may be obtained for rental (if feasible) during the trial period. If an ACD is unavailable for rental, a waiver may be granted with supporting documentation. All components, accessories, and switches, including mounting devices and lap trays necessary for use, must be used during the trial period before a decision to purchase can be approved. ACD systems and equipment that have been purchased are anticipated to last a minimum of 3 years.

**Referto:** Chapter 37, "Speech-Language Pathology (SLP) Services" for procedure codes related to therapy or training for use of an ACD during the trial period.

Requests for accessories that were unavailable at the time of the initial prescription may be considered once every 2 years with adequate supporting documentation. ACDs may be replaced every 3 years when one of the following occurs:

- They are lost or irreparably damaged.
- Three years have passed since the initial prescription and the ACD is no longer functional.
- Documentation supports medical necessity and appropriateness for replacing the current ACD.

#### **10.2.1.1 Prior Authorization Requirements for Purchase or Rental**

Prior authorization requests must include all of the following information or documentation:

- The medical diagnosis and how it relates to the client's communication needs
- Any significant medical information pertinent to the use of the ACD
- The limitations of the client's current communication abilities, system, and devices
- A statement as to why the prescribed ACD is the most effective, with a comparison of benefits versus alternative options
- A complete description of the ACD with all accessories, components, mounting devices, and modifications necessary for client use (must include the manufacturer's name, model number, and retail price)
- Documentation that the client is mentally, emotionally, and physically capable of operating and using the requested ACD
- A professional assessment must be conducted by a licensed speech-language pathologist in conjunction with other disciplines, such as physical or occupational therapy. This assessment must be completed before the ACD is prescribed by the physician. The prescribing physician should base the prescription on the professional assessment. The professional assessment by a licensed speech-language pathologist must include the following information:
  - Communication status and limitations
  - Speech and language skills assessment, including prognosis for speech or written communication
  - A description of the client's cognitive readiness
  - A description of the client's interactional, behavioral, or social abilities
  - A description of the client's capabilities, including intellectual, postural, physical, and sensory (visual and auditory)
  - A description of the client's motivation to communicate
  - A description of the client's residential, vocational, and educational setting
  - A description of how the ACD will be implemented or integrated into environments
  - A description of alternative ACDs considered, including a comparison of capabilities
  - A description of the ability of the ACD to meet the projected communication needs and growth potential of the client and how long the ACD will meet the client's needs
  - A detailing of any anticipated changes, modifications, or upgrades and projected time frames (short and long term)
  - A detailed training plan (who, what, when, and where)
- Specifications of the ACD, all of the component accessories that are necessary for the proper use of the ACD, and documentation of all necessary therapies and training

Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Prior Authorization Request for Augmentative Communication Devices (ACDs) form.

It is recommended that the preliminary evaluation for an ACD include the involvement of an occupational or physical therapist to assess the client's seating and postural needs and the motor skills required to use the ACD.

### **10.2.2 Modifications**

Modifications may be prior authorized with adequate supporting documentation of medical necessity and appropriateness when one of the following occurs:

- The client's needs have changed.
- A capability of or potential for communication develops that could not have been anticipated.

ACD modifications and requests for accessories that were unavailable at the time of the initial prescription may be considered once every 2 years with adequate supporting documentation.

#### **10.2.2.1 Prior Authorization Requirements for Modifications**

Documentation required for modifications of ACDs must include:

- A re-evaluation by a licensed speech-language pathologist.
- A prescription from the treating physician.
- Documentation that significant changes have occurred in the client's environment, physical abilities, or linguistic abilities and that such changes impair or affect the client's ability to benefit from the ACD currently in use.
- Documentation that the prescribed modification provides the client with the potential for an increased level of functional communication with significant reduction of disability.

### **10.2.3 Repairs**

All repairs require prior authorization. Nonwarranty repairs of an ACD system may be considered for prior authorization with documentation from the manufacturer explaining why the repair is not covered by warranty and with documentation of medical necessity.

Providers must use procedure code K0739 when billing nonwarranty repairs.

The CSHCN Services Program does not pay shipping and handling charges.

#### **10.2.3.1 Prior Authorization Requirements for ACD Repairs**

Documentation required for repairs of ACDs must include:

- A prescription from the treating physician.
- A statement that describes the needed repair.
- Justification of medical necessity.
- The estimated cost of repairs.

### **10.2.4 Replacement**

Replacement of ACDs or components is considered in the following circumstances:

- When loss or irreparable damage has occurred
- It has been 3 years since the initial prescription, and the ACD is no longer functional
- Documentation supports medical necessity or appropriateness of replacing the current ACD

### 10.2.4.1 Prior Authorization Requirements for Replacement

Prior authorization requests must include a joint statement from the prescribing physician and a licensed speech-language pathologist that includes:

- The cause of loss or damage and what measures have been taken to prevent reoccurrences.
- Information stating the client's abilities or communication needs are unchanged, or no other ACDS currently available are better suited to the client's needs.
- A new evaluation or assessment if requesting a different ACD from one that has been lost or damaged.

### 10.2.5 Excluded Items

Excluded items that are not related to the ACD system and software components that are not necessary to operate the system are not a benefit of the CSHCN Services Program. Excluded items include, but are not limited to:

- Printers.
- Wireless internet access devices.
- Voice prosthetics or artificial larynxes.
- Speech generating software programs for personal computers or PDAs (procedure code E2511).

## 10.3 Claims Information

The [CSHCN Services Program Documentation of Receipt](#) form is required and must be completed before reimbursement can be made for any equipment delivered to a client. The certification form is available in both [English](#) and [Spanish](#), and must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. Documentation of delivery must include one of the following:

- A delivery slip or invoice signed and dated by client or caregiver. The delivery slip or invoice must contain the client's full name, the address to which the supplies were delivered, the item description, and the numerical quantities that were delivered to the client.
- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies that were delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

The date of delivery on the form is the date of service (DOS) that should appear on the claim. Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. This information is not filed with the claim. It must be retained for the life of the piece of equipment or until the equipment is authorized for replacement.

ACD services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

## 10.4 Reimbursement

ACDs may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for the purchase or rental of ACDs is as follows:

- Rental will be reimbursed for short term use of the item (less than one year). When the rental period is expected to exceed 10 months, purchase must be considered.
- Purchase of an ACD is justified when the estimated duration of need multiplied by the rental rate exceeds the purchase price of the equipment.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 10.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **BLOOD PRESSURE MONITORING AND DEVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**





# BLOOD PRESSURE MONITORING AND DEVICES

## Table of Contents

|             |  |          |
|-------------|--|----------|
| <b>11.1</b> | <b>Enrollment .....</b>  | <b>3</b> |
| <b>11.2</b> | <b>Benefits, Limitations, and Authorization Requirements .....</b>                     | <b>3</b> |
| 11.2.1      | Blood Pressure Devices .....   | 3        |
| 11.2.1.1    | Self-Measured Blood Pressure Monitoring and Ambulatory Blood Pressure Monitoring ..... | 3        |
| 11.2.1.2    | Manual and Automated Blood Pressure Devices .....                                      | 4        |
| 11.2.1.3    | Hospital-Grade Blood Pressure Devices .....  | 5        |
| 11.2.1.4    | Blood Pressure Device Components Repair or Replacement .....                           | 6        |
| 11.2.2      | Authorization Requirements .....   | 6        |
| 11.2.2.1    | Ambulatory Blood Pressure Monitoring .....   | 6        |
| 11.2.2.2    | Manual and Automated Blood Pressure Devices .....                                      | 6        |
| 11.2.2.3    | Hospital-Grade Blood Pressure Devices .....  | 7        |
| 11.2.2.3.1  | <i>Rental</i> .....  | 7        |
| 11.2.2.3.2  | <i>Purchase</i> .....  | 8        |
| 11.2.2.4    | Blood Pressure Device Components Repair or Replacement .....                           | 8        |
| <b>11.3</b> | <b>Documentation of Receipt .....</b>  | <b>8</b> |
| <b>11.4</b> | <b>Claims Information .....</b>  | <b>8</b> |
| <b>11.5</b> | <b>Reimbursement .....</b>   | <b>9</b> |
| <b>11.6</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b>                                | <b>9</b> |

## 11.1 Enrollment

To enroll in the CSHCN Services Program, durable medical equipment (DME) providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out of state DME (noncustom DME) providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, “Services Provided Outside of Texas” in Chapter 3, “Client Benefits and Eligibility” for more detailed information.

## 11.2 Benefits, Limitations, and Authorization Requirements

### 11.2.1 Blood Pressure Devices

Blood pressure monitoring by either Self-Measured blood pressure monitoring (SMBPM) or Ambulatory blood pressure monitoring (ABPM) is a benefit of CSHCN Services Program when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Blood pressure devices and components are benefits of the CSHCN Services Program only in the home setting for self-monitoring when the equipment is prescribed by a physician.

Providers must maintain documentation, including the diagnosis, that supports medical necessity of the requested equipment in the client’s medical record and is subject to retrospective review.

#### 11.2.1.1 Self-Measured Blood Pressure Monitoring and Ambulatory Blood Pressure Monitoring

SMBPM and ABPM are indicated for the evaluation of one of the following conditions:

- White coat hypertension that is defined as:

- A clinic or office blood pressure greater than 140/90mm HG on at least three separate clinic or office visits with two separate measurements at each visit.
- At least two documented separate blood pressure measurements taken outside the clinic or office, which are less than 140/90mm Hg.
- No evidence of end-organ damage
- Resistant hypertension
- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

SMBPM and ABPM are indicated for initial diagnosis of hypertension and should not be used for maintenance monitoring. SMBPM may also be indicated for re-evaluation of clients previously diagnosed with hypertension.

**11.2.1.2 Manual and Automated Blood Pressure Devices**

Manual blood pressure devices (procedure code A4660) require manual cuff inflation with real-time visualization of the results displayed on the manometer. Automated blood pressure devices (procedure code A4670) inflate the cuff manually or automatically and display the blood pressure results on a small screen.

The purchase of manual or automated blood pressure devices may be considered when submitted with one of the following diagnosis codes:

| Diagnosis Codes |       |       |        |        |        |        |        |
|-----------------|-------|-------|--------|--------|--------|--------|--------|
| I10             | I110  | I119  | I120   | I129   | I130   | I1310  | I1311  |
| I132            | I150  | I151  | I152   | I158   | I159   | I160   | I161   |
| I169            | I1A0  | I219  | I21A1  | I21A9  | I21B   | I2541  | I2582  |
| I2585           | I2601 | I2602 | I2609  | I2690  | I2692  | I2693  | I2694  |
| I2699           | I270  | I271  | I2720  | I2721  | I2722  | I2723  | I2724  |
| I2729           | I2781 | I2782 | I2783  | I2789  | I279   | I340   | I341   |
| I342            | I3481 | I3489 | I349   | I350   | I351   | I352   | I358   |
| I359            | I360  | I361  | I362   | I368   | I369   | I370   | I371   |
| I372            | I378  | I379  | I38    | I39    | I421   | I422   | I423   |
| I424            | I425  | I428  | I440   | I441   | I442   | I4430  | I4439  |
| I444            | I445  | I4460 | I4469  | I447   | I450   | I4510  | I4519  |
| I452            | I454  | I455  | I456   | I4589  | I459   | I4710  | I4711  |
| I4719           | I4720 | I4729 | I479   | I480   | I4811  | I4819  | I4820  |
| I4821           | I483  | I484  | I4891  | I4892  | I495   | I501   | I5020  |
| I5021           | I5022 | I5023 | I5030  | I5031  | I5032  | I5033  | I5040  |
| I5041           | I5042 | I5043 | I50810 | I50811 | I50812 | I50813 | I50814 |
| I5082           | I5083 | I5084 | I5089  | I509   | I5A    | I950   | I951   |
| I952            | I953  | I9581 | I9589  | I959   | N000   | N001   | N002   |
| N003            | N004  | N005  | N006   | N007   | N008   | N009   | N00A   |
| N010            | N011  | N012  | N013   | N014   | N015   | N016   | N017   |

| Diagnosis Codes |       |       |       |         |         |         |       |
|-----------------|-------|-------|-------|---------|---------|---------|-------|
| N018            | N019  | N01A  | N02A  | N02B1   | N02B2   | N02B3   | N02B4 |
| N02B5           | N02B6 | N02B9 | N030  | N031    | N032    | N033    | N034  |
| N035            | N036  | N037  | N038  | N039    | N03A    | N040    | N041  |
| N0420           | N0421 | N0422 | N0429 | N043    | N044    | N045    | N046  |
| N047            | N048  | N049  | N04A  | N050    | N051    | N052    | N053  |
| N054            | N055  | N056  | N057  | N058    | N059    | N05A    | N08   |
| N170            | N171  | N172  | N178  | N179    | N181    | N182    | N1830 |
| N1831           | N1832 | N184  | N185  | N186    | N189    | N19     | N250  |
| N251            | N2589 | N259  | N269  | N270    | N271    | Q208    | Q2110 |
| Q2111           | Q2112 | Q2113 | Q2114 | Q2115   | Q2116   | Q2119   | Q2120 |
| Q2121           | Q2122 | Q2123 | R001  | T800XXA | T81718A | T8172XA |       |

Manual and automated blood pressure devices that have been purchased are anticipated to last a minimum of 1 year and may be considered for replacement when 1 year has passed or when the equipment is not functional and not repairable.

### 11.2.1.3 Hospital-Grade Blood Pressure Devices

The rental or purchase of a hospital-grade blood pressure device (procedure code A9279 with modifier U1) may be considered when documentation from the physician supports medical necessity and explains why the client could not use a standard automatic blood pressure device.

A hospital-grade blood pressure device, as defined by the CSHCN Services Program, includes memory for continuous recording, has an alarm system to notify the caregiver of abnormal readings, and is capable of frequent or continuous automatic blood pressure and heart rate monitoring with correction of motion artifact.

The following indications are recognized by the CSHCN Services Program for hospital-grade blood pressure devices:

- Hypotension
- Essential hypertension
- Hypertensive heart disease
- Hypertensive renal disease
- Myocardial infarction
- Pulmonary embolism
- Acute pulmonary heart disease
- Chronic pulmonary heart disease
- Valve disorders
- Cardiomyopathy
- Conduction disorders
- Cardiac dysrhythmias
- Heart failure
- Acute kidney failure

- Chronic kidney disease
- Hydronephrosis
- Vesicoureteral reflux with neuropathy
- Bulbus cordis anomalies and anomalies of cardiac septal closure
- Embolism
- Stenosis of either coronary artery stent or peripheral vascular stent

Hospital-grade blood pressure devices that have been purchased are anticipated to last a minimum of 3 years and may be considered for replacement when 3 years have passed or when the equipment is not functional and not repairable.

For clients who are birth through 11 months of age, the rental or purchase of a hospital-grade blood pressure device is a benefit when documentation supports medical necessity and includes an explanation of why the client cannot use a standard automated blood pressure device.

For clients who are 12 months of age or older, the rental or purchase of a hospital-grade blood pressure device is a benefit on a case-by-case basis. Supporting documentation of medical necessity must be provided.

#### **11.2.1.4 Blood Pressure Device Components Repair or Replacement**

Replacement of blood pressure cuffs (procedure code A4663) or replacement of other components (procedure code A9900) may be considered when submitted with documentation of medical necessity explaining why a blood pressure cuff or other component(s) needs to be replaced.

Repair of equipment (procedure code A9900) will be considered after the factory warranty has expired.

#### **11.2.2 Authorization Requirements**

Providers must submit the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\)](#) for services that require prior authorization.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for a hospital-grade blood pressure monitor.

##### **11.2.2.1 Ambulatory Blood Pressure Monitoring**

SMBPM and ABPM do not require authorization or prior authorization.

Providers must document that the SMBPM or ABPM was performed for at least 24 hours.

##### **11.2.2.2 Manual and Automated Blood Pressure Devices**

Prior authorization is not required for manual (procedure code A4660) and automated (procedure code A4670) blood pressure devices if the client's diagnosis is listed in Section 11.2.1.2, "Manual and Automated Blood Pressure Devices" in this chapter. Providers must maintain documentation to support medical necessity in the medical record.

Prior authorization is required for all other diagnoses and requires medical review of written documentation of the medical need for a manual and automatic blood pressure device. Documentation should include the diagnosis and the rationale for monitoring blood pressure in the home.

### 11.2.2.3 Hospital-Grade Blood Pressure Devices

Prior authorization is required for the rental or purchase of the hospital-grade blood pressure device. Documentation must support medical necessity for the hospital-grade blood pressure device, support the client's need for self-monitoring, and explain why the client could not use an automated blood pressure device. The documentation must include:

- All pertinent diagnoses.
- Initial evaluation.
- Symptoms.
- Duration of symptoms.
- Any recent hospitalizations (within the past 12 months).
- Comorbid conditions.
- How frequent or continuous BP monitoring will affect treatment.
- All pertinent laboratory and radiology results.
- Client's weight.
- A family or caregiver(s) who has an understanding of cause and effect, awareness of the client's condition, and who has agreed to accept the responsibility to be trained to use the hospital-grade monitor.

#### 11.2.2.3.1 Rental

Prior authorization may be granted for a 6-month rental. The request must be submitted with documentation of medical necessity as outlined above that supports the client's need for self-monitoring and addressing why an automated blood pressure device will not meet the client's needs. The rental of the device may be reimbursed once every calendar month for a maximum of 6 months.

Recertification for one additional 6-month period may be considered when the physician provides current documentation that supports the ongoing medical necessity of self-monitoring and that confirms the client or family is compliant with its use.

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

ABPM is limited to two services per lifetime, any provider.

ABPM over two services may be considered when documentation of medical necessity is submitted with the claim.

Only one method of blood pressure monitoring (SMBPM or ABPM) may be reimbursed within a rolling 12-month period. SMBPM submitted within the same rolling 12-month period as AMPM will be denied.

Procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings – excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs – day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

Procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

#### 11.2.2.3.2 Purchase

Purchase of a hospital-grade blood pressure device will not be considered for prior authorization until the client has completed a 6-month trial period.

Purchase of a hospital-grade blood pressure device may be prior authorized when all of the following criteria are met:

- The client is 12 months of age or older.
- Documentation of medical necessity supports the client's need for ongoing self-monitoring and addresses why an automated blood pressure device will not meet the client's needs.

All rental costs of the hospital-grade blood pressure device apply toward the purchase price.

#### 11.2.2.4 Blood Pressure Device Components Repair or Replacement

Replacement of blood pressure cuffs or replacement of other components may be considered for purchase with prior authorization when submitted with documentation of medical necessity explaining why the blood pressure cuff or other component(s) need to be replaced.

Repair of equipment will be considered for prior authorization after the factory warranty has expired.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

Chapter 17, "Durable Medical Equipment (DME)" for more information about DME service.

Providers must use the following procedure codes for ABPM:

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| 93784           | 93786 | 93788 | 93790 |

Providers must use the following procedure codes for SMPM:

| Procedure Codes |       |
|-----------------|-------|
| 99473           | 99474 |

### 11.3 Documentation of Receipt

When the equipment is delivered, providers must complete the [CSHCN Services Program Documentation of Receipt form](#). The date of delivery on the form is the date of service that should appear on the claim. The provider must request a signature at the time of delivery from the client or client's representative. The provider should retain this form and not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The documentation of receipt form is available in both [English](#) and [Spanish](#).

### 11.4 Claims Information

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment. Home health DME providers must use the DM3 benefit code when submitting claims and authorization.

DME services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions.

## 11.5 Reimbursement

DME may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Items or services that do not have a maximum fee determined by the Health and Human Services Commission (HHSC) are manually priced. If an item is manually priced, the manufacturer’s suggested retail price (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are considered for reimbursement at the MSRP minus a discount as determined by HHSC.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

**Important:** *The provider must agree to accept the CSHCN Services Programs reimbursement as payment in full.*

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 11.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

## Table of Contents

- 12.1 Enrollment .....3
- 12.2 Benefits, Limitations, and Authorization Requirements.....3
  - 12.2.1 Authorization Requirements ..... 4
- 12.3 Claims Information.....4
- 12.4 Reimbursement.....5
- 12.5 TMHP-CSHCN Services Program Contact Center .....5

## 12.1 Enrollment

To enroll in the CSHCN Services Program, a certified registered nurse anesthetist (CRNA) must be a registered nurse (RN) approved by the Texas Board of Nursing (BON) to practice as an advanced practice registered nurse (APRN). They must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. They must be actively enrolled in Texas Medicaid. Each CRNA must be enrolled individually. Out-of-state CRNA providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 12.2 Benefits, Limitations, and Authorization Requirements

Services provided by CRNAs must be within the scope of practice for the APRN as defined by Texas State law and prescribed and supervised by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) who must be licensed in the state in which they practice. CRNA services are a benefit for the same covered services that are provided by a physician. All limitations applied to physicians for the same service will also be applied to the CRNA. Services provided by a CRNA are a benefit of the CSHCN Services Program if provided under one of the following conditions:

- No physician anesthesiologist is on the medical staff of the facility where the services are provided (e.g., rural settings).
- No physician anesthesiologist is available to provide the services.
- The physician performing the procedure requiring the services or the eligible client requiring the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services in accordance with policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

The CSHCN Services Program will not reimburse the CRNA for equipment, drugs, or supplies. These are the responsibility of the facility where the CRNA services are provided and are included in the facility reimbursement. The CRNA may be directly reimbursed for professional services.

**Referto:** Section 31.2.5, “Anesthesia Services” in Chapter 31, “Physician” for additional information about services provided by CRNAs.

### 12.2.1 Authorization Requirements

Anesthesia services are exempt from authorization requirements.

## 12.3 Claims Information

All CRNA services must be billed with a CRNA individual provider number, even if the CRNA is part of a group. Claims for anesthesia services provided by CRNAs must include the following:

- Appropriate Current Procedural Terminology (CPT) anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary.
- One of the following modifier combinations:
  - QX and U2—Services provided with medical direction of an anesthesiologist. (Must be submitted by a CRNA who provided services under the medical direction of an anesthesiologist.)
  - QZ and U1—Services provided without medical direction of an anesthesiologist; with direction by the physician. (Must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the physician.)
- Anesthesia time in minutes.
- Provider’s usual and customary charges for services being billed.

Modifiers U1 (indicating one anesthesia claim is expected) and U2 (indicating two anesthesia claims are expected) are state-defined modifiers that may be billed by an anesthesiologist or CRNA.

Modifier U1, indicating that only one claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 12.4 Reimbursement

CRNAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician anesthesiologist.

A CRNAs reimbursement for performing an anesthesia service when supervised by a physician other than an anesthesiologist is 92 percent of the maximum allowable fee.

A CRNA under the supervision of an anesthesiologist may be reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

**Referto:** Section 31.2.5, “Anesthesia Services” in Chapter 31, “Physician” for detailed information about the reimbursement methodology for anesthesiology services.

Time units are based on the total time in minutes indicated on the claim divided by 15 minute increments. Providers billing anesthesia time must refer to the *Current Procedural Terminology (CPT) Manual*, Time Reporting Section, definition of time: “Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.”

## 12.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# **CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP)**

## **Table of Contents**

## 13.1 Enrollment

|   |          |
|---|----------|
| <b>13.1 Enrollment</b> .....  | <b>3</b> |
| <b>13.2 Benefits, Limitations, and Authorization Requirements</b> ..... | <b>3</b> |
| 13.2.1 Prior Authorization Requirements .....                           | 4        |
| <b>13.3 Claims Information</b> .....                                    | <b>4</b> |
| <b>13.4 Reimbursement</b> .....   | <b>4</b> |
| <b>13.5 TMHP-CSHCN Services Program Contact Center</b> .....            | <b>5</b> |

To enroll in the CSHCN Services Program, a provider must be licensed in the State of Texas as a CRCP and actively enrolled in Texas Medicaid. A provider must be enrolled individually and assigned a National Provider Identifier (NPI) by the National Plan and Provider Enumeration System (NPPES), whether practicing independently or contracting with a home health agency or other outpatient organization.

CRCPs may enroll as a CSHCN Services Program provider by completing the provider enrollment application available online through the Provider Enrollment and Management System (PEMS). Out-of-state CRCPs must be located in the United States, within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program enrollment procedures.

## 13.2 Benefits, Limitations, and Authorization Requirements

Services performed by CRCPs are a benefit of the CSHCN Services Program if the client meets one of the following criteria:

- Has a respiratory or cardiorespiratory diagnosis requiring CRCP services
- Requires mechanical ventilation or depends on other medical technology to aid respiration

If a client meets the criteria listed above, the client may receive up to 30 visits for respiratory care services provided by a CRCP, per calendar year.



Services that are a benefit include, but are not limited to:

- CRCP services and treatments prescribed by a physician.
- Educating the client or appropriate family members about the in-home respiratory care.

Procedure codes 99503 and 99504 must be used when requesting prior authorization or billing for services. Procedure code 99503 is limited to 30 per calendar year, by any provider.

Expendable supplies are not a benefit for CRCPs.

**Referto:** Chapter 36, “Respiratory Equipment and Supplies” for more information about obtaining supplies.

### 13.2.1 Prior Authorization Requirements

CRCP services must be prior authorized. Before services are performed, requests for CRCP services must be submitted in writing using the [CSHCN Services Program Prior Authorization Request for Respiratory Care—Certified Respiratory Care Practitioner \(CRCP\) form](#). Services may be prior authorized for a maximum of 2 months at a time.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

## 13.3 Claims Information

All CRCP services must be billed with the CRCP’s individual provider identifier whether practicing independently or contracting with a home health agency or other outpatient organization. Claims for CRCP services must include pertinent diagnosis codes.

CRCP services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 13.4 Reimbursement

CRCPs may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

### **13.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **DENTAL**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# DENTAL

## Table of Contents

- 14.1 Enrollment .....4**
- 14.2 Benefits, Limitations, and Authorization Requirements.....4**
  - 14.2.1 Prior Authorization Requirements..... 4
  - 14.2.2 Substitute Dentist ..... 5
  - 14.2.3 Diagnostic Services ..... 6
    - 14.2.3.1 Prior Authorization Requirements..... 6
    - 14.2.3.2 Clinical Oral Evaluations ..... 7
    - 14.2.3.3 Cone-Beam Imaging ..... 8
    - 14.2.3.4 First Dental Home ..... 9
    - 14.2.3.5 Radiographs or Diagnostic Imaging ..... 10
    - 14.2.3.6 Tests and Oral Pathology Procedures..... 11
  - 14.2.4 Orthodontia Services ..... 12
    - 14.2.4.1 Prior Authorization Requirements..... 12
    - 14.2.4.2 Required Documentation ..... 12
    - 14.2.4.3 Submitting Local Codes for Orthodontic Procedures..... 13
  - 14.2.5 Preventive Services ..... 18
    - 14.2.5.1 Authorization Requirements ..... 18
    - 14.2.5.2 Oral Hygiene Instruction ..... 18
    - 14.2.5.3 Dental Prophylaxis and Topical Fluoride Treatment ..... 18
    - 14.2.5.4 Dental Sealants ..... 19
    - 14.2.5.5 Caries Arresting Medicament ..... 19
    - 14.2.5.6 Space Maintainers ..... 19
    - 14.2.5.7 Noncovered Counseling Services..... 20
      - 14.2.5.7.1 *Dental Nutrition Counseling* ..... 20
      - 14.2.5.7.2 *Tobacco Counseling* ..... 20
  - 14.2.6 Therapeutic Services..... 21
    - 14.2.6.1 Prior Authorization Requirements..... 21
    - 14.2.6.2 Anesthesia Requirements for Clients who are Six Years of Age or Younger..... 21
    - 14.2.6.3 Interrupted Treatment Plan ..... 22
    - 14.2.6.4 Restorations ..... 22
      - 14.2.6.4.1 *Direct Restorations and Other Restorative Services* ..... 26
    - 14.2.6.5 Endodontics..... 26
      - 14.2.6.5.1 *Prior Authorization* ..... 26
      - 14.2.6.5.2 *Pulp Caps and Pulpotomy*..... 27
      - 14.2.6.5.3 *Root Canals*..... 28
    - 14.2.6.6 Periodontics ..... 29
    - 14.2.6.7 Prosthodontics (Removable) and Maxillofacial Prosthetics ..... 31
      - 14.2.6.7.1 *Maxillofacial Prosthetics* ..... 34
      - 14.2.6.7.2 *Implants*..... 35
      - 14.2.6.7.3 *Fixed Prosthodontics*..... 35
    - 14.2.6.8 Oral and Maxillofacial Surgery..... 37

|             |   |           |
|-------------|---|-----------|
| 14.2.6.9    | Adjunctive General Services.....  | 39        |
| 14.2.6.9.1  | <i>Emergency Dental Treatment Services</i> .....  | 40        |
| 14.2.6.10   | Dental Anesthesia .....   | 41        |
| 14.2.6.10.1 | <i>Anesthesia Permit Levels</i> .....   | 41        |
| 14.2.6.10.2 | <i>Method for Counting Minutes for Timed Procedure Codes</i> .....  | 42        |
| 14.2.6.11   | Dental Behavior Management .....  | 43        |
| 14.2.6.12   | Internal Bleaching of Discolored Tooth .....  | 43        |
| 14.2.6.13   | Noncovered Services .....   | 44        |
| 14.2.7      | Dental Treatment in Hospitals and ASCs.....   | 44        |
| 14.2.7.1    | Dental Hospital Calls.....  | 44        |
| 14.2.7.2    | Authorization and Prior Authorization Requirements .....  | 44        |
| 14.2.7.3    | Dental General Anesthesia Provided in the Inpatient or Outpatient<br>Setting (Medically Necessary Dental Rehabilitation or Restoration<br>Services) ..... | 44        |
| 14.2.8      | Doctor of Dentistry Services as a Limited Physician .....   | 45        |
| 14.2.8.1    | Authorization Requirements .....  | 46        |
| 14.2.8.2    | Surgery.....  | 46        |
| 14.2.8.3    | Cleft/Craniofacial Surgery by a Dentist Physician.....  | 48        |
| 14.2.8.4    | Evaluation and Management or Consultation.....  | 48        |
| 14.2.8.5    | Radiology and Laboratory Procedures.....  | 49        |
| 14.2.8.6    | Other Procedures Payable to a Dentist Physician.....  | 49        |
| 14.2.8.7    | Anesthesia by Dentist Physician.....  | 49        |
| <b>14.3</b> | <b>Claims Information.....</b>  | <b>50</b> |
| 14.3.1      | Dental Emergency Claims.....  | 50        |
| 14.3.2      | Tooth Identification (TID) and Surface Identification (SID) Systems .....   | 51        |
| 14.3.3      | Supernumerary Tooth Identification .....  | 51        |
| <b>14.4</b> | <b>Reimbursement.....</b>   | <b>52</b> |
| <b>14.5</b> | <b>TMHP-CSHCN Services Program Contact Center.....</b>  | <b>52</b> |

## 14.1 Enrollment

To enroll in the CSHCN Services Program, dental providers must be actively enrolled in Texas Medicaid, maintain an active license status with the Texas State Board of Dental Examiners (TSBDE) (see Title 22 *Texas Administrative Code* (TAC), §§110.1–110.18), have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state dental providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

To be eligible to receive reimbursement for dental anesthesia providers must have the following information on file with TMHP:

- Current anesthesia permit level issued by the TSBDE (applies to all dental providers)
- Proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology (required to be reimbursed at the enhanced rate for procedure codes D9222 and D9223), if applicable

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in 26 TAC, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC §§351.1–351.883 and specifically including the fraud and abuse provisions contained in 1 TAC §§371.1–371.1719.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 14.2 Benefits, Limitations, and Authorization Requirements

Diagnostic, therapeutic, and preventive dental services are a benefit of the CSHCN Services Program. Orthodontic services, medically necessary dental rehabilitation and restoration services, care of dental emergencies, and medically necessary services provided by doctors of dental surgery (DDS) or doctors of dental medicine (DMD) including, but not limited to, cleft-craniofacial surgery are also a benefit of the CSHCN Services Program.

### 14.2.1 Prior Authorization Requirements

Prior authorization is required for all orthodontia services and selected dental services.

All requests for prior authorization must be submitted using the [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#). The TMHP-CSHCN Services Program may require the submission of X-rays, models, etc., for specific prior-authorized services. All prior authori-

zation requests must include specific rationale for the requested service, including documentation of medical necessity and appropriateness of the recommended treatment. Additional documentation, including current periapical radiographs, must be maintained in the client's medical or dental record and submitted to the CSHCN Services Program on request.

Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the dental provider treating the client. If indicated on the form, an authorized representative's signature is acceptable. All signatures and dates must be current. Stamped signatures are not permitted. Alterations to dates and signatures, such as cross-outs or white-outs, are not allowed. Submitted forms without an original hand-written signature and date will be rejected. Providers must keep the original, signed forms in the client's medical record as documentation.

**Important:** *Refer to each individual section under Benefits and Limitations for specific information about prior authorization requirements.*

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

**Tip:** *Photocopy this form and retain the original for future use.*

**Note:** *Fax transmittal confirmations are not accepted as proof of timely prior authorization submission.*

### 14.2.2 Substitute Dentist

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

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

- The substitute dentist's NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature.

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

*Note: Dental services must be filed on the ADA claim form.*

### **14.2.3 Diagnostic Services**

The CSHCN Services Program may reimburse the following diagnostic dental services for CSHCN Services Program eligible clients:

- Clinical oral evaluations
- Radiographs or diagnostic imaging
- Tests or examinations, including oral pathology procedures

Based on the American Academy of Pediatric Dentistry's (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, compassionate, culturally competent, and family-centered way. Establishment of a client's dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.

In providing a dental home for a client, the dentist enhances the ability to assist children and their parents in the quest for optimum oral health care. A First Dental Home (FDH) visit can be initiated as early as 6 months of age and is billed using procedure code D0145. The FDH visit includes, but is not limited to:

- Oral examination.
- Oral hygiene instruction.
- Dental prophylaxis, if appropriate.
- Topical fluoride application using fluoride varnish, if appropriate.
- Caries risk assessment.
- Dental anticipatory guidance.

Diagnostic services should be performed for all clients, preferably starting within the first 6 months of the eruption of the first primary tooth, but no later than 1 year of age. Dental home providers should record the oral and physical health history, perform a caries assessment, develop an appropriate preventive oral health regimen, and communicate with and counsel the client's parent, legal guardian, or primary caregiver.

Caries susceptibility tests (procedure code D0425) are used to analyze the acidic level of the oral cavity using acid or alkali sensitive materials to ascertain the client's likelihood of developing caries. Caries susceptibility tests are considered part of all other dental procedures and are not separately reimbursed.

Requesting providers must retain in the client's medical record all documentation to support the diagnosis and treatment of trauma.

#### **14.2.3.1 Prior Authorization Requirements**

Prior authorization is required for cone-beam imaging (procedure code D0367) and for diagnostic services not adequately described by more specific procedure codes where an unspecified procedure code (D0999) is necessary.



To obtain prior authorization, a [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#) must be submitted along with documentation supporting medical necessity and appropriateness. Documentation required includes, but is not limited to:

- Presenting condition(s).
- Medical necessity.
- The status of the client’s treatment.

Prior authorization is not required for any other diagnostic service.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

Section 14.2.3.3, “Cone-Beam Imaging” in this chapter.

### 14.2.3.2 Clinical Oral Evaluations

Documentation supporting medical necessity for procedure codes D0140, D0160, D0170, and D0180 must be maintained by the provider in the client’s medical record and must include:

- The client complaint supporting medical necessity for the examination.
- The area of the mouth that was examined or the tooth involved.
- A description of what was done during the treatment.
- Supporting documentation of medical necessity, including, but not limited to, radiographs or photographs.

The following clinical oral evaluation procedure codes may be considered for reimbursement:

| Procedure Code | Comments and Limitations  |
|----------------|---|
| D0120          | <ul style="list-style-type: none"> <li>• Used for periodic and comprehensive oral evaluations</li> <li>• Limited to once every 6 months by the same provider</li> <li>• Procedure code D8660 will deny when billed for the same date of service by the same provider</li> <li>• Age limitation = NA</li> </ul>  |
| D0140          | <ul style="list-style-type: none"> <li>• Used only for the initial emergency examination of a specific tooth or area of the mouth</li> <li>• Limited to once per day by the same provider and twice per day for any provider</li> <li>• Provider must document the medical necessity and the specific tooth or area of the mouth on the claim</li> <li>• Denied when billed with procedure code D0160 for the same date of service by the same provider</li> <li>• May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period</li> <li>• Age limitation = NA</li> </ul> |
| D0145          | <ul style="list-style-type: none"> <li>• Age limitation = 6 months through 35 months of age</li> <li>• Limited to one service per day and ten services per client lifetime, with at least 60 days between visits by any provider</li> </ul>   |

| Procedure Code | Comments and Limitations  |
|----------------|---|
| D0150          | <ul style="list-style-type: none"> <li>Used for a comprehensive oral evaluation; limited to one service every three years by the same provider; procedure code D8660 will deny when billed for the same date of service by the same provider</li> <li>Age limitation = NA</li> </ul>  |
| D0160          | <ul style="list-style-type: none"> <li>Used for a problem-focused, detailed, and extensive oral evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim</li> <li>May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period</li> <li>Limited to once per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul> |
| D0170          | <ul style="list-style-type: none"> <li>Used as a follow up to a problem-focused evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim</li> <li>Denied when billed with procedure code D0140 or D0160 on the same date of service by the same provider</li> <li>Limited to once per day by any provider</li> <li>Age limitation = NA</li> </ul>  |
| D0180          | <ul style="list-style-type: none"> <li>Used for extensive periodontal evaluation of pain or problems</li> <li>Denied when billed on the same date of service as procedure code D0120, D0140, D0145, D0150, D0160, or D0170 by the same provider</li> <li>May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period</li> <li>Age limitation = 13 years of age or older</li> </ul>                       |

A caries risk assessment procedure code (D0601, D0602, or D0603) will be required on the same claim, for the same date of service, by the same provider when dental examination procedure code D0120, D0145, or D0150 is submitted for reimbursement. The client's dental condition(s) that justifies the risk assessment classification submitted with the claim must be clearly documented and maintained by the provider in the client's medical record.

Professionally developed caries risk assessment tools are available at:

- American Dental Association (ADA)
- American Academy of Pediatric Dentistry (AAPD)
- Department of State Health Services (DSHS), Oral Health Program

#### 14.2.3.3 Cone-Beam Imaging

Cone-beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone-beam imaging is limited to initial treatment planning, surgery, and post-surgical follow-up.

Procedure code D0367 must be prior authorized by the TMHP Dental Director.

Procedure code D0367 is limited to a combined maximum of three services per calendar year. Additional services may be considered by the TMHP Dental Director with documentation of medical necessity.

#### **14.2.3.4 First Dental Home**

Based on the American Academy of Pediatric Dentistry's definition, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance

The dental home provider must keep supporting documentation for procedure code D0145 in the client's medical record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver's oral health
- Oral evaluation
- An appropriate preventive oral health regimen
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Anticipatory guidance communicated to the client's parent, legal guardian, or primary caregiver, to include the following:
  - Oral health and home care
  - Oral health of primary caregiver or other family members
  - Development of mouth and teeth
  - Oral habits
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Medications and oral health
  - Fluoride varnish application
  - Any referrals, including dental specialist's name

Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 will be denied when billed on the same date of service, for any provider as D0145.

A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider.

Reimbursement for procedure code D0145 is limited to dentists certified by the Texas Department of State Health Services (DSHS). Providers can complete a free continuing education course online or attend classroom training to be certified to provide First Dental Home services. For information about training, refer to the Department of State Health Services (DSHS) Oral Health Program web page at [hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/dental-providers/first-dental-home](https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/dental-providers/first-dental-home).

#### 14.2.3.5 Radiographs or Diagnostic Imaging

The number of radiograph films required for a complete intraoral series is dependent on the age of the client. An intraoral series requires at least eight films. Adults and children older than 12 years of age require 12 to 20 films to be considered an intraoral series. A panoramic radiographic image (procedure code D0330) plus a minimum of four bitewing radiographic images (procedure code D0274) may be considered equivalent to a comprehensive intraoral series including radiographic images (procedure code D0210).

Supporting documentation must be kept in the client's dental record when medical necessity is not evident on radiographs.

The following radiographs or diagnostic imaging procedure codes may be considered for reimbursement:

| Procedure Code | Limitations   |
|----------------|---|
| D0210          | <ul style="list-style-type: none"> <li>Limited to one service every three years by the same provider</li> <li>Denied when submitted on an emergency claim</li> <li>Age limitation = 2 years or older</li> </ul>                     |
| D0220          | <ul style="list-style-type: none"> <li>Limited to one per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul>  |
| D0230          | <ul style="list-style-type: none"> <li>Age limitation = 1 year of age or older</li> </ul>   |
| D0240          | <ul style="list-style-type: none"> <li>Limited to two per day by the same provider</li> <li>Age limitation = NA</li> </ul>  |
| D0250          | <ul style="list-style-type: none"> <li>Limited to one per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul>  |
| D0270          | <ul style="list-style-type: none"> <li>Limited to one per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul>  |
| D0272          | <ul style="list-style-type: none"> <li>Denied when billed with procedure code D0210 same day, by the same provider</li> <li>Limited to one per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul> |
| D0273          | <ul style="list-style-type: none"> <li>Denied when billed with procedure code D0210 same day, by the same provider</li> <li>Limited to one per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul> |

| Procedure Code | Limitations   |
|----------------|---|
| D0274          | <ul style="list-style-type: none"> <li>Denied when billed with procedure code D0210 same day, by the same provider</li> <li>Limited to one per day by the same provider</li> <li>Age limitation = 2 years of age or older</li> </ul>  |
| D0277          | <ul style="list-style-type: none"> <li>Denied when billed with procedure code D0210 same day, by the same provider</li> <li>Denied when billed with procedure code D0330 same day, by the same provider</li> <li>Limited to one per day by the same provider</li> <li>Age limitation = 2 years of age or older</li> </ul>             |
| D0310          | <ul style="list-style-type: none"> <li>Age limitation = 1 year of age or older</li> </ul>   |
| D0320          | <ul style="list-style-type: none"> <li>Age limitation = 1 year of age or older</li> </ul>   |
| D0321          | <ul style="list-style-type: none"> <li>Age limitation = 1 year of age or older</li> </ul>   |
| D0322          | <ul style="list-style-type: none"> <li>Age limitation = 1 year of age or older</li> </ul>   |
| D0330          | <ul style="list-style-type: none"> <li>Limited to one per day by any provider</li> <li>Limited to one service every 3 years by the same provider</li> <li>Age limitation = 3 years of age or older</li> </ul>   |
| D0340          | <ul style="list-style-type: none"> <li>Denied when billed with procedure code D8080</li> <li>Limited to one per day by the same provider</li> <li>Age limitation = 1 year of age or older</li> </ul>  |
| D0350          | <ul style="list-style-type: none"> <li>Must be used when billing for photographs</li> <li>Accepted only when diagnostic quality radiographs cannot be taken</li> <li>Documentation of medical necessity must be submitted with the claim</li> <li>Limited to one per day by the same provider</li> <li>Age limitation = NA</li> </ul> |
| D0367          | <ul style="list-style-type: none"> <li>Age limitation = NA</li> <li>Prior authorization is required</li> <li>Limited to a combined maximum of three services per calendar year</li> <li>Additional services may be considered with documentation of medical necessity</li> </ul>  |

#### 14.2.3.6 Tests and Oral Pathology Procedures

The following procedure codes may be considered for reimbursement and are limited to clients who are 1 year of age or older:

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| D0415           | D0460 | D0470 | D0502 |

Procedure code D0460:

- Includes multiple teeth and contralateral comparisons based on medical necessity.

- Is considered part of any endodontic procedure and is not separately reimbursed when billed on the same date of service as any endodontic procedure.
- Is not payable when billed for primary teeth.
- Is limited to one service per day by the same provider.

**Referto:** Section 14.2.6, “Therapeutic Services” in this chapter for additional information about endodontic procedures.

When billing for diagnostic procedures not adequately described by other procedure codes, providers should use procedure code D0999.

Procedure code D0470 is limited to once per lifetime, any provider.

Only one emergency or trauma claim per client, per day may be submitted. Separate services may be submitted for the same client on the same date of service, one for emergency or trauma and one for nonemergency or routine care.

When billing electronically for emergency or trauma-related dental services, use the ET modifier to indicate emergency.

#### **14.2.4 Orthodontia Services**

Orthodontia services are benefits of the CSHCN Services Program for clients with prior authorization and an appropriate diagnosis code that indicates cleft lip, cleft palate, congenital anomalies of skull and face bones, dentofacial functional abnormalities, or major anomalies of jaw size.

Orthodontia for cosmetic purposes only is not a benefit of the CSHCN Services Program. All removable or fixed orthodontic appliances must be billed with procedure codes D8210 or D8220.

##### **14.2.4.1 Prior Authorization Requirements**

Prior authorization is required for all orthodontic services except for the initial orthodontic visit. Prior authorization is only approved for a complete orthodontic treatment plan, and all active orthodontic treatments must be completed within 36 months. Prior authorization is not transferable to another dentist. The new provider must request prior authorization to complete the orthodontic treatment initiated by the previous provider.

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) will not be prior authorized, but the time frame may be considered for extension not to exceed 36 months of actual treatment.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

##### **14.2.4.2 Required Documentation**

To obtain prior authorization, the provider must submit the [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#).

The following documentation must accompany the form, and must include the date of service the documentation was obtained:

- A complete orthodontia treatment plan including all the procedures required to complete full treatment such as:
  - Extractions
  - Orthognathic surgery
  - Upper and lower appliances
  - Monthly adjustments

- Appliance removal (if needed)
- Special appliances
- All diagnostic models
- A cephalometric radiograph with tracing
- Facial photographs
- A full series of radiographs or a panoramic radiograph

**Note:** *Diagnostic models, radiographs, and any other paper diagnostic tools submitted to TMHP will be returned to the submitting provider. Requests submitted with damaged diagnostic models will be returned to the provider as an incomplete request.*

A prior authorization request for orthodontia services must include one of the following indications:

- Cleft lip
- Cleft palate
- Congenital anomalies of skull and face bones
- Dentofacial functional abnormalities
- Major anomalies of jaw size

A prior authorization request for comprehensive orthodontic treatment or crossbite therapy submitted without the [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#), diagnostic model, radiographs (X-rays), and any other necessary supporting documentation will not be considered and will be returned to the provider as incomplete.

The following information must be provided in the case of a transfer of care from one provider to another:

- A request for prior authorization as outlined above
- Explanation of why the client left the previous provider
- Explanation of the client's treatment status

#### **14.2.4.3 Submitting Local Codes for Orthodontic Procedures**

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

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

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

**Example:** *For a claim with three details, where details 1 and 3 are submitted with procedure code W-D8210 and detail 2 is not, enter the following information in the NTE02 at the 2400 loop:*

DPC1014D 1046D  
(The space shows that detail 2 needs no local code.)

**Example:** If all three details require a local code, enter DPC and the appropriate local codes in sequence without any spaces between the codes:

DPC1024D1055D1056D

(The absence of spaces indicates that local codes are needed for all three details.)

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

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

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

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

The following procedures are not included in comprehensive treatment:

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

Monthly adjustments (procedure code D8670) for comprehensive orthodontics are limited to one service per calendar month.

Only one retainer per arch per lifetime (procedure code D8680) is allowed. The delivery of a retainer includes any visits for retainer adjustments. Retainer adjustments are not reimbursed separately.

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

| CDT Procedure Code | Remarks Code | Description                           |
|--------------------|--------------|---------------------------------------|
| D8080              | Z2009        | Diagnostic workup, approved           |
|                    | <i>or</i>    | <i>or</i>                             |
|                    | Z2011        | Orthodontic appliance, upper (braces) |
|                    | <i>or</i>    | <i>or</i>                             |
|                    | Z2012        | Orthodontic appliance, lower (braces) |

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

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

Diagnostic model (procedure code D0470) are included in procedure codes (D8010 or D8020).



The orthodontic diagnostic work-up procedures are considered inclusive to procedure codes D8010 or D8020 and are not reimbursed separately. Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral/facial photographic images obtained intraorally or extraorally (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when billed with any one of the following procedure codes: D8010 or D8020.

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

| Remarks Code | Description                     |
|--------------|---------------------------------|
| 1033D        | Mandibular, fixed, 2x4 retainer |
| 1034D        | Mandibular, fixed, 3x3 retainer |
| 1035D        | Mandibular, fixed, 4x4 retainer |
| Z2014        | Orthodontic retainer, upper     |
| Z2015        | Orthodontic retainer, lower     |

Procedure code D8010 includes a crossbite workup and removable appliance. Use the following remarks codes according to the services provided:

| Remarks Code | Description                            |
|--------------|--|
| 8110D        | Crossbite therapy, removable appliance |
| Z2018        | Crossbite, workup                      |

Procedure code D8020 includes a crossbite workup and the fixed appliance. Use the following remarks codes according to the services provided:

| Remarks Code | Description                        |
|--------------|------------------------------------|
| 8120D        | Crossbite therapy, fixed appliance |
| Z2018        | Crossbite, workup                  |

The orthodontic diagnostic work up procedures are considered inclusive procedures. Procedure codes D0330, D0340, D0350, and D0470 are denied when billed with a diagnostic work up procedure.

The following tables display the special fixed and removable orthodontic appliances. Under the current provisions of the *Health Insurance Portability and Accountability Act* (HIPAA), all fixed appliances are designated as procedure code D8220, and all removable appliances are designated as procedure code D8210. These are entered as a line item on the paper American Dental Association (ADA) Dental Claim Form with the appropriate fee. However, the remarks codes (former local procedure codes), as appropriate and listed below, also need to be entered on the authorization request form and in the Remarks field of the dental claim form (paper and electronic) to ensure correct authorization, accurate records, and reimbursement. *Failure to bill the correct procedure codes may result in claim processing delays.*

**Note:** *Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services.*

Use the following remarks codes in the Remarks field for fixed appliances (procedure code D8220):

| Remarks Code | Fixed Appliances Description                             |
|--------------|--|
| 1000D        | Appliance for horizontal projections                     |
| 1001D        | Appliance for recurved springs                           |
| 1002D        | Arch wires for crossbite correction, for total treatment |
| 1003D        | Banded maxillary expansion appliance                     |

| Remarks Code | Fixed Appliances Description  |
|--------------|---|
| 1008D        | Bonded expansion device   |
| 1012D        | Crib  |
| 1015D        | Distalizing appliance with springs  |
| 1016D        | Expansion device  |
| 1018D        | Fixed expansion device  |
| 1019D        | Fixed lingual arch  |
| 1020D        | Fixed mandibular holding arch   |
| 1021D        | Fixed rapid palatal expander  |
| 1025D        | Herbst appliance, fixed or removable  |
| 1026D        | Interocclusal cast cap surgical splints   |
| 1028D        | Jasper jumpers  |
| 1029D        | Lingual appliance with hooks  |
| 1030D        | Mandibular anterior bridge  |
| 1031D        | Mandibular bihelix, similar to a quad helix for mandibular expansion to attempt nonextraction treatment |
| 1036D        | Mandibular lingual, 6x6, arch wire  |
| 1042D        | Maxillary lingual arch with spurs   |
| 1043D        | Maxillary and mandibular distalizing appliance  |
| 1044D        | Maxillary quad helix with finger springs  |
| 1045D        | Maxillary and mandibular retainer with pontics  |
| 1049D        | Modified quad helix appliance   |
| 1050D        | Modified quad helix appliance, with appliance   |
| 1051D        | Nance stent   |
| 1052D        | Nasal stent   |
| 1057D        | Palatal bar   |
| 1058D        | Post surgical retainer  |
| 1059D        | Quad helix appliance held with transpalatal arch horizontal projections                                 |
| 1060D        | Quad helix maintainer   |
| 1061D        | Rapid palatal expander (RPE), i.e., quad helix, haas, or menne  |
| 1068D        | Stapled palatal expansion appliance   |
| 1072D        | Thumb sucking appliance, requires submission of models  |
| 1076D        | Transpalatal arch   |
| 1077D        | Two bands with transpalatal arch and horizontal projections forward                                     |
| 1078D        | W-appliance   |

Use the following remarks codes in the Remarks field for removable appliances (procedure code D8210):

| Remarks Code | Removable Appliances Description |
|--------------|----------------------------------|
| 1004D        | Bite plate/bite plane            |
| 1005D        | Bionator                         |
| 1006D        | Bite block                       |

| Remarks Code | Removable Appliances Description  |
|--------------|---|
| 1007D        | Bite plate with push springs  |
| 1010D        | Chateau appliance (face mask, palatal expander, and hawley)                               |
| 1011D        | Coffin spring appliance   |
| 1013D        | Dental obturator, definitive (obturator)  |
| 1014D        | Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator) |
| 1017D        | Face mask (protraction mask)  |
| 1022D        | Frankel appliance   |
| 1023D        | Functional appliance for reduction of anterior open bite and crossbite                    |
| 1024D        | Head gear (face bow)  |
| 1027D        | Intrusion arch  |
| 1032D        | Mandibular lip bumper   |
| 1037D        | Mandibular removable expander with bite plane (crozat)                                    |
| 1038D        | Mandibular ricketts rest position splint  |
| 1039D        | Mandibular splint   |
| 1040D        | Maxillary anterior bridge   |
| 1041D        | Maxillary bite-opening appliance with anterior springs                                    |
| 1046D        | Maxillary Schwarz   |
| 1047D        | Maxillary splint  |
| 1048D        | Mobile intraoral arch (MIA), similar to a bihelix for nonextraction treatment             |
| 1053D        | Occlusal orthotic device  |
| 1054D        | Orthopedic appliance  |
| 1055D        | Other mandibular utilities  |
| 1056D        | Other maxillary utilities   |
| 1062D        | Removable bite plane  |
| 1063D        | Removable mandibular retainer   |
| 1064D        | Removable maxillary retainer  |
| 1065D        | Removable prosthesis  |
| 1066D        | Sagittal appliance, 2-way   |
| 1067D        | Sagittal appliance, 3-way   |
| 1069D        | Surgical arch wires   |
| 1070D        | Surgical splints (surgical stent/wafer)   |
| 1071D        | Surgical stabilizing appliance  |
| 1073D        | Tongue thrust appliance, requires submission of models                                    |
| 1074D        | Tooth positioner, full maxillary and mandibular   |
| 1075D        | Tooth positioner with arch  |

The following procedure codes are used to bill orthodontic services:

| ADA Procedure Codes |       |       |       |       |       |       |       |       |       |
|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D5951               | D5952 | D5953 | D5954 | D5955 | D5958 | D5959 | D5960 | D7280 | D7997 |

| ADA Procedure Codes |       |       |       |       |       |       |       |       |
|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|
| D8010               | D8020 | D8080 | D8210 | D8220 | D8660 | D8670 | D8680 | D8999 |

The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate NPI when billing claims.

### 14.2.5 Preventive Services

The following dental preventive services are benefits of the CSHCN Services Program:

- Oral hygiene instruction
- Dental prophylaxis and topical fluoride treatment
- Dental sealants
- Space maintainers, including recementation and removal

#### 14.2.5.1 Authorization Requirements

Authorization or prior authorization is not required for preventive dental services.

#### 14.2.5.2 Oral Hygiene Instruction

Procedure code D1330 may be considered for reimbursement for clients who are 1 year of age or older in an office setting when the services are above and beyond the routine brushing and flossing instructions included in the prophylaxis procedure codes and when additional time and expertise is directed toward the client's care. Procedure code D1330 is limited to once per rolling year by any provider and is denied when billed on the same day as procedure codes D1110, D1120, D1206, or D1208 by any provider.

Procedure code D1330 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate NPI when billing claims.

#### 14.2.5.3 Dental Prophylaxis and Topical Fluoride Treatment

When performing fluoride treatments, procedure code D1120 and D1208 or procedure code D1110 and D1208 must be billed on the same date of service.

Topical application of fluoride (procedure code D1206 or D1208) is limited to once every six months, by any provider.

Procedure codes D1110 and D1120 include oral health instructions, and are limited to one prophylaxis per 6 calendar months, by any provider. Procedure codes D1110 and D1120 will be denied when submitted on an emergency claim.

The following procedure codes may be considered for reimbursement but are not payable on the same date of service as any D4000 series (periodontal) procedure codes:

| Procedure Code | Age Limitation                   |
|----------------|----------------------------------|
| D1110          | 13 years of age or older         |
| D1120          | 6 months through 12 years of age |
| D1206          | NA                               |
| D1208          | NA                               |

The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate NPI when billing claims.

#### 14.2.5.4 Dental Sealants

Dental sealants are a benefit for clients who are 1 through 20 years of age when applied to primary teeth (Tooth Identification [TID] A, B, I, J, K, L, S, and T) or permanent teeth (TID 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32).

Dental sealants may be applied by a dentist or dental hygienist.

Procedure codes D1351 and D1352 are limited to once per lifetime, per TID, by any provider. Exceptions may be considered when pretreatment documentation clearly supports medical necessity.

Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of teeth. The tooth must be at risk for dental decay and be free of proximal caries and restorations on the surface to be sealed. Each tooth must be billed separately using procedure code D1351. Reimbursement is on a per tooth basis, regardless of the number of surfaces sealed. Tooth numbers and surfaces must be indicated on the claim form.

Dental sealants and replacement sealants are limited to one every 3 years, per tooth, for the same provider. Procedure code D1351 is not payable on the same date of service as any of D4000 series (periodontal) procedure codes. During claims processing or retrospective review, if the claim, narrative, documentation, or charting by a provider includes language, terms, or acronyms indicating a preventative resin was applied, the procedure will be reimbursed as a dental sealant, not as a restorative procedure.

Procedure code D1351 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate NPI when billing claims.

Procedure code D1351 will be denied if it is billed on the same date of service for the same permanent TID as procedure code D1352.

Procedure code D1352 may be reimbursed for posterior permanent teeth only (TID 2-5, 12-15, 18-21, or 28-31) to clients who are 5 years of age or older.

Procedure code D1352 will be denied if a moderate or high caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior to procedure code D1352.

Procedure codes D1351 and D1352 will be denied if billed as an emergency claim.

#### 14.2.5.5 Caries Arresting Medicament

Application of caries arresting medicament (procedure code D1354) is a benefit for clients who are birth through 6 years of age.

Procedure code D1354 is limited to once per lifetime per TID (A-T and 3, 14, 19, and 30), any provider.

Procedure code D1354 will be denied if billed on the same date of service for the same TID as procedure code D1351 or D1352, any provider.

Procedure code D1354 will be denied when billed within six months of procedure code D9222 or 00170 with modifier U3 by any provider.

*Note: Silver diamine fluoride is the only material providers may use for procedure code D1354.*

#### 14.2.5.6 Space Maintainers

One space maintainer per tooth ID may be reimbursed per lifetime, per client. Replacement space maintainers may be considered on appeal with documentation supporting medical or dental necessity.

Space maintainers may be reimbursed with procedure codes D1510, D1516, D1517, D1520, D1526, D1527, and D1575.

Procedure codes D1510 and D1520 are limited to once per lifetime, per quadrant, by any provider.

Procedure codes D1516, D1517, D1526, and D1527 are limited to once per lifetime, per tooth ID, any provider.

Procedure codes D1551, D1552, and D1553 may be reimbursed for clients who are 1 through 12 years of age. Procedure codes D1551 and D1552 are limited to once per lifetime, same provider.

Procedure codes D1553 and D1556 are limited to once per quadrant, per lifetime, any provider.

Procedure code D1551 will be denied if D1516 has been reimbursed within the previous rolling year, same provider.

Procedure code D1552 will be denied if billed within one rolling year of procedure code D1517, same provider.

Procedure codes D1556, D1557, and D1558 may be reimbursed for clients who are 1 through 20 years of age. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device. The provider may be reimbursed if the space maintainer was placed by a different provider.

Procedure codes D1510, D1516, D1517, D1520, D1526, and D1527 may be reimbursed for clients who are 1 through 12 years of age. These procedure codes are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate NPI when billing claims.

Space maintainers are designed to prevent tooth movement and are a benefit in the following situations:

- After premature loss of a deciduous (primary) tooth, first or second molars (tooth identification) (TID): A, B, I, and J for clients who are 1 through 12 years of age.
- After premature loss of deciduous (primary) tooth, first or second molars (tooth identification) (TID): K, L, S, and T for clients who are 1 through 12 years of age.
- After loss of a permanent first molar (TID: 3 and 14) for clients who are 3 through 12 years of age.
- After loss of a permanent first molar (TID: 19 and 30) for clients who are 3 through 12 years of age.
- After premature loss of a deciduous (primary) second molar (TID: A, J, K, and T) for clients who are 3 through 7 years of age billed with (procedure code D1575).

*Note: Premature loss is defined as loss of the tooth prior to the expected or normal life of the tooth. For a deciduous/primary molar, this is before eruption of the comparable bicuspid permanent tooth.*

Space maintainers submitted with procedure code D1575 are limited to one per tooth ID, per client.

Procedure code D1575 is limited to once per lifetime, per quadrant, any provider.

#### **14.2.5.7 Noncovered Counseling Services**

##### **14.2.5.7.1 Dental Nutrition Counseling**

Procedure code D1310 is not a benefit of the CSHCN Services Program as a separate procedure. Dental nutrition counseling is included as part of all preventive, therapeutic, orthodontic, and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to their primary care physician. The provider can refer the client to a CSHCN Services Program-enrolled licensed dietitian for further nutrition counseling.

##### **14.2.5.7.2 Tobacco Counseling**

Procedure code D1320 is not a benefit of the CSHCN Services Program as a separate procedure. Tobacco counseling is considered part of any preventive, therapeutic, orthodontic, and diagnostic dental procedures.

## 14.2.6 Therapeutic Services

The following therapeutic dental services are benefits of the CSHCN Services Program:

- Restorations
- Endodontics
- Periodontics
- Prosthodontics, both fixed and removable
- Maxillofacial prosthetics
- Implants
- Oral and maxillofacial surgery
- Adjunctive general services, including, but not limited to:
  - Dental anesthesia
  - Dental hospital call
  - Desensitizing medicaments
  - Dental behavior management
  - Internal bleaching of discolored tooth
  - Occlusal adjustments

### 14.2.6.1 Prior Authorization Requirements

Prior authorization requirements for specific procedures are contained within each section below. Prior authorization for therapeutic services is valid up to 90 days (this does not apply to orthodontic services).

To obtain prior authorization, the following must be submitted:

- The [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#)
- Provider documentation supporting the medical necessity and appropriateness of the recommended treatment

Each distinct dental procedure code to be performed that requires prior authorization must be listed on the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form. Repetitive dental procedure codes must be listed to indicate the total quantity to be performed.

Additional documentation, including current periapical radiographs, must be maintained in the client's medical record and submitted to the CSHCN Services Program on request.

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

### 14.2.6.2 Anesthesia Requirements for Clients who are Six Years of Age or Younger

For clients who are six years of age or younger, the following will apply:

- All Level 4 sedation/general anesthesia services provided by a dentist (procedure codes D9222 and D9223), and any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA) (procedure code 00170 with modifier U3) provided in conjunction with dental therapeutic services must be prior authorized.
- The dentist performing the therapeutic dental procedure is responsible for obtaining prior authorization and is also responsible for providing the anesthesia prior authorization information to the anesthesiology provider.

- The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Procedure code 00170 with modifier U3, and procedure codes D9222 and D9223 is limited to once per six calendar months by any provider.

Requests for prior authorization must include, but is not limited to, the following client-specific documents and information:

- A completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form
- A completed CSHCN Services Program Prior Authorization Request for Dental of Orthodontia Services form
- The location of where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital)
- Name of the group providing the Level 4 anesthesia services
- A narrative unique to the client, detailing the reasons for the proposed level of sedation (indicate procedure code D9222, D9223, or 00170 with modifier U3). The narrative must include a history of prior treatment, information about failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).
- Diagnostic quality radiographs or photographs
  - When appropriate radiographs or photographs cannot be taken prior to general anesthesia. The narrative must support the reasons for an inability to perform diagnostic services. For special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP dental director.

*Note: In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the TMHP dental director.*

#### **14.2.6.3 Interrupted Treatment Plan**

Prior authorization for an incomplete treatment plan is not transferable to the new provider. The new provider must obtain prior authorization to complete the treatment plan initiated by the original provider.

#### **14.2.6.4 Restorations**

Restorations do not require prior authorization except for onlays and crowns. Procedure code D2999 requires prior authorization.

Consideration of restoration reimbursement is contingent on compliance with the following limitations:

- Restorations on primary teeth and permanent posterior teeth may be reimbursed on the basis of the surface or surfaces restored and are paid as a total maximum fee per tooth.
- More than one restoration on a single surface is considered a single restoration. A multiple surface restoration cannot be billed as two or more separate one-surface restorations.
- The restorations must show definite crossing of the plane of each surface listed for primary and permanent tooth restoration completed to be considered for reimbursement as a multiple surface restoration.



- All reimbursement for tooth restorations include local anesthesia and pulp protection media, where indicated, without additional charges. These services will deny as part of another service if billed separately.
- The CSHCN Services Program may reimburse restorations and therapeutic care based on medical necessity. Therapeutic procedures are not reimbursed for preventive purposes.

Inlay or onlay restorations and crowns—single restorations only may be reimbursed a maximum fee when performed on permanent teeth. This fee includes the actual inlay or onlay or crown, any provisional crown, and any preparatory work before the seating of the permanent crown.

Reimbursement for crowns and onlay restorations are payable once per client, per tooth every ten years. Additional crowns and onlays may be considered with prior authorization and documentation of medical necessity.

Reimbursement for crowns and onlay restorations require submission of post-operative bitewing radiograph(s) (for posterior teeth) or post-operative periapical radiograph(s) (for anterior teeth) with the claim to verify that the restoration meets the standard of care.

Single restoration only crown procedure codes are limited to CSHCN Services Program clients who are 13 years of age or older.

Procedure code D2799 is denied as part of the global fee for a crown.

Use the following procedure codes for restoration services:

| Procedure Codes                           | Limitations                  |
|---|------------------------------|
| <b>Amalgam Restorations</b>               |                              |
| D2140                                     | A = NA                       |
| D2150                                     | A = NA                       |
| D2160                                     | A = 1 year of age or older   |
| D2161                                     | A = 1 year of age or older   |
| <b>Resin-Based Composite Restorations</b> |                              |
| D2330                                     | A = NA                       |
| D2331                                     | A = NA                       |
| D2332                                     | A = 1 year of age or older   |
| D2335                                     | A = 1 year of age or older   |
| D2390                                     | A = NA                       |
| D2391                                     | A = NA                       |
| D2392                                     | A = NA                       |
| D2393                                     | A = 1 year of age or older   |
| D2394                                     | A = 1 year of age or older   |
| <b>Inlay or Onlay Restorations</b>        |                              |
| D2510                                     | A = 13 years of age or older |
| D2520                                     | A = 13 years of age or older |
| D2530                                     | A = 13 years of age or older |
| D2542                                     | A = 13 years of age or older |
| D2543                                     | A = 13 years of age or older |
| D2544                                     | A = 13 years of age or older |
| <b>A = Age limitation</b>                 |                              |

| <b>Procedure Codes</b>    | <b>Limitations</b>  |
|---------------------------|---|
| D2650                     | A = 13 years of age or older  |
| D2651                     | A = 13 years of age or older  |
| D2652                     | A = 13 years of age or older  |
| D2662                     | A = 13 years of age or older  |
| D2663                     | A = 13 years of age or older  |
| D2664                     | A = 13 years of age or older  |
| D2710                     | A = 13 years of age or older  |
| D2720                     | A = 13 years of age or older  |
| D2721                     | A = 13 years of age or older  |
| D2722                     | A = 13 years of age or older  |
| D2740                     | A = 16 years of age or older, limited to TID #4-13 and 20-29 only.  |
| D2750                     | A = 16 years of age or older, limited to TID #4-13 and 20-29 only.  |
| D2751                     | A = 16 years of age or older, limited to TID #4-13 and 20-29 only.  |
| D2752                     | A = 16 years of age or older, limited to TID #4-13 and 20-29 only.  |
| D2780                     | A = 13 years of age or older  |
| D2781                     | A = 13 years of age or older  |
| D2782                     | A = 13 years of age or older  |
| D2783                     | A = 13 years of age or older  |
| D2790                     | A = 13 years of age or older  |
| D2791                     | A = 13 years of age or older  |
| D2792                     | A = 13 years of age or older  |
| D2794                     | A = 13 years of age or older  |
| D2910                     | A = 13 years of age or older; will be denied if billed with the following procedure codes within one rolling year, same TID, same provider: D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663 or D2664. |
| D2915                     | A = 6 years of age or older   |
| D2920                     | A = 1 year of age or older, payable to any CSHCN Services Program dental provider, including the same provider that performed the original crown cementation  |
| D2930                     | A = NA  |
| D2931                     | A = 6 years of age or older   |
| D2932                     | A = 1 year of age or older, limited to TID C-H, M-R, and all permanent teeth.   |
| D2933                     | A = NA, limited to TID C-H and M-R primary teeth.   |
| D2934                     | A = NA  |
| D2940                     | A = NA  |
| D2950                     | A = 6 years of age or older   |
| D2952                     | A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2952 for the same tooth, for the same date of service, by the same provider                                  |
| D2953                     | A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2953 for the same tooth, for the same date of service, by the same provider                                  |
| <b>A = Age limitation</b> |   |

| Procedure Codes            | Limitations   |
|----------------------------|---|
| D2954                      | A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2954 for the same tooth, for the same date of service, by the same provider                    |
| D2955                      | A = 4 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2955 for the same tooth, for the same date of service, by the same provider                     |
| D2957                      | A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2957 for the same tooth, for the same date of service, by the same provider                    |
| D2960                      | A = 13 years of age or older  |
| D2961                      | A = 13 years of age or older  |
| D2962                      | A = 13 years of age or older  |
| D2971                      | A = 13 years of age or older, limited to four services per lifetime for each tooth by any provider  |
| D2980                      | A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2980 for the same tooth, for the same date of service, by the same provider                      |
| D2999                      | A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2999 for the same tooth, for the same date of service, by the same provider, prior authorization |
| Other Restorative Services |   |
| D2951                      | Limited to two times per lifetime for permanent teeth, same TID, any provider. Additional services will be considered with documentation of medical necessity. A = 6 years of age or older                          |
| <b>A = Age limitation</b>  |   |

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

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D2140           | D2150 | D2160 | D2161 | D2330 | D2331 | D2332 | D2391 | D2392 | D2393 |
| D2394           |       |       |       |       |       |       |       |       |       |

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

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

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

#### 14.2.6.4.1 Direct Restorations and Other Restorative Services

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

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

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

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

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| D2140           | D2150 | D2160 | D2161 | D2330 | D2331 | D2332 | D2335 | D2390 |

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

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

#### 14.2.6.5 Endodontics

The following procedures are limited to four permanent teeth without prior authorization:

- Initial endodontic therapy (procedure codes D3310, D3320, and D3330)
- Retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348)

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

##### 14.2.6.5.1 Prior Authorization

Prior authorization is required for root canal therapy and retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348) in excess of four root canals. To obtain prior authorization, the [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#) must be submitted with documentation of medical necessity.

Documentation supporting medical necessity must be maintained in the client's dental record and include the following:

- The medical necessity before treatment, during treatment, and post treatment
- Periapical radiographs
- The final size of the file to which the canal was enlarged and the type of filling material used
- Any reason that the root canal may appear radiographically unacceptable must be documented in the client's dental record

Prior authorization is required for procedure code D3460. Documentation of medical necessity must include the following:

- The client is 16 years of age or older.
- Regular treatment failed.
- The client's anatomy is such that no other fixed or removable prosthodontic alternatives are available, including, but not limited to anodontia, a result of trauma, or birth defect.

Prior authorization is required for an unspecified endodontic procedure, procedure code D3999.

**Referto:** Section 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

#### 14.2.6.5.2 Pulp Caps and Pulpotomy

| Procedure Code            | Limitations   |
|---------------------------|---|
| D3110                     | A = 1 year and older  |
| D3120                     | A = 1 year and older  |
| D3220                     | <ul style="list-style-type: none"> <li>• A = NA.</li> <li>• Limited to once per lifetime, per primary tooth (TID A through T)</li> <li>• Will be denied when performed within 6 months of pulpal therapy (procedure codes D3230 and D3240) on the same primary TID, by the same provider</li> <li>• Will be denied when performed within 6 months of root canal therapy (procedure codes D3310, D3320, and D3330) on the same permanent TID by the same provider</li> </ul> |
| D3230                     | A = 1 year and older  |
| D3240                     | A = 1 year and older  |
| <b>A = Age limitation</b> |   |

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

Direct pulp caps (procedure code D3110) may be reimbursed when billed with the following procedure codes for the same tooth ID, on the same date of service, by the same provider:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D2140           | D2150 | D2160 | D2161 | D2330 | D2331 | D2332 | D2335 | D2390 | D2391 |
| D2392           | D2393 | D2394 | D2510 | D2520 | D2530 | D2542 | D2543 | D2544 | D2650 |
| D2651           | D2652 | D2662 | D2663 | D2664 | D2710 | D2720 | D2721 | D2722 | D2740 |
| D2750           | D2751 | D2752 | D2780 | D2781 | D2782 | D2783 | D2790 | D2791 | D2792 |
| D2794           | D2931 | D2932 |       |       |       |       |       |       |       |

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

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

### 14.2.6.5.3 Root Canals

Root canals may only be reimbursed when performed on permanent teeth.

Reimbursement for endodontic therapy (procedure codes D3310, D3320, and D3330), or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348) includes all appointments, radiographs, and procedures necessary to complete the treatment, including, but not limited to:

- Pulpotomy
- Radiographs performed pre-, intra-, and postoperatively

Re-treatment claims for an incomplete pulpotomy performed by a dentist not associated with the original treating dentist or dental group will be considered for reimbursement upon appeal.

Documentation of medical necessity and the incomplete initial pulpotomy must be submitted with the appeal. The appeal must also include a written narrative and pre- and post-treatment X-rays, which will be reviewed by a Texas licensed dentist.

**Note:** *The identified, original treating dentist or dental group will not be considered for reimbursement.*

The following services are not considered part of the endodontic therapy procedures or the retreatment procedures of a previous root canal and may be reimbursed separately:

- Diagnostic evaluation
- Radiographs performed at the initial, periodic, or emergency service visits

Root canal therapy not carried to completion with a final filling should not be billed using a root canal therapy procedure code. It must be billed using procedure code D3999. Providers must file the claim with a narrative description of the procedures that were completed.

The date of service for a root canal is the date when the service was initiated.

Procedure codes D3220, D3351, D3352, and D3353 performed on a tooth within the 6 months preceding a root canal is considered part of the root canal. The total amount reimbursed will not exceed the total dollar amount allowed for procedure codes D3310, D3320, and D3330, or D3346, D3347, and D3348.

Apicoectomy (procedure codes D3410, D3421, D3425, and D3426) billed after root canal therapy or retreatment of a previous root canal may be reimbursed separately.

Refer to the following table for additional limitations for endodontic services:

| Procedure Codes           | Limitations  |
|---------------------------|--|
| D3110                     | A = 1 year of age or older, refer to Section 14.2.6.4, "Restorations" in this chapter for additional limitations |
| D3120                     | A = 1 year of age or older   |
| D3220                     | A = NA; see additional restrictions in Section 14.2.6.5.2, "Pulp Caps and Pulpotomy" in this chapter             |
| D3230                     | A = 1 year of age or older   |
| D3240                     | A = 1 year of age or older   |
| D3310                     | A = 6 years of age or older, limited to 4 teeth without prior authorization, #1-32 only                          |
| D3320                     | A = 6 years of age or older, limited to 4 teeth without prior authorization, #1-32 only                          |
| D3330                     | A = 6 years of age or older, limited to 4 teeth without prior authorization, #1-32 only                          |
| <b>A = Age limitation</b> |  |

| Procedure Codes           | Limitations   |
|---------------------------|---|
| D3346                     | A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only |
| D3347                     | A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only |
| D3348                     | A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only |
| D3351                     | A = 6 years of age or older   |
| D3352                     | A = 6 years of age or older   |
| D3353                     | A = 6 years of age or older   |
| D3410                     | A = 6 years of age or older   |
| D3421                     | A = 6 years of age or older   |
| D3425                     | A = 6 years of age or older   |
| D3426                     | A = 6 years of age or older   |
| D3430                     | A = 6 years of age or older   |
| D3450                     | A = 6 years of age or older   |
| D3460                     | A = 16 years of age or older, prior authorization                                       |
| D3470                     | A = 6 years of age or older   |
| D3910                     | A = 1 years of age or older   |
| D3920                     | A = 6 years of age or older   |
| D3950                     | A = 6 years of age or older   |
| D3999                     | A = 1 year of age or older, prior authorization   |
| <b>A = Age limitation</b> |   |

#### 14.2.6.6 Periodontics

Medical necessity for *third-molar* sites includes, but is not limited to:

- Medical or dental history documenting need due to inadequate healing of bone following third-molar extraction, including date of third-molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depths to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for *other than third-molar* sites, includes, but is not limited to:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injury).
- Intra- or extra-oral radiographs of treatment sites.
- If medical necessity is not radiographically evident, intraoral photographs would be appropriate to request; otherwise, intraoral photographs would be optional unless requested preoperatively by the Health and Human Services Commission (HHSC) or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.

- Bone graft and barrier material used.

The preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when billed on the same date of service as any D4000 series periodontal procedure code.

Periodontal scaling and root planing (procedure codes D4341 and D4342) will be denied when submitted for the same date of service as other D4000 series codes, except D4341 and D4342, any provider.

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

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

Periodontal medicaments (procedure code D4381) must be applied to all affected teeth at the same visit to be effective, and are limited to one service per client, same TID, per rolling year for clients who are 13 years of age or older.

Periodontal maintenance (procedure code D4910) may be reimbursed only if one of the following occurs:

- A periodontal surgery or nonsurgical periodontal service (procedure code (D4240, D4241, D4260, or D4261) is billed for the same client by any provider.
- There is documented evidence of periodontal therapy while the client was not CSHCN Services Program eligible in the client's dental record within 90 days before the periodontal maintenance.

Periodontal maintenance may be reimbursed no more than 3 times within this 90-day period for the same client, by any provider.

The periodontic procedure codes in the following table that are limited to clients who are 13 years of age or older may also be considered for younger clients based on the medical condition with supporting documentation of medical necessity.

| Procedure Codes | Limitations  |
|-----------------|--|
| D4210           | A = 13 years of age or older, DOC, PP1   |
| D4211           | A = 13 years of age or older, DOC, PP1   |
| D4230           | A = 13 years of age or older   |
| D4231           | A = 13 years of age or older   |
| D4240           | A = 13 years of age or older, DOC, PP2   |
| D4241           | A = 13 years of age or older, DOC, PP2   |
| D4245           | A = 13 years of age or older, prior authorization, DOC, PP2                        |
| D4249           | A = 13 years of age or older, prior authorization                                  |
| D4260           | A = 13 years of age or older, limited to once per quadrant, per day, same provider |
| D4261           | A = 13 years of age or older, limited to once per quadrant, per day, same provider |

**A = Age limitation.**

**Photo = photographs are required when medical necessity is not evident on the radiographs.**

**DOC = Documentation is required when medical necessity is not evident on radiographs.**

**PP1 = Pre- and postoperative photographs are required, pre- and postoperative.**

**PP2 = Pre- and postoperative photographs are required when medical necessity is not evident on the radiographs.**



| Procedure Codes | Limitations   |
|-----------------|---|
| D4266           | A = 13 years of age or older, prior authorization, DOC, PP2   |
| D4267           | A = 13 years of age or older, prior authorization, DOC, PP2   |
| D4270           | A = 13 years of age or older, prior authorization, DOC, PP1   |
| D4273           | A = 13 years of age or older, prior authorization, DOC, PP1   |
| D4274           | A = 13 years of age or older, prior authorization   |
| D4275           | A = 13 years of age or older, DOC, PP1, limited to one service per day, same provider   |
| D4276           | A = 13 years of age or older, prior authorization, DOC, PP1   |
| D4277           | A = 13 years of age or older, prior authorization, DOC, PP1   |
| D4278           | A = 13 years of age or older, prior authorization, DOC, PP1; procedure code D4278 must be billed on the same date of service as procedure code D4277 or it will be denied   |
| D4283           | A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4283 must be billed with primary procedure code D4273 on the same claim, for the same date of service, by the same provider  |
| D4285           | A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4285 must be billed with primary procedure code D4275 on the same claim, for the same date of service, by the same provider  |
| D4341           | A = 13 years of age or older, prior authorization, denied when submitted on the same date of service as D4355; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity. |
| D4342           | A = 13 years of age or older, prior authorization; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity.   |
| D4355           | A = 13 years of age or older, DOC, PP1  |
| D4381           | A = 13 years of age or older, limited to one service per client, same TID, per rolling year   |
| D4910           | A = 13 years of age or older, denied if billed within 90 days after a full mouth debridement, additional limitations, DOC, PP1  |
| D4920           | A = 13 years of age or older  |
| D4999           | A = 13 years of age or older, prior authorization   |

**A = Age limitation.**

**Photo = photographs are required when medical necessity is not evident on the radiographs.**

**DOC = Documentation is required when medical necessity is not evident on radiographs.**

**PP1 = Pre- and postoperative photographs are required, pre- and postoperative.**

**PP2 = Pre- and postoperative photographs are required when medical necessity is not evident on the radiographs.**

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter.

#### 14.2.6.7 Prosthodontics (Removable) and Maxillofacial Prosthetics

Local anesthesia is denied as part of removable prosthodontics procedures.

Denture reline procedures are allowed if the reline makes the denture serviceable. Denture reline and rebase procedures are denied if billed within 1 rolling year of a complete or partial denture.

- Maxillary reline and rebase procedure codes D5710, D5720, D5730, D5740, D5750, and D5760 are denied as part of complete or partial maxillary denture procedures D5110, D5130, D5211, and D5213.
- Mandibular reline and rebase procedure codes D5711, D5721, D5731, D5741, D5751, and D5761 are denied as part of complete or partial mandibular denture procedures D5120, D5140, D5212, and D5214.

Repairs to partial maxillary dentures (procedure code D5670) are denied as part of maxillary procedure codes D5211, D5213, and D5640.

Repairs to partial mandibular dentures (procedure code D5671) are denied as part of mandibular procedure codes D5212, D5214, and D5640.

The cost of repairs cannot exceed replacement costs.

Procedure codes D5867 and D5875 are denied as part of any repair or modification of any removable prosthetic.

Use the following procedure codes for prosthodontic (removable) services:

| Procedure Codes                                   | Limitations                                      |
|---|--|
| D5110   | A = 1 year of age or older, prior authorization  |
| D5120   | A = 1 year of age or older, prior authorization  |
| D5130   | A = 3 years of age or older, prior authorization |
| D5140   | A = 3 years of age or older, prior authorization |
| D5211   | A = 6 years of age or older, prior authorization |
| D5212   | A = 6 years of age or older, prior authorization |
| D5213   | A = 6 years of age or older, prior authorization |
| D5214   | A = 6 years of age or older, prior authorization |
| D5410   | A = 1 year of age or older                       |
| D5411   | A = 1 year of age or older                       |
| D5421   | A = 6 years of age or older                      |
| D5422   | A = 6 years of age or older                      |
| D5511   | A = 1 year of age or older, prior authorization  |
| D5512   | A = 1 year of age or older, prior authorization  |
| D5520   | A = 3 years of age or older, prior authorization |
| D5611   | A = 3 years of age or older                      |
| D5612   | A = 3 years of age or older                      |
| D5630   | A = 6 years of age or older                      |
| D5640   | A = 6 years of age or older                      |
| D5650   | A = 6 years of age or older                      |
| D5660   | A = 6 years of age or older                      |
| D5670   | A = 6 years of age or older                      |
| D5671   | A = 6 years of age or older                      |
| <b>A = Age limitation and NA = Not applicable</b> |  |

| <b>Procedure Codes</b>                            | <b>Limitations</b>   |
|---|--|
| D5710   | <ul style="list-style-type: none"> <li>A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5720, D5730, D5740, D5750, and D5760, same provider.</li> </ul>  |
| D5711   | <ul style="list-style-type: none"> <li>A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5721, D5731, D5741, D5751, and D5761, same provider.</li> </ul>  |
| D5720   | <ul style="list-style-type: none"> <li>A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied within three rolling years of procedure codes D5710, D5730, D5740, D5750, and D5760, same provider.</li> </ul>             |
| D5721   | <ul style="list-style-type: none"> <li>A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5731, D5741, D5751, and D5761, same provider.</li> </ul> |
| D5730   | <ul style="list-style-type: none"> <li>A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5740, D5750, and D5760, same provider.</li> </ul>                       |
| D5731   | <ul style="list-style-type: none"> <li>A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider.</li> </ul>                       |
| D5740   | <ul style="list-style-type: none"> <li>A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5750, and D5760, same provider.</li> </ul>                      |
| D5741   | <ul style="list-style-type: none"> <li>A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5751, and D5761, same provider.</li> </ul>                      |
| D5750   | <ul style="list-style-type: none"> <li>A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5760, same provider.</li> </ul>                       |
| D5751   | <ul style="list-style-type: none"> <li>A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5761, same provider.</li> </ul>                       |
| D5760   | <ul style="list-style-type: none"> <li>A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5750, same provider.</li> </ul>                      |
| D5761   | <ul style="list-style-type: none"> <li>A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5751, same provider.</li> </ul>                      |
| D5810   | A = 1 year of age or older, prior authorization  |
| D5811   | A = 1 year of age or older, prior authorization  |
| D5820   | A = 6 years of age or older, prior authorization   |
| D5821   | A = 6 years of age or older, prior authorization   |
| D5850   | A = 1 year of age or older, prior authorization  |
| D5851   | A = 1 year of age or older, prior authorization  |
| D5862   | A = 13 years of age or older, prior authorization  |
| D5863   | A = 6 years of age or older, prior authorization   |
| <b>A = Age limitation and NA = Not applicable</b> |  |

| Procedure Codes                                   | Limitations                                      |
|---|--|
| D5864   | A = 6 years of age or older, prior authorization |
| D5865   | A = 6 years of age or older, prior authorization |
| D5866   | A = 6 years of age or older, prior authorization |
| D5899   | A = 1 year of age or older, prior authorization  |
| <b>A = Age limitation and NA = Not applicable</b> |  |

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter.

#### 14.2.6.7.1 Maxillofacial Prosthetics

Use the following procedure codes for maxillofacial prosthetic services:

| Procedure Codes                                   | Limitations  |
|---|--|
| D5911   | A = NA, prior authorization                            |
| D5912   | A = NA, prior authorization                            |
| D5913   | A = NA, prior authorization                            |
| D5914   | A = NA, prior authorization                            |
| D5915   | A = NA, prior authorization                            |
| D5916   | A = NA, prior authorization                            |
| D5919   | A = NA, prior authorization                            |
| D5922   | A = NA, prior authorization                            |
| D5923   | A = NA, prior authorization                            |
| D5924   | A = NA, prior authorization                            |
| D5925   | A = NA, prior authorization                            |
| D5926   | A = NA, prior authorization                            |
| D5927   | A = NA, prior authorization                            |
| D5928   | A = 1 year of age or older, prior authorization        |
| D5929   | A = 1 year of age or older, prior authorization        |
| D5931   | A = 1 year of age or older, prior authorization        |
| D5932   | A = NA, prior authorization                            |
| D5933   | A = NA, prior authorization                            |
| D5934   | A = 1 year of age or older, prior authorization        |
| D5935   | A = 1 year of age or older, prior authorization        |
| D5936   | A = 1 year of age or older, prior authorization        |
| D5937   | A = NA, prior authorization                            |
| D5951   | A = NA, prior authorization                            |
| D5952   | A = birth through 12 years of age, prior authorization |
| D5953   | A = 13 years of age or older, prior authorization      |
| D5954   | A = NA, prior authorization                            |
| D5955   | A = 13 years of age or older, prior authorization      |
| D5958   | A = NA, prior authorization                            |
| D5959   | A = NA, prior authorization                            |
| <b>A = Age limitation and NA = Not applicable</b> |  |

| Procedure Codes                                   | Limitations                 |
|---|-----------------------------|
| D5960   | A = NA, prior authorization |
| D5982   | A = NA, prior authorization |
| D5983   | A = NA, prior authorization |
| D5984   | A = NA, prior authorization |
| D5985   | A = NA, prior authorization |
| D5986   | A = NA, prior authorization |
| D5987   | A = NA, prior authorization |
| D5988   | A = NA, prior authorization |
| D5999   | A = NA, prior authorization |
| <b>A = Age limitation and NA = Not applicable</b> |                             |

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter.

#### 14.2.6.7.2 Implants

Implants require prior authorization.

Use the following procedure codes for implant services:

| Procedure Codes           | Limitations  |
|---------------------------|--|
| D6010                     | A = 16 years of age or older, prior authorization  |
| D6040                     | A = 16 years of age or older, prior authorization  |
| D6050                     | A = 16 years of age or older, prior authorization  |
| D6055                     | A = 16 years of age or older, prior authorization  |
| D6056                     | A = 16 years of age or older, prior authorization  |
| D6057                     | A = 16 years of age or older, prior authorization  |
| D6080                     | A = 16 years of age or older, prior authorization  |
| D6090                     | A = 16 years of age or older, prior authorization  |
| D6092                     | A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider |
| D6093                     | A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider |
| D6095                     | A = 16 years of age or older, prior authorization  |
| D6100                     | A = 16 years of age or older, prior authorization  |
| D6199                     | A = 16 years of age or older, prior authorization  |
| <b>A = Age limitation</b> |  |

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter for more information about prior authorization requirements.

#### 14.2.6.7.3 Fixed Prosthodontics

Prior authorization is required for fixed prosthodontics. Fixed prosthodontics are limited to CSHCN Services Program clients who are 16 years of age or older, as the client must be old enough to have mature teeth and minimal jaw growth remaining.

Required documentation for prior authorization includes, but is not limited to:

- The [CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form](#).

- Documentation of medical necessity for the requested procedure includes, but is not limited to:
  - Documentation supporting that the mouth is free of disease; no untreated periodontal, endodontic disease, or rampant caries.
  - Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown, except when a Maryland bridge is placed.
  - Tooth Identification (TID) System noting only permanent teeth.
  - Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.
  - Appropriate pretreatment radiographs of each involved tooth, such as periapical views must be maintained in the client’s medical record and submitted to the CSHCN Services Program on request. Panoramic films are inadequate to detect caries or tooth structure necessary to evaluate the request.

Prior authorization will not be given when:

- Films show two good abutment teeth, except when a Maryland bridge will be replaced.
- There is untreated periodontal or the presence of endodontic disease, or rampant caries which would contraindicate the treatment.

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter.

The following fixed prosthetics (pontics, retainers, and abutments), may be reimbursed with a maximum fee and include any preparatory work before placement of the fixed prosthetic.

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D6210           | D6211 | D6212 | D6240 | D6241 | D6242 | D6245 | D6250 | D6251 | D6252 |
| D6545           | D6548 | D6549 | D6720 | D6721 | D6722 | D6740 | D6750 | D6751 | D6752 |
| D6780           | D6781 | D6782 | D6783 | D6790 | D6791 | D6792 |       |       |       |

Each abutment and each pontic constitutes a unit in a fixed partial-denture bridge (bridgework).

The following procedure codes are considered part of any other service and are not reimbursed separately:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D6600           | D6601 | D6602 | D6603 | D6604 | D6605 | D6606 | D6607 | D6608 | D6609 |
| D6610           | D6611 | D6612 | D6613 | D6614 | D6615 |       |       |       |       |

Use the following procedure codes for fixed prosthodontics services. These codes require prior authorization:

| Procedure Codes Limitations                      |       |       |       |       |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Fixed Partial Denture Pontics                    |       |       |       |       |       |       |       |       |       |
| D6210  | D6211 | D6212 | D6240 | D6241 | D6242 | D6245 | D6250 | D6251 | D6252 |
| Fixed Partial Denture Retainers—Inlays or Onlays |       |       |       |       |       |       |       |       |       |
| D6545  | D6548 | D6549 |       |       |       |       |       |       |       |
| Fixed Partial Denture Retainers—Crowns           |       |       |       |       |       |       |       |       |       |
| D6720  | D6721 | D6722 | D6740 | D6750 | D6751 | D6752 | D6780 | D6781 | D6782 |
| D6783  | D6790 | D6791 | D6792 |       |       |       |       |       |       |

| Procedure Codes Limitations          |       |       |       |       |       |
|--------------------------------------|-------|-------|-------|-------|-------|
| Other Fixed Partial Denture Services |       |       |       |       |       |
| D6920                                | D6930 | D6940 | D6950 | D6980 | D6999 |

#### 14.2.6.8 Oral and Maxillofacial Surgery

Prior authorization is required for most oral and maxillofacial surgery, including, but not limited to, invasive procedures for clients with cleft lip, cleft palate, or craniofacial anomalies, which must be performed by a cleft and craniofacial team or a coordinated multidisciplinary team.

All oral surgery procedures include local anesthesia and visits for routine postoperative care.

Use the following table for oral and maxillofacial surgery procedure codes and prior authorization requirements.

| Procedure Codes                            | Limitations   |
|--|---|
| D7111                                      | A = NA  |
| D7140                                      | A = NA  |
| D7210                                      | A = NA  |
| D7220                                      | A = NA  |
| D7230                                      | A = NA  |
| D7240                                      | A = NA  |
| D7241                                      | A = 1 year of age or older  |
| D7250                                      | A = 1 year of age or older  |
| D7260                                      | A = NA, prior authorization   |
| D7261                                      | A = NA, prior authorization   |
| D7270                                      | A = NA  |
| D7272                                      | A = 1 year of age or older, prior authorization   |
| D7280                                      | A = 1 year of age or older. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider.  |
| D7282                                      | A = 1 year of age or older  |
| D7283                                      | A = 1 year of age or older, prior authorization, permanent dentition only (tooth identification [TID] 2-15 and 18-31). To obtain prior authorization, a copy of the orthodontic treatment plan must be submitted along with a current panoramic radiograph to determine medical necessity and a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form. |
| D7285                                      | A = NA, prior authorization   |
| D7286                                      | A = NA, prior authorization   |
| D7290                                      | A = NA, prior authorization   |
| D7291                                      | A = 1 year of age or older, prior authorization   |
| D7310                                      | A = 1 year of age or older, prior authorization   |
| D7320                                      | A = 1 year of age or older, prior authorization   |
| D7340                                      | A = 1 year of age or older, prior authorization   |
| D7350                                      | A = 1 year of age or older, prior authorization   |
| D7410                                      | A = NA, prior authorization   |
| A = Age limitation and NA = Not applicable |   |

| Procedure Codes                                   | Limitations   |
|---|---|
| D7411   | A = NA, prior authorization                         |
| D7413   | A = NA, prior authorization                         |
| D7414   | A = NA, prior authorization                         |
| D7440   | A = NA, prior authorization                         |
| D7441   | A = NA, prior authorization                         |
| D7450   | A = NA, prior authorization                         |
| D7451   | A = NA, prior authorization                         |
| D7460   | A = NA, prior authorization                         |
| D7461   | A = NA, prior authorization                         |
| D7465   | A = NA, prior authorization                         |
| D7471   | A = NA, prior authorization                         |
| D7472   | A = NA, prior authorization                         |
| D7510   | A = NA  |
| D7520   | A = NA  |
| D7530   | A = NA, prior authorization                         |
| D7540   | A = NA, prior authorization                         |
| D7550   | A = NA, prior authorization                         |
| D7560   | A = NA, prior authorization                         |
| D7670   | A = NA  |
| D7820   | A = NA, prior authorization                         |
| D7880   | A = NA, prior authorization                         |
| D7899   | A = 1 year of age or older, prior authorization     |
| D7910   | A = NA  |
| D7911   | A = NA  |
| D7912   | A = NA  |
| D7955   | A = NA, prior authorization                         |
| D7961   | A = 12 through 20 years of age, prior authorization |
| D7962   | A = NA, prior authorization                         |
| D7970   | A = NA, prior authorization                         |
| D7971   | A = NA, prior authorization                         |
| D7972   | A = 1 year of age or older, prior authorization     |
| D7980   | A = NA, prior authorization                         |
| D7983   | A = NA, prior authorization                         |
| D7997   | A = NA, prior authorization                         |
| D7999   | A = NA, prior authorization                         |
| <b>A = Age limitation and NA = Not applicable</b> |   |

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter.



### 14.2.6.9 Adjunctive General Services

Refer to individual procedure codes in the following table for prior authorization requirements:

| Procedure Code   | Limitations   |
|--|---|
| D9110  | A = NA, see additional benefit information listed below table   |
| D9120  | A = 13 years of age or older, prior authorization   |
| D9210  | A = NA, denied when billed on the same day as procedure code D9248, any provider  |
| D9211  | A = NA, denied when billed on the same day as procedure code D9248, any provider  |
| D9212  | A = NA, denied when billed on the same day as procedure code D9248, any provider  |
| D9222  | A = NA, prior authorization, DOC, limited to 15 minutes (1 unit) per day  |
| D9223  | A = NA, prior authorization, DOC, limited to 2 hours and 45 minutes (11 units) per day must be billed with primary procedure code D9222, same provider  |
| D9230  | A = NA, denied when billed on the same day as procedure code D9248, any provider  |
| D9239  | A = NA, limited to 15 minutes (1 unit) per day, denied when billed on the same day as procedure code D9222, any provider  |
| D9243  | A = NA, limited to 1 hour and 15 minutes per day (5 units), must be billed with primary procedure code D9239, same provider   |
| D9248  | A = NA, DOC, limited to one service per day and two services per 12 months, refer to Section 14.2.6.10, "Dental Anesthesia" in this chapter. Denied when billed on the same day as procedure codes D9222, D9239, D9420, and D9920, any provider. Additional services may be considered with prior authorization and documentation of medical necessity. |
| D9310  | A = NA, prior authorization   |
| D9420  | A = NA, prior authorization, DOC, refer to Section 14.2.7.1, "Dental Hospital Calls" in this chapter. Limited to two times per rolling year, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.   |
| D9430  | A = NA  |
| D9440  | A = NA  |
| D9610  | A = NA, prior authorization, limited to once per client per day, DOC  |
| D9612  | A = NA, prior authorization, limited to once per client per day, DOC. Limited to two times per rolling year, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.   |
| D9630  | A = NA, prior authorization, DOC  |
| D9910  | A = NA, limited to once per six months, any provider, not to be used for bases, liners, or adhesives  |
| D9920  | A = 1 year of age or older, prior authorization, denied when billed on the same day as procedure code D9222, D9230, or D9239 or with an evaluation, prophylactic treatment, or radiographic procedure, DOC; claim must include diagnosis of intellectual disability, refer to Section 14.2.6.11, "Dental Behavior Management" in this chapter.          |
| D9930  | A = NA  |
| D9944  | A = NA  |
| <b>A = Age limitation, NA = Not applicable, and DOC = Documentation required</b> |   |

| Procedure Code   | Limitations   |
|--|---|
| D9950  | A = 13 years of age or older, prior authorization   |
| D9951  | A = 13 years of age or older, prior authorization, may be reimbursed once every three rolling years per client, any provider, considered full-mouth procedure |
| D9952  | A = 13 years of age or older, prior authorization, may be reimbursed once per lifetime per provider, considered full-mouth procedure                          |
| D9970  | A = NA, one service per day, any provider   |
| D9974  | A = 13 years of age or older, DOC, refer to Section 14.2.6.12, “Internal Bleaching of Discolored Tooth” in this chapter                                       |
| D9999  | A = NA, prior authorization, DOC  |
| <b>A = Age limitation, NA = Not applicable, and DOC = Documentation required</b> |   |

**Note:** For those procedures requiring prior authorization, the prior authorization is valid up to 90 days from the date it is issued.

**Referto:** Section 14.2.6.1, “Prior Authorization Requirements” in this chapter for more information about prior authorization requirements.

Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

#### 14.2.6.9.1 Emergency Dental Treatment Services

Procedure code D9110 is an emergency service only. The type of treatment rendered and tooth identification must be indicated. It must be for a service other than a prescription or topical medication. The reason for the emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form.

Procedure code D9110 is a benefit for the following:

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

- Procedures necessary to relieve pain associated with pericoronitis, particularly third molars

Procedure code D9110 is not a benefit for the following:

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

#### 14.2.6.10 Dental Anesthesia

All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia.

Providers must have a level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to receive an enhanced rate for procedure codes D9222 and D9223.

All levels of sedation must have clinical documentation and a narrative in the client's dental record to support medical necessity of the service. The client's dental record must be available for review by representatives of HHSC or its designee.

##### 14.2.6.10.1 Anesthesia Permit Levels

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

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

Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. The following procedure codes may be used to bill dental anesthesia and indicates the minimum anesthesia permit level to be reimbursed for these procedure codes:

| Procedure Codes | Level of Sedation |
|-----------------|-------------------|
| D9211           | Level 3           |
| D9212           | Level 3           |
| D9222           | Level 4           |
| D9223           | Level 4           |
| D9230           | Level 1           |
| D9239           | Level 3           |
| D9243           | Level 3           |

| Procedure Codes | Level of Sedation |
|-----------------|-------------------|
| D9248           | Level 2           |

Dental anesthesia is not age-restricted.

Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately.

Procedure codes D9239 is limited to 15 minutes (1 unit) per day. Procedure code D9243 is limited to 1 hour and 15 minutes per day (5 units).

Reimbursement of procedure code D9248 is limited to one service per client per day. Procedure code D9248 is limited to two times per year, per client.

If more than two nonintravenous (IV) conscious sedation services are required by any provider in a 12 month period, prior authorization is required.

Any dentist providing nonintravenous (IV) conscious sedation must comply with all TSBDE Rules and American Academy of Pediatric Dentistry (AAPD) Guidelines, including maintaining a current permit to provide non-IV conscious sedation. Claims must include a provider statement indicating that the procedure was provided in full compliance with these guidelines. Documentation supporting medical necessity and appropriateness for the use of non-IV conscious sedation must be maintained in the client's records and is subject to retrospective review.

Supporting documentation includes, but is not limited to the following:

- Narrative addressing the reason non-IV conscious sedation was necessary
- Medications used to provide the non-IV conscious sedation
- The duration of the non-IV conscious sedation, including the start and end times
- Monitored statistics, such as vital signs and oxygen saturation levels
- Any resuscitative measures that may have been necessary

The following procedure codes are denied when billed on the same day as procedure code D9248:

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| D9210           | D9211 | D9212 | D9230 |

**Referto:** Section 14.2.7.3, “Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)” in this chapter.

#### 14.2.6.10.2 Method for Counting Minutes for Timed Procedure Codes

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

Time intervals for 1 through 12 units are as follows:

| Units   | Number of Minutes             |
|---------|-------------------------------|
| 0 units | 0 minutes through 7 minutes   |
| 1 unit  | 8 minutes through 22 minutes  |
| 2 units | 23 minutes through 37 minutes |
| 3 units | 38 minutes through 52 minutes |
| 4 units | 53 minutes through 67 minutes |

| Units    | Number of Minutes               |
|----------|---------------------------------|
| 5 units  | 68 minutes through 82 minutes   |
| 6 units  | 83 minutes through 97 minutes   |
| 7 units  | 98 minutes through 112 minutes  |
| 8 units  | 113 minutes through 127 minutes |
| 9 units  | 128 minutes through 142 minutes |
| 10 units | 143 minutes through 157 minutes |
| 11 units | 158 minutes through 172 minutes |
| 12 units | 173 minutes through 187 minutes |

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

#### 14.2.6.11 Dental Behavior Management

Procedure code D9920 is considered for prior authorization in addition to therapeutic procedures when provided in the office and when the client has a diagnosis of an intellectual disability described as mild, moderate, severe, profound, or unspecified.

Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and is subject to retrospective review.

Supporting documentation includes, but is not limited to, the following:

- A current physician statement addressing the intellectual disability, signed and dated within 1 year before the dental behavior management
- The client's diagnosis of intellectual disability
- A description of the service performed, including the specific problem and the behavior management technique applied
- Personnel and supplies required to provide the behavioral management
- The duration of the behavior management, including the start and end times

Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure.

Except for those procedures requiring prior authorization, admission to an outpatient or freestanding ambulatory surgical center (ASC) for the purpose of performing dentistry services must be authorized.

**Referto:** Section 24.5.1, "Benefits, Limitations, and Authorization Requirements" in Chapter 24, "Hospital" for more information about prior authorization in an ASC.

#### 14.2.6.12 Internal Bleaching of Discolored Tooth

Internal bleaching of a discolored tooth is an accepted endodontic treatment for clients who are 13 years of age or older. It is intended to remove and change the organic material in the enamel of an infected or traumatized tooth. It is considered medically necessary when chemical change of the contents in the interior of the tooth is judged necessary to complete an endodontic treatment to the tooth for therapeutic, not cosmetic purposes. Prior authorization is not required. Procedure code D9974 may be considered for reimbursement when the claim is filed with documentation supporting medical necessity. Claims that are filed without documentation supporting medical necessity are denied as incomplete.

### 14.2.6.13 Noncovered Services

The following therapeutic services are not benefits of the CSHCN Services Program.

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D3331           | D3332 | D3333 | D6058 | D6059 | D6060 | D6061 | D6062 | D6063 | D6064 |
| D6065           | D6066 | D6067 | D6068 | D6069 | D6070 | D6071 | D6072 | D6073 | D6074 |
| D6075           | D6076 | D6077 | D6094 | D6194 | D7412 | D7671 | D7771 | D7830 | D9972 |
| D9973           |       |       |       |       |       |       |       |       |       |

## 14.2.7 Dental Treatment in Hospitals and ASCs

Dental rehabilitation and restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

### 14.2.7.1 Dental Hospital Calls

Dental hospital calls may be reimbursed for clients of any age that require medically necessary general anesthesia or dental treatment in the inpatient or outpatient hospital setting. Providers may bill procedure code D9420 in addition to the dental services performed in the inpatient or outpatient setting. Documentation supporting the medical necessity of the dental hospital call must be retained in the client's dental record and is subject to retrospective review. Procedure code D9420 is limited to twice per rolling year, per client, any provider. Additional services may be considered with prior authorization and documentation of medical necessity.

**Referto:** Chapter 24, "Hospital" for more information about requirements for inpatient and outpatient services.

### 14.2.7.2 Authorization and Prior Authorization Requirements

All inpatient hospital admissions for dental services require prior authorization. Except for those specific procedures that require prior authorization, admission to freestanding ASCs or outpatient hospital ambulatory surgical centers (HASCs) for the purpose of performing dentistry services require authorization.

The [CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia](#) must be submitted to the TMHP-CSHCN Services Program with supporting documentation of medical necessity.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for additional information.  
Chapter 24, "Hospital."

**Referto:** [CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only form](#)

**Referto:** [CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only form.](#)

### 14.2.7.3 Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)

Dental rehabilitation or restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

CSHCN Services Program dental services should be billed using the following Current Procedural Terminology (CPT) procedure codes and modifier where appropriate:

- Anesthesia services for general dental anesthesia, procedure code 00170 with modifier U3

- ASC or HASC dental rehabilitation or restoration, procedure code 41899 with modifier U3
- Physical examinations before dental restorations under anesthesia, procedure codes 99202, 99222, and 99282
- Restorations under anesthesia, procedure codes 99222 and 99282

Supporting documentation must be retained in the client's chart and must reflect compliance with the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia and the CSHCN Services Program Policy About the Criteria for Dental Therapy Under General Anesthesia, Attachment 1. Dental general anesthesia may be reimbursed once every 6 months per client any provider.

All supporting documentation must be maintained in the client's medical record. The client's record must be available for review by representatives of the CSHCN Services Program, the Department of State Health Services (DSHS), the CSHCN Services Program claims contractor, and HHSC. The dental provider is required to maintain the following documentation in the client's dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narrative justifying the need for general anesthesia
- Client's demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraora or perioral photography, or diagram of dental pathology
- Proposed dental plan of care
- Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed [CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form](#)
- The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that the parent or guardian understands and agrees with the dentist's assessment of their child's behavior
- Dentist's attestation statement and signature, which is put on the bottom of the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form or included in the client's dental record as a separate form

Hospital and outpatient facility admissions are subject to medical necessity review.

#### **14.2.8 Doctor of Dentistry Services as a Limited Physician**

The CSHCN Services Program covers services provided by a DDS or DMD if the services are a benefit and furnished within the dentist's scope of practice as defined by Texas state law. To participate in the CSHCN Services Program as a dentist practicing as a limited physician, a dentist (DDS or DMD) must be enrolled separately as a dentist practicing as a limited physician.

The CSHCN Services Program recognizes the standards of care needed to appropriately address the repair of cleft and craniofacial anomalies as outlined in the guidelines prepared by the American Cleft Palate - Craniofacial Association ([acpa-cpf.org](http://acpa-cpf.org)).

A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients with complex medical conditions who require treatment by a broad range of medical specialists. Standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach either by a C/C team or by an equivalent coordinated multidisciplinary team. The following exceptions may be considered to this requirement:

- A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. (Medical record documentation must explain the reasons the client is unable to travel.)
- A C/C or equivalent multidisciplinary team is not available in the area, or the team approach cannot be coordinated over multiple locations. (Medical record documentation must describe attempts to coordinate a team approach.)
- A C/C or equivalent multidisciplinary team is available but the client or the client's parent/ guardian refuses to receive care from the team. (Medical record documentation must explain the reason for the refusal of the care offered by the team.)

**Referto:** Section 31.2.39.11, "Cleft/Craniofacial Procedures" in Chapter 31, "Physician" for more detailed information.

If a client has third-party insurance coverage available that requires reconstructive facial surgery involving the bony skeleton of the face (including midface osteotomies and cleft lip and palate repairs performed by a physician), the CSHCN Services Program cannot consider a claim for payment unless all third-party payer requirements are met.

#### 14.2.8.1 Authorization Requirements

The following procedure codes require prior authorization and may be considered with medical review of documentation of medical necessity. These procedures may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.

| Procedure Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 11950           | 11951 | 11952 | 11954 | 15630 | 15781 | 15788 | 15789 |

Documentation of medical necessity indication that the procedure was performed due to trauma or injury must be submitted with the authorization request.

Unless otherwise noted in the following tables, all other procedure codes in this section do not require authorization or prior authorization.

#### 14.2.8.2 Surgery

The following surgery CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 10060           | 10061 | 10140 | 10160 | 10180 | 11000 | 11010 | 11011 | 11012 | 11042 |
| 11043           | 11044 | 11102 | 11103 | 11104 | 11105 | 11106 | 11107 | 11200 | 11201 |
| 11305           | 11306 | 11307 | 11308 | 11310 | 11311 | 11312 | 11313 | 11420 | 11421 |
| 11422           | 11423 | 11424 | 11426 | 11440 | 11441 | 11442 | 11443 | 11444 | 11446 |
| 11620           | 11621 | 11622 | 11623 | 11624 | 11626 | 11640 | 11641 | 11642 | 11643 |

\*If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.

\*\* Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.



| Procedure Codes  |        |        |         |         |         |         |         |        |         |
|--|--------|--------|---------|---------|---------|---------|---------|--------|---------|
| 11644  | 11646  | 11900  | 11901   | 11950** | 11951** | 11952** | 11954** | 11960  | 11970   |
| 11971  | 12001  | 12002  | 12004   | 12005   | 12006   | 12007   | 12011   | 12013  | 12014   |
| 12015  | 12016  | 12017  | 12018   | 12020   | 12021   | 12031   | 12032   | 12034  | 12035   |
| 12036  | 12037  | 12051  | 12052   | 12053   | 12054   | 12055   | 12056   | 12057  | 13120   |
| 13121  | 13122  | 13131  | 13132   | 13133   | 13151   | 13152   | 13153   | 13160  | 14020   |
| 14021  | 14040* | 14041* | 14060*  | 14061*  | 14301   | 14302   | 15004   | 15005  | 15115   |
| 15116  | 15120* | 15121* | 15135*  | 15136*  | 15155*  | 15156*  | 15157*  | 15240* | 15241*  |
| 15260*   | 15261* | 15275  | 15276   | 15277   | 15278   | 15574   | 15576*  | 15620  | 15630** |
| 15730  | 15733  | 15740  | 15750   | 15756   | 15757   | 15758   | 15760   | 15769  | 15770   |
| 15781**  | 15786  | 15787  | 15788** | 15789** | 15819   | 15820*  | 15821*  | 15851  | 15852   |
| 17250  | 20100  | 20525  | 20551   | 20552   | 20600   | 20604   | 20605   | 20606  | 20615   |
| 20660  | 20670  | 20680  | 20690   | 20692   | 20693   | 20694   | 20696   | 20697  | 20900   |
| 20902*   | 20910  | 20912  | 20920   | 20922   | 20955   | 20956   | 20957   | 20962  | 20969   |
| 20970  | 20972  | 20973  | 20999*  | 21010   | 21011   | 21012   | 21013   | 21014  | 21025   |
| 21026  | 21029  | 21030  | 21031   | 21032   | 21040   | 21046   | 21047   | 21048  | 21049   |
| 21050  | 21060  | 21070  | 21073   | 21076*  | 21077*  | 21079*  | 21080*  | 21081* | 21082*  |
| 21083*   | 21084* | 21085* | 21086*  | 21087*  | 21088*  | 21089*  | 21100*  | 21110* | 21116   |
| 21120*   | 21121* | 21122* | 21123*  | 21125*  | 21127*  | 21137*  | 21138*  | 21139* | 21141*  |
| 21142*   | 21143* | 21145* | 21146*  | 21147*  | 21150*  | 21151*  | 21154*  | 21155* | 21159*  |
| 21160*   | 21172* | 21175* | 21179*  | 21180*  | 21181*  | 21182*  | 21183*  | 21184* | 21188*  |
| 21193*   | 21194* | 21195* | 21196*  | 21198*  | 21199*  | 21206*  | 21208*  | 21209* | 21210*  |
| 21215*   | 21230* | 21235* | 21240   | 21242   | 21243   | 21244*  | 21245*  | 21246* | 21247*  |
| 21255*   | 21256* | 21260* | 21261*  | 21263*  | 21267*  | 21268*  | 21270*  | 21275* | 21280*  |
| 21282*   | 21295* | 21296* | 21299*  | 21315   | 21320   | 21325   | 21330   | 21335  | 21336   |
| 21337  | 21338  | 21339  | 21340   | 21343   | 21344   | 21345   | 21346   | 21347  | 21348   |
| 21355  | 21356  | 21360  | 21365   | 21366   | 21385   | 21386   | 21387   | 21390  | 21395   |
| 21400  | 21401  | 21406  | 21407   | 21408   | 21421   | 21422   | 21423   | 21431  | 21432   |
| 21433  | 21435  | 21436  | 21440   | 21445   | 21450   | 21452   | 21453   | 21454  | 21461   |
| 21462  | 21465  | 21470  | 21480   | 21485   | 21490   | 21497*  | 21499*  | 21685  | 29800   |
| 29804  | 29999* | 30000  | 30020   | 30120   | 30124   | 30125   | 30130   | 30140  | 30150   |
| 30160  | 30200  | 30300  | 30310   | 30460*  | 30462*  | 30580*  | 30600*  | 30620* | 30630*  |
| 30801  | 30802  | 30901  | 30903   | 30905   | 30906   | 30930   | 30999*  | 31020  | 31080   |
| 31081  | 31084  | 31085  | 31086   | 31087   | 31090   | 31200*  | 31201   | 31603  | 31605   |
| 31830  | 40490  | 40500  | 40510   | 40520   | 40525   | 40527*  | 40530*  | 40650* | 40652*  |
| 40654*   | 40700* | 40701* | 40702*  | 40720*  | 40761*  | 40799*  | 40800   | 40801  | 40804   |
| 40805  | 40806  | 40808  | 40810   | 40812   | 40814   | 40816   | 40818   | 40819  | 40820   |
| <p>*If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.</p> <p>** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.</p> |        |        |         |         |         |         |         |        |         |

| Procedure Codes   |        |        |        |        |        |        |        |        |        |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 40830   | 40831  | 40840  | 40842  | 40843  | 40844  | 40845  | 40899* | 41000  | 41005  |
| 41006   | 41007  | 41008  | 41009  | 41010  | 41015  | 41016  | 41017  | 41018  | 41100  |
| 41105   | 41108  | 41110  | 41112  | 41113  | 41114  | 41115  | 41116  | 41120  | 41130  |
| 41250   | 41251  | 41252  | 41510  | 41520  | 41599* | 41800  | 41805  | 41806  | 41820  |
| 41821   | 41822  | 41823  | 41825  | 41826  | 41827  | 41828  | 41830  | 41850  | 41870  |
| 41872   | 41874  | 41899* | 42000  | 42100  | 42104  | 42106  | 42107  | 42120  | 42140  |
| 42145*  | 42160  | 42180  | 42182  | 42200* | 42205* | 42210* | 42215* | 42220* | 42225* |
| 42226*  | 42227* | 42235* | 42260* | 42280* | 42281* | 42299* | 42300  | 42305  | 42310  |
| 42320   | 42330  | 42335  | 42340  | 42400  | 42405  | 42408  | 42409  | 42410  | 42415  |
| 42420   | 42425  | 42426  | 42440  | 42450  | 42500  | 42505  | 42507  | 42509  | 42510  |
| 42550   | 42600  | 42650  | 42660  | 42665  | 42699* | 42700  | 42720  | 42725  | 42800  |
| 42804   | 42806  | 42808  | 42809  | 42810  | 42815  | 42890  | 42892  | 42894  | 42900  |
| 42950   | 42960  | 42961  | 42962  | 42970  | 42999* | 61501  | 61559* | 62147  | 64400  |
| 64640   | 64681  | 64722  | 64736  | 64738  | 64740  | 64742  | 67900  | 67914  | 67915  |
| 67916   | 67917  | 67921  | 67922  | 67923  | 67924  | 67930  | 67935  | 67950* | 67961* |
| 67966*  | 67971  | 67973  | 67974  | 67975  | J0558  | J0561  |        |        |        |
| *If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.  |        |        |        |        |        |        |        |        |        |
| ** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues. |        |        |        |        |        |        |        |        |        |

#### 14.2.8.3 Cleft/Craniofacial Surgery by a Dentist Physician

The following additional codes may be reimbursed to a provider enrolled as a cleft/craniofacial surgeon. Prior authorization is required.

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 30540           | 30545 | 30560 | 61550 | 61552 | 61556 | 61557 | 61558 | 62115 | 62117 |

Septoplasty (procedure code 30520) for nonrelated repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies may be prior authorized with documentation to support medical necessity.

#### 14.2.8.4 Evaluation and Management or Consultation

The following evaluation and management or consultation service procedure codes are payable to a dentist physician:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99201           | 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 |
| 99218           | 99219 | 99220 | 99221 | 99222 | 99223 | 99231 | 99232 | 99233 | 99238 |
| 99241           | 99242 | 99243 | 99244 | 99245 | 99251 | 99252 | 99253 | 99254 | 99255 |
| 99281           | 99282 | 99283 | 99284 | 99285 |       |       |       |       |       |

Evaluation and management codes for home services are not reimbursed to dentists or dentistry groups.

### 14.2.8.5 Radiology and Laboratory Procedures

The following diagnostic radiology and laboratory procedure codes are payable to a dentist physician:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 70100           | 70110 | 70120 | 70130 | 70140 | 70150 | 70160 | 70170 | 70190 | 70200 |
| 70250           | 70260 | 70300 | 70310 | 70320 | 70328 | 70330 | 70332 | 70336 | 70350 |
| 70355           | 70370 | 70371 | 70380 | 70390 | 73100 | 76942 | 88305 | 88331 | 88332 |

**Referto:** The CMS website at [www.cms.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp](http://www.cms.gov/CLIA/10_Categorization_of_Tests.asp) for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

### 14.2.8.6 Other Procedures Payable to a Dentist Physician

The following additional CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90284           | 92511 | 96369 | 96370 | 96372 | 96374 | J0121 | J0290 | J0295 | J0330 |
| J0558           | J0561 | J0690 | J0692 | J0694 | J0696 | J0697 | J0698 | J0702 | J0720 |
| J0744           | J1020 | J1030 | J1040 | J1100 | J1165 | J1170 | J1200 | J1364 | J1580 |
| J1631           | J1720 | J1790 | J1810 | J1840 | J1850 | J1885 | J1940 | J2010 | J2060 |
| J2401           | J2402 | J2510 | J2540 | J2560 | J2700 | J2770 | J2920 | J2930 | J3000 |
| J3260           | J3300 | J3301 | J3303 | J3370 | J3430 | J3480 | J3490 | T1013 |       |

Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service.

Procedure code T1013 billed with modifier U1 is limited to once per day, per provider; procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

Procedure codes 90284, J1459, J1561, J1568, J1569, and J1572 will be denied if billed with the same date of service by any provider as the following procedure codes (unless otherwise indicated):

| Procedure Codes   |        |       |       |        |       |        |        |        |       |
|---|--------|-------|-------|--------|-------|--------|--------|--------|-------|
| 90284   | J1459* | J1460 | J1560 | J1561* | J1566 | J1568* | J1569* | J1572* | J7504 |
| J7511   |        |       |       |        |       |        |        |        |       |
| <b>*These procedure codes may be billed more than once per day but will not be reimbursed if billed in combination with any other procedure code in this table.</b> |        |       |       |        |       |        |        |        |       |

### 14.2.8.7 Anesthesia by Dentist Physician

In addition to the procedure codes discussed under “Benefits and Limitations” in this chapter, the following anesthesia CPT procedure codes are payable to a dentist physician:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 00100           | 00102 | 00160 | 00162 | 00164 | 00170 | 00190 | 00192 | 00300 | 99100 |
| 99116           | 99135 | 99140 |       |       |       |       |       |       |       |

## 14.3 Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on a paper ADA Dental Claim Form. Providers can obtain copies of this form by contacting the ADA at 1-800-947-4746 or ordering online from the ADA website at [www.ada.org](http://www.ada.org). TMHP does not supply the forms. Any paper dental claim submitted using any other version of the dental claim form is not processed and is returned to the submitter.

When completing a paper ADA Dental Claim Form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Providers billing electronically must submit dental claims in American National Standards Institute (ANSI) ASC X12 837D format. Specifications are available to providers developing in-house systems, software developers, and vendors. Because each software package is different, field locations may vary. Providers should contact the software developer or vendor for information about their software. Providers or software vendors may direct questions about development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Claims must contain the billing provider's full name, address, and NPI. The billing provider's full name and address must be entered in Block 48 of the paper ADA Dental Claim Form, and the ten-digit NPI must be entered in Block 49. *A claim without a provider name, address, and NPI cannot be processed.*

The Healthcare Common Procedure Coding System (HCPCS)/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at [www.cms.gov/medicare/coding/ncci-coding-edits](http://www.cms.gov/medicare/coding/ncci-coding-edits) or correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.13, "Instructions for Completing the Paper ADA Dental Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank.

### 14.3.1 Dental Emergency Claims

The Emergency Indicator field has been removed from the HIPAA-approved 837D electronic transaction. Dental providers submitting electronic claims in the 837D format must use modifier *ET* to report emergency services. Modifier *ET* must be placed in the SVC01 section of the 837D format.

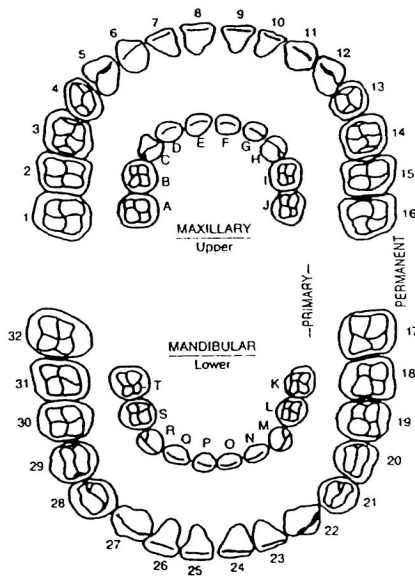
Additionally, the Comments field should be used to document the specific nature of the emergency. The Comments field in the HIPAA-approved 837D electronic transaction is 80 bytes long.

To indicate a dental emergency on a paper claim submission (ADA Dental Claim Form), check Block 45, Treatment Resulting From (check the applicable box), and 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, Remarks.

Only one emergency or trauma claim per client, per day may be submitted. Separate services (one for emergency or trauma and one for nonemergency or routine) may be submitted for the same client on the same day, any provider, for separate services and procedure codes.

### 14.3.2 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. Anterior teeth have facial and incisal surfaces only. Posterior teeth have buccal and occlusal surfaces only.



| SID      | SID | SID | SID   |
|----------|-----|-----|-------|
| Buccal   | DB  | DFI | DLIF  |
| Distal   | DF  | DFL | DOLB  |
| Facial   | DI  | DFM | MIDF  |
| Incisal  | DL  | DIL | MIDL  |
| Lingual  | DO  | DLB | MIDLF |
| Mesial   | IL  | DLM | MIFL  |
| Occlusal | MB  | DOB | MLBD  |
|          | MI  | DOL | MLDF  |
|          | ML  | ILF | MODB  |
|          | MO  | MBD | MODL  |
|          | OB  | MID | MODLB |
|          | OL  | MIF | MOLB  |
|          |     | MLB |       |
|          |     | MLF |       |
|          |     | MLI |       |
|          |     | MOB |       |
|          |     | MOD |       |
|          |     | MOL |       |
|          |     | OBL |       |

### 14.3.3 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the CDT published by the ADA.

The TID for each identified supernumerary tooth is used for paper and electronic claims and can only be billed with the following codes:

- For primary teeth only: D7111
- For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510

| Permanent Teeth Upper Arch |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|----------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Tooth #                    | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| Super #                    | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 |

| Permanent Teeth Lower Arch |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|----------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Tooth #                    | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |
| Super #                    | 82 | 81 | 80 | 79 | 78 | 77 | 76 | 75 | 74 | 73 | 72 | 71 | 70 | 69 | 68 | 67 |

| Primary Teeth Upper Arch |    |    |    |    |    |    |    |    |    |    |
|--------------------------|----|----|----|----|----|----|----|----|----|----|
| Tooth #                  | A  | B  | C  | D  | E  | F  | G  | H  | I  | J  |
| Super #                  | AS | BS | CS | DS | ES | FS | GS | HS | IS | JS |

| Primary Teeth Lower Arch |    |    |    |    |    |    |    |    |    |    |
|--------------------------|----|----|----|----|----|----|----|----|----|----|
| Tooth #                  | T  | S  | R  | Q  | P  | O  | N  | M  | L  | K  |
| Super #                  | TS | SS | RS | QS | PS | OS | NS | MS | LS | KS |

## 14.4 Reimbursement

Dental services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 14.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **DIABETIC EQUIPMENT AND SUPPLIES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# DIABETIC EQUIPMENT AND SUPPLIES

## Table of Contents

|             |  |           |
|-------------|--|-----------|
| <b>15.1</b> | <b>Enrollment</b> .....  | <b>3</b>  |
| <b>15.2</b> | <b>Benefits, Limitations, and Authorization Requirements</b> ..... | <b>3</b>  |
| 15.2.1      | Glucose Monitor and Supplies .....                                 | 3         |
| 15.2.1.1    | Non Diabetic Diagnosis Codes .....                                 | 5         |
| 15.2.1.2    | Glucose Monitor .....  | 5         |
| 15.2.1.3    | Glucose Testing Supplies .....                                     | 6         |
| 15.2.1.3.1  | <i>Insulin-Dependent Clients</i> .....                             | 6         |
| 15.2.1.3.2  | <i>Non-Insulin-Dependent Clients</i> .....                         | 6         |
| 15.2.1.4    | Glucose Tabs and Gel .....   | 7         |
| 15.2.1.5    | Prior Authorization Requirements .....                             | 7         |
| 15.2.2      | Continuous Glucose Monitors (CGM) .....                            | 7         |
| 15.2.2.1    | Prior Authorization Requirements .....                             | 8         |
| 15.2.2.2    | Associated Supplies .....  | 9         |
| 15.2.2.3    | Noncovered Services .....  | 9         |
| 15.2.3      | Insulin Pump .....   | 10        |
| 15.2.3.1    | Prior Authorization Requirements .....                             | 11        |
| 15.2.3.2    | CGM Integrated External Insulin Pump .....                         | 12        |
| 15.2.4      | Insulin and Insulin Syringes .....                                 | 12        |
| <b>15.3</b> | <b>Documentation of Receipt</b> .....                              | <b>12</b> |
| <b>15.4</b> | <b>Claims Information</b> .....                                    | <b>13</b> |
| <b>15.5</b> | <b>Reimbursement</b> .....   | <b>13</b> |
| <b>15.6</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....            | <b>13</b> |



## 15.1 Enrollment

To enroll in the CSHCN Services Program, providers of diabetic equipment and supplies must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state diabetic equipment and supplies providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 15.2 Benefits, Limitations, and Authorization Requirements

Diabetic equipment and supplies including glucose monitors, testing supplies, insulin and insulin syringes, and external insulin pumps and supplies may be reimbursed by the CSHCN Services Program.

### 15.2.1 Glucose Monitor and Supplies

Blood testing supplies may be reimbursed without prior authorization when submitted with one of the following diagnoses:

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| E0800           | E0801   | E0810   | E0811   | E0821   | E0822   | E0829   | E08311  |
| E08319          | E083211 | E083212 | E083213 | E083219 | E083291 | E083292 | E083293 |
| E083299         | E083311 | E083312 | E083313 | E083319 | E083391 | E083392 | E083393 |
| E083399         | E083411 | E083412 | E083413 | E083419 | E083491 | E083492 | E083493 |
| E083499         | E083511 | E083512 | E083513 | E083519 | E083521 | E083522 | E083523 |
| E083529         | E083531 | E083532 | E083533 | E083539 | E083541 | E083542 | E083543 |
| E083549         | E083551 | E083552 | E083553 | E083559 | E083591 | E083592 | E083593 |
| E083599         | E0836   | E0837X1 | E0837X2 | E0837X3 | E0837X9 | E0839   | E0840   |
| E0841           | E0842   | E0843   | E0844   | E0849   | E0851   | E0852   | E0859   |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| E08610          | E08618  | E08620  | E08621  | E08622  | E08628  | E08630  | E08638  |
| E08641          | E08649  | E0865   | E0869   | E088    | E089    | E0900   | E0901   |
| E0910           | E0911   | E0921   | E0922   | E0929   | E09311  | E09319  | E093211 |
| E093212         | E093213 | E093219 | E093291 | E093292 | E093293 | E093299 | E093311 |
| E093312         | E093313 | E093319 | E093391 | E093392 | E093393 | E093399 | E093411 |
| E093412         | E093413 | E093419 | E093491 | E093492 | E093493 | E093499 | E093511 |
| E093512         | E093513 | E093519 | E093521 | E093522 | E093523 | E093529 | E093531 |
| E093532         | E093533 | E093539 | E093541 | E093542 | E093543 | E093549 | E093551 |
| E093552         | E093553 | E093559 | E093591 | E093592 | E093593 | E093599 | E0936   |
| E0937X1         | E0937X2 | E0937X3 | E0937X9 | E0939   | E0940   | E0941   | E0942   |
| E0943           | E0944   | E0949   | E0951   | E0952   | E0959   | E09610  | E09618  |
| E09620          | E09621  | E09622  | E09628  | E09630  | E09638  | E09641  | E09649  |
| E0965           | E0969   | E098    | E099    | E1010   | E1011   | E1021   | E1022   |
| E1029           | E10311  | E10319  | E103211 | E103212 | E103213 | E103219 | E103291 |
| E103292         | E103293 | E103299 | E103311 | E103312 | E103313 | E103319 | E103391 |
| E103392         | E103393 | E103399 | E103411 | E103412 | E103413 | E103419 | E103491 |
| E103492         | E103493 | E103499 | E103511 | E103512 | E103513 | E103519 | E103521 |
| E103522         | E103523 | E103529 | E103531 | E103532 | E103533 | E103539 | E103541 |
| E103542         | E103543 | E103549 | E103551 | E103552 | E103553 | E103559 | E103591 |
| E103592         | E103593 | E103599 | E1036   | E1037X1 | E1037X2 | E1037X3 | E1037X9 |
| E1039           | E1040   | E1041   | E1042   | E1043   | E1044   | E1049   | E1051   |
| E1052           | E1059   | E10610  | E10618  | E10620  | E10621  | E10622  | E10628  |
| E10630          | E10638  | E10641  | E10649  | E1065   | E1069   | E108    | E109    |
| E1100           | E1101   | E1110   | E1121   | E1122   | E1129   | E11311  | E11319  |
| E113211         | E113212 | E113213 | E113219 | E113291 | E113292 | E113293 | E113299 |
| E113311         | E113312 | E113313 | E113319 | E113391 | E113392 | E113393 | E113399 |
| E113411         | E113412 | E113413 | E113419 | E113491 | E113492 | E113493 | E113499 |
| E113511         | E113512 | E113513 | E113519 | E113521 | E113522 | E113523 | E113529 |
| E113531         | E113532 | E113533 | E113539 | E113541 | E113542 | E113543 | E113549 |
| E113551         | E113552 | E113553 | E113559 | E113591 | E113592 | E113593 | E113599 |
| E1136           | E1137X1 | E1137X2 | E1137X3 | E1137X9 | E1139   | E1140   | E1141   |
| E1142           | E1143   | E1144   | E1149   | E1151   | E1152   | E1159   | E11610  |
| E11618          | E11620  | E11621  | E11622  | E11628  | E11630  | E11638  | E11641  |
| E11649          | E1165   | E1169   | E118    | E119    | E1300   | E1301   | E1310   |
| E1311           | E1321   | E1322   | E1329   | E13311  | E13319  | E133211 | E133212 |
| E133213         | E133219 | E133291 | E133292 | E133293 | E133299 | E133311 | E133312 |
| E133313         | E133319 | E133391 | E133392 | E133393 | E133399 | E133411 | E133412 |
| E133413         | E133419 | E133491 | E133492 | E133493 | E133499 | E133511 | E133512 |
| E133513         | E133519 | E133521 | E133522 | E133523 | E133529 | E133531 | E133532 |
| E133533         | E133539 | E133541 | E133542 | E133543 | E133549 | E133551 | E133552 |

| Diagnosis Codes |         |         |         |         |         |        |         |
|-----------------|---------|---------|---------|---------|---------|--------|---------|
| E133553         | E133559 | E133591 | E133592 | E133593 | E133599 | E1336  | E1337X1 |
| E1337X2         | E1337X3 | E1337X9 | E1339   | E1341   | E1342   | E1343  | E1344   |
| E1349           | E1351   | E1352   | E1359   | E13610  | E13620  | E13621 | E13622  |
| E13628          | E13630  | E13638  | E13641  | E13649  | E1365   | E1369  | E138    |
| E139            | P702    | Z7984   |         |         |         |        |         |

**15.2.1.1 Non Diabetic Diagnosis Codes**

| Diagnosis Codes |       |        |        |        |        |        |        |
|-----------------|-------|--------|--------|--------|--------|--------|--------|
| E161            | E162  | E71111 | E71310 | E71311 | E71312 | E71313 | E71314 |
| E71318          | E7132 | E7420  | E7421  | E7429  | E88810 | E88811 | E88818 |
| E88819          | E88A  | K911   | R7303  | R7309  | R81    |        |        |

Diagnoses not listed may be considered for prior authorization with supporting documentation of medical necessity.

**15.2.1.2 Glucose Monitor**

The purchase of a blood glucose monitor may be reimbursed once every three years using the following procedure codes:

| Procedure Code | Limitation                             |
|----------------|--|
| E2100          | 1 per 3 years with prior authorization |
| E2101          | 1 per 3 years with prior authorization |

Blood glucose monitors with integrated voice synthesizers (procedure code E2100) and blood glucose monitors with integrated lancing blood sample (procedure code E2101) may be considered for prior authorization with documentation of medical necessity.

Prior authorization is required for blood glucose monitors with special features (procedure codes E2100 and E2101). The following documentation supporting medical necessity of the special feature requested must be submitted with the prior authorization request:

- *Integrated voice synthesizer.* Supporting documentation for procedure code E2100 must include an additional diagnosis such as significant visual impairment and must include a statement from the physician that indicates that the client is unable to use a regular monitor and that the additional diagnosis or condition is not correctable.
- *Integrated lancing/blood sample.* Supporting documentation for procedure code E2101 must include a diagnosis of diabetes and significant manual dexterity impairment related, but not limited to, neuropathy, seizure activity, cerebral palsy, or Parkinson’s. The documentation must include a statement from the physician indicating that the client is unable to use a regular monitor and has a significant manual dexterity impairment that is not correctable.

Standard home glucose monitors (procedure code E0607) are not a benefit of the CSHCN Services Program.

### 15.2.1.3 Glucose Testing Supplies

The following procedure codes may be reimbursed for glucose testing supplies when billed with one of the diagnosis codes listed in the Section 15.2.1, “Glucose Monitor and Supplies” in this chapter:

| Procedure Code | Limitation          |
|----------------|---------------------|
| A4233          | 1 per 6 months      |
| A4234          | 1 per 6 months      |
| A4235          | 1 per 6 months      |
| A4236          | 1 per 6 months      |
| A4250          | 1 box per 6 months  |
| A4252          | 10 strips per month |
| A4256          | 2 per year          |
| A4258          | 2 per year          |

#### 15.2.1.3.1 Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require authorization up to the quantities listed when they are provided to an insulin-dependent client with a valid diagnosis. If the client is insulin-dependent, providers must submit claims with modifier U9 for these procedure codes:

| Procedure Code  | Limitation        |
|---|-------------------|
| A4253*  | 2 boxes per month |
| A4259   | 1 box per month   |
| A9275*  | 2 per month       |
| * A client may receive a combined total of two per calendar month of procedure codes A4253 and A9275, either two of one procedure code or one of each procedure code. |                   |

#### 15.2.1.3.2 Non-Insulin-Dependent Clients

The following procedure codes for diabetic supplies do not require authorization up to the quantities listed when provided to a non-insulin-dependent client with an approved diagnosis:

| Procedure Code  | Limitation           |
|---|----------------------|
| A4253*  | 1 box per month      |
| A4259   | 1 box every 2 months |
| A9275*  | 1 per month          |
| * A client may receive only one per calendar month of either procedure code A4253 or A9275. |                      |

Blood testing supplies for diagnoses other than those listed in the Section 15.2.1, “Glucose Monitor and Supplies” in this chapter may be considered for prior authorization with documentation of medical necessity.

For items that do not require prior authorization, the provider must indicate on a completed, signed prescription how many times a day the client is required to test blood glucose or ketone levels when applicable (not all supplies are related to testing glucose or urine, e.g., batteries).

### 15.2.1.4 Glucose Tabs and Gel

Procedure code A9150 may be reimbursed for glucose tablets or gel with prior authorization. Documentation of medical necessity and one of the diagnosis codes listed in the Section 15.2.1, “Glucose Monitor and Supplies” in this chapter must be included with the prior authorization request. Procedure code A9150 may be prior authorized with a quantity of 1 every 6 months as determined with prior authorization.

### 15.2.1.5 Prior Authorization Requirements

Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified in the specific sections of this chapter. Prior authorization is required when documentation of medical necessity supports additional quantities that exceed specified limits.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested equipment or supplies. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the diabetic equipment or supplies.

## 15.2.2 Continuous Glucose Monitors (CGM)

The following procedure codes and related supplies are benefits in the home setting when the services are provided by home health durable medical equipment (DME), medical supplier (DME), and custom DME providers:

| Procedure Codes | Limitations         |
|-----------------|---------------------|
| A4238           | One per month       |
| A4239           | One unit per month  |
| E2102           | One per three years |
| E2103           | One per three years |

A therapeutic or non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone BGM to confirm testing results. A non-therapeutic or adjunctive CGM requires the user to verify their glucose levels or the trends displayed on a CGM with a BGM before making treatment decisions.

The CGM system includes the following:

- A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels)
- A transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor)
- A receiver/monitor (records and stores the data and alerts the client when glucose levels are too high or too low)

Only CGM consisting of all three parts including the sensor, transmitter, and receiver/monitor are covered. Coverage requires a dedicated receiver/monitor. A CGM that uses a smart device (e.g., smart phone, tablet, watch, personal computer) as a receiver is not classified as durable medical equipment and therefore not covered by the CSHCN Services Program.

The non-adjunctive CGM system includes the device (procedure code E2103) and associated supplies (procedure code A4239).

The adjunctive CGM system includes a receiver/monitor (procedure code E2102) and associated supplies (procedure code A4238).

A CGM device (procedure code A9278) and associated supplies (procedure codes A9276 and A9277) for use with non-durable medical equipment are informational only.

Procedure codes E2102 and E2103 are limited to once per three rolling years, any provider.

Other home glucose monitors (procedure codes E2100 and E2101) will be denied when submitted within three calendar years of procedure codes E2102 or E2103.

The supply allowance (procedure code A4238 or A4239) used with a CGM system encompasses all items necessary for the use of the device. The DME provider is responsible for delivering all appropriate items and quantities to the client for continuous usage of the CGM.

CGM are devices used as a supplement to SBGM. Allowance for SBGM supplies billed in addition to an approved CGM system will be reduced to two boxes for test strips (procedure code A4253) and one box for lancets (procedure code A4259) during the same calendar year by any provider.

The provider is responsible for submitting appropriate claims using procedure codes E2103 and A4239 for therapeutic devices and supplies. Claims must be submitted with modifier KF for a class III device (designated by FDA) and associated supplies. No modifier is required for a class II device (designated by FDA).

| Modifier | Description                                |
|----------|--|
| KF       | Item designated by FDA as class III device |

Procedure code A4239 will be denied when submitted during the same calendar month by any provider as procedure codes A4250, A4256, A9275, E2100, or E2101.

#### 15.2.2.1 Prior Authorization Requirements

Prior authorization is required for a CGM device (procedure codes E2102 and E2103) and its associated supplies (procedure codes A4238 and A4239) that exceed the limit of once per calendar month. All prior authorization requests must be submitted on the CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form.

CGM must be prescribed by the health-care provider who manages the client's diabetes. The order must include the make and model of the requested CGM device. A long-term personal CGM system for clients with diabetes to use at home may be considered for prior authorization for clients who have a documented diagnosis of insulin dependent diabetes mellitus and with clinical documentation of the following criteria:

- The client uses BGM and performs frequent testing (at least four times per day).
- The client has an insulin treatment regimen that requires frequent adjustments based on self blood glucose monitoring (SBGM) or CGM testing results.
- There is documentation that the client demonstrates compliance with his or her insulin regimen by monitoring his or her blood sugar with finger sticks.
- If the client already owns a monitor, the client must also meet at least two of the following criteria for the initial order of the monitor and supplies:
  - Elevated glycosylated hemoglobin level (HbA1c) > 7.0 percent
  - History of dawn phenomenon with fasting blood sugars that frequently exceed 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
  - History of diabetic ketoacidosis

The provider must submit the CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies Form indicating the following:

- The client or caregiver possesses the following competencies:
  - The cognitive and physical abilities to use the CGM
  - An understanding of cause and effect
  - The ability to learn to use the device
  - The ability to hear and view CGM alerts and respond appropriately
  - The willingness to support the use of the CGM
- The prescribing provider attests the following:
  - A training or education plan will be completed prior to initiation of CGM therapy.
  - The client or caregiver will be given face-to-face education and instruction.
  - The client or caregiver will be able to demonstrate proficiency in integrating CGM therapy with the current treatment regimen for glucose control.

Prior to prescribing a CGM device, the ordering provider should verify that the client meets the CGM manufacturers' recommendations for:

- Medical Conditions.
- Appropriate age range.
- Testing and calibration requirements.

The initial prior authorization will be valid for six months. If the client complies with the use of the CGM and treatment plan, the physician may write an order and submit an updated PA request for an additional six months. After the first year, an order for replacement sensors, transmitter, and receiver may be submitted for a 12-month period.

#### **15.2.2.2 Associated Supplies**

When a CGM device (procedure code E2102 or E2103) is approved, the related supplies (procedure code A4238 or A4239) are also covered once per calendar month. Prior authorization for the related supplies is required only when the extra supplies provided exceed the allowance of once per calendar month.

Prior authorization to approve the initial once per calendar month allowance for the related supplies (procedure code A4238 or A4239) is also required when the client already owns a CGM device and the provider is not requesting a new CGM device. Clinical documentation of the following must be submitted with the prior authorization request:

- The client-owned device meets the CMS definition of a non-adjunctive CGM.
- A physician's statement verifying the client's current condition meets the non-adjunctive CGM coverage criteria.

SBGM-related supplies (procedure codes A4233, A4234, A4235, A4236, A4253, and A4259) provided within the same calendar month as an approved CGM device (procedure code E2103) and related supplies (procedure code A4239) will require prior authorization and documentation of medical necessity. Providers must use modifier U9 for insulin-dependent clients.

#### **15.2.2.3 Noncovered Services**

The following services are not benefits of the CSHCN Services Program:

- Diagnostic glucose devices
- CGM without a dedicated receiver

- Smart devices (smart phones, tablets, personal computers, etc.) used as CGM monitors
- Non-medical items, even if the items may be used to serve a medical purpose

### 15.2.3 Insulin Pump

An external insulin pump may be considered for rental or purchase with prior authorization and documentation of medical necessity. The following procedure codes may be reimbursed with prior authorization for the external insulin pump:

| Procedure Code | Limitation                                       |
|----------------|--|
| E0784          | 1 per month (rental)<br>1 per 3 years (purchase) |
| A9900          | As needed for the replacement bag                |

External insulin pump supplies do not require prior authorization up to the maximum quantities allowed. The following procedure codes may be reimbursed for the external insulin pump supplies:

| Procedure Code | Limitation   |
|----------------|--|
| A4224          | 4 per month  |
| A4225          | 15 per month   |
| A4230          | 10 per month   |
| A4231          | 15 per month   |
| A4232          | 10 per month   |
| A4601          | 1 per 6 months   |
| A4602          | 1 per 6 months   |
| A6257          | 15 per month   |
| A6258          | 30 per month   |
| A6259          | 15 per month   |
| A9274          | 15 per month   |
| A9900          | As needed with prior authorization   |
| K0604          | 1 per 6 months   |
| K0605          | 1 per 6 months   |
| E0784          | 1 per 3 years with prior authorization (purchase)<br>1 per month with prior authorization (rental) |

Procedure codes A4230 and A4231 cannot be billed during the same calendar month.

Providers must bill the pump (procedure code E0784) used in the CGM integrated system with modifier UD. Providers also must bill procedure codes E2102 or E2103 with modifier U4 for the integrated system.

Additional quantities may be considered with documentation of medical necessity and prior authorization.

A tubeless external insulin pump (Omnipod) may be considered for prior authorization and must be submitted using procedure code E0784 with modifier U1 and supply procedure code A9274 for the disposable pods, supplies, and accessories.

An external insulin pump must be ordered by, and the client's follow-up care must be managed by, a prescribing provider with experience managing clients with insulin pumps and who is knowledgeable in the use of insulin pumps.



### 15.2.3.1 Prior Authorization Requirements

Prior authorization requests for the rental and purchase of the external insulin pumps (procedure code E0784) must be submitted on the [CSHCN Services Program Prior Authorization Request for Diabetic Equipment and Supplies form](#). Supporting medical necessity documentation must include past and current blood glucose levels and the most recent glycosylated hemoglobin level (HbA1C).

The rental of an external insulin pump may be considered for prior authorization with submission of clinical documentation that indicates one of the following:

- The client has a diagnosis of diabetes mellitus and meets at least 2 of the following criteria while on multiple daily injections of insulin:
  - Elevated glycosylated hemoglobin level (HbA1c) greater than 7.0 percent
  - History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
  - History of severe glycemic excursions with wide fluctuations in blood glucose
  - History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness

In addition to the clinical documentation, the provider must submit the [CSHCN Services Program Prior Authorization Diabetic Equipment and Supplies form](#) and include documentation that the client or caregiver possess the following competencies:

- The cognitive and physical abilities to use the recommended insulin pump treatment regimen
- An understanding of cause and effect
- The willingness to support the use of the external insulin pump

The prior authorization request form must also include documentation that the prescribing provider has attested to the following:

- A training/education plan will be completed prior to initiation of pump therapy.
- The client or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

***Note:** Providers may bill with procedure code A9900 for the replacement of alkaline batteries for the external ambulatory infusion pump during the rental period.*

The purchase of an external insulin pump may be considered for prior authorization after it has been rented for a three-month trial period and all of the following documentation is provided:

- The training/education plan has been completed.
- The pump is the appropriate equipment for the specific client.
- The client is compliant with the use of the pump.

Rental of an external insulin pump may be reimbursed for a 3-month trial, which must occur before purchase can be authorized.

In order for the external insulin pump to be considered for purchase, the physician must provide documentation that it is the appropriate equipment for the client and the client is compliant with use.

Replacement leg bag (procedure code A9900) must be prior authorized with documentation supporting medical necessity.

An internal insulin pump will not be prior authorized because the pump is included in the reimbursement for the surgery to place the pump.

### 15.2.3.2 CGM Integrated External Insulin Pump

A CGM integrated pump system, also called a closed-loop glucose management system, connects a CGM and an insulin pump. The system uses an algorithm to calculate insulin doses from the CGM readings based on thresholds of measured glucose levels and tells the pump to deliver or suspend the insulin into the client's body.

Clients currently utilizing an external insulin pump or who meet the criteria for an external insulin pump may be reimbursed for a CGM specific pump and CGM device to form an integrated system through prior authorization.

Prior authorization for an integrated system should be requested utilizing pump procedure code E0784 with modifier UD combined with one of the following CGM procedure codes:

- E2102
- E2103 with modifier U4

Tubeless external insulin pump (Omnipod) may be considered as an alternative to the CGM integrated pump system through prior authorization using pump procedure code E0784 with modifier U1 combined with disposable supply procedure code A9274.

Some CGM integrated pump systems might use smart devices to monitor the system instead of a CGM receiver/monitor. CSHCN Services Program excludes coverage for non-medical items, even when the items may be used to serve a medical purpose. The device provider is responsible for supplying the software applications to make the system work appropriately.

Once the client is on a CGM integrated insulin pump, either with therapeutic CGM capability or with adjunctive CGM capability, the claims for a stand-alone CGM will be denied.

The following modifiers should be used to bill for CGM integrated external insulin pump systems:

| Modifier | Description   |
|----------|---|
| UD       | Used for pump with CGM for integrated pump system         |
| U1       | Used for pump with Omnipod system                         |
| U4       | Used for CGM devices with pump for integrated pump system |

### 15.2.4 Insulin and Insulin Syringes

Insulin and insulin syringes are available through the Texas Medicaid Vendor Drug Program.

**Referto:** Section 3.1.1, "Prescription Drug Benefits" in Chapter 3, "Client Benefits and Eligibility" for more information.

## 15.3 Documentation of Receipt

When the equipment is delivered, providers must complete the [CSHCN Services Program Documentation of Receipt form](#). The date of delivery on the form is the date of service that should appear on the claim. The provider must request a signature from the client or client's representative at the time of delivery. The provider should retain this form and not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The documentation of receipt form is available in both [English](#) and [Spanish](#).

## 15.4 Claims Information

Diabetic equipment and supplies must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 15.5 Reimbursement

Diabetic equipment and supplies are reimbursed the lower of the billed amount, the amount allowed by CMS when available, or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 15.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **DIAGNOSTIC RADIOLOGY SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# DIAGNOSTIC RADIOLOGY SERVICES

## Table of Contents

|             |   |           |
|-------------|---|-----------|
| <b>16.1</b> | <b>Enrollment</b> .....   | <b>3</b>  |
| <b>16.2</b> | <b>Benefits, Limitations, and Authorization Requirements</b> .....  | <b>3</b>  |
| 16.2.1      | Diagnostic Radiology Services Provided by Hospitals .....   | 3         |
| 16.2.2      | Diagnostic Radiology Services Provided by Physicians, Advanced Practice<br>Registered Nurses (APRNs), Physician Assistants, and Clinics ..... | 3         |
| 16.2.3      | Cardiac Blood Pool Imaging .....  | 4         |
| 16.2.4      | Computed Tomography (CT) Scan .....   | 4         |
| 16.2.5      | Contrast Material .....   | 6         |
| 16.2.6      | Magnetic Resonance Angiography (MRA) .....  | 6         |
| 16.2.6.1    | MRA Authorization Requirements .....  | 7         |
| 16.2.7      | Magnetic Resonance Imaging (MRI) .....  | 7         |
| 16.2.7.1    | MRI Authorization Requirements .....  | 7         |
| 16.2.7.2    | MRI Benefits and Limitations .....  | 8         |
| 16.2.8      | Mammography Certification .....   | 8         |
| 16.2.9      | Positron Emission Tomography (PET) .....  | 9         |
| 16.2.10     | X-ray and Ultrasound Procedures .....   | 9         |
| 16.2.10.1   | Diagnostic Imaging .....  | 10        |
| 16.2.10.2   | Interventional Radiological Procedures .....  | 10        |
| 16.2.10.3   | Abdominal Flat Plates (AFPs) and Kidney, Ureter, and Bladder (KUB) .....  | 10        |
| 16.2.10.4   | Reimbursement Information .....   | 11        |
| 16.2.10.5   | X-ray and Ultrasound Prior Authorization Requirements .....   | 11        |
| 16.2.11     | Noncovered Services .....   | 11        |
| <b>16.3</b> | <b>Claims Information</b> .....   | <b>11</b> |
| <b>16.4</b> | <b>Reimbursement</b> .....  | <b>12</b> |
| 16.4.1      | One-day Payment Window Reimbursement Guidelines .....   | 13        |
| <b>16.5</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....   | <b>14</b> |

## 16.1 Enrollment

To enroll and be reimbursed for services in the CSHCN Services Program, diagnostic radiology services providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state and federal laws and requirements. Out-of-state radiology providers must meet all of the above conditions and be located in the United States within 50 miles of the Texas state border.

Physicians, dentists, advanced practice registered nurses (APRNs), physician assistants, hospitals, and radiological laboratories are eligible to enroll in Texas Medicaid and to receive reimbursement for CSHCN Services Program diagnostic radiology services that are within the scope of their practice to render.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 16.2 Benefits, Limitations, and Authorization Requirements

### 16.2.1 Diagnostic Radiology Services Provided by Hospitals

When submitting claims for services provided in an inpatient or outpatient hospital setting, radiologists may be reimbursed only for the interpretation. All medically necessary diagnostic radiology services provided to hospital inpatients must be ordered by the client’s attending or consulting physician. Additionally, the medical necessity must be documented in the client’s medical record.

### 16.2.2 Diagnostic Radiology Services Provided by Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants, and Clinics

In compliance with Health and Human Services (HHS) regulations, physicians, APRNs, physician assistants, and clinics may not submit claims for diagnostic radiology services provided outside of their offices. These services must be submitted directly by the facility or provider that performs the service. This regulation does not affect services performed by the physician or others under his or her personal supervision in the physician’s office.

For services provided by physicians in their offices or clinics, providers may submit total or technical components, as applicable, for procedures that were performed using equipment owned by that physician and located in that physician's office. The technical component is denied when submitted by a physician in the inpatient or outpatient hospital setting. If the physician is a member of a clinic that owns and operates radiology facilities, the physician may submit these services. However, if the physician practices independently and shares space in a medical complex where radiology facilities are located, the physician may not submit these services even if he or she owns or shares ownership of the facility unless he or she personally supervises and is responsible for the daily operation of the facilities.

If a physician owns equipment and performs studies in his or her office, but has a radiologist come to the office to perform the interpretations, the physician may submit all services connected with the study and may reimburse the radiologist for an interpretation or the physician may submit the technical component and allow the interpreting physician to submit the interpretation separately. A separate charge for radiology interpretation submitted by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the client. Providers who perform the technical service and interpretation must submit the total component. Providers who perform only the technical service must submit the technical component. Providers who perform only the interpretation must submit the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure submitted with the same date of service, for the same client, any provider, are denied.

Claims are considered for reimbursement based on the order in which they are received. For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure submitted with the same dates of service for the same client by any provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be reimbursed if a radiologist is not submitting the interpretation component of radiology procedures.

If duplicate submissions are found between a radiologist and other specialties, the radiologist's claim is considered for reimbursement and the other providers' claims are denied.

*Note: For the purposes of this chapter, "APRN" includes nurse practitioner and clinical nurse specialist providers only.*

### 16.2.3 Cardiac Blood Pool Imaging

Procedure codes 78472, 78473, 78481, 78483, 78494, and 78496 for cardiac blood pool imaging services are benefits of the CSHCN Services Program.

### 16.2.4 Computed Tomography (CT) Scan

CT imaging may be reimbursed by the CSHCN Services Program using the following procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 70450           | 70460 | 70470 | 70480 | 70481 | 70482 | 70486 | 70487 | 70488 | 70490 |
| 70491           | 70492 | 70496 | 70498 | 71250 | 71260 | 71270 | 71275 | 72125 | 72126 |
| 72127           | 72128 | 72129 | 72130 | 72131 | 72132 | 72133 | 72191 | 72192 | 72193 |
| 72194           | 73200 | 73201 | 73202 | 73206 | 73700 | 73701 | 73702 | 73706 | 74150 |
| 74160           | 74170 | 74174 | 74175 | 74176 | 74177 | 74178 | 75571 | 75572 | 75573 |
| 75574           | 75635 | 76376 | 76377 | 76380 | 77011 |       |       |       |       |

Prior authorization is not required for up to four CT imaging procedures per year.

Prior authorization will be considered for any additional CT procedures with documentation of a severe or life-threatening medical condition that requires close monitoring with CT imaging to determine appropriate treatment, and that without such monitoring and treatment, the condition could progress to severe disability or death.

Prior authorization requests for CT scans that exceed four per client, per rolling year must be submitted on the [CSHCN Services Program Authorization and Prior Authorization Request form](#) and must include documentation of medical necessity for the procedure.

Medical necessity for CT scans includes, but is not limited to, clients with any of the following:

- Ventriculoperitoneal shunt
- Routine postoperative follow-up of ventriculoperitoneal shunt
- Congenital anomaly or deformity
- Suspected fracture when plain film is inconclusive
- Hydrocephalus
- Epilepsy
- Other neurological symptoms
- Craniofacial malformation
- Primary or metastatic cancer
- Known or suspected primary tumor (malignant or nonmalignant)
- Tumor staging
- Progressively severe symptoms despite conservative management

**Note:** *The American College of Radiology Practice Guidelines for CT scans may be used as a reference for specific indications.*

Documentation of medical necessity, including the specific rationale for the requested procedure, must be maintained in the client's medical record.

CT scan procedure codes are subject to National Correct Coding Initiative (NCCI) relationships with the following exceptions.

The procedure codes in Column A of the following table will be denied if they are billed with the procedure codes in Column B:

| Column A (Denied) | Column B  |
|-------------------|---|
| 70450             | 70460   |
| 70450, 70460      | 70470   |
| 70480             | 70481   |
| 70480, 70481      | 70482   |
| 70486             | 70487   |
| 70486, 70487      | 70488   |
| 70490             | 70491   |
| 70490, 70491      | 70492   |
| 76376, 76377      | 70496, 70498, 71275, 72191, 73206, 73706, 74175 |
| 71250, 76380      | 71260   |
| 71250, 71260      | 71270   |



| Column A (Denied)   | Column B            |
|---------------------|---------------------|
| 72125               | 72126               |
| 72125, 72126        | 72127               |
| 72128               | 72129               |
| 72128, 72129        | 72130               |
| 72131               | 72132               |
| 72131, 72132        | 72133               |
| 72192               | 72193               |
| 72192, 72193        | 72194               |
| 73200               | 73201               |
| 73200, 73201        | 73202               |
| 73700               | 73701               |
| 73700, 73701        | 73702               |
| 76380               | 74150               |
| 74150, 76380        | 74160               |
| 74150, 74160, 76380 | 74170               |
| 76376               | 76377               |
| 76380               | 77011               |
| 70480, 70481, 70482 | 70450, 70460, 70470 |

**16.2.5 Contrast Material**

Radiological procedures that specify *with contrast* include payment for high osmolar, low osmolar, and paramagnetic contrast material. No additional payment is made for contrast material.

**16.2.6 Magnetic Resonance Angiography (MRA)**

MRA procedures of the head and neck, chest, abdomen, pelvis, and the lower extremities are benefits for CSHCN Services Program clients. The use of MRA in some areas of the body (spinal canal and upper extremities) is considered investigational and is not a benefit of the CSHCN Services Program. The CSHCN Services Program may reimburse either an MRA or a conventional angiography but not both in the same day without documentation of medical necessity for both tests.

| Region       | Procedure Code(s)                        | Benefits and Limitations   |
|--------------|--|--|
| Head or Neck | 70544, 70545, 70546, 70547, 70548, 70549 | An MRA of the head or neck is a benefit when indicated and used to visualize or rule out cerebrovascular disease, subarachnoid and intracerebral hemorrhage, and occlusion or stenosis of intracranial vessels.  |
| Chest        | 71555                                    | An MRA of the chest is a benefit when performed to evaluate coronary artery disease or anomalous arteriopulmonary systems and to identify thoracic aneurysms or pulmonary embolisms in cases when contrast material is contraindicated. MRAs are also benefits for evaluating the coronary vessels in coronary artery disease, vasculitis, or vessel patency postoperatively.<br><br>An MRA of the chest is a benefit when used to diagnose a pulmonary embolism only when the client has a documented allergy to iodinated contrast material. |

| Region            | Procedure Code(s) | Benefits and Limitations   |
|-------------------|-------------------|--|
| Abdomen           | 74185             | An MRA of the abdomen is a benefit when used to assess the main renal arteries for the evaluation of renal artery stenosis, abdominal aortic aneurysm or dissection, and associated occlusive disease.   |
| Pelvis            | 72198             | An MRA of the pelvis is a benefit when performed to evaluate pelvic arteries for stenosis and for the detection, grading, and differentiation of renovascular disease.   |
| Lower Extremities | 73725             | An MRA of the lower extremities is a benefit when indicated for the evaluation of peripheral vascular disease related to the lower extremities, such as hemangioma, atherosclerosis, arterial embolism and thrombosis, and arterial anomalies. |

If an MRA and a conventional angiography are performed on the same day, the documentation of medical necessity must indicate that a conventional angiography did not identify a viable run off vessel for bypass, that MRA results were inconclusive, or other medical necessity documentation.

### 16.2.6.1 MRA Authorization Requirements

Authorization is not required for MRA services.

### 16.2.7 Magnetic Resonance Imaging (MRI)

MRI, including functional MRI and intraoperative MRI, is a benefit of the CSHCN Services Program.

The CSHCN Services Program considers functional MRI (fMRI) medically necessary when it is being used as a part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, and which might potentially be put at risk during the proposed surgery.

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep-brain stimulators

The following procedure codes may be used to bill MRI procedures:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 70336           | 70540 | 70542 | 70543 | 70551 | 70552 | 70553 | 70554 | 70555 | 70557 |
| 70558           | 70559 | 71550 | 71551 | 71552 | 72141 | 72142 | 72146 | 72147 | 72148 |
| 72149           | 72156 | 72157 | 72158 | 72195 | 72196 | 72197 | 73218 | 73219 | 73220 |
| 73221           | 73222 | 73223 | 73718 | 73719 | 73720 | 73721 | 73722 | 73723 | 74181 |
| 74182           | 74183 | 75557 | 75559 | 75561 | 75563 | 75565 | 76376 | 76377 | 77046 |
| 77047           | 77048 | 77049 | 77084 |       |       |       |       |       |       |

### 16.2.7.1 MRI Authorization Requirements

Authorization is not required for up to four MRI procedures per rolling year.

Prior authorization will be considered for any additional MRI procedures with documentation of a severe or life-threatening medical condition that:

- Requires close monitoring with MRI to determine appropriate treatment.
- Could progress to severe disability or death without such monitoring or treatment.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

### 16.2.7.2 MRI Benefits and Limitations

Procedure codes 75559 or 75563 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, or 93018.

MRI procedure codes are subject to NCCI relationships with the following exceptions.

The following procedure codes in Column A will be denied when billed with the same date of service by the same provider as the procedure codes in Column B

| Column A (Denied)   | Column B     |
|---|--------------|
| 01922, 76350, 77021   | 70557        |
| 01922, 36000, 36005, 36406, 36410, 70557, 76000, 76350, 76942, 77002, 77021, 96360, 96365, 96372, 96374, 96375        | 70558        |
| 01922, 36000, 36005, 36406, 36410, 70557, 70558, 76000, 76350, 76942, 77002, 77021, 96360, 96365, 96372, 96374, 96375 | 70559        |
| 01922, 76350  | 71550, 74181 |
| 01922, 36000, 36005, 36011, 36406, 36410, 71550, 71551, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, 96375 | 71552        |
| 01922, 36000, 36005, 36011, 36406, 36410, 74181, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, 96375        | 74182        |
| 01922, 36000, 36005, 36011, 36406, 36410, 74181, 74182, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, 96375 | 74183        |

### 16.2.8 Mammography Certification

DSHS issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA) because the FDA recognizes the DSHS certification. TMHP will continue to accept mammography certification issued by the FDA.

Providers are reminded to check the expiration date of their certification and submit an updated mammography certification prior to its expiration date. Mail or fax certifications to:

Texas Medicaid & Healthcare Partnership  
 Provider Enrollment  
 PO Box 200795  
 Austin, TX 78720-0795  
 Fax: 1-512-514-4214

### 16.2.9 Positron Emission Tomography (PET)

The CSHCN Services Program may reimburse for PET scans (procedure codes 78608, 78811, 78812, 78813, 78815, and 78816) in the office, inpatient hospital, or outpatient hospital setting when they are used to map an epileptogenic focus prior to surgical treatment of a seizure disorder.

Procedure code 78608 must be submitted with one of the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |      |
|-----------------|--------|--------|--------|--------|------|
| G249            | G40201 | G40209 | G40211 | G40219 | R569 |

Procedure codes 78811, 78812, 78813, 78815, and 78816 must be submitted with one of the following diagnosis codes:

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| C000            | C001    | C003    | C004    | C005    | C006    | C008    | C430    |
| C43111          | C43112  | C43121  | C43122  | C4321   | C4322   | C4330   | C4331   |
| C4339           | C434    | C4351   | C4352   | C4359   | C4361   | C4362   | C4371   |
| C4372           | C438    | C439    | C4400   | C4409   | C441021 | C441022 | C441091 |
| C441092         | C441121 | C441122 | C441191 | C441192 | C441221 | C441222 | C441291 |
| C441292         | C441921 | C441922 | C441991 | C441992 | C44202  | C44209  | C44292  |
| C44299          | C44301  | C44309  | C44390  | C44391  | C44399  | C4440   | C4449   |
| C44500          | C44501  | C44509  | C44590  | C44591  | C44599  | C44602  | C44609  |
| C44692          | C44699  | C44702  | C44709  | C44792  | C44799  | C4480   | C4489   |
| C4490           | C4499   | C518    | C6201   | C6202   | C6210   | C6291   | C6292   |
| C710            | C711    | C712    | C713    | C714    | C715    | C716    | C717    |
| C718            | C719    | C7641   | C7642   | C792    | C7931   | D030    | D03111  |
| D03112          | D03121  | D03122  | D0321   | D0322   | D0330   | D0339   | D034    |
| D0351           | D0352   | D0359   | D0361   | D0362   | D0371   | D0372   | D038    |
| D039            | D4011   | D4012   | D430    | D431    | D432    |         |         |

In addition to the diagnosis codes listed above, procedure codes 78813 and 78815 may also be considered for reimbursement with the following diagnosis codes:

| Diagnosis Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| C4000           | C4001 | C4002 | C4010 | C4011 | C4012 | C4020 | C4021 |
| C4022           | C4030 | C4031 | C4032 | C4080 | C4081 | C4082 | C4090 |
| C4091           | C4092 | C410  | C411  | C412  | C413  | C414  | C419  |

*Note: Other diagnoses may be considered on a case-by-case basis through prior authorization after review by the CSHCN Services Program Medical Director or a designee.*

### 16.2.10 X-ray and Ultrasound Procedures

Radiology services include, but are not limited to, diagnostic imaging and interventional radiological procedures.

### 16.2.10.1 Diagnostic Imaging

The following procedure codes for diagnostic imaging may be considered for reimbursement by the CSHCN Services Program:

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| 70030           | 76831 | 76881 | 76882 | 76883 | 93980 |

The following procedure codes for contrast material may be considered for reimbursement when used during an echocardiography.

| Procedure Codes |
|-----------------|
| Q9950           |

Procedure code Q9950 must be billed in conjunction with procedure code 93306.

### 16.2.10.2 Interventional Radiological Procedures

Interventional radiological procedures employ image guidance methods to gain access to deep soft tissue and organs.

The following procedure codes for interventional radiological procedures may be considered for reimbursement by the CSHCN Services Program:

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| 74235           | 75956 | 75957 | 75958 | 75959 | 76937 |

Physicians may be reimbursed for only the professional interpretation component of procedure codes 75956, 75957, 75958, and 75959.

Procedure code 75956 may be reimbursed when it is billed in conjunction with procedure code 33880.

Procedure code 75957 may be reimbursed when it is billed in conjunction with procedure code 33881.

Procedure code 75958 may be reimbursed when it is billed in conjunction with procedure code 33883.

**Note:** Procedure code 33884 may be reimbursed when it is billed in conjunction with procedure code 33883 on the same day, by the same provider. Therefore, if procedure code 75958 is rendered with procedure code 33884, procedure codes 33884 and 33883 must be billed to prevent denial of the claim.

Procedure code 75959 may be reimbursed when it is billed in conjunction with procedure code 33886.

Procedure code 76937 is an add-on code and must be billed in conjunction with the appropriate primary procedure, on the same day, by the same provider.

### 16.2.10.3 Abdominal Flat Plates (AFPs) and Kidney, Ureter, and Bladder (KUB)

The following procedure codes for AFPs and KUB procedures are included in the cost of the more complicated X-ray and will not be reimbursed separately:

| Procedure Codes |       |       |
|-----------------|-------|-------|
| 74000           | 74010 | 74020 |

**Exception:** The AFP and KUB procedures may be reimbursed separately if documentation is submitted with the claim that indicates that the results of these X-rays required more complicated X-rays.

#### 16.2.10.4 Reimbursement Information

The CSHCN Services Program may reimburse the facility/provider that performs the X-ray or ultrasound service. Physicians, group practices, and clinics are not reimbursed for radiology services that are provided outside their offices.

Physicians may be reimbursed for the total component for radiology and ultrasound services that are rendered in the office using equipment owned by the physician.

Separate charges for injectable radioactive materials may be reimbursed.

X-ray and ultrasound procedure codes are subject to NCCI relationships with the following exceptions. The procedure codes in Column A of the following table will be denied if they are billed with the same date of service by the same provider as the procedure codes in Column B:

| Column A (Denied) | Column B     |
|-------------------|--------------|
| 75958             | 75956, 75957 |

#### 16.2.10.5 X-ray and Ultrasound Prior Authorization Requirements

Procedure code 93980 requires prior authorization.

Documentation for procedure code 93980 must include at least one of the following:

- An occurrence of trauma
- Signs and symptoms of a vascular occlusion, which includes, but is not limited to, pain, discoloration, or abnormal visualization of penile area
- Evaluation success of surgical treatment of Peyronie's disease

#### 16.2.11 Noncovered Services

The following services are included in other services and will not be reimbursed separately by the CSHCN Services Program:

- Intraoperative ultrasonic guidance is considered a part of a surgical procedure and will not be reimbursed separately.
- The attending or consulting physician will not be reimbursed for an interpretation that is billed with the same date of service for the same client as an interpretation that is billed by the radiologist. The attending or consulting physician's interpretation is included in the reimbursement for the client workup and will not be reimbursed separately.
- Oral preparations for X-rays are included in the charge for the X-ray and will not be reimbursed separately.

The following services are not benefits of the CSHCN Services Program:

- Portable X-ray services
- Baseline screening and comparison studies
- Infertility and obstetrical services

### 16.3 Claims Information

Claims for diagnostic radiology services must include the referring provider. Radiologists are required to identify the referring provider by full name and address or NPI in Block 17 of the CMS-1500 paper claim form.

Diagnostic radiology services must be submitted to TMHP in an approved electronic format on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms and UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper CMS-1500 claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper UB-04 CMS-1450 claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be billed on the UB-04 CMS-1450 paper claim form as an ancillary charge. Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays, but a description including the location and the number of views must be provided or the applicable HCPCS code may be provided.

Professional services provided by a physician must be billed separately by the physician. The NPI of the ordering physician must be in Block 78-79. The itemized charges must be retained by the facility for at least 5 years from the date of service.

## 16.4 Reimbursement

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRN and physician assistant providers may be reimbursed for the technical component for radiology and ultrasound services that are rendered in the office setting using equipment owned by the APRN or physician assistant provider at the lower of the billed amount or 85 percent of the amount reimbursed to physicians for the same service by Texas Medicaid.

When submitting claims for services provided in an inpatient or outpatient hospital setting, radiologists may be reimbursed only for the interpretation.

Hospital inpatient services may be reimbursed at 80 percent of the rate authorized by *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA), which is equivalent to the hospital’s Medicaid interim rate.

Outpatient imaging services rendered by outpatient hospital providers may be reimbursed at a flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

Reimbursement of the separate technical and interpretation components cannot exceed reimbursement for the total component.

For MRA, MRI, and PET imaging services, providers may be reimbursed according to the following reimbursement methodology:

- MRA services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- For MRI services, both professional and radiological services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- For PET services, physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid, and outpatient facilities may be reimbursed at a flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

For X-ray and ultrasound services, providers may be reimbursed according to the following reimbursement methodology:

- Physicians may be reimbursed at the lower of the billed amount or the amount allowed by Texas Medicaid.
- APRN and physician assistant providers may be reimbursed at the lower of the billed amount or 85 percent of the amount reimbursed to physicians for the same service by Texas Medicaid.
- Outpatient facilities are reimbursed at a flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code.

**Referto:** Section 24.6.2.1, “Revenue Code and Procedure Code Requirements for All Outpatient Services” in Chapter 24, “Hospital” for information about the revenue code and procedure code claim requirements for outpatient services.

- Inpatient facilities are reimbursed at 80 percent of the rate allowed by TEFRA. Reimbursement of the separate components, technical and interpretation, will not exceed the reimbursement for the total component.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/pages/topics/rates.aspx](http://www.tmhp.com/pages/topics/rates.aspx).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

#### **16.4.1 One-day Payment Window Reimbursement Guidelines**

According to the one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within 1 day of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

The one-day payment window reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

**Referto:** Section 24.3.7, “Payment Window Reimbursement Guidelines” in Chapter 24, “Hospital” for additional information about the one-day payment window reimbursement guidelines.



## **16.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **DURABLE MEDICAL EQUIPMENT (DME)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# DURABLE MEDICAL EQUIPMENT (DME)

## Table of Contents

- 17.1 Enrollment .....4**
  - 17.1.1 Custom DME Requirements..... 4
- 17.2 Program Overview and Guidelines .....5**
  - 17.2.1 Custom DME ..... 5
  - 17.2.2 Standard DME..... 5
  - 17.2.3 Program Guidelines ..... 6
- 17.3 Benefits, Limitations, and Authorization Requirements.....7**
  - 17.3.1 Adaptive Strollers ..... 7
    - 17.3.1.1 Authorization Requirements ..... 7
  - 17.3.2 Ambulation Aids ..... 8
    - 17.3.2.1 Crutches, Walkers, Gait and Ambulation Belts, and Canes ..... 8
  - 17.3.3 Breast Prosthesis ..... 8
    - 17.3.3.1 Breast Prosthesis Prior Authorization Requirements..... 9
      - 17.3.3.1.1 *Prior Authorization for Medically Necessary Prostheses Beyond Set Limitations* .....9
      - 17.3.3.1.2 *Prior Authorization for Procedure Codes L8035 and L8039* .....9
  - 17.3.4 Burn Care Garments ..... 9
  - 17.3.5 Cochlear Implant Device ..... 10
  - 17.3.6 Continuous Passive Motion (CPM) Device ..... 10
  - 17.3.7 Enuresis Alarms ..... 10
    - 17.3.7.1 Prior Authorization Requirements..... 10
  - 17.3.8 Gait Trainers (Supported or Sling Walkers)..... 10
    - 17.3.8.1 Authorization Requirements ..... 10
  - 17.3.9 Hospital Beds (Manual and Electric) ..... 10
    - 17.3.9.1 Authorization and Prior Authorization Requirements ..... 11
    - 17.3.9.2 Pressure Reducing Pads..... 11
    - 17.3.9.3 Positional Pillows and Cushions ..... 12
    - 17.3.9.4 Hospital Cribs and Enclosed Beds ..... 12
      - 17.3.9.4.1 *Prior Authorization Requirements*..... 12
  - 17.3.10 Hygiene Equipment ..... 12
    - 17.3.10.1 Bath or Shower Chair ..... 13
      - 17.3.10.1.1 *Levels of Design*..... 13
    - 17.3.10.2 Authorization Requirements ..... 14
    - 17.3.10.3 Adaptive Feeder Seats ..... 14
    - 17.3.10.4 Commode Chair ..... 14
      - 17.3.10.4.1 *Prior Authorization Requirements for Level 1: Stationary Commode Chair* ..... 14
      - 17.3.10.4.2 *Prior Authorization Requirements for Level 2: Mobile Commode Chair* ..... 15
      - 17.3.10.4.3 *Prior Authorization Requirements for Level 3: Custom Commode Chair* ..... 15
      - 17.3.10.4.4 *Authorization Requirements for Extra-wide and Heavy-Duty*

|             |  |           |
|-------------|--|-----------|
|             | <i>Commode Chair</i> .....   | 15        |
| 17.3.10.4.5 | <i>Authorization Requirements for Foot Rest</i> .....                      | 15        |
| 17.3.10.4.6 | <i>Authorization Requirements for Replacement Commode Pail or Pan</i> .... | 15        |
| 17.3.10.5   | Commode Chair with Integrated Seat Lifts.....                              | 15        |
| 17.3.10.6   | Commode Seat Lift Mechanism .....  | 16        |
| 17.3.11     | Infusion Pumps.....  | 17        |
| 17.3.12     | Portable Paraffin Units .....  | 17        |
| 17.3.13     | Seat Lift Mechanism .....  | 17        |
| 17.3.14     | Special Needs Car Seats and Travel Restraints.....                         | 18        |
| 17.3.14.1   | Car Seats .....  | 18        |
| 17.3.14.1.1 | <i>Prior Authorization Requirement for Car Seats</i> .....                 | 18        |
| 17.3.14.2   | Travel Restraints .....  | 19        |
| 17.3.15     | Standers, Prone or Supine .....  | 19        |
| 17.3.15.1   | Authorization Requirements .....   | 20        |
| 17.3.16     | TENS Units .....   | 20        |
| 17.3.17     | Transfer Boards.....   | 20        |
| 17.3.18     | Travel Chairs .....  | 20        |
| 17.3.18.1   | Prior Authorization Requirements.....                                      | 20        |
| 17.3.19     | Wheelchairs .....  | 20        |
| 17.3.19.1   | Seating Evaluation Requirements .....                                      | 21        |
| 17.3.19.2   | Wheelchair Authorization Requirements .....                                | 22        |
| 17.3.19.3   | Manual Wheelchairs .....   | 23        |
| 17.3.19.4   | Custom Manual Wheelchairs .....  | 24        |
| 17.3.19.5   | Power Wheelchairs .....  | 24        |
| 17.3.19.6   | Approval Criteria for Power Wheelchairs.....                               | 24        |
| 17.3.19.6.1 | <b>Age</b> .....   | <b>25</b> |
| 17.3.19.6.2 | <b>Level of Physical Function</b> .....                                    | <b>25</b> |
| 17.3.19.6.3 | <b>Cognitive Level</b> .....   | <b>25</b> |
| 17.3.19.6.4 | <b>Environmental Assessment</b> .....                                      | <b>25</b> |
| 17.3.19.7   | Wheelchair Battery .....   | 25        |
| 17.3.19.8   | Wheelchair Positioning Equipment.....                                      | 25        |
| 17.3.19.9   | Wheelchair Power Elevating Leg Lifts.....                                  | 25        |
| 17.3.19.10  | Wheelchair Power Seat Elevation System .....                               | 26        |
| 17.3.20     | Portable Wheelchair Ramps.....   | 26        |
| 17.3.21     | Noncovered Rehabilitative and Therapeutic DME.....                         | 27        |
| 17.3.22     | Repairs and Modifications .....  | 27        |
| <b>17.4</b> | <b>Documentation of Receipt</b> .....                                      | <b>28</b> |
| <b>17.5</b> | <b>Rental of Equipment</b> .....   | <b>28</b> |
| <b>17.6</b> | <b>Claims Information</b> .....  | <b>28</b> |
| <b>17.7</b> | <b>Reimbursement</b> .....   | <b>29</b> |
| <b>17.8</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....                    | <b>30</b> |

## 17.1 Enrollment

To enroll in the CSHCN Services Program, DME providers must be actively enrolled in Texas Medicaid, have a valid CSHCN Services Program Provider Agreement, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state DME (noncustom DME) providers must meet all these conditions, be located in the United States within 50 miles of the Texas state border and be approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

*By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.*

*CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.*

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 3.1.4, “Services Provided Outside of Texas” in Chapter 3, “Client Benefits and Eligibility” for more detailed information.

### 17.1.1 Custom DME Requirements

Providers who wish to enroll with the CSHCN Services Program as customized DME providers must complete the CSHCN Services Program Provider Enrollment Application as specified in Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities.” Additionally, applicants must either provide evidence of having current certification from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) as an assistive technology supplier and/or assistive technology practitioner, or provide three separate letters of recommendation from practicing occupational therapists (OTs) or physical therapists (PTs) serving a pediatric population. These letters must include the name, address, and telephone number of the recommending therapist, place of therapist’s employment, and number of years the therapist has worked with the specific custom DME applicant in providing custom DME. The CSHCN Services Program requires that PTs and OTs writing letters of recommendation are not employed by the applicant nor receive any form of compensation for the letters of recommendation.

Providers must send the completed documentation to:

Texas Medicaid & Health Partnership  
Attn: Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795  
800-568-2413

Additional information and provider enrollment forms are available on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

## 17.2 Program Overview and Guidelines

The CSHCN Services Program considers requests for coverage of the following types of DME and services when they are medically necessary and appropriate:

- *Rehabilitative equipment*: purchase, rental, modification, and repair items such as ambulation aids, wheelchairs (manual and power), standers, hospital beds, hygiene equipment, etc.
- *Miscellaneous equipment*: items such as paraffin units, enuresis alarms, and special needs car seats

All DME must be prescribed by a licensed physician. This equipment is primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of illness, injury, or disability. DME is appropriate for use in the home or community setting. Unique or novel DME that is a benefit of the CSHCN Services Program must have a well-established history or efficacy. The DME must have valid and peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

There is no single authority, such as a federal agency, that confers the official status of “DME” on any device or product. Therefore, the CSHCN Services Program within the Department of State Health Services (DSHS), retains the right to determine which DME devices or products are benefits of the CSHCN Services Program. To be considered for reimbursement, DME must be a benefit of the CSHCN Services Program and must be authorized or prior authorized, if required, as indicated in the sections below. Requests for authorization or prior authorization must be submitted in writing. Requests for equipment that requires *prior* authorization must be completed and received before the requested date of service.

The CSHCN Services Program may reimburse providers for both custom and standard (noncustom) DME.

### 17.2.1 Custom DME

Custom DME is medical equipment that is made or modified specifically to address the *individual* client’s needs. After it is issued, customized equipment is the client’s property. Examples of covered custom DME include:

- Adaptive strollers.
- Custom-fitted wheelchairs (manual and power) and positioning components.
- Gait trainers.
- Hospital crib or enclosed bed.
- Portable wheelchair ramps.
- Scooters.
- Special needs car seats.
- Standers (prone and supine).
- Travel chair.

### 17.2.2 Standard DME

Noncustom DME is medical equipment that can be obtained from a store or a mail-order company and does not require adaptation or modification for the client’s use. Examples of covered noncustom DME include:

- Adaptive feeder seats.

- Ambulation aids.
- Feeding equipment (parenteral and enteral).
- Hospital beds.
- Hygiene equipment.
- Portable paraffin units.
- Standard wheelchairs.
- Transcutaneous electrical nerve stimulator (TENS) units.
- Transfer boards.

### **17.2.3 Program Guidelines**

All DME providers must adhere to the following program guidelines concerning the products and services they provide:

- Provide new equipment—not used, reconditioned, or damaged equipment or parts.
- Ensure that clients are measured and that the equipment is assembled and fitted by knowledgeable staff.
- Request authorization or prior authorization for equipment based on the recommendations of a team that includes the client, physician, therapist, and vendor, whenever possible.
- Ensure that staff experienced in the fitting of DME delivers the equipment with all accessories directly to the person specified in the delivery instructions. The parent, client, or guardian must sign the [CSHCN Services Program Documentation of Receipt form](#) only at the time of delivery, and only when the item with all accessories meets the satisfaction of the parent, client, or guardian.
- Provide instruction to the family, client, or guardian about the proper use and maintenance of the equipment.
- Provide free inspection, adjustments, and maintenance between the fourth and the fifth months after delivery of a power chair.
- Lend a medically appropriate item to the client, at no charge, if the prescribing physician determines immediate need from the time the vendor receives authorization and until the prescribed item is delivered.
- Do not purchase accessories, inserts, or other positioning devices shop-built by a vendor unless specifically approved after review of medical justification submitted from the prescribing physician, OT, or PT. Detailed cost justification is also required.
- Never reclaim an item delivered to a client when the CSHCN Services Program Documentation of Receipt form has been signed by the parent, client, or guardian, even if the CSHCN Services Program denies vendor payment for failure to comply with claims processing deadlines.
- Use objective OTs or PTs to perform the wheelchair and equipment evaluations and to make equipment recommendations for CSHCN Services Program clients. An objective therapist is one who is not hired or paid by the DME provider or company to perform these evaluations.

Any evidence of noncompliance with items above may be grounds for removing the provider from the CSHCN Services Program provider list or other sanctions as agreed upon by the medical reviewers.

## 17.3 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program must authorize all requests for both standard and custom DME. Requests must be submitted on the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) form](#).

**Note:** *The physician's signature is only required on page 1 of the form in the Statement of Medical Necessity section. Providers must submit page 1 of the form to TMHP. Pages 2 through 5 are only required for certain DME requests. Refer to the text under the form title to determine which of these pages must be submitted in addition to page 1.*

Custom DME and more complex equipment requires prior authorization; all other and standard DME must be authorized. The sections below identify the equipment that requires authorization and the equipment that requires prior authorization. Authorization requests and prior authorization requests should be submitted on a [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) form](#).

Prior authorization is required for quantities exceeding the limitations defined in the sections below.

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

The custom DME prior authorization period is no more than 75 days from the date of approval. If the client's eligibility is due to end before the 75 days, providers will still receive a 75-day authorization from the date of the approval.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

### 17.3.1 Adaptive Strollers

Adaptive strollers may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs.

Adaptive strollers are mobility devices that resemble regular strollers purchased for healthy infants and toddlers. Adaptive strollers have a limited range of accessories that allow some positioning for clients with minor postural problems.

#### 17.3.1.1 Authorization Requirements

Adaptive strollers may be authorized only when medically necessary and when all of the following conditions are met:

- The stroller has a firm back and seat, or insert.
- A stroller (rather than a wheelchair) is specifically recommended by the licensed therapist completing the wheelchair evaluation.
- The requested stroller meets *all* recommendations made in the wheelchair evaluation.
- The client is not expected to develop motor skills necessary for self-propulsion and is not expected to need a travel chair or wheelchair within 2 years of the request date, *or* the client is expected to be ambulatory within 1 year of the request date.

Authorization requests for clients older than 2 years of age must meet the above criteria, and there must be medical documentation of the need for a stroller versus a wheelchair. Medical documentation should indicate that a stroller allows adequate support for a client's particular condition, stature, and need for positioning (completion of the [CSHCN Services Program Wheelchair Seating Evaluation Form](#) serves as medical documentation).



The following criteria must be met for the level of stroller requested:

- *Level 1: Basic stroller.* The client meets the criteria for a stroller.
- *Level 2: Stroller with tray for oxygen and/or ventilator.* The client meets the criteria for a Level 1 stroller and is oxygen- or ventilator-dependent.
- *Level 3: Stroller with positioning inserts.* The client meets the criteria for a Level 1 or Level 2 stroller and requires additional positioning support.

Providers should use the following procedure codes and modifiers to submit claims for strollers. Levels 2 and 3 require the addition of a modifier:

| Description  | Procedure Code and Modifier (As Applicable) |
|--|---|
| Level 1: Basic Stroller                                  | E1035                                       |
| Level 2: Stroller with tray for oxygen and/or ventilator | E1035 with TF modifier                      |
| Level 3: Stroller with positioning inserts               | E1035 with TG modifier                      |

### 17.3.2 Ambulation Aids

#### 17.3.2.1 Crutches, Walkers, Gait and Ambulation Belts, and Canes

Ambulation aids may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs.

Crutches, walkers, gait and ambulation belts, and canes may be authorized for any condition resulting in limited functional ambulation. Any enrolled DME provider may be reimbursed for nonspecialized equipment at Medicare-allowable rates. The provider is required to submit authorization requests and claims with the appropriate procedure codes. Ambulation aids may be rented if the need is short term. The anticipated total rental cost must be less than the purchased price.

#### 17.3.3 Breast Prosthesis

The following procedure codes for external breast prostheses are benefits of the CSHCN Services Program when provided by a licensed prosthetist or licensed orthotist to clients with a history of a medically necessary mastectomy procedure:

| Procedure Code | Limitations   |
|----------------|---|
| L8000          | 4 per rolling year  |
| L8001          | 4 per rolling year, per modifier<br>Modifier LT or RT required. |
| L8002          | 4 per rolling year  |
| L8010          | 8 per rolling year  |
| L8015          | 2 per rolling year  |
| L8020          | 1 per 6 rolling months  |
| L8030          | 1 per 2 rolling years   |
| L8031          | 1 per 2 rolling years   |
| L8032          | 8 per rolling year, same procedure, any provider                |
| L8033          | 8 per rolling year  |
| L8035          | Requires prior authorization                                    |
| L8039          | Requires prior authorization                                    |

**Referto:** Section 31.2.40, “Diagnostic and Surgical/Reconstructive Breast Therapies” in Chapter 31, “Physician” for information about mastectomy procedures and related services.

### **17.3.3.1 Breast Prosthesis Prior Authorization Requirements**

Prior authorization is required for the following:

- Medically necessary prostheses beyond set limitations outlined in the table above.
- Procedure codes L8035 and L8039.

Prior authorization must be requested using the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

#### **17.3.3.1.1 Prior Authorization for Medically Necessary Prostheses Beyond Set Limitations**

Medically necessary prostheses beyond set limitations may be prior authorized if any of the following is met for procedure codes L8000, L8001, L8002, L8010, L8015, L8020, L8030, L8031, L8032, and L8033:

- Loss or irreparable damage. If the external breast prosthesis is lost or irreparably damaged, prior authorization for a replacement of the same type may be considered for coverage at any time.
- Change in the client’s condition. If a different external breast prosthesis is needed due to a change in the client’s medical condition, prior authorization for prosthesis of a different type will be considered for coverage at any time.

#### **17.3.3.1.2 Prior Authorization for Procedure Codes L8035 and L8039**

Prior authorization requests for external breast prosthesis procedure codes L8035 or L8039 must include documentation of medical necessity for the requested device.

The prior authorization request for procedure codes L8035 and L8039 must include the following information:

- The client’s diagnosis
- Prior treatment for the diagnosis
- Medical necessity of the requested prosthesis
- A clear, concise description of the prosthesis requested

The prior authorization request for procedure code L8039 must also include the following information:

- Reason for recommending this particular prosthesis
- A procedure code that is comparable to the prosthesis requested
- Documentation that indicates this prosthesis is not investigational or experimental
- The setting in which the service is to be rendered
- The physician’s intended fee for this prosthesis

The physician must maintain documentation of medical necessity in the client’s medical record. Services are subject to retrospective review.

### **17.3.4 Burn Care Garments**

The CSHCN Services Program may reimburse providers for burn care products. The burn must be second or third degree with hypertrophic scarring, and the garment must be specific to the location of the burn. Burn care management garments may also be considered for reimbursement for other conditions (e.g., large hemangiomas or lymphangiomas), with documentation from the physician regarding medical necessity. Providers must use the following procedure codes when submitting claims for burn care services:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| A6501           | A6502 | A6503 | A6504 | A6505 | A6506 | A6507 | A6508 | A6509 | A6510 |
| A6511           | A6512 |       |       |       |       |       |       |       |       |

### 17.3.5 Cochlear Implant Device

*Referto:* Chapter 20, “Hearing Services” for more information about cochlear implant benefits and limitations.

### 17.3.6 Continuous Passive Motion (CPM) Device

A CPM may be authorized for rental only for no more than a 2-week period after knee surgery. Recertification for additional services may be considered with documentation of medical necessity.

### 17.3.7 Enuresis Alarms

Enuresis alarms used for the treatment of primary nocturnal enuresis may be considered for purchase using procedure code S8270 with documentation of medical necessity.

#### 17.3.7.1 Prior Authorization Requirements

The CSHCN Services Program may consider prior authorization for a once in a lifetime purchase of an enuresis alarm if the client meets all of the following criteria:

- Is 5 to 20 years of age
- Has experienced bedwetting a minimum of three nights a week in the previous month or at least one bedwetting episode weekly for 1 year
- Has no daytime bedwetting
- Has been examined by a physician, and physical or organic causes for nocturnal enuresis (e.g., renal disease, neurological disease, infection, etc.) have been ruled out

### 17.3.8 Gait Trainers (Supported or Sling Walkers)

Gait trainers may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client’s needs.

The gait trainer should be needed at home as well as school or the therapy clinic. The CSHCN Services Program does not cover equipment for use solely in schools or clinics.

#### 17.3.8.1 Authorization Requirements

The following documentation must be included with an authorization request for gait trainers:

- Client’s condition, functional level, height, and weight
- Whether the client is expected to be ambulatory, and if so, when
- The time, frequency, and location where the gait trainer is used
- The length of time the gait trainer is expected to be needed (should be a minimum of 6 months)
- The plan for training the school and home caregivers in the correct and safe use of the equipment

### 17.3.9 Hospital Beds (Manual and Electric)

The rental or purchase of the following beds and cribs may be reimbursed:

- Manual or an electric hospital bed with or without a mattress
- Hospital crib
- Enclosed bed

- Accessories (e.g., safety enclosure frame or canopy)

A rental may be approved if the need is short-term (e.g., postsurgery or life expectancy of 6 months or less as certified by the prescribing physician). The anticipated total rental cost must be less than the purchase price.

A purchase may be approved for the long-term care of clients whose conditions have progressed to the point that they are severely neurologically or orthopedically limited, etc.

### 17.3.9.1 Authorization and Prior Authorization Requirements

To request authorization for manual or electric hospital beds, the provider must submit documentation of medical necessity and a completed [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

The following documentation must be included with the request for authorization or with the first claim:

- Client's diagnosis
- Client's age
- Client's height and weight
- Limitations of the caregiver
- Explanation addressing why a standard bed or crib will not meet the client's needs

Electric hospital beds may be considered for prior authorization as a purchase (long-term use) or as a rental (short-term use) if any of the following conditions exist:

- Client is able to assist with his or her personal care and can physically operate the controls
- Caregiver is physically limited and cannot crank a manual bed
- Caregiver needs to be able to adjust the bed quickly to assist with the client's personal care

All requests for the purchase of an electric hospital bed with or without a mattress require medical review.

The following procedure codes may be used to request authorization and to submit claims for reimbursement of rental or purchase of equipment:

| Procedure Codes            |        |       |        |       |        |        |        |        |        |
|----------------------------|--------|-------|--------|-------|--------|--------|--------|--------|--------|
| E0250                      | E0251* | E0255 | E0256* | E0260 | E0261* | E0265  | E0266* | E0271* | E0272* |
| E0277                      | E0290* | E0303 | E0304  | E0305 | E0310  | E0315* |        |        |        |
| <b>*For purchase only.</b> |        |       |        |       |        |        |        |        |        |

The purchase of a hospital bed without a mattress may be considered for reimbursement only if a custom mattress or bed positioning system is also authorized due to medical necessity.

### 17.3.9.2 Pressure Reducing Pads

Pressure-reducing pads for beds may be a benefit of the CSHCN Services Program.

Most pressure-reducing pads do not require prior authorization up to the approved limitations.

The following pressure-reducing pads procedure codes require prior authorization and the provider must submit with documentation of medical necessity and appropriateness:

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| E0184           | E0185 | E0186 | E0371 | E0372 | E0373 |

To request authorization for pressure-reducing pads, the provider must submit documentation of medical necessity and a completed [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

Pressure relief beds are not benefits of the CSHCN Services Program.

### **17.3.9.3 Positional Pillows and Cushions**

Procedure code E0190 must be billed with modifier UD for the purchase of reflex wedges and positional devices (positional pillows and cushions).

### **17.3.9.4 Hospital Cribs and Enclosed Beds**

Hospital cribs and enclosed beds must be prior authorized. Hospital cribs or enclosed beds are considered custom equipment.

#### **17.3.9.4.1 Prior Authorization Requirements**

Documentation supporting medical necessity must be submitted with the prior authorization request form. Prior authorization is not granted when the documentation indicates strictly a behavioral control need. A diagnosis alone without documentation of medical necessity and functional skills is insufficient information to approve a hospital crib or enclosed bed. Documentation must include all of the following:

- Client's diagnosis, medical needs, developmental level, and functional skills
- Age, length or height, and weight of client
- Description of any other less-restrictive devices that have been used, the length of time used, and why they were ineffective
- Description of why a regular child's crib, regular bed, or standard hospital bed cannot be used
- Name of manufacturer and the manufacturer's suggested retail price (MSRP)

Accessories may include safety enclosure frame or canopy. The protective crib top may also be prior authorized based on the criteria previously listed.

Providers must use procedure codes E0300, E0328, and E0329 to bill for hospital cribs. Providers must use procedure code E0316 when requesting a safety enclosure or canopy for a hospital bed or crib. Requests must be made to the CSHCN Services Program using the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

### **17.3.10 Hygiene Equipment**

Hygiene equipment may be noncustom DME, or may be custom DME if it is in any way customized to the individual client's needs.

Hygiene equipment should be rented if the need is for short-term use and if renting is more cost-effective. The anticipated total rental cost must be less than the purchased price. Documentation of the client's anticipated independence with the equipment is required for rental and purchase. Additionally, equipment may be authorized for clients who are nonambulatory in order to assist the parents and enhance safety in the care of clients with spina bifida, cerebral palsy, and other paralytic conditions.

The following hygiene equipment may be authorized:

- Tub rails (not wall mounted or permanently attached)
- Manual or hydraulic bathtub lifts
- Commodes or potty chairs
- Commode chair with integrated seat lift
- Commode seat lift mechanism

- Hygiene adaptations (e.g., raised toilet seats)
- Patient lifts
- Bath seats or chairs

*Note: Bath seats may be covered for clients when the medical condition indicates the need for support when bathing. Bath chairs will not be purchased for clients who are younger than 1 year of age or who weigh less than 30 pounds.*

### **17.3.10.1 Bath or Shower Chair**

A bath or shower chair (procedure code E0240), bathtub stool or bench, or bathtub transfer bench may be considered for those clients who cannot safely utilize a regular bath tub or shower.

A bath or shower chair may be prior authorized for clients who meet the Level 1, 2, or 3 criteria.

A Level 3 custom bath or shower chair may be prior authorized only if the client does not also have any type of commode chair. The client must have a shower that is adapted for rolling equipment. Ramps will not be prior authorized for access to showers.

A custom bath or shower chair may be considered for prior authorization only if the client does not also have any type of commode chair.

#### **17.3.10.1.1 Levels of Design**

- A level 1 device may be considered if the client:
  - Is either unable to stand independently or is unstable while standing, or
  - Is unable to independently enter or exit the shower or bathtub due to limited functional use of the upper or lower extremities, and
  - Maintains the ability to ambulate short distances (with or without assistive device), or
  - Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).
- A level 2 device may be considered if the client:
  - Has good upper body stability, and
  - Has impaired functional ambulation, including, but not limited to lower body paralysis, osteoarthritis, or
  - Is nonambulatory
  - The client must have a shower that is adapted for rolling equipment; access ramps for showers will not be considered for prior authorization.
- A level 3 device may be considered if the client requires:
  - Trunk and/or head or neck support, or
  - Positioning to accommodate conditions, including, but not limited to spasticity, or frequent/uncontrolled seizures.

A tub stool or bench may be considered for prior authorization for clients who meet the Level 1 criteria.

A tub transfer bench may be considered for prior authorization for clients who meet the Level 1 or 2 criteria.

A heavy-duty tub transfer bench may be considered for prior authorization for clients who meet the Level 1 or 2 criteria and who weigh more than 200 pounds.

The purchase of a bath or shower chair is limited to one every five years.

Providers may be reimbursed for procedure code E0240 using the following modifiers:

| Level   | Modifier    |
|---------|-------------|
| Level 1 | No modifier |
| Level 2 | TF          |
| Level 3 | TG          |

### 17.3.10.2 Authorization Requirements

Noncustom hygiene equipment must be authorized. The following documentation should be included with the authorization request for any custom and noncustom hygiene equipment:

- Client's condition, height, weight, age, and functional level
- Anticipated length of time the client will need the equipment
- Description of postural condition of the child including tone, head control, trunk control, upper extremity, and lower extremity
- Transfer status

*Note: Custom hygiene equipment must be prior authorized.*

### 17.3.10.3 Adaptive Feeder Seats

Adaptive feeder seats may be authorized for any condition resulting in postural insecurity, including cerebral palsy and spina bifida. Documentation of medical necessity must be submitted with the claim.

### 17.3.10.4 Commode Chair

The following limitations apply to commode chair and accessory procedure codes:

| Procedure Code | Limitation    |
|----------------|---------------|
| E0163          | 1 per 3 years |
| E0163-TG       | 1 per 3 years |
| E0165          | 1 per 3 years |
| E0165-TG       | 1 per 3 years |
| E0167          | 1 per 3 years |
| E0168          | 1 per 3 years |
| E0168-TF       | 1 per 3 years |
| E0168-TG       | 1 per 3 years |
| E0170          | 1 per 3 years |
| E0171          | 1 per 3 years |
| E0172          | 1 per 3 years |
| E0175          | 1 per 3 years |

#### 17.3.10.4.1 Prior Authorization Requirements for Level 1: Stationary Commode Chair

A stationary commode chair with fixed or removable arms may be considered for prior authorization when the client has a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

For stationary commode chairs to be considered for reimbursement, providers should use commode chair procedure codes without a modifier.

#### 17.3.10.4.2 Prior Authorization Requirements for Level 2: Mobile Commode Chair

A mobile commode chair with fixed or removable arms may be considered for prior authorization when the following criteria are met:

- Client meets the criteria for a Level 1 commode chair
- Client is on a bowel program and requires a combination commode and bath chair for performing the bowel program and then bathing
- Client does not have any type of bath chair

For mobile commode chairs to be considered for reimbursement, providers should use commode chair procedure codes with modifier TF.

#### 17.3.10.4.3 Prior Authorization Requirements for Level 3: Custom Commode Chair

A custom stationary or mobile commode chair with fixed or removable arms and head, neck, and/or trunk support attachments may be considered for prior authorization when the following criteria are met:

- Client meets the criteria for a Level 1 or 2 commode chair
- Client has a medical condition that results in an inability to support their head, neck, and/or trunk without assistance
- Client does not have any type of bath chair

For custom stationary commode chairs to be considered for reimbursement, providers should use commode chair procedure codes with modifier TG.

#### 17.3.10.4.4 Authorization Requirements for Extra-wide and Heavy-Duty Commode Chair

An extra-wide/heavy-duty commode chair is defined as one with a width greater than or equal to 23 inches and capable of supporting a patient who weighs 300 pounds or more. The client must meet the criteria for a Level 1, 2, or 3 commode chair and weigh 300 pounds or more.

Providers should use a heavy-duty commode chair procedure code with modifier TF or TG for an extra-wide or heavy-duty commode chair. Modifier TF should be used for a mobile extra-wide heavy-duty commode chair. Modifier TG should be used for a custom extra-wide heavy-duty commode chair.

#### 17.3.10.4.5 Authorization Requirements for Foot Rest

A foot rest is used to support the feet during use of the commode chair and may be considered for prior authorization when the client meets the criteria for a Level 1, 2, or 3 commode chair, and the foot rest is necessary to support contractures of the lower extremities for a client who is paraplegic or quadriplegic.

#### 17.3.10.4.6 Authorization Requirements for Replacement Commode Pail or Pan

Replacement commode pails or pans may be prior authorized once per year. With documentation of medical necessity, additional quantities may be considered for prior authorization.

### 17.3.10.5 Commode Chair with Integrated Seat Lifts

A commode chair with an integrated seat lift mechanism for the top of the commode (procedure codes E0170 and E0171) must be prior authorized for clients who meet all of the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The commode chair with integrated seat lift must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.



The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

The submitted documentation must include an assessment completed by a physician, physical or occupational therapist that includes:

- A description of the client's current level of function without the device.
- An explanation for why a nonmechanical commode elevation device, such as commode rails or elevated commode seat, will not meet the client's needs.
- Documentation identifying how the commode seat lift will improve the client's function.
- What mobility-related activities of daily living (MRADLs) the client will be able to perform with the commode chair with integrated seat lift that he or she is unable to perform without the commode seat lift and how this will increase independence.
- The client's goals for use of the commode chair with integrated seat lifts.

A commode chair with an integrated seat lift mechanism option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

Documentation confirming that all appropriate therapeutic modalities, such as medication and physical therapy, have been tried but have failed to enable the client to transfer from a chair to a standing position must be kept in the client's medical record.

Prior authorization will be given for only mechanical or powered commode assist devices, not both. If a client already owns one or more mechanical commode assist devices, a powered commode seat lift will not be prior authorized unless there has been a documented change in the client's condition such that the client can no longer use the mechanical equipment.

A seat lift mechanism is limited to those types which operate smoothly, can be controlled by the client, and effectively assist a patient in standing up and sitting down without other assistance. A commode seat lift operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of the CSHCN Services Program.

#### **17.3.10.6 Commode Seat Lift Mechanism**

A commode seat lift mechanism for the top of the commode (procedure code E0172) must be prior authorized for clients who meet all of the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.

The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

The submitted documentation must include an assessment completed by a physician, physical or occupational therapist that includes:

- A description of the client's current level of function without the device.
- An explanation for why a nonmechanical commode elevation device, such as commode rails or elevated commode seat, will not meet the client's needs.

- Documentation identifying how the commode seat lift mechanism will improve the clients function.
- What MRADLs the client will be able to perform with the commode seat lift mechanism that he or she is unable to perform without the seat lift mechanism and how this will increase independence.
- The client's goals for use of the commode seat lift mechanism.

A commode seat lift mechanism option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

Documentation confirming that all appropriate therapeutic modalities, such as medication and physical therapy, have been tried but have failed to enable the client to transfer from a chair to a standing position must be kept in the client's medical record.

Prior authorization will be given for only mechanical or powered commode assist devices, not both. If a client already owns one or more mechanical toilet assist devices, a seat lift mechanism will not be prior authorized unless there has been a documented change in the client's condition such that the client can no longer use the mechanical equipment.

Seat lift mechanisms are limited to those types which operate smoothly, can be controlled by the client, and effectively assist a patient in standing up and sitting down without other assistance. A seat lift mechanism operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of the CSHCN Services Program.

### **17.3.11 Infusion Pumps**

The CSHCN Services Program may reimburse providers for an external ambulatory infusion pump, when it is prescribed by a physician and authorized by the program. Requests must be submitted to the CSHCN Services Program using the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

### **17.3.12 Portable Paraffin Units**

Portable paraffin units (procedure code E0235) may be authorized for clients with juvenile rheumatoid arthritis or similar conditions resulting in decreased range of motion and joint pain. Documentation of a home program developed and monitored by an OT or PT or the client's physician must be submitted with the authorization request. Only one portable paraffin unit may be authorized in a 3-year period without documentation of medical necessity for the second unit.

### **17.3.13 Seat Lift Mechanism**

A medically necessary seat lift mechanism is one that operates smoothly, can be controlled by the client, and effectively assist the client in standing up and sitting down without other assistance.

A seat lift mechanism (procedure codes E0627 and E0629) may be prior authorized for clients who meet all of the following criteria:

- The client must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to correct or ameliorate the client's condition.
- Once standing, the client must have the ability to ambulate.
- The client must be completely incapable of standing up from a regular armchair or any chair in their home.

The fact that a client has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all clients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

The submitted documentation must include an assessment completed by a physician, physical or occupational therapist that includes:

- A description of the client's current level of function without the device.
- The duration of time the client is alone during the day without assistance.
- Documentation identifying how the seat lift mechanism will improve the client's function.
- What MRADLs the client will be able to perform with the seat lift mechanism that he or she is unable to perform without the seat lift mechanism and how this will increase independence.
- The client's goals for use of the seat lift mechanism.

A seat lift mechanism option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

Documentation confirming that all appropriate therapeutic modalities, such as medication and physical therapy, have been tried but have failed to enable the client to transfer from a chair to a standing position must be kept in the client's medical record.

Seat lift mechanisms are limited to those types that operate smoothly, can be controlled by the client, and effectively assist a client in standing up and sitting down without other assistance. A seat lift mechanism operated by a spring release mechanism with a sudden, catapult-like motion and jolts the client from a seated to a standing position is not a benefit of the CSHCN Services Program.

### **17.3.14 Special Needs Car Seats and Travel Restraints**

The CSHCN Services Program may reimburse providers for special needs car seats and travel restraints when they are medically necessary and appropriate. Services and equipment must be authorized and must be provided by a trained provider who is certified in car seat installation.

The CSHCN Services Program reimburses providers for special-needs car seats and travel restraints using the same methodology as custom manual rehabilitative equipment.

#### **17.3.14.1 Car Seats**

All children must be transported as safely as possible. Children with breathing disorders, casts, neuromuscular deficits, or other health-care needs may need to use special needs car seats or travel restraints.

Providers supplying special-needs car seats must be CSHCN Services Program custom DME providers and must have received approved training from the manufacturer of the product requested. The comprehensive training must include correct use of car seats for children with special needs, and the proper installation of top tethers. Providers must demonstrate proficiency in the installation of the top tethers during this training. Installation of the top tether is essential for proper use of the car seat and is included in the reimbursement of the car seat.

Providers must keep a statement on record that is signed and dated by the child's parent or guardian and the provider stating:

- A manufacturer-trained provider has installed the top tether in the automobile in which the child will be transported.
- A manufacturer-trained provider has trained the client's parent(s) or guardian(s) in the correct use of the car seat.
- The client's parent(s) or guardian(s) has demonstrated the correct use of the car seat to a manufacturer-trained provider.

##### **17.3.14.1.1 Prior Authorization Requirement for Car Seats**

Requests for authorization of special-needs car seats must be submitted for medical review using procedure code E1399 (rental or purchase) and must include the following written documentation:

- Documentation that the child weighs more than 40 pounds or is more than 40 inches in height (actual height and weight must be provided).
- Providers must include a description of the child's postural condition, specifically including head and trunk control, including why a booster chair or seatbelt will not meet the client's needs.
- Providers must include the child's expected long-term need for the car seat.
- A photocopy of the training certification of the individual installing the car seat must accompany each request for authorization to be considered for reimbursement by the CSHCN Services Program. Authorizations are not given to a provider until training is completed and the CSHCN Services Program claims contractor receives a copy of the training certificate.
- Providers must include the name of the individual installing the car seat on the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) form](#) or providers must include documentation with the form indicating that the top tether was factory installed by the vehicle's manufacturer before vehicle purchase.
- Installation of the top tether is essential for proper use of the car seat and is included in reimbursement for the car seat. Providers may not bill the CSHCN Services Program for the installation of the top tether.
- Providers must keep a statement on record that is signed and dated by the child's parent or guardian and the provider stating that a top tether was installed by a manufacturer-trained provider in the automobile used to transport the child; parent training in the correct use of the car seat was provided by a manufacturer-trained provider; and the parent demonstrated the correct use of the car seat to a manufacturer-trained provider.

The manufacturer's weight limitation should be carefully considered when fitting the child for a car seat and should allow for at least 12 months of anticipated growth.

The CSHCN Services Program considers replacement after 7 years (normal useful life) or if a car is involved in an accident. (Some manufacturers may replace car seats at no cost following an accident, if a police report from the accident is provided.)

Car seat accessories for correct positioning, available from the manufacturers, may be authorized when medically necessary. Only car seat modifications and accessories that have been crash-tested with the car seat and provided by the manufacturer of the car seat may be authorized.

#### **17.3.14.2 Travel Restraints**

The CSHCN Services Program may reimburse providers for travel restraints used in a family vehicle to restrain a child whose medical condition requires him or her to be transported in a supine position.

Requests for authorization of a travel restraint must document the medical necessity of transporting the child in a supine position.

Procedure code E0700 may be used to submit claims for travel restraints.

#### **17.3.15 Standers, Prone or Supine**

Prone or supine standers (procedure codes E0638, E0641, and E0642) may be considered for reimbursement when prescribed by a practitioner licensed to do so for clients with diagnoses such as cerebral palsy, spina bifida, paraplegia, or other conditions resulting in paralysis of both lower extremities. Procedure code E0638 with modifier UA should be used to identify an upright or prone system stander, and modifier UB should be used to identify a supine stander. The medical condition must indicate the need for a standing program that must specifically be provided in the home environment. As many clients receive standing programs at school, the home standing program should coordinate with the school plan.

Standers provided by the CSHCN Services Program are for use *only* in the client's home environment. Schools and therapy providers must provide their own equipment for standing programs in settings outside the client's home. The equipment provided for home use does *not* need to be identical to the equipment used in the school setting because they have to accommodate a variety of changing postural issues, and they require more heavy-duty equipment due to increased use and wear and tear on the equipment. DME providers supplying standers must be enrolled in the CSHCN Services Program as custom DME providers.

#### **17.3.15.1 Authorization Requirements**

The following documentation must be included with an authorization request:

- Client's condition, functional level, height, and weight
- Frequency and amount of time of client's standing program (e.g., 45 minutes, three times daily)
- The anticipated medical benefits expected from the stander
- Name of the therapist coordinating school and home standing programs or monitoring the home standing program
- Plan for training the school and home caregivers in the correct and safe use of the equipment

#### **17.3.16 TENS Units**

When prescribed by a physician or other provider authorized to do so, a TENS unit may be authorized for rental or purchase for the management of pain. Medical review is required. Reimbursement is at Medicare-allowable rates. Replacement electrodes may be authorized as a supply item if a TENS unit was previously purchased by the CSHCN Services Program.

Documentation of a home program developed and monitored by an OT or PT or the client's physician must be submitted with the authorization request. No more than one TENS unit may be authorized in a 2-year period without documentation of medical necessity for the second unit.

*Referto:* Chapter 27, "Neurostimulators and Neuromuscular Stimulators."

#### **17.3.17 Transfer Boards**

Transfer boards (procedure code E0705) may be approved for any covered condition that results in paralysis or significant weakness of both lower extremities. This item *cannot* be considered for rental. Documentation of medical necessity must be submitted with the claim.

#### **17.3.18 Travel Chairs**

Travel chairs may be noncustom DME, or they may be custom DME if they are in any way customized to the individual client's needs. Travel chairs are generally lighter in weight than noncustom manual wheelchairs and are designed to be pushed with ease by attendants or caretakers rather than being self-propelled. Travel chairs have little flexibility for customization.

##### **17.3.18.1 Prior Authorization Requirements**

Travel chairs may be prior authorized using the same guidelines as manual wheelchair prior authorizations for clients who are unable to self-propel a manual wheelchair and who are not appropriate for a power wheelchair due to cognitive issues, inaccessibility of the home, types of diagnoses, or levels of physical function.

#### **17.3.19 Wheelchairs**

The CSHCN Services Program may authorize a standard manual wheelchair. All other wheelchair requests for custom manual or power wheelchair, seating system, or modification of a wheelchair must be prior authorized. The CSHCN Services Program does not reimburse providers for wheelchairs for

children who are residents of nursing facilities or intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Providing wheelchairs for these children is the responsibility of the facility licensed to care for them.

### 17.3.19.1 Seating Evaluation Requirements

A seating evaluation performed by a physical therapist (PT), an occupational therapist (OT), or physician does not require prior authorization. A seating assessment performed by a physician is considered part of the physician evaluation and management service and will not be reimbursed separately.

Procedure code 97542 may be reimbursed for a seating assessment performed by the OT or PT when billed with the modifiers as follows:

| Practitioner           | Procedure Code | Modifiers |
|------------------------|----------------|-----------|
| Occupational therapist | 97542          | GO and UC |
| Physical therapist     | 97542          | GP and UC |

The seating assessment must:

- Explain how the client or family will be trained in the use of the equipment.
- Anticipate changes in the client's needs and include anticipated modifications or accessory needs, as well as the growth potential of the wheelchair.
- Include significant medical information pertinent to the client's mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client's physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client's current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client's needs.
- Include the client's height, weight, and a description of where the equipment is to be used.
- Include seating measurements.
- Include the accessibility of client's residence.
- Include manufacturer's information, including the description of the specific base, any attached seating system components, and any attached accessories, as well as the manufacturer's retail pricing information and itemized pricing for manually priced components.
- Include documentation supporting medical necessity for all accessories.
- Be documented on the Wheelchair Seating Evaluation Form, which must be signed and dated by the qualified practitioner completing the assessment (PT, OT, or physician). All signatures and dates must be current, unaltered, and original. Electronic signatures may be accepted when the national and state standards set by Health and Human Services, Department of Commerce, and the Texas Uniform Electronic Transactions Act are met. Stamped signatures and dates will not be accepted.
- Be submitted with the prior authorization request for the wheeled mobility system. The form must be completed, signed, and dated as outlined above.

Seating assessments are reimbursed in 15-minute increments (units) and are limited to four units (one hour).

### 17.3.19.2 Wheelchair Authorization Requirements

Written requests for prior authorization and authorization of all wheelchairs must include the following two forms:

- [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form.](#)

*Note: The physician's signature is only required on page 1 of the form in the Statement of Medical Necessity section. Providers must submit page 1 of the form to TMHP. Pages 2 through 5 are only required for certain DME requests. Refer to the text under the form title to determine which of these pages must be submitted in addition to page 1.*

- [CSHCN Services Program Wheelchair Seating Evaluation Form.](#)

A PT or an OT who is not employed by the DME provider must complete the evaluation and the CSHCN Services Program Wheelchair Seating Evaluation Form.

Authorization for wheelchair modifications or repairs for an existing seating system also require the wheelchair seating evaluation.

CSHCN Services Program-approved custom DME providers are required to submit these assessments with their requests for the wheelchairs. Therapists must use the [CSHCN Services Program Wheelchair Seating Evaluation Form](#).

The initial purchase of all manual wheelchairs and wheeled mobility systems must include the wheelchair base or frame, and the following standard components, which will not be prior authorized separately:

Complete set of standard propulsion and caster wheels, including all of the following:

- Propulsion or caster tires of any size, made of solid rubber or plastic
- Standard hand rims
- Complete wheel lock assembly
- Bearings
- Standard footrest assembly (fixed, detachable, or swing away), including standard footplates, calf rests/pads, and ratchet assembly
- Standard armrests (fixed non-adjustable or detachable non-adjustable), including standard foam or plastic arm pads
- Standard seat and back upholstery

Medically necessary non-standard components may be considered for prior authorization with documentation of medical necessity for the requested component. Such components include, but are not limited to, the following:

- Flat-free inserts
- Foam filled propulsion or caster tires
- Pneumatic propulsion or caster tires
- Non-standard hand rims (including ergonomic and contoured)
- Non-standard length footrests
- Custom footrests
- Elevating footrests
- Angle adjustable footplates

- Adjustable height fixed armrests
- Adjustable height detachable armrests
- Custom size arm pads
- Gel arm pads
- Arm troughs
- Elevating leg rests

Each power motorized device must include all of the following basic components that may not be prior authorized separately:

- Lap belt or safety belt (This does not include multiple-attachment-point positioning belts or padded belts.)
- Battery charger, single mode
- Batteries (initial)
- Complete set of tires and casters, any type
- Leg rests
- Foot rests or foot platform
- Arm rests
- Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by client weight capacity
- Controller and input device

Wheelchairs, components, and accessories must be billed using the most appropriate procedure code that describes the item.

### **17.3.19.3 Manual Wheelchairs**

Manual wheelchairs may be noncustom DME, or they may be custom DME if they are modified or in any way customized to the individual client's needs.

The CSHCN Services Program may reimburse providers for a manual wheelchair when the equipment is medically necessary. The physician or therapist is responsible for maintaining documentation indicating nonfunctional ambulation, situations where ambulation is contraindicated, or when ambulation is not adequate for independently accessing the community. Conditions that may debilitate a client to the point that ambulation would be detrimental to the client's health (e.g., cancer, cystic fibrosis, cardiac conditions, etc.) may also be considered.

Eligible clients may receive a manual wheelchair in addition to a power wheelchair or travel chair. The manual chair is purchased as a backup; therefore, cost and accessories should be minimal. Aside from having a manual wheelchair backup for a power wheelchair, the CSHCN Services Program does not authorize purchase of more than one form of mobility equipment per eligible client.

No more than one manual wheelchair may be authorized in a 3-year period without documentation of medical necessity for a second or replacement wheelchair. If the wheelchair is stolen or damaged in an accident before it is scheduled to be replaced, a police report must be submitted with the authorization request form to justify replacing it.

Rental must be considered for short-term needs when the total rental cost is expected to be less than the purchase price. If public funds were used to pay for a wheelchair within the last 3 years, specific justification is required to prior authorize a new chair.



If an immediate need for a wheelchair is indicated in the [CSHCN Services Program Wheelchair Seating Evaluation Form](#) and the CSHCN Services Program has approved a wheelchair, DME providers are required to provide a loaner wheelchair free of charge until the approved equipment is delivered to the client.

#### **17.3.19.4 Custom Manual Wheelchairs**

When any custom wheelchair or seating system is requested, the CSHCN Services Program requires an assessment utilizing the CSHCN Services Program Wheelchair Seating Evaluation Form to be submitted by a PT or OT not employed by a DME provider. Assessments are also required when an existing seating system is being modified. CSHCN Services Program-approved custom DME providers are required to submit these forms with their requests for prior authorization.

Requests for customized manual wheelchairs must include a complete description of the specific base, any attached seating system components, and any attached accessories not included in the base price. Requests must also include the MSRPs for the individual components, including justification for components that would be considered part of the wheelchair. The CSHCN Services Program requires that the manufacturers' price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after the authorization has been granted, the provider must submit new price sheets with the claim to document the price changes so that the price discrepancy between the authorization and the claim can be manually reviewed.

#### **17.3.19.5 Power Wheelchairs**

Model-specific power wheelchairs, including three-wheelers and scooters, must be prior authorized. Eligible children may receive, or already have, a manual wheelchair or travel chair in addition to the power wheelchair. No more than one electric wheelchair may be authorized in a 5-year period without documentation of medical necessity for a second or replacement wheelchair. If public funds were used for payment of a power wheelchair within the last 5 years, medical justification is required to give authorization for a new power wheelchair. If the wheelchair is stolen or damaged in an accident before it is scheduled to be replaced, a police report must be submitted with the authorization request form to justify replacing the equipment.

Requests for customized power wheelchairs must include a complete description of the specific base, any attached seating system components, and any attached accessories not included in the base price. Requests must also include the MSRPs for the individual components, including justification for components that would be considered part of the wheelchair. The CSHCN Services Program requires that the manufacturers' price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after the authorization has been granted, the provider must submit new price sheets with the claim to document the price changes so that the price discrepancy between the authorization and the claim can be manually reviewed.

#### **17.3.19.6 Approval Criteria for Power Wheelchairs**

Written requests for prior authorization of power wheelchairs should be submitted on a [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#). A CSHCN Services Program Wheelchair Seating Evaluation Form completed by an OT or PT not employed by the DME provider requesting the equipment modification must be submitted with the authorization request.

***Note:** The physician's signature is only required on page 1 of the form in the Statement of Medical Necessity section. Providers must submit page 1 of the form to TMHP. Pages 2 through 5 are only required for certain DME requests. Refer to the text under the form title to determine which of these pages must be submitted in addition to page 1.*

**17.3.19.6.1 Age**

Power wheelchairs can be approved for clients who are 18 months to 21 years of age (the normally developing child begins to walk and explore between 18 months to 2 years of age). The CSHCN Services Program supports providing power wheelchairs to match normal developmental milestones.

**17.3.19.6.2 Level of Physical Function**

The child must have control of some body part to operate a power wheelchair. The child's level of function must be defined by one of the following:

- The child is unable to self-propel a manual wheelchair, even if adapted
- Self-propulsion is possible, but activity is extremely labored leaving the child exhausted at the necessary destination, such as classroom or school bathroom
- Self-propulsion is possible, but contrary to treatment regimen. Examples include joint protection, energy conservation, and preservation of cardiovascular or respiratory function

**17.3.19.6.3 Cognitive Level**

The child must be able to receive and follow directions related to driving or controlling the wheelchair in a safe manner.

The client's level of judgment and impulse control must be such that the wheelchair will be used appropriately with minimal risk of either accidental or intentional injury to self or others.

**17.3.19.6.4 Environmental Assessment**

The therapist assessing the client is required to ask pertinent questions found on the [CSHCN Services Program Wheelchair Seating Evaluation Form](#) to ensure safe use and selection of the appropriate power wheelchair that will best serve the client.

**17.3.19.7 Wheelchair Battery**

A battery charger and initial batteries are included as part of the purchase price of a power wheelchair.

Replacement batteries and/or a replacement battery charger for a power wheelchair require prior authorization. The provider must submit the date of purchase and serial number of the client's currently owned wheelchair as well as the reason for the replacement batteries and/or the replacement battery charger. Documentation must include why the batteries and or battery charger no longer meets the client's needs.

**17.3.19.8 Wheelchair Positioning Equipment**

Wheelchair positioning equipment includes, but is not limited to, tilt-in-space options, solid backs and seats, abductors, cushions, and footrests. The equipment may be authorized based on the individual client's seating or positioning needs as detailed in the [CSHCN Services Program Wheelchair Seating Evaluation Form](#).

**17.3.19.9 Wheelchair Power Elevating Leg Lifts**

Power elevating leg lifts (procedure code E1010) may be prior authorized for clients who have compromised upper extremity function that limits the client's ability to use manual elevating leg rests. The client must meet criteria for a power wheelchair with a reclining back and one of the following:

- A musculoskeletal condition such as flexion contractures of the knees and legs or the placement of a cast or brace that prevents 90 degree flexion at the knee
- Significant edema of the lower extremities that requires having an elevating leg rest
- Hypotensive episodes that require frequent positioning changes
- Required to maintain anatomically correct positioning and reduce exposure to skin shear in clients needing power tilt and recline

The submitted documentation must include an assessment completed by a physician, physical, or occupational therapist that includes:

- A description of the client's current level of function without the device.
- Documentation identifying how the power elevating leg lifts will improve the client's function.
- What MRADLs the client will be able to perform with the power elevating leg lifts that he or she is unable to perform without the power elevating leg lifts and how this will increase independence.
- The client's goals for use of the power elevating leg lifts.
- A power elevating leg lifts option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs.

#### **17.3.19.10 Wheelchair Power Seat Elevation System**

Use of a power seat elevation system will:

- Facilitate independent transfers, particularly uphill transfers, to and from the wheelchair with less upper arm strain.
- Augment the client's reach to facilitate independent performance of MRADLs in the home, school, or community.

A power seat elevation system may be prior authorized to promote independence in a client who meets both of these criteria:

- Does not have the ability to stand and pivot transfer independently.
- Has limited reach or range of motion in the shoulder or hand that prohibits independent performance of MRADLs, (such as bathing, dressing, feeding, grooming, hygiene, meal preparation, and toileting).

The submitted documentation must include an assessment completed by a physician, physical, or occupational therapist that includes:

- A description of the client's current level of function without the device.
- The duration of time the client is alone during the day without assistance.
- Documentation identifying how the seat lift will improve the client's function.
- What MRADLs the client will be able to perform with the seat lift that he or she is unable to perform without the wheelchair seat lift and how this will increase independence.
- The client's goals for use of the power seat elevation system.

A power seat elevation system option will not be authorized for the convenience of a caregiver, or if the device will not allow the client to become independent with MRADLs and transfers.

#### **17.3.20 Portable Wheelchair Ramps**

Providers must submit documentation of medical necessity with the request for authorization form. The CSHCN Services Program may authorize and reimburse portable or threshold ramps only. A portable ramp is defined as a ramp that is not physically attached to the dwelling, that may be moved (disassembly may be required, such as in the case of a modular ramp), and that meets the standards as set by the *Americans with Disabilities Act*.

Portable wheelchair ramps that allow access to the client's home may be authorized if the need is documented. The CSHCN Services Program may approve requests for ramps to allow access to two entrances to the client's home. Once two accessible entrances are provided, the client or family is not

expected to require another ramp or a replacement ramp. Requests for a replacement ramp require medical review and documentation of need, including an explanation of what happened to the previous ramp.

The ramp is expected to go with the client if he or she changes residential locations. The CSHCN Services Program does *not* replace portable ramps due to a client's relocation. Ramps may need to be modified to fit a different dwelling if the client moves. The CSHCN Services Program considers the required modifications for reimbursement rather than the purchase of a replacement ramp.

### **17.3.21 Noncovered Rehabilitative and Therapeutic DME**

Noncovered rehabilitative and therapeutic DME includes, but is not limited to:

- Adaptive furniture, bolsters, and wedges.
- Corner chairs and floor sitters.
- Creepers.
- Home modifications, including ramps (except portable ramps for wheelchairs).
- Hydrocollators.
- Parallel bars.
- Powered equipment, including ceiling or track lifts (except powered wheelchairs and electric beds).
- Pressure relief beds.
- Vehicle modifications.
- Vocational, educational, and recreational equipment, even when adapted.

Other miscellaneous DME may be authorized based on review of documentation of medical necessity. This documentation must be submitted with the authorization request form.

### **17.3.22 Repairs and Modifications**

The term *repair* is used to describe replacing existing parts or accessories. The term *modification* is used to describe adding or changing parts or accessories. If the item was purchased by the program or through another source, and is a CSHCN Services Program-approved item (e.g., hospital bed, stander, or wheelchair), the item may be authorized. All manufacturers' warranties must be upheld. Providers must submit the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#) for repairs or modifications.

Powered equipment (electronics) may be repaired only by DME vendors who are authorized by the specific manufacturer to repair electronics.

Authorization requests for wheelchair repairs or modifications for an existing seat system must be submitted with an assessment and completed [CSHCN Services Program Wheelchair Seating Evaluation Form](#).

Repairs and modifications must be cost-effective. The cost of a new piece of equipment must be considered when the total cost of repairs and modifications will be greater than \$1,000.00. The age of the current equipment and the amount of time that remains until the original equipment may be replaced (e.g., every three years for a manual wheelchair and every five years for a power wheelchair), must be considered when reviewing a request for repairs or modifications. Providers must use procedure code K0739 when requesting authorization and submitting a claim for reimbursement of repairs.

## 17.4 Documentation of Receipt

When the equipment is delivered, providers must complete the [CSHCN Services Program Documentation of Receipt form](#). The documentation of receipt form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The documentation of receipt form is available in both [English](#) and [Spanish](#).

Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by client or caregiver. The delivery slip or invoice must contain the client's full name and address to which the supplies were delivered, the item description, and the numerical quantities that were delivered to the client.
- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

The CSHCN Services Program does not reimburse providers separately for shipping and handling or freight charges, except when power equipment must be sent to a location other than to the vendor for repair.

## 17.5 Rental of Equipment

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

## 17.6 Claims Information

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment. Home health DME providers must use the DM3 benefit code when submitting claims and authorization requests.

DME services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

**Note:** *The CSHCN Services Program reimburses prior authorized custom DME even if the client is no longer eligible to receive services when the equipment is delivered. Claims must be submitted with a valid authorization number for the custom DME procedure code.*

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The provider must submit the delivery date as the date of service along with the appropriate procedure codes when requesting authorization and when submitting claims.

The CSHCN Services Program requires that manufacturers’ price sheets be submitted along with price quotes at the time of submission for authorization. If a price change occurs after authorization, the provider must submit new price sheets with the claim to document the price changes so the price discrepancy between the authorization and claim can be manually reviewed.

All claims and authorization requests submitted by CSHCN Services Program home health DME providers must be submitted with benefit code DM3.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

## 17.7 Reimbursement

Items or services addressed in this chapter are reimbursed by the lessor or one of the following:

- The provider’s billed charges.
- A maximum fee determined by CSHCN.
- Manual pricing based on the retail price minus a discount as determined by CSHCN.
  - Note:** Manual pricing is based on the manufacturer’s suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent whichever is applicable or the provider’s documented invoice cost. The MSRP, AWP, or the documented invoice cost must be submitted with the appropriate procedure code to be considered for reimbursement.*
- *Noncustomized.* The lessor of the billed amount or the maximum fee allowed by the CSHCN Services Program.
- *Customized, nonpowered equipment (e.g., manual wheelchairs).* The lower of the billed amount or the MSRP less 18 percent.
- *Power wheelchairs.* The lower of the billed amount or the MSRP less 18 percent.
- *Other.* When no MSRP is published, the lower of the billed amount or the dealer’s cost plus 25 percent.
- *Delayed delivery penalty.* A claim submitted for customized DME delivered to the client more than 75 days after the authorization date shall be reduced by 10 percent.

- *Repairs and modifications.* Providers may be reimbursed for repairs and modifications at the MSRP of the part minus 18 percent, plus labor time for all equipment or wheelchairs including standard or custom and powered or nonpowered. Actual shipping costs may be reimbursed if the component is serviced at a regional center. Replacement versus repair costs must be considered.
- *Replacement batteries and/or replacement battery chargers.* Replacement batteries and/or replacement battery chargers may be considered for reimbursement if no longer under warranty. Batteries and battery chargers will not be considered for replacement within the first six months of delivery to the client. Batteries and battery chargers within the six months after delivery are considered part of the purchase price. A maximum of one hour of labor may be prior authorized to install new batteries. Labor will not be prior authorized for a new power wheelchair or for replacement battery chargers.
- *Battery disposal fees, taxes, and other associated DME charges.* The CSHCN Services Program does not reimburse providers separately for associated DME charges including, but not limited to, battery disposal fees or state taxes. Reimbursement for associated charges is included in the reimbursement for the specific piece of equipment.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

**Important:** *The provider must agree to accept the CSHCN Services Programs reimbursement as payment in full.*

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 17.8 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **EXPENDABLE MEDICAL SUPPLIES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**





# EXPENDABLE MEDICAL SUPPLIES

## Table of Contents

|             |  |          |
|-------------|--|----------|
| <b>18.1</b> | <b>Enrollment .....</b>  | <b>3</b> |
| <b>18.2</b> | <b>Benefits, Limitations, and Authorization Requirements .....</b> | <b>3</b> |
| 18.2.1      | Incontinence Supplies .....  | 4        |
| 18.2.2      | Wound Care Supplies .....  | 6        |
| 18.2.3      | Examples of Covered Supplies .....                                 | 7        |
| 18.2.4      | Diapers, Briefs, Pull-ups, and Liners .....                        | 7        |
| 18.2.4.1    | Gastrostomy Devices .....  | 7        |
| 18.2.4.1.1  | <i>Authorization Requirements .....</i>                            | <i>7</i> |
| <b>18.3</b> | <b>Claims Information .....</b>                                    | <b>8</b> |
| <b>18.4</b> | <b>Reimbursement .....</b>   | <b>9</b> |
| <b>18.5</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b>            | <b>9</b> |

## 18.1 Enrollment

To enroll in the CSHCN Services Program, providers of expendable medical supplies must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state expendable medical supplies providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border. Providers located more than 50 miles from the Texas border will be considered for approval by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 18.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program provides benefits for expendable medical supplies for eligible clients. Expendable is defined as being intended for single or short-term use and is typically discarded after use.

An expendable medical supply is defined as an item necessary to carry out a medical procedure or to maintain the client’s health at home.

Some supplies, including, but not limited to, straight catheters, may be cleaned and reused. Supplies are a benefit only for those clients residing at home.

Expendable medical supplies are limited to a quantity used by the typical client.

Prior authorization is required when the request exceeds the limitations listed in the tables below for a client with exceptional needs. Documentation of medical necessity is required and must support the need for the additional quantities. The following tables provide listings of these supplies and limitation amounts.

Providers must fill out all sections of the prior authorization form. Providers should refer to the Instructions page for each request form.

Prior authorization and authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must

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

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

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

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

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

Appropriate limitations for miscellaneous procedure codes B9998 and T1999 and procedure code A9273, are determined on a case-by-case basis through prior authorization.

**Note:** *Products that are a form of nutritional intake requested using procedure code B9998 will be considered with medical nutritional products.*

### 18.2.1 Incontinence Supplies

| Procedure Code   | Maximum Limitation        | Procedure Code      | Maximum Limitation | Procedure Code | Maximum Limitation |
|--|---------------------------|---------------------|--------------------|----------------|--------------------|
| A4310  | 2 per month               | A4311               | 2 per month        | A4312          | 2 per month        |
| A4313  | 2 per month               | A4314               | 2 per month        | A4315          | 2 per month        |
| A4316  | 2 per month               | A4320               | 15 per month       | A4322          | 30 per month       |
| A4326  | 40 per month <sup>^</sup> | A4327               | 4 per month        | A4328          | 4 per month        |
| A4330  | As needed                 | A4335               | 2 per month        | A4338          | 2 per month        |
| A4340  | 2 per month               | A4344               | 2 per month        | A4346          | 2 per month        |
| A4349  | 40 per month <sup>^</sup> | A4351 <sup>**</sup> | 150 per month      | A4352          | 150 per month      |
| A4353  | 150 per month             | A4354               | 2 per month        | A4355          | 2 per month        |
| A4356  | 2 per month               | A4357               | 2 per month        | A4358          | 2 per month        |
| A4361  | As needed                 | A4362               | As needed          | A4363          | As needed          |
| A4364  | As needed                 | A4367               | As needed          | A4368          | As needed          |
| * Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization. |                           |                     |                    |                |                    |
| ** Modifier SC must be submitted when billing for a hydrophilic catheter.  |                           |                     |                    |                |                    |
| <sup>^</sup> 40 per month of any combination of A4326 and A4349.   |                           |                     |                    |                |                    |

| Procedure Code | Maximum Limitation                          | Procedure Code | Maximum Limitation  | Procedure Code | Maximum Limitation  |
|----------------|---|----------------|---------------------|----------------|---------------------|
| A4369          | As needed                                   | A4371          | As needed           | A4372          | As needed           |
| A4373          | As needed                                   | A4375          | As needed           | A4376          | As needed           |
| A4377          | As needed                                   | A4378          | As needed           | A4379          | As needed           |
| A4380          | As needed                                   | A4381          | As needed           | A4382          | As needed           |
| A4383          | As needed                                   | A4384          | As needed           | A4385          | As needed           |
| A4387          | As needed                                   | A4388          | As needed           | A4389          | As needed           |
| A4390          | As needed                                   | A4391          | As needed           | A4392          | As needed           |
| A4393          | As needed                                   | A4394          | As needed           | A4395          | As needed           |
| A4396          | 1 per day                                   | A4398          | As needed           | A4399          | 1 per day           |
| A4400          | As needed                                   | A4402          | 4 per month         | A4404          | As needed           |
| A4405          | As needed                                   | A4406          | As needed           | A4407          | As needed           |
| A4408          | As needed                                   | A4409          | As needed           | A4410          | As needed           |
| A4411          | As needed                                   | A4412          | As needed           | A4413          | As needed           |
| A4414          | As needed                                   | A4415          | As needed           | A4421          | As needed           |
| A4422          | As needed                                   | A4436          | 1 per month         | A4437          | 1 per month         |
| A4554          | 120 per month                               | A4927          | 1 per month         | A5051          | As needed           |
| A5052          | As needed                                   | A5053          | As needed           | A5054          | As needed           |
| A5055          | As needed                                   | A5056          | As needed           | A5057          | As needed           |
| A5061          | As needed                                   | A5062          | As needed           | A5063          | As needed           |
| A5071          | As needed                                   | A5072          | As needed           | A5073          | As needed           |
| A5081          | As needed                                   | A5082          | As needed           | A5083          | As needed           |
| A5093          | As needed                                   | A5102          | 2 per month         | A5105          | 4 per year          |
| A5112          | 2 per month                                 | A5113          | 2 per month         | A5114          | 2 per month         |
| A5120          | 50 per month                                | A5121          | As needed           | A5122          | As needed           |
| A5126          | As needed                                   | A5131          | 1 per month         | A5200          | 2 per month         |
| T1999          | As needed<br>(Prior Authorization required) | T4521          | Limited per policy* | T4522          | Limited per policy* |
| T4523          | Limited per policy*                         | T4524          | Limited per policy* | T4525          | Limited per policy* |
| T4526          | Limited per policy*                         | T4527          | Limited per policy* | T4528          | Limited per policy* |
| T4529          | Limited per policy*                         | T4530          | Limited per policy* | T4531          | Limited per policy* |
| T4532          | Limited per policy*                         | T4533          | Limited per policy* | T4534          | Limited per policy* |
| T4535          | Limited per policy*                         | T4537          | As needed           | T4540          | As needed           |

\* Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization.

\*\* Modifier SC must be submitted when billing for a hydrophilic catheter.

^ 40 per month of any combination of A4326 and A4349.

| Procedure Code  | Maximum Limitation  | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation  |
|---|---------------------|----------------|--------------------|----------------|---------------------|
| T4541   | 120 per month       | T4542          | 120 per month      | T4543          | Limited per policy* |
| T4544   | Limited per policy* | T4543          |                    |                |                     |
| <p>* Any combination of diapers, pull-ups, briefs, or liners limited to a maximum of 240 per month without requiring prior authorization.</p> <p>** Modifier SC must be submitted when billing for a hydrophilic catheter.</p> <p>^ 40 per month of any combination of A4326 and A4349.</p> |                     |                |                    |                |                     |

## 18.2.2 Wound Care Supplies

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation |
|----------------|--------------------|----------------|--------------------|----------------|--------------------|
| A4213          | As needed          | A4216          | As needed          | A4217          | 10 per month       |
| A4244          | 4 per month        | A4246          | 4 per month        | A4247          | 6 per month        |
| A4248          | As needed          | A4305          | As needed          | A4306          | As needed          |
| A4331          | 2 per month        | A4332          | 50 per month       | A4333          | 2 per month        |
| A4334          | 2 per month        | A4366          | As needed          | A4416          | As needed          |
| A4417          | As needed          | A4419          | As needed          | A4423          | As needed          |
| A4424          | As needed          | A4425          | As needed          | A4426          | As needed          |
| A4427          | As needed          | A4429          | As needed          | A4430          | As needed          |
| A4431          | As needed          | A4432          | As needed          | A4433          | As needed          |
| A4434          | As needed          | A4435          | As needed          | A4452          | 100 per month      |
| A4455          | 4 per month        | A4456          | 60 per month       | A4554          | 120 per month      |
| A6010          | As needed          | A6011          | As needed          | A6021          | As needed          |
| A6022          | As needed          | A6023          | As needed          | A6024          | As needed          |
| A6025          | As needed          | A6154          | As needed          | A6197          | As needed          |
| A6197          | As needed          | A6198          | As needed          | A6199          | As needed          |
| A6203          | As needed          | A6204          | As needed          | A6205          | As needed          |
| A6210          | As needed          | A6211          | As needed          | A6214          | As needed          |
| A6215          | As needed          | A6217          | As needed          | A6218          | As needed          |
| A6220          | As needed          | A6221          | As needed          | A6228          | As needed          |
| A6229          | As needed          | A6230          | As needed          | A6234          | As needed          |
| A6235          | As needed          | A6236          | As needed          | A6238          | As needed          |
| A6239          | As needed          | A6240          | As needed          | A6241          | As needed          |
| A6242          | As needed          | A6248          | As needed          | A6250          | 2 per month        |
| A6251          | As needed          | A6252          | As needed          | A6253          | As needed          |
| A6254          | As needed          | A6255          | As needed          | A6256          | As needed          |
| A6258          | 30 per month       | A6259          | 15 per month       | A6260          | As needed          |
| A6261          | As needed          | A6262          | As needed          | A6403          | As needed          |
| A6404          | As needed          | A6407          | As needed          | A6410          | As needed          |
| A6411          | As needed          | A6412          | As needed          | A6441          | As needed          |
| A6442          | As needed          | A6443          | As needed          | A6444          | As needed          |

| Procedure Code | Maximum Limitation | Procedure Code | Maximum Limitation                       | Procedure Code | Maximum Limitation |
|----------------|--------------------|----------------|--|----------------|--------------------|
| A6445          | As needed          | A6446          | As needed                                | A6447          | As needed          |
| A6448          | As needed          | A6449          | As needed                                | A6450          | As needed          |
| A6451          | As needed          | A6452          | As needed                                | A6453          | As needed          |
| A6454          | As needed          | A6455          | As needed                                | A6456          | As needed          |
| A6550          | 15 per month       | A9273          | As needed (Prior Authorization required) |                |                    |

### 18.2.3 Examples of Covered Supplies

The following categories of medical supplies are a benefit of the CSHCN Services Program. This list is not all-inclusive:

- *Incontinence supplies*, including, but not limited to, diapers, briefs, pull-ups, liners, urinary catheters, gloves, lubricants, skin disinfectants, ostomy and catheterization supplies, pouches, wafers, cleaning solutions, catheters, and syringes.
- *Feeding supplies*, including, but not limited to, feeding bags for pumps, tubing, nasogastric tubes, syringes, nonobtured gastrostomy tubes, and low profile nonobtured gastrostomy devices (also known as gastrostomy button). Nonobtured gastrostomy tubes and nonobtured low profile gastrostomy devices are limited to two per year. (Enteral feeding pumps are considered durable medical equipment [DME].)
- *Wound care supplies*, including, but not limited to, dressings, tape, bandages, masks, eye patches, and ace wraps.
- *Diabetic care*, such as testing supplies and lancets. (Glucose monitors are considered DME.)
- *Miscellaneous supplies* used in the treatment of a medical condition.

**Referto:** Chapter 15, “Diabetic Equipment and Supplies” for more detailed information.

Chapter 17, “Durable Medical Equipment (DME)” for more detailed information.

Chapter 36, “Respiratory Equipment and Supplies” for more detailed information.

Articles of daily living are not a benefit of the CSHCN Services Program.

### 18.2.4 Diapers, Briefs, Pull-ups, and Liners

Diapers, briefs, pull-ups, or liners in any combination may be covered for clients who are 4 years of age and older who are incontinent as a direct result of a medical condition. Diapers, briefs, pull-ups, or liners do not require prior authorization up to a combined total of 240 items per month.

Fax transmittal confirmations are not accepted as proof of timely prior authorization submissions.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

#### 18.2.4.1 Gastrostomy Devices

The CSHCN Services Program may reimburse providers for gastrostomy devices when prescribed by a physician.

##### 18.2.4.1.1 Authorization Requirements

Four gastrostomy tubes will be allowed per client, per rolling year, without prior authorization only when prescribed by a physician.

Prior authorization is required when more than four gastrostomy or jejunostomy tubes are requested in a rolling year. This will allow for two gastrostomy or jejunostomy tubes and two for back up.

When requesting prior authorization, providers must submit documentation supporting medical necessity that includes, but is not limited to:

- A failure of the tube.
- An infection at gastrostomy site.
- The need for an extra tube to have on hand in case of dislodgement.

The following procedure codes must be used to submit claims for gastrostomy devices:

| Procedure Code         | Maximum Limitations   |
|------------------------|---|
| B4034                  | 31 per month  |
| B4035                  | 31 per month  |
| B4036                  | 31 per month  |
| B4081                  | As needed   |
| B4082                  | As needed   |
| B4083                  | As needed   |
| B4087                  | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B4088                  | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998                  | As needed (Prior Authorization required)  |
| B9998 with modifier U1 | 4 per month   |
| B9998 with modifier U2 | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998 with modifier U3 | 4 per month, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier        |
| B9998 with modifier U4 | 4 per rolling year, any combination of B4087, B4088, B9998 with U2 modifier, B9998 with U4 modifier |
| B9998 with modifier U5 | 4 per month, any combination of B9998 with U3 modifier, B9998 with U5 modifier                      |

Providers may not bill a quantity greater than the number of days in the month for which they are submitting a claim. Claims with a quantity greater than the number of days in that month may be subject to a recoupment.

**Referto:** Section 4.3, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

Section 31.2.21, “Gastrostomy Devices” in Chapter 31, “Physician” for information related to gastrostomy tube devices.

### 18.3 Claims Information

Expendable medical supplies must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Home health DME providers must use benefit code DM3 on all claims and authorization and prior authorization requests. All other providers must use benefit code CSN on all claims and authorization and prior authorization requests.

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 18.4 Reimbursement

Expendable medical supplies may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Supplies may be reimbursed using the appropriate HCPCS codes. The CSHCN Services Program requires the provider to submit an itemized claim form for supplies for reimbursement.

Reimbursement for miscellaneous procedure codes B9998 and T1999 is determined by prior authorization based on one of the following:

- The average wholesale price (AWP) less 10.5 percent, or the manufacturer’s suggested retail price (MSRP) less 18 percent, whichever is applicable
- The provider’s documented invoice cost

The AWP, MSRP, or the documented invoice cost must be submitted with the appropriate procedure code to be considered for reimbursement.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 18.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)

## Table of Contents

|             |   |          |
|-------------|---|----------|
| <b>19.1</b> | <b>Enrollment .....</b>   | <b>3</b> |
| <b>19.2</b> | <b>Benefits, Limitations and Authorization Requirements .....</b> | <b>3</b> |
| 19.2.1      | General Medical Services .....                                    | 3        |
| 19.2.2      | Preventive Care Medical Checkups .....                            | 4        |
| 19.2.3      | Telecommunication Services .....                                  | 4        |
| 19.2.4      | Behavioral Health Services .....                                  | 5        |
| 19.2.5      | Dental Services .....   | 5        |
| 19.2.6      | Vision Services .....   | 6        |
| <b>19.3</b> | <b>Claims Filing .....</b>  | <b>6</b> |
| <b>19.4</b> | <b>Reimbursement .....</b>  | <b>6</b> |
| <b>19.5</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b>           | <b>6</b> |

## 19.1 Enrollment

Rural health clinics (RHCs), federally qualified health centers (FQHCs), federally qualified look-alikes (FQL), federally qualified satellites (FQS) and rural health clinics can enroll as providers for the Children with Special Health Care Needs (CSHCN) Services Program.

To enroll in the CSHCN Services Program, FQHC and RHC providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process through the Provider Enrollment and Management System (PEMS), and comply with all applicable state laws and requirements.

Out-of-state FQHC and RHC providers must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1).

*Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.*

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program enrollment procedures.

## 19.2 Benefits, Limitations and Authorization Requirements

### 19.2.1 General Medical Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC providers and billed with a general services modifier:

| General Medical Services   |       |       |       |       |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| T1015  | 96160 | 96161 | 99381 | 99382 | 99383 | 99384 | 99385 | 99386 | 99387 |
| 99391  | 99392 | 99393 | 99394 | 99395 | 99396 | 99397 |       |       |       |
| <b>General medical services must be billed with one of the appropriate modifiers: AH, AJ, AM, SA, TD, TE, or U7.</b> |       |       |       |       |       |       |       |       |       |

**Note:** *Procedure codes 96160 and 96161 are benefits of the CSHCN Services Program for clients who are 12 through 18 years of age and are limited to once per calendar year, any provider.*

**Referto:** Section 31.2.18.10, “Preventive Care Medical Checkup Components” in Chapter 31, “Physician” in the Physician chapter for more specific information about guidelines and requirements for procedure codes 96160 and 96161.

The general medical services modifiers are defined as follows:

| Modifier | Services Performed   |
|----------|--|
| AH       | Services Performed By Psychologist   |
| AJ       | Services Performed By Social Worker  |
| AM       | Services Performed By Physician, Team Member Services                        |
| SA       | Services Performed By Nurse Practitioner In Collaboration With Physician     |
| TD       | Services Performed By Registered Nurse                                       |
| TE       | Services Performed By Lpn Or Lvn   |
| U7       | Services Performed By Physician Assistant Other Than For Assisant At Surgery |

All services provided during an RHC encounter must be submitted using procedure code T1015. The total submitted amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code T1015 to designate the health-care professional providing the services: AH, AJ, AM, SA, TD, TE, or U7.

### 19.2.2 Preventive Care Medical Checkups

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC providers and billed with one of the general services modifiers above:

| Preventive Care Medical Checkups |       |       |       |       |       |       |       |       |       |
|----------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 96160                            | 96161 | 99381 | 99382 | 99383 | 99384 | 99385 | 99386 | 99387 | 99391 |
| 99395                            | 99396 | 99397 |       |       |       |       |       |       |       |

**Note:** Procedure codes 96160 and 96161 are benefits of the CSHCN Services Program for clients who are 12 through 18 years of age and are limited to once per calendar year, any provider.

**Referto:** Section 31.2.18.10, “Preventive Care Medical Checkup Components” in Chapter 31, “Physician” in the Physician chapter for more specific information about guidelines and requirements for procedure codes 96160 and 96161.

Adult preventive care must be billed with diagnosis code Z0000 or Z0001. Pediatric preventive care must be billed with diagnosis code Z00121 or Z00129. The provider cannot submit modifier EP for pediatric services.

### 19.2.3 Telecommunication Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC providers for telemedicine services at a distant site location:

| Procedure Codes |       |       |       |       |       |       |       |       |  |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|--|
| 99202           | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 |  |

**Referto:** Section 38.2.2, “Telemedicine Services” in Chapter 38, “Telecommunication Services” for more detailed information about telemedicine services.

### 19.2.4 Behavioral Health Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC or RHC providers are billed with a general services modifier:

| Behavioral Health Services |       |       |       |       |       |
|----------------------------|-------|-------|-------|-------|-------|
| 90847                      | 90853 | 90865 | 96130 | 96132 | 96136 |

Mental health services must be billed using one of the appropriate general services modifiers as listed and defined below:

| Modifier | Services performed  |
|----------|---|
| AH       | Services performed by psychologist  |
| AJ       | Services performed by social worker   |
| AM       | Services performed by physician, team member services                         |
| U1       | Services performed by licensed professional counselor                         |
| U2       | Services performed by licensed marriage and family therapist                  |
| U7       | Services performed by physician assistant other than for assistant at surgery |

### 19.2.5 Dental Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC or RHC providers:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| D0120           | D0140 | D0145 | D0150 | D0160 | D0170 | D0180 | D0330 | D0340 | D0350 |
| D0470           | D1110 | D1120 | D1206 | D1208 | D1351 | D1352 | D1510 | D1516 | D1517 |
| D1520           | D1526 | D1527 | D1551 | D1552 | D1553 | D1575 | D2140 | D2150 | D2160 |
| D2161           | D2330 | D2331 | D2332 | D2335 | D2390 | D2391 | D2392 | D2393 | D2394 |
| D2750           | D2751 | D2791 | D2792 | D2930 | D2931 | D2932 | D2933 | D2934 | D2940 |
| D2950           | D2954 | D2971 | D3220 | D3230 | D3240 | D3310 | D3320 | D3330 | D3346 |
| D3347           | D3348 | D3351 | D3352 | D3353 | D4341 | D4355 | D5211 | D5212 | D5611 |
| D5612           | D5630 | D5640 | D5650 | D5660 | D5670 | D5671 | D5720 | D5721 | D5740 |
| D5741           | D5760 | D5761 | D6549 | D7140 | D7210 | D7220 | D7230 | D7250 | D7270 |
| D7286           | D7510 | D7550 | D7910 | D7970 | D7971 | D7997 | D7999 | D8010 | D8020 |
| D8080           | D8210 | D8220 | D8660 | D8670 | D8680 | D9110 | D9211 | D9212 | D9215 |
| D9230           | D9248 | D9330 | D9974 | D9999 |       |       |       |       |       |

Procedure codes D8210, D8220, and D8080 must be billed with the appropriate Diagnostic Procedure Code (DPC) remarks codes for correct claims processing:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1000D           | 1001D | 1002D | 1003D | 1004D | 1005D | 1006D | 1007D | 1008D | 1010D |
| 1011D           | 1012D | 1013D | 1014D | 1015D | 1016D | 1017D | 1018D | 1019D | 1020D |
| 1021D           | 1022D | 1023D | 1024D | 1025D | 1026D | 1027D | 1028D | 1029D | 1030D |
| 1031D           | 1032D | 1045D | 1046D | 1047D | 1048D | 1049D | 1050D | 1051D | 1052D |
| 1053D           | 1054D | 1055D | 1056D | 1057D | 1058D | 1059D | 1060D | 1061D | 1062D |
| 1063D           | 1064D | 1065D | 1066D | 1067D | 1068D | 1069D | 1070D | 1071D | 1072D |

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1073D           | 1074D | 1075D | 1076D | 1077D | 1078D | Z2009 | Z2011 | Z2012 |

### 19.2.6 Vision Services

The procedure codes in the following table are a benefit of the CSHCN Services Program when they are provided by FQHC or RHC providers:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 92002           | 92004 | 92012 | 92014 | 92015 | 92020 | 92025 | 92060 | 92065 | 92081 |
| 92082           | 92083 | 92100 | 92201 | 92202 | 92230 | 92235 | 92240 | 92242 | 92250 |
| 92260           | 92265 | 92270 | 92273 | 92274 | 92285 | 92286 | 92287 | 95930 | 95933 |
| S0620           | S0621 |       |       |       |       |       |       |       |       |

### 19.3 Claims Filing

All services require documentation to support the medical necessity of the service rendered. All services provided are subject to retrospective review and recoupment if documentation does not support the service that was submitted for reimbursement.

FQHC and RHC services must be submitted to TMHP in an approved electronic format or on the following paper claim forms:

For FQHC:

| Services         | Claim Form  |
|------------------|---|
| Medical services | <a href="#">UB-04 CMS-1450 or CMS-1500 paper claim form</a>         |
| Dental services  | <a href="#">American Dental Association (ADA) Dental Claim Form</a> |

For RHC:

| Services         | Claim Form                                      |
|------------------|---|
| Medical services | <a href="#">UB-04 CMS-1450 paper claim form</a> |

When completing a paper claim form, the provider must include all required information on the claim because information is not keyed from attachments. Super bills or itemized statements are not accepted as claim supplements.

### 19.4 Reimbursement

CSHCN FQHCs are reimbursed the lower of the billed amount or the Texas Medicaid provider-specific prospective payment system encounter rates.

CSHCN freestanding and hospital-based RHCs are reimbursed the lower of the billed amount or the Texas Medicaid provider-specific per visit rates.

### 19.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# HEARING SERVICES

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# HEARING SERVICES

## Table of Contents

|             |   |           |
|-------------|---|-----------|
| <b>20.1</b> | <b>Enrollment</b>   | <b>4</b>  |
| 20.1.1      | Non-Implantable Hearing Aid Devices and Services  | 4         |
| 20.1.2      | Implantable Hearing Aid Devices and Services  | 4         |
| <b>20.2</b> | <b>Benefits, Limitations, and Authorization Requirements – Non-Implantable Devices and Services</b> | <b>4</b>  |
| 20.2.1      | Hearing Screening   | 5         |
| 20.2.2      | Abnormal Hearing Screens  | 5         |
| 20.2.3      | Hearing Testing, Examination, and Evaluation Services   | 6         |
| 20.2.3.1    | Audiometric Testing   | 6         |
| 20.2.3.2    | Otological Examination  | 6         |
| 20.2.3.3    | Vestibular Evaluations  | 6         |
| 20.2.3.4    | Authorization/Documentation Requirements  | 7         |
| 20.2.3.5    | Limitations   | 7         |
| 20.2.4      | Hearing Aid Devices and Accessories   | 7         |
| 20.2.4.1    | Documentation Requirements  | 10        |
| 20.2.4.2    | Prior Authorization Requirements  | 10        |
| 20.2.4.3    | Limitations   | 11        |
| 20.2.5      | Hearing Aid Services  | 11        |
| 20.2.5.1    | Documentation Requirements  | 12        |
| 20.2.5.2    | Prior Authorization Requirements  | 13        |
| 20.2.5.3    | Limitations   | 13        |
| <b>20.3</b> | <b>Benefits, Limitations, and Authorization Requirements – Implantable Devices and Services</b>     | <b>13</b> |
| 20.3.1      | Bone-Anchored Hearing Device (BAHD)   | 13        |
| 20.3.1.1    | Electromagnetic Bone Conduction Hearing Device  | 14        |
| 20.3.1.2    | Prior Authorization Requirements  | 14        |
| 20.3.1.3    | Limitations   | 14        |
| 20.3.2      | Cochlear Implants   | 14        |
| 20.3.2.1    | *Device, Implantation and Supplies  | 15        |
| 20.3.2.2    | Auditory Rehabilitation   | 15        |
| 20.3.2.3    | Frequency Modulation (FM) Systems   | 15        |
| 20.3.2.4    | Authorization Requirements  | 16        |
| 20.3.2.5    | Limitations   | 16        |
| 20.3.2.6    | Sound Processor Replacement Guidelines  | 17        |
| <b>20.4</b> | <b>Claims Information</b>   | <b>17</b> |
| 20.4.1      | Claims Filing for Non-Implantable Hearing Devices and Services                                      | 18        |
| 20.4.1.1    | Claims Filing for Non-implantable Hearing Aid Devices   | 18        |
| 20.4.2      | Claims Filing for Implantable Hearing Devices and Services  | 18        |
| <b>20.5</b> | <b>Reimbursement</b>  | <b>18</b> |
| 20.5.1      | Reimbursement for Hearing Tests   | 19        |



---

20.5.2 Reimbursement for Non-Implantable Hearing Devices and Services ..... 19

20.5.3 Reimbursement for Implantable Hearing Devices and Services..... 19

**20.6 TMHP-CSHCN Services Program Contact Center .....19**

## 20.1 Enrollment

Appropriately-licensed providers may enroll as CSHCN Services Program providers by completing the provider enrollment application available through the TMHP-CSHCN Services Program. Providers must be actively enrolled as Texas Medicaid providers before enrolling in the CSHCN Services Program. Out-of-state providers must meet all applicable enrollment requirements, and be located in the United States, within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

### 20.1.1 Non-Implantable Hearing Aid Devices and Services

A provider of hearing aid fitting and dispensing services must be licensed by the Texas State Committee of Examiners for Speech, Language, Pathology, and Audiology.

Hearing aid fitters and dispensers may enroll with the CSHCN Services Program as individuals or as facilities.

### 20.1.2 Implantable Hearing Aid Devices and Services

To enroll in the CSHCN Services Program, hearing services professionals who provide implantable hearing devices and services must be appropriately enrolled according to their licensure and scope of practice.

## 20.2 Benefits, Limitations, and Authorization Requirements – Non-Implantable Devices and Services

The CSHCN Services Program hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device.

Such services may be reimbursed to audiologists or hearing aid fitters and dispensers as follows:

- Audiologist and physician providers may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss including, but not limited to, the following:

- Hearing screening
- Audiometric testing
- Otological examination
- Vestibular evaluation
- Hearing aid evaluation
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories, fitting and dispensing visits, and revisits including, but not limited to, the following:
  - Ear molds
  - Hearing aid device
  - Hearing aid fitting
  - Follow-up visits at 30 days (first follow-up) and 60 days (second follow-up)
  - Hearing aid repair
  - Refit and evaluation after repair
  - Hearing aid batteries and supplies

***Note:** Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a non-implantable hearing aid device are not considered part of the CSHCN Services Program hearing services benefit. Providers may refer to the other CSHCN Services Program Provider Manual chapters for benefit and limitation information about other hearing-related services.*

All services provided to CSHCN Services Program clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations noted in this chapter. Providers must request prior authorization for medically necessary services that exceed benefit limitations and for those services for which prior authorization is required.

***Note:** CSHCN Services Program clients who are 17 years of age or older who are legal residents of the state of Texas, and who are employable, may be eligible for assistance from the Texas Workforce Commission (TWC). The CSHCN Services Program may request that clients who meet these requirements apply to TWC, as the CSHCN Services Program is the payor of last resort.*

### **20.2.1 Hearing Screening**

A hearing screening that is provided due to client concern, or at the provider's discretion, is a benefit for clients of any age when the client is referred by a CSHCN Services Program-enrolled physician, and the screening is provided by a CSHCN Services Program-enrolled provider that is licensed to perform these services.

### **20.2.2 Abnormal Hearing Screens**

Clients with abnormal hearing screens must be referred to a CSHCN Services Program-enrolled licensed audiologist or physician that provides audiology services.

Clients who are birth through 35 months of age with suspected or confirmed hearing loss must be referred to Early Childhood Intervention (ECI) as soon as possible but no longer than 7 days after identification, even if the client is also referred to an appropriate provider for further testing. The client's responsible adult may refuse to permit the referral or decline ECI services at any time. The provider must document the client's responsible adult's decision in the client's medical record.

## 20.2.3 Hearing Testing, Examination, and Evaluation Services

### 20.2.3.1 Audiometric Testing

A basic comprehensive audiometry survey is a benefit of the CSHCN Services Program and includes the following tests:

- Tympanometry and reflex threshold measurements
- Screening test, pure tone, air only
- Pure tone audiometry
- Speech audiometry threshold
- Comprehensive audiometry threshold evaluation and speech recognition

The following procedure codes may be reimbursed for a basic comprehensive audiometry survey:

| Procedure Codes |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|
| 92550           | 92551 | 92552 | 92553 | 92555 | 92556 | 92557 |

The following additional audiometric tests may also be reimbursed by the CSHCN Services Program:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 92558           | 92563 | 92565 | 92567 | 92568 | 92570 | 92571 | 92572 | 92575 | 92576 |
| 92577           | 92579 | 92582 | 92583 | 92584 | 92587 | 92588 | 92650 | 92651 | 92652 |
| 92653           |       |       |       |       |       |       |       |       |       |

### 20.2.3.2 Otological Examination

An otological examination is a benefit of the CSHCN Services Program when it is medically necessary and provided by a CSHCN Services Program-enrolled physician licensed to perform this service.

Procedure codes 92502 and 92504 may be reimbursed for otological examination.

An otological examination may also include physician evaluation and management services that are provided to diagnose or treat medical conditions.

**Referto:** Section 31.2.18, “Evaluation and Management (E/M) Services” in Chapter 31, “Physician” for more information about medically necessary physician evaluation and management services.

### 20.2.3.3 Vestibular Evaluations

A vestibular evaluation is a benefit of the CSHCN Services Program when it is medically necessary and provided by a CSHCN Services Program-enrolled physician, and the screening is provided by a CSHCN Services Program-enrolled provider licensed to perform these services.

The following procedure codes may be reimbursed for vestibular evaluations:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 92531           | 92532 | 92533 | 92534 | 92537 | 92538 | 92540 | 92541 | 92542 | 92544 |
| 92545           | 92546 | 92547 |       |       |       |       |       |       |       |

#### **20.2.3.4 Authorization/Documentation Requirements**

Authorization is not required for hearing services for the evaluation and diagnosis of hearing loss. Documentation of medical necessity must be maintained by the provider in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

#### **20.2.3.5 Limitations**

Procedure codes 92553 and 92556 are not billable on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service by the same provider for the same client, they will be denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Procedure codes 92551, 92552, and 92553 for pure tone audiometry are limited to one of any of these procedure codes per day, same provider, same client.

Procedure code 92547 is an add-on code, and must be billed with the primary procedure code (92540, 92541, 92542, 92544, 92545, or 92546) with the same date of service by the same provider to be considered for reimbursement.

Procedure codes 92558, 92587, 92588, 92650, 92651, 92652, and 92653 may be reimbursed once per day for the same provider and the same client for testing performed in both ears. For testing performed solely in one ear, providers must use modifier 52.

Procedure codes 92620, 92621, and 92625 may be reimbursed for evaluative and therapeutic services and are limited to four services per rolling year. Providers must submit prior authorization requests with documentation of medical necessity.

Procedure code 92621 is an add-on code, and must be billed with the primary procedure code 92620, on the same day by the same provider in order to be considered for reimbursement.

Procedure codes 99211 and 99212 will be denied when billed for the same date of service by the same provider as procedure code 92592 or 92593.

Tympanometry (impedance testing) procedure code 92567 may be reimbursed as an objective diagnostic test of middle ear disease and is limited to three services per rolling year by any provider.

Procedure code 92591 may be reimbursed for a hearing screening or other hearing aid examination.

Two hearing aid revisits may be reimbursed per calendar year. Procedure code 92592 may be reimbursed for the first and second revisits for monaural hearing aid fittings. Procedure code 92593 may be reimbursed for the first and second revisits for binaural hearing aid fittings.

Additional hearing aid checks may be reimbursed within a period of six months after a second revisit. Providers must submit a prior authorization request and documentation of medical necessity for the additional hearing aid checks.

#### **20.2.4 Hearing Aid Devices and Accessories**

Nonimplantable hearing aid devices and accessories are benefits of the CSHCN Services Program.

**Important:** *TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from the manufacturers of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.*

The CSHCN Services Program may reimburse hearing aid fitters and dispensers for the following services:

| Service                 | Limitation   |
|-------------------------|--|
| Hearing aid devices     | <p><b>Limitation:</b> 1 per ear every 5 rolling years. One of the following may be reimbursed:</p> <ul style="list-style-type: none"> <li>• If only one ear requires a hearing aid device, one monaural hearing aid procedure code with the appropriate modifier LT or RT may be reimbursed without prior authorization once every 5 years from the dispensing date of the initial services.</li> <li>• If within the same 5-year period, the other ear requires a hearing aid device, a second monaural hearing aid device procedure code with the appropriate modifier LT or RT may be reimbursed without prior authorization and a separate 5-year period will begin for the second device.</li> <li>• If both ears require a hearing aid device at the same time, one binaural hearing aid procedure code may be reimbursed once every 5 years from the dispensing date of the initial services without prior authorization. For binaural procedure codes, bill a quantity of 1.</li> </ul> <p>Replacement hearing aid devices that are required within the same 5-year period must be prior authorized.</p> <p>Repairs or modifications may be reimbursed once per rolling year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. If repairs are required more than once per year, additional repairs or modifications may be reimbursed with prior authorization if medical necessity can be demonstrated.</p> <p><b>Procedure codes:</b> See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications.</p> <p><b>Date of service:</b> The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device.</p> <p>The date of service for the repair or modification is the date the client receives the repaired or modified hearing aid device.</p> <p><b>Warranty note:</b> During the warranty period, the CSHCN Services Program may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. The CSHCN Services Program will not reimburse hearing aid repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.</p> |
| Hearing aid accessories | <p><b>Limitation:</b> As often as is medically necessary with prior authorization.</p> <p><b>Note:</b> <i>Hearing aid accessories that are not part of the hearing aid package include, but are not limited to, chin straps, clips, boots, and headbands. The items are not supplied by TMHP; the accessories must be purchased from a vendor of the provider's choice.</i></p> <p><b>Procedure code:</b> V5267</p> <p><b>Date of service:</b> The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device, or the date the client receives the replacement accessory item.</p>   |

| Service                      | Limitation   |
|------------------------------|--|
| Ear impression               | <p><b>Limitation:</b> 1 each per hearing aid device as follows:</p> <ul style="list-style-type: none"> <li>• For monaural procedure codes, bill a quantity of 1.</li> <li>• For binaural procedure codes, bill a quantity of 2.</li> </ul> <p>Replacement ear molds may be reimbursed as often as is medically necessary.</p> <p><b>Procedure codes:</b> V5275</p> <p><b>Date of service:</b> The date of service for the ear impression is the date the ear impression is taken.</p>  |
| Ear molds                    | <p><b>Limitation:</b> For clients who are 20 years of age or younger - as medically necessary. (Documentation that supports medical necessity must be maintained in the client’s medical record.)</p> <p>For clients who are 21 years of age or older - custom ear molds are limited to 3 ear molds per ear, per rolling year, any provider; disposable ear molds are limited to 4 ear molds per ear, per 30 days, any provider.</p> <p><b>Procedure codes:</b> V5264 and V5265 (billed with modifier LT or RT)</p> <p><b>Date of service:</b> The date of service for the ear mold is the date the ear mold is dispensed to the client.</p>   |
| Batteries (replacement only) | <p><b>Limitation:</b> Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by the CSHCN Services Program. If a hearing aid has not been reimbursed by the CSHCN Services Program in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity.</p> <p><b>Procedure code:</b> V5266</p> <p><b>Date of service:</b> The date of service is the date the client receives the replacement batteries.</p> <p><b>Warranty note:</b> Replacement batteries that are supplied as part of the manufacturer’s warranty will not be reimbursed separately by the CSHCN Services Program.</p> |

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| V5030           | V5040 | V5171 | V5172 | V5181 | V5244 | V5246 | V5247 | V5254 | V5255 |
| V5256           | V5257 | V5298 |       |       |       |       |       |       |       |

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| V5100           | V5211 | V5212 | V5213 | V5214 | V5215 | V5221 | V5249 | V5250 | V5251 |
| V5252           | V5253 | V5258 | V5259 | V5260 | V5261 | V5298 |       |       |       |

### **20.2.4.1 Documentation Requirements**

Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client's medical record:

- Hearing loss in the better ear of 35 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz.
- A spondee threshold in the better ear of 35 dBHL or greater when pure tone thresholds cannot be established.
- Hearing loss in each ear is less than 35 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher.
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance.

Clients meet the criteria for binaural aids if they meet the conditions for a monaural hearing aid and have at least a 35-dBHL hearing loss in both ears.

Providers must also include the model number, serial number, and warranty dates of the purchased hearing aid device in the client's medical record.

### **20.2.4.2 Prior Authorization Requirements**

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the previous table.

Prior authorization is required for the following:

- Replacement hearing aid devices that are required within the same 5-year period  
A replacement hearing aid device may be considered for prior authorization when loss or irreparable damage has occurred. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.
- Hearing aid accessories that are not part of the hearing aid package including, but not limited to, chin straps, clips, boots, and headbands  
Requests for prior authorization for hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands will be considered when the requests are submitted with documentation that shows that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
- Hearing aid devices that are not currently a benefit of the CSHCN Services Program but that are medically necessary.

The prior authorization request must include:

- The medical necessity for the requested hearing aid device.
- The name of the manufacturer.
- The manufacturer's suggested retail price (MSRP) or the provider's documented invoice cost if the MSRP is not available.
- The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
- For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair or modification.



For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization requests must be submitted to the TMHP-CSHCN Services Program Authorization Department using the [CSHCN Services Program Authorization and Prior Authorization Request Form](#). Documentation that supports medical necessity for the requested device, service, or supply must be included with the form. See Chapter 4, “Prior Authorizations and Authorizations” for more information about the authorizations and claims filing processes.

### 20.2.4.3 Limitations

A hearing aid dispensed through the CSHCN Services Program must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.
- Meet the needs of the individual client that receives the device

Providers must dispense each hearing aid reimbursed through the CSHCN Services Program with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer’s postage and handling charges
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

*Note: The client, client’s family, or caregiver(s) must agree to accept the responsibility for, and be trained in, the proper use of the hearing aid device.*

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of the CSHCN Services Program but that are medically necessary.

Procedure code V5251 may be reimbursed with prior authorization.

A monaural hearing aid device procedure code and a binaural hearing aid device procedure code will not be reimbursed within the same 5-year period.

### 20.2.5 Hearing Aid Services

The CSHCN Services Program may reimburse hearing aid fitters and dispensers for the following services:

| Service                                | Limitation   |
|--|--|
| Hearing aid examination and evaluation | <p><b>Limitation:</b> As often as is medically necessary.</p> <p><b>Procedure code:</b> 92590, 92591, 92594, and 92595</p> <p><b>Date of service:</b> The date of service is the date the service is rendered to the client.</p> |

| Service                       | Limitation   |
|-------------------------------|--|
| Hearing aid assessment        | <p><b>Limitation:</b> As often as is medically necessary.</p> <p><b>Procedure code:</b> V5010</p> <p><b>Date of service:</b> The date of service is the date the service is rendered to the client.</p>  |
| Fitting and dispensing visits | <p><b>Limitation:</b> 1 fitting per hearing aid procedure code, regardless of the number of times a device is returned as unacceptable during a 30-day trial period.</p> <p><b>Procedure code:</b> V5011</p> <p><b>Date of service:</b> The date of service for the fitting, orientation, and checking visit is the date the client successfully completes the 30-day trial period and accepts the hearing aid device.</p> <p>The post-fitting check of the hearing aid must be performed within 5 weeks of the initial fitting, and is included in the reimbursement for the dispensing procedure. No separate reimbursement will be made.</p> <p><b>Limitation:</b> 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins.</p> <p><b>Procedure codes:</b> V5090, V5110, V5160, V5200, V5240, and V5241</p> <p><b>Date of service:</b> The date of service for the dispensing visit is the date the client receives the hearing aid device and a new 30-day trial period begins.</p> <p>The dispensing fee may be reimbursed separately from the fitting of the hearing aid.</p> |
| Revisit(s)                    | <p><b>Limitation:</b> 2 per calendar year when billed by any provider. Additional hearing aid checks may be reimbursed with prior authorization.</p> <p><b>Procedure codes:</b> 92592 (first and second revisits for monaural fittings) and 92593 (first and second revisits for binaural fittings)</p> <p><b>Date of service:</b> The date of service is the date the service is rendered to the client.</p>  |

### 20.2.5.1 Documentation Requirements

*Client Acknowledgment Statement* (created by the provider)-To confirm that the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need, the client must sign an acknowledgment statement before the provider dispenses the hearing aid device and supplies. The statement must be maintained in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the device, service, or supply.

*30-Day Trial Period Certification Statement* (created by the provider)-To confirm that the client was allowed a 30-consecutive-day trial period that began with the dispensing date, the hearing aid fitter/dispenser must provide the client with a written agreement that includes the beginning and ending dates of the 30-day trial period. The contract agreement must include all charges and fees associated with the trial period as well as the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement and a copy must also be maintained in the client's medical record.

A new certification statement must be provided each time a new trial period begins.

The fitter/dispenser must allow 30 days to elapse from the hearing aid dispensing date before completing the 30-day trial period certification statement, which indicates that the client has completed the trial period and has accepted the dispensed hearing aid. The certification statement must be maintained by the provider in the client's medical record.

For hearing aids that are dispensed in a provider's office, if a client fails to return by the end date of the trial period, the provider must contact the client. After 3 attempts have been made, if the client does not return to the provider's office, the provider must document all contact attempts with the client and maintain this documentation in the client's file. Retrospective review may be performed to ensure documentation supports the contact attempts and the client's failure to return to the provider's office.

### **20.2.5.2 Prior Authorization Requirements**

Prior authorization is not required for fitting and dispensing visits and revisits.

### **20.2.5.3 Limitations**

The following hearing aid visits may be reimbursed by the CSHCN Services Program:

- The fitting and dispensing visits that encompass a 30-day trial period and include a post-fitting check 5 weeks after the trial period has been successfully completed
- A first revisit as needed after the post-fitting check
- A second revisit as needed after the first revisit

The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid.

A trial period of up to 30 days is authorized by Texas Occupations Code §402.401. The 30-day trial period, and any charged rental fee, must meet the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140.

After the hearing aid has been dispensed, the client must be allowed a 30-consecutive-day trial period that begins with the dispensing date to determine satisfaction with a purchased hearing aid. During the 30-day trial period, if the client is not satisfied with the purchased hearing aid or if hearing is not improved with the use of the purchased hearing aid, the client may return it to the provider. Providers may dispense additional hearing aids as medically necessary until the client is satisfied with the results of a hearing aid or until the provider determines that the client cannot benefit from the dispensing of an additional hearing aid. A new trial period begins with the dispensing date of each hearing aid.

The hearing aid provider must use the appropriate fitting and dispensing procedure code for services rendered during the trial period. No additional fees may be charged to the client or to the CSHCN Services Program during this period.

The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting.

## **20.3 Benefits, Limitations, and Authorization Requirements – Implantable Devices and Services**

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone-anchored hearing device (BAHD), are benefits of the CSHCN Services Program for clients of all ages.

### **20.3.1 Bone-Anchored Hearing Device (BAHD)**

A bone-anchored hearing device (BAHD) may be reimbursed by the CSHCN Services Program for clients who are five years of age or older and who meet the medical necessity criteria. The following procedure codes may be reimbursed with prior authorization for the BAHD and related components:

| <b>Procedure Codes</b> |       |       |       |       |       |       |       |       |       |
|------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L8690                  | L8691 | L8692 | L8693 | L8694 | 69711 | 69714 | 69716 | 69717 | 69719 |
| 69726                  | 69727 | 69728 | 69729 | 69730 | V5266 |       |       |       |       |

**20.3.1.1 Electromagnetic Bone Conduction Hearing Device**

Removal or repair of an electromagnetic bone conduction hearing device may be reimbursed using procedure code 69711. This service is limited to two procedures per lifetime when billed by any provider.

The implantation or replacement of an electromagnetic bone conduction hearing device is not a benefit.

**20.3.1.2 Prior Authorization Requirements**

Prior authorization is required. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request form and may be granted if the client is five years of age or older and all of the following documentation is provided:

- Previous attempts at hearing aids and why these devices are inadequate or have failed.
- Scores on hearing tests for bone conduction thresholds and on maximum speech discrimination.
- Audiological testing showing good inner ear function.
- Assessment that shows the client is motivated, is able to follow given instructions, and is willing to participate in follow-up therapy.
- Appropriate indication that may be causing hearing impairment. Indications include, but are not limited to, one of the following:
  - Acquired deformities of auricle or pinna
  - Congenital anomalies of the external ear canal, middle ear or skull and face bones
  - Malignant neoplasm, benign neoplasm or carcinoma of the external ear canal and/or tympanic cavity
  - Otosclerosis in clients who cannot undergo stapedectomy
  - Severe chronic conductive or sensorineural hearing loss (i.e. otitis media, malformations of the inner ear)

**20.3.1.3 Limitations**

Replacement batteries for the BAHD may be reimbursed without prior authorization as follows:

- Using procedure code V5266
- Limited to clients with a previously-paid BAHD

Replacement batteries for clients who did not receive the hearing device through the CSHCN Services Program may be reimbursed on appeal with a physician’s statement documenting medical necessity.

The BAHD is Food and Drug Administration (FDA)-approved for clients who are 5 years of age or older. Clients who are younger than 5 years of age do not have sufficient bone density for implantation of the device.

BAHD procedure codes are subject to NCCI relationships with the following exceptions. The procedure codes in Column A of the following table will be denied if they are billed with the same date of service by the same provider as procedure codes in Column B:

| Column A (Denied)              | Column B |
|--------------------------------|----------|
| L8691, L8692, L8693, and L8694 | L8690    |

**20.3.2 Cochlear Implants**

Cochlear implants, auditory brain implants (ABIs), and auditory rehabilitation are benefits of the CSHCN Services Program.

### 20.3.2.1 \* Device, Implantation and Supplies

Procedure codes 69930 and S2235 may be reimbursed for the cochlear implant and the ABI devices and implantation.

The following procedure codes may be reimbursed for equipment:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L7368           | L8499 | L8614 | L8615 | L8616 | L8617 | L8618 | L8619 | L8623 | L8624 |
| L8625           | L8627 | L8628 | L8629 |       |       |       |       |       |       |

[Revised] Procedure codes 92601, 92602, 92603, 92604, 92622, and 92623 may be reimbursed for diagnostic analysis and subsequent programming of the implant. Procedure code 92623 is an add-on procedure code and must be billed with primary procedure code 92622 on the same day, by the same provider in order to be considered for reimbursement.

The following procedure codes may be reimbursed for batteries:

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| L8621           | L8622 | L8623 | L8624 |

Replacement batteries for the cochlear device (procedure codes L8621, L8622, L8623, and L8624) are limited to clients with a previously billed cochlear implant procedure, device, or supply.

**Note:** Replacement batteries beyond the limit of two batteries per calendar year require prior authorization and may be considered with documentation that supports the need for additional batteries.

### 20.3.2.2 Auditory Rehabilitation

Auditory rehabilitation may be a benefit of the CSHCN Services Program when medically necessary for clients who have received a surgically implanted hearing device, or clients who have prelingual or postlingual hearing loss if the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation services:

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| 92626           | 92627 | 92630 | 92633 |

Procedure Code 92627 Is An Add-on Procedure And Must Be Billed With Primary Procedure Code 92626, On The Same Day, By The Same Provider In Order To Be Considered For Reimbursement.

The benefit for auditory rehabilitation is one evaluation and 12 visits per 180-day period, without prior authorization. Additional therapy services may be available through the speech therapy benefit.

**Referto:** Chapter 37, “Speech-Language Pathology (SLP) Services” for additional information about the CSHCN Services Program speech therapy benefit.

### 20.3.2.3 Frequency Modulation (FM) Systems

An FM system may be a benefit of the CSHCN Services Program for clients who are 12 months of age and older when it is needed as an assistive listening device for use with a cochlear implant and the following criteria are met:

- At least three months have elapsed since the surgical implantation of the cochlear device
- The client is unable to obtain the FM device through any other source

The assistive listening device (FM system) for use with a cochlear implant may be reimbursed with prior authorization using procedure code V5273.

Replacement or repair of an FM system will not be considered for coverage during the manufacturer's warranty period.

#### **20.3.2.4 Authorization Requirements**

All implants must be prior authorized. Requests for prior authorization must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request form. The following information must accompany the request for prior authorization:

- Documentation from the audiologist and otolaryngologist that indicates the client is a good candidate for the procedure and meets the requirements outlined earlier in this chapter.
- Documentation that a referral to an appropriate auditory rehabilitation provider is in place.
- Documentation from the client's primary physician, neurologist, or school diagnostician that the client has the cognitive ability to use the implant.

The battery charger unit for the lithium-ion battery procedure code L7368 is limited to one replacement per five rolling years with prior authorization.

The prior authorization request will not be granted if one or more of the following situations exist:

- The client has an active ear infection.
- The client is deaf due to lesions of the acoustic nerve or central auditory pathways.
- There is radiological documentation of absent cochlear development.
- The client or the client's parents lack the cognitive ability or willingness to complete auditory rehabilitation.

The purchase, replacement, or repair of an assistive listening device (FM system) for use with a cochlear implant must be prior authorized.

Auditory rehabilitation services beyond the limit of 12 visits per 180-day period must be prior authorized and will be considered for clients who are 12 months of age through 20 years of age with documentation that supports the medical necessity of continued services.

#### **20.3.2.5 Limitations**

Clients must meet the following criteria:

- The client is 12 months of age or older.
- The client has a profound, bilateral, sensorineural hearing loss.
- The client who requests the cochlear implant has had limited or no benefit from a trial with appropriately fitted hearing aids. A trial of three to six months is required for clients who do not have previous experience with hearing aids unless there is a documented reason that hearing aids will not work for that particular client.
- The client has the cognitive ability to use auditory cues.
- The client or parents are willing and able to comply with auditory rehabilitation.
- The client is assessed by both an audiologist and an otolaryngologist experienced in the implantation of cochlear implants or ABIs and who indicate that the client is a good candidate for the procedure.

ABI is an adaptation of a cochlear implant and may be reimbursed for services rendered to clients who are 12 years of age and older.

The cochlear implant or ABI device must be approved by the FDA and must be age-appropriate for the client.

The device and separate components include the following:

- Cochlear device
- Headpiece or headset
- Microphone
- Transmitting coil
- Transmitter cable
- External speech processor
- Zinc air batteries
- Alkaline AA batteries
- Recharger units
- Rechargeable AA batteries.

Replacement equipment and components are also a benefit of the CSHCN Services Program. Replacement equipment includes batteries, sound processors, cables, coils, headsets, and microphones.

Non-rechargeable batteries are limited to a maximum of 15 zinc air or a maximum of 31 alkaline batteries may be reimbursed per month without prior authorization. Rechargeable lithium-ion batteries (procedure codes L8623 and L8624) are limited to 2 batteries per calendar year.

Prior authorization is required for replacement of external sound processors and rechargeable AA batteries for a cochlear implant or ABI device.

#### **20.3.2.6 Sound Processor Replacement Guidelines**

Unless ordered by a physician, a processor must be used for 12 months before the replacement of a unit is considered for reimbursement. The replacement of a sound processor requires prior authorization with adjustment to reimbursement based on the manufacturer's trade-in policy. The physician must submit documentation of medical necessity when requesting prior authorization for the replacement of the sound processor.

## **20.4 Claims Information**

Hearing services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements. To avoid claim denials, providers billing as a group must use the performing NPI number on their claims.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

### **20.4.1 Claims Filing for Non-Implantable Hearing Devices and Services**

Audiology services must be billed using the audiology provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates “Audiologist.” Hearing aid fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates “Hearing Aid.”

#### **20.4.1.1 Claims Filing for Non-implantable Hearing Aid Devices**

To be reimbursed for a non-implantable hearing aid device, providers must submit paper claims with documentation that shows the provider’s cost for the hearing aid device. The documentation submitted with the claim must be a manufacturer invoice that shows the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the Internet will not be accepted and should not be

submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice shows the actual price the provider paid for the hearing aid device.

Providers are required to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submission does not allow for the submission of attachments.

As the amount billed on a claim, providers must use the net acquisition cost, which is the actual price the provider paid for the device, including the wholesale cost plus sales tax, shipping and handling, and any reductions resulting from discounts or rebates. Providers must not use usual and customary fees as the amount billed.

**Note:** *The requirement to submit the net acquisition cost of the hearing aid device applies only to non-implantable monaural and binaural hearing aid devices including, but not limited to, procedure code V5298.*

### **20.4.2 Claims Filing for Implantable Hearing Devices and Services**

Claims for implantable hearing devices must be billed using the appropriate provider number and benefit code (for electronic claims only, if applicable).

## **20.5 Reimbursement**

For fee information, providers can refer to the OFL on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*



### **20.5.1 Reimbursement for Hearing Tests**

The CSHCN Services Program may reimburse physicians or audiologists who provide hearing tests to clients whose hearing is found to be suspect on the routine screening, whether or not hearing is found to be impaired. Services are reimbursed at the lesser of the billed charges or the amount allowed by Texas Medicaid.

### **20.5.2 Reimbursement for Non-Implantable Hearing Devices and Services**

The CSHCN Services Program may reimburse hearing aid devices the lesser of the following:

- The invoice cost of the hearing aid device
- The acquisition cost of the hearing aid device
- The maximum allowable Texas Medicaid fee for the hearing aid device procedure code

Procedure code V5267 is manually priced and may be reimbursed the lower of the billed amount or the MSRP less 18 percent when purchased.

### **20.5.3 Reimbursement for Implantable Hearing Devices and Services**

Cochlear implants or ABIs may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

BAHD devices and services may be reimbursed as follows:

- Noncustom durable medical equipment (DME) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- Expendable medical supplies may be reimbursed the lower of the billed amount or the amount allowed by CMS, when available, or Texas Medicaid.
- Ambulatory surgical centers (ASCs) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid based on ASC groupings approved by CMS.
- Inpatient hospital care may be reimbursed at 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment.
- Orthotics and prosthetics may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.
- Physicians and audiologists may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

## **20.6 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# HOME HEALTH SERVICES

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# HOME HEALTH SERVICES

## Table of Contents

- 21.1 Enrollment .....3**
- 21.2 Benefits, Limitations, and Authorization Requirements .....3**
  - 21.2.1 Prior Authorization Requirements for Home Health Services ..... 4
    - 21.2.1.1 Authorization Requirements ..... 4
    - 21.2.1.2 Plan of Care (POC) ..... 5
- 21.3 Home Health Aide (HHA) Services .....7**
  - 21.3.1 Supervision of Home Health Aides ..... 8
  - 21.3.2 Skilled Nursing and Home Health Aide Services..... 8
    - 21.3.2.1 Medical Necessity..... 9
  - 21.3.3 Skilled Nursing Services..... 9
    - 21.3.3.1 Limitations for Skilled Nursing Services ..... 10
    - 21.3.3.2 Extended Skilled Nursing Services..... 11
  - 21.3.4 Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services ..... 12
    - 21.3.4.1 Prior Authorization for Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services ..... 12
    - 21.3.4.2 Limitations for Occupational Therapy (OT) and Physical Therapy (PT) ..... 13
    - 21.3.4.3 Limitations for Speech-Language Pathology (SLP) ..... 13
  - 21.3.5 Medical Nutritional Counseling Services..... 13
    - 21.3.5.1 Prior Authorization for Medical Nutritional Counseling Services ..... 13
- 21.4 Claims Information.....13**
- 21.5 Reimbursement.....14**
- 21.6 TMHP-CSHCN Services Program Contact Center .....15**

## 21.1 Enrollment

To enroll in the CSHCN Services Program, home health agencies providing home health services must be actively enrolled in Texas Medicaid, have a valid provider agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, be a licensed and certified home and community services support agency (HCSSA), and comply with all applicable state laws and requirements. Out-of-state home health providers must meet all these conditions, be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 21.2 Benefits, Limitations, and Authorization Requirements

Home health services are a benefit of the CSHCN Services Program for clients requiring services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis.

Home health services are considered medically necessary for a client who:

- Requires skillful observations and judgment to improve health status, skilled assessment, or skilled treatments and procedures.
- Requires individualized, intermittent, or part-time acute skilled care.
- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition.
  - Loss of function.
  - Imminent risk to health status due to medical fragility or risk of death.

Providers must be a licensed and certified home health agency enrolled in the CSHCN Services Program and must comply with all applicable federal, state, and local laws and regulations and CSHCN Services Program policies and procedures.

A parent or guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing (SN) services even if he or she is employed by an enrolled provider.

### **21.2.1 Prior Authorization Requirements for Home Health Services**

Home health services require prior authorization. Prior authorization requests must be submitted on the [CSHCN Services Program Authorization and Prior Authorization Request Form](#).

#### **21.2.1.1 Authorization Requirements**

Prior authorization of home health services is required. Medical necessity documentation must be submitted along with the prior authorization request. Requests may be submitted by any approved method to the claims administrator.

Verbal orders will not be accepted. All prior authorization requests must be signed and dated by the ordering practitioner.

***Note:** An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign and date all documentation related to the provision of SN, HHA, or extended skilled nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

Prior authorization must be obtained before the start of care however, if the service is medically necessary, provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day. A completed [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#) and all other required documentation must be received within these deadlines for prior authorization to be considered. Dates of service requested before the submission date or the practitioner signature date will be denied as late submissions. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete prior authorization requests.

SN services or HHA services (procedure codes G0156, G0299, and G0300) will not be authorized during the same day as extended SN services (procedure codes S9123 and S9124).

SN and HHA services may not be provided during overlapping time periods (procedure codes G0156, G0299, and G0300), but can be requested for the same day.

SN services or HHA services (procedure codes G0156, G0299, and G0300) will not be authorized when the client is receiving PPECC services (procedure code T1026).

The initial nursing assessment is used to establish the POC and must support the medical necessity for the client to receive SN services, HHA services, extended SN services, PT services, OT services, speech-language pathology services, or medical nutritional counseling services. The provider must have an RN perform an initial client assessment or reassessment in the client's home. For initial prior authorization, providers must obtain prior authorization before the start of care (SOC). Initial prior authorization period may not exceed 60 calendar days.

***Note:** The initial RN assessment is an administrative cost and will not be reimbursed.*

The initial nursing assessment/reassessments must include, but are not limited to the following:

- Complexity and intensity of the client's care
- Stability and predictability of the client's condition
- Frequency of the client's need for SN care
- Identified medical needs and goals
- Description of wounds, if present
- Comprehension level of the client or parent, guardian or caregiver
- Receptivity to training and ability level of the client or parent, guardian or caregiver

The initial assessment and any reassessments are performed by an RN. The initial assessment must be completed no earlier than five business days before the client's SOC. Reassessments are required when changes in the client's condition occur during the course of the prior authorization period and revision of the plan of care is needed. Revisions to the POC must be submitted as soon as the need is identified but no later than 3 business days from the date of the revision.

If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing acute, intermittent, part-time SN or HHA visits services beyond the initial 60 calendar day prior authorization period. Requests received after the five business days allowed will be denied for dates of service that occurred before the revision is approved.

For extension of acute intermittent, part-time SN or HHA services, providers must obtain prior authorization on the [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#) before the end of the current prior authorization period. A new client assessment and a current POC must also be submitted. Extension requests that are received after the current prior authorization expires will be denied for dates of service that occur before the extension request is approved.

### 21.2.1.2 Plan of Care (POC)

A copy of the home health provider's POC must be submitted for documentation of the required information. The POC must be signed by the practitioner who is ordering home health services and who will provide ongoing supervision of the POC. The POC must be signed and dated no earlier than 30 days prior to the start of care, reviewed and signed every 60 days at a minimum by the ordering practitioner or sooner if the client's condition changes and a reassessment and revision of the plan of care is needed. Dates of service requested before the submission date or practitioner signature date will be denied.

Providers must obtain prior authorization no earlier than three business days before the start of care (SOC) for an initial authorization. The initial prior authorization period may not exceed 60 calendar days. For extensions, providers must obtain prior authorization within seven business days before the end of the authorization period.

Providers are required to deliver the requested services from the SOC date, which is the date agreed to by the ordering practitioner, registered nurse (RN), home health agency, client, parent or guardian. The SOC must be documented on the POC.

A provider requesting prior authorization for SN and HHA services must submit all of the following documentation:

- A completed [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#)
- A completed client nursing assessment
- The completed POC must be signed and dated by the assessing RN and the ordering practitioner.

***Note:** Home health providers may submit a client nursing assessment and a POC on forms developed by the home health agency along with the prior authorization request. Home health agency forms must contain all criteria specified.*

The POC must be initiated and written in a clear and legible format by the assessing RN and include the following:

- The client's CSHCN number
- The ordering practitioner's license number
- The provider's NPI number
- Date the client was last seen by the ordering practitioner
- The start of care (SOC) date for home health services

- 
- All pertinent diagnoses
  - The client's mental status
  - The prognosis
  - The types of service requested, including the number of visits and amount, duration, and frequency with measurable goals and objectives for each service provided
  - The equipment and/or supplies required
  - Rehabilitation potential
  - Prior and current functional limitations
  - Activities permitted
  - Nutritional requirements
  - Medications, including the dose, route and frequency
  - Treatments, including amount and frequency
  - Wound care orders and measurements
  - Safety measures to protect against injury
  - Instructions for timely discharge or referral

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN or HHA visits or extended SN visits that will safely meet the client's needs. The amount and duration of SN, extended SN, or HHA visits requested will be evaluated by the claims administrator.

HHA services will not be prior authorized when the client is receiving extended SN services simultaneously but can be requested on the same day.

The home health agency must ensure the requested services are supported by the client assessment, POC, and signed and dated orders.

Physician orders must be submitted on the [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#) and include but are not limited to the following:

- Client name, date of birth, gender, and CSHCN Services Program Identification number
- Ordering practitioner name, contact information and NPI number
- Date last seen by the ordering practitioner
- Diagnoses and description of current medical condition
- Prognosis
- Mental status
- Documentation of medical necessity that the client requires part-time intermittent skilled nursing or ongoing extended skilled nursing services
- Nursing services required, i.e., RN, LVN, HHA
- Medication administration (dose/route/frequency), if applicable
- Treatments ordered
- Wound care, if applicable
- Other therapies if required
- Dietary and nutritional needs

- Activity level
- Other services as needed
- Functional status
- Safety measures
- Equipment/supplies needed
- Rehab potential

If a provider or client discontinues SN or HHA visits, or extended services, during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

A new [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#). A physician, APRN, or PA signature is required on the form.

- A new client assessment and a current POC,
- A change of provider letter signed and dated by the client, parent, guardian or caregiver documenting:
  - The date the client ended SN or HHA visits, or extended SN services, (effective date of change) with the previous provider,
  - The names of previous and new providers,
  - An explanation of why providers were changed.

Providers who terminate services must give reasonable notice to the client and must maintain documentation of the reason in the client's medical record.

Concurrent services for telemonitoring are allowed for distinctly different medical reasons. Duplication of services by any provider will not be prior authorized.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for additional information about authorization and prior authorization requirements.

### 21.3 Home Health Aide (HHA) Services

HHA visits (procedure code G0156) must be provided by a qualified HHA under the supervision of a qualified licensed individual (registered nurse [RN], physical therapist, occupational therapist) who is employed by the home health agency.

HHA services may include, but are not limited to, the following:

- Obtaining and recording the client's vital signs
- Observation, reporting, and documentation of the client's status and the care or service furnished
- Hygiene and grooming including, but not limited to:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
  - Nail and skin care
  - Oral hygiene
- Toileting and elimination care
- Ambulation
- Exercise



- Range of motion exercises
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client's health care at home
- Assisting client with his or her self-administered medication
- Reporting changes in the client's condition and needs
- Completing appropriate documentation

### 21.3.1 Supervision of Home Health Aides

When HHA services have been ordered, an RN or therapist (PT or OT) must provide the HHA written instructions and supervision for the tasks delegated to the HHA.

The requirements for HHA supervision are as follows:

- When HHA services are provided in addition to an SN service, an RN must make a supervisory visit to the client's residence at least once every two weeks. The supervisory visit must occur when the HHA is present and providing care to the client.
- When HHA services are provided in addition to PT or OT services, the appropriate therapist may make the supervisory visit at least every two weeks in place of an RN. The supervisory visit must occur when the HHA is present and providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

### 21.3.2 Skilled Nursing and Home Health Aide Services

The following definitions apply to CSHCN Services Program home health skilled nursing (SN) and home health aide (HHA) services:

- **Acute** is defined as a condition or exacerbation that is anticipated to improve and reach resolution within 60 days.
- **Part-time** is defined as SN or HHA visits less than eight hours per day for any number of days per week. Part-time visits may be delivered in interval visits up to 2.5 hours (10 units) per visit, not to exceed a combined total of three visits per day (7.5 hours [30 units]).
- **Intermittent** is defined as SN or HHA visits provided for less than eight hours per visit and less frequently than daily. Daily visits may be considered for a short-term period (7 to 10 days) when medically necessary. Examples might include a new diabetic who is blind or may have cognitive difficulties. Intermittent visits are not to exceed a combined total of three visits per day (7.5 hours total [30 units]).

SN visits are nursing services ordered by a physician, included in the [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#), and provided by a registered nurse (RN) or licensed vocational nurse (LVN) under the supervision of a licensed RN. SN visits may be considered when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically is expected to resolve in less than 60 calendar days.

**Note:** Providers must bill procedure codes G0156, G0299, or G0300 for conditions which are expected to resolve in 60 calendar days or less.

HHA visits are services ordered by the physician, included on the [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#), and are services the HHA is permitted to perform under State law. HHA visits may be considered when a client requires assistance with activities

of daily living for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically is expected to resolve in less than 60 calendar days. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days.

*Note: An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign and date all documentation related to the provision of SN and HHA services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

### **21.3.2.1 Medical Necessity**

SN and HHA Services are considered medically necessary for a client who:

- Requires the skills of a nurse to perform observations and judgments to improve health status, skilled nursing assessments, or skilled treatment or procedures;
- Requires individualized, intermittent, or part-time acute skilled care;
- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in:
  - Deterioration of a chronic condition
  - Loss of function, or
  - Imminent risk to health status due to medically fragility, or risk of death

Home health extended SN services are medically necessary when a client is medically fragile and has a disability, or chronic condition that requires ongoing skilled nursing beyond the level of intermittent part-time acute care. Medical necessity is defined by the following criteria:

- The client must require ongoing skilled nursing services provided by a RN or LVN
- The client must have a serious, chronic condition or disability that requires ongoing and complex SN interventions and monitoring beyond the level of intermittent part-time acute skilled care
- The client's care requires the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living
- The client lives with an ongoing threat to his or her continued well-being, deterioration of his or her condition and risk of death.

### **21.3.3 Skilled Nursing Services**

Home health SN services are a benefit of the CSHCN Services Program when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. SN services are intended to provide SN care to promote independence and support the client living at home.

SN services are limited to SN procedures performed by a registered nurse (RN) or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Act* and include the following:

- Direct SN care and parent, guardian, or caregiver training and education
- SN observation, assessment, and evaluation by an RN, provided that the ordering practitioner specifically requests that the nurse visit the client for this purpose and the signed and dated orders reflect the medical necessity for the visit.
- Supervision of delegated services provided by an HHA or others over whom the RN is administratively or professionally responsible.

Skilled nursing visits (procedure codes G0299 and G0300) are limited to procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Act* and 42 Code of Federal Regulations §§ 409.32, 409.33, and 409.44. These services include the following:

- Direct skilled nursing care, training, and education for parents, guardians, and caregivers
- Skilled nursing observation, assessment, and evaluation by an RN (if a physician specifically requests that a nurse visit the client for this purpose and the physician's order reflects the medical necessity of the visit)

Determining whether a service requires the skill of an RN or LVN is based on the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

If the service can be safely and effectively performed by an average non-clinician without the direct supervision of an RN or LVN, the service is not considered skilled nursing. A service that could be performed by an average non-clinician is not skilled nursing even if there is no competent person to perform it.

Some services are classified as skilled nursing on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters). If these services are reasonable and necessary to the treatment of the client's illness or injury, they may be covered. In some cases, the client's condition may require a service that is ordinarily considered unskilled and falls outside the scope of skilled nursing. This would occur when the client's condition necessitates an RN or LVN to perform the service safely and effectively.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be considered skilled nursing even if it is taught to the client, the client's family, or other caregivers. When the client needs the skilled nursing care and there is no one trained, able, and willing to provide it, the services of a nurse may be considered reasonable and necessary.

Skilled nursing must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled nursing is needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is skilled nursing or not.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

### **21.3.3.1 Limitations for Skilled Nursing Services**

Skilled nursing must be provided on a part-time or intermittent basis.

If medically necessary, SN and HHA visits are limited to a maximum of 30 units (7.5 hours) per day. SN or HHA visits may be provided on consecutive days.

SN Services will not be prior authorized when the client is receiving extended SN services.

Skilled nursing visits to obtain routine laboratory specimens may be reimbursed when the only alternative to obtain the specimen is to transport the client by ambulance. Collection of the laboratory specimen is considered part of the visit.

Skilled nursing visits requested primarily to provide the following services will not be prior authorized:

- Respite care

- Child care
- Activities of daily living for the client
- Housekeeping services
- Individualized, comprehensive case management beyond the service coordination required by the *Texas Nursing Practice Act*

A parent, guardian, primary caregiver, or alternate caregiver may not be reimbursed for skilled nursing, even if he or she is employed by an enrolled provider.

Total parenteral nutrition (TPN) is not a benefit through home health services.

**Referto:** Section 26.6, “Total Parenteral Nutrition (TPN)” in Chapter 26, “Medical Nutrition Services” for more detailed information.

### **21.3.3.2 Extended Skilled Nursing Services**

Extended SN services may be a benefit of the CSHCN Services Program for medically fragile clients who meet the medical necessity criteria. Clients must require ongoing skilled nursing services provided by an RN or LVN.

Medically fragile clients are those who have a serious, chronic condition that requires extended and complex skilled nursing interventions and monitoring. Their care requires the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living. These individuals live with an ongoing threat to their continued well-being, deterioration of their condition, and risk of death.

Providers must bill procedure codes S9123 and S9124 for medically fragile clients requiring extended and complex skilled nursing care.

Medically fragile conditions include, but are not limited to:

- Cerebral palsy
- Cystic fibrosis
- Muscular dystrophy
- Other diagnoses which may be considered on a case by case basis with documentation of medical necessity

Services may include, but are not limited to:

- Skilled nursing assessment;
- Administration of medications, including IV medications and chemotherapy;
- Sterile catheter insertion;
- Medical treatments that require the skill of a licensed nurse; and
- Education of the client or parent, guardian, or caregiver.

Services must be delivered according to the following criteria:

- Services must be medically necessary and appropriate;
- Services must be prescribed by a physician, APRN, or PA;
- Services must be provided according to an established Plan of Care (POC) which is reviewed, signed, at minimum by the ordering practitioner every 60 days.

Up to 400 hours of extended SN services may be approved per client per calendar year with documented justification of need and cost effectiveness.

*Note: Extended SN services may not exceed 400 hours per client per calendar year.*

### **21.3.4 Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services**

OT (procedure code G0152), PT (procedure code G0151), and SLP (procedure code G0153) services are benefits of the CSHCN Services Program for clients with acute or chronic medical conditions when documentation from the prescribing physician and the treating therapist indicates there is or will be progress made toward goals.

#### **21.3.4.1 Prior Authorization for Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) Services**

Evaluations or re-evaluations do not require prior authorization. Therapy treatment services require prior authorization.

Prior authorization for therapy services will be considered when all of the following criteria are met:

- The client has acute or chronic medical conditions resulting in a significant decrease in functional ability that will benefit from therapy services in an office, home, or outpatient setting.
- Documentation must support treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

Documentation supporting the medical need for therapy services includes:

- A completed CSHCN Services Program Prior Authorization Request form:
  - Initial Outpatient Therapy ([TP1](#)) Form for initial therapy treatment services, or
  - Extension of Outpatient Therapy ([TP2](#)) Form for extension of on-going therapy treatment services.

*Note: The request form must be signed and dated by the ordering physician, APRN, or PA and therapy provider(s). A request form that is missing required information is considered incomplete.*

- A current evaluation or re-evaluation for each therapy service requested and comprehensive treatment plan with the following:
  - Date of the evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals, including prior treatment goals, for the therapy discipline and associated disciplines requested, related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement

- Requested dates of service
- Date and signature of the licensed therapist

#### **21.3.4.2 Limitations for Occupational Therapy (OT) and Physical Therapy (PT)**

The following outpatient OT or PT treatment procedure codes will be denied if billed on the same date of service as procedure codes G0152 or G0151 respectively, by any provider:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 97012           | 97016 | 97018 | 97022 | 97024 | 97026 | 97028 | 97032 | 97033 | 97034 |
| 97035           | 97036 | 97110 | 97112 | 97113 | 97116 | 97124 | 97140 | 97150 | 97530 |
| 97535           | 97537 | 97542 | 97750 | 97755 | 97760 | 97761 | 97763 | 97999 |       |

Therapy evaluations or re-evaluations are limited to four per 180 days, any provider for procedure codes G0151 and G0152.

#### **21.3.4.3 Limitations for Speech-Language Pathology (SLP)**

Outpatient speech therapy treatments (procedure codes 92507, 92521, 92522, 92523, 92524, 92526, 92610, and S9152) will deny if billed on the same date of service as procedure code G0153 by any provider.

Therapy evaluations or re-evaluations are limited to four per 180 days, any provider for procedure code G0153.

### **21.3.5 Medical Nutritional Counseling Services**

Medical nutritional counseling services (procedure codes 97802, 97803, and S9470) are a benefit of the CSHCN Services Program when provided in the home by a licensed dietician. If either procedure code 97802 or 97803 is billed with procedure code S9470 for the same date of service, then either procedure code 97802 or 97803 is reimbursed, and procedure code S9470 is denied.

Medical nutritional therapy procedure codes 97802, 97803, and nutritional counseling procedure code S9470 will not be reimbursed when the client is receiving PPECC services.

**Referto:** Section 26.4.2, “Benefits, Limitations, and Authorization Requirements” in Chapter 26, “Medical Nutrition Services” for additional information about medical nutritional counseling services.

#### **21.3.5.1 Prior Authorization for Medical Nutritional Counseling Services**

Prior authorization is required for medical nutritional counseling services. Prior authorization must be submitted using the [CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form and Instructions](#).

Providers are responsible for maintaining documentation to support medical necessity of nutritional counseling services in the clinical record.

## **21.4 Claims Information**

Home health services claims must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) [NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Services and supplies that exceed the 28-items-per-page limitation must be submitted on separate UB-04 CMS-1450 paper claim forms.

## 21.5 Reimbursement

Skilled nursing visits provided by home health agencies enrolled in the CSHCN Services Program must be billed in 15-minute increments.

One practicing registered nurse skilled nursing visit may be reimbursed every 30 days outside of the prior authorized visits when skilled nursing visits have been authorized for the particular client.

Skilled nursing provided in the day care or school setting will not be reimbursed.

All claims for reimbursement of procedure codes G0156 (HHA services), G0299 (RN services), and G0300 (LVN services) are based on the actual amount of billable time associated with the service. For those services in which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven, and converted to 0 units of service if they are seven or fewer minutes.

For example:  $68 \text{ total billable minutes} / 15 = 4 \text{ units} + 8 \text{ minutes}$ . Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore,  $68 \text{ total billable minutes} = 5 \text{ units of service}$ .

Time intervals for 1 through 8 units are as follows:

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

| Units   | Number of Minutes               |
|---------|---------------------------------|
| 6 units | 83 minutes through 97 minutes   |
| 7 units | 98 minutes through 112 minutes  |
| 8 units | 113 minutes through 127 minutes |

Procedure codes G0156, G0299, and G0300 will be limited to 30 units per day, for any procedure, any provider. All services are reimbursed hourly.

Procedure codes S9123 and S9124 must be used when billing for extended SN services. The unit of service is hour increments.

**Note:** *These codes cannot be billed in conjunction with procedure codes G0156 (Home Health Aide), G0299 (RN services), and G0300 (LVN Services) on the same day unless approved by the CSHCN Medical Director. If approved, procedure codes G0156, G0299, and G0300 will not be reimbursed on the same day.*

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

Two medical nutritional counseling visits (procedure code S9470) may be reimbursed per rolling calendar year.

Reimbursement for mileage is not a benefit of the CSHCN Services Program.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 21.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **HOME HEALTH (SKILLED NURSING) CARE**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# HOME HEALTH (SKILLED NURSING) CARE

## Table of Contents

|             |  |          |
|-------------|--|----------|
| <b>22.1</b> | <b>Enrollment .....</b>  | <b>3</b> |
| <b>22.2</b> | <b>Benefits, Limitations, and Authorization Requirements .....</b> | <b>3</b> |
| 22.2.1      | Authorization Requirements .....                                   | 4        |
| <b>22.3</b> | <b>Claims Information .....</b>                                    | <b>4</b> |
| <b>22.4</b> | <b>Reimbursement .....</b>   | <b>5</b> |
| <b>22.5</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b>            | <b>5</b> |

## 22.1 Enrollment

To enroll in the CSHCN Services Program, home health agencies providing skilled nursing services must be actively enrolled in Texas Medicaid, have a valid provider agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, be a licensed and certified home and community services support agency (HCSSA), and comply with all applicable state laws and requirements. Out-of-state home health skilled nursing providers must meet all these conditions, be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 22.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may cover up to 200 hours per client, per year of part-time, intermittent skilled nursing services (procedure codes S9123 and S9124). These services must be provided in the home by an HCSSA-registered nurse (RN) or licensed vocational nurse (LVN) enrolled in the CSHCN Services Program.

The admission visit performed by the agency RN may be reimbursed at the same rate as the home visit and counts toward the 200 hours per year. RN visits to perform assessments that are required to complete the plan of care may be reimbursed at the same rate as the home visit and will count toward the 200 hours per year limit.

Skilled nursing services must meet the following conditions for reimbursement by the CSHCN Services Program:

- Prescribed by a physician
- Medically necessary and appropriate
- Provided according to an established plan of care which is reviewed, at a minimum, by the prescribing physician every 60 days
- Authorized

Skilled nursing can include, but is not limited to:

- Periodic nursing assessment of a client.
- Visits for administering medications, including intravenous (IV) medications and chemotherapy.
- Visits for acute illness, postsurgical, and sterile wound care.
- Education of the primary caregiver and client about the illness process and the skills required to care for the client's medical needs.
- Medical treatments that require the skills of a licensed nurse.
- Transition from an inpatient to a community-based home setting.

The CSHCN Services Program covers other services, therapies, supplies, and equipment that may be provided in the home. Refer to Chapter 21, "Home Health Services" for guidelines.

Skilled nursing services do not include respite care. Families should be referred to the DSHS regional office in their area for respite care services.

**Referto:** Chapter 1, "TMHP and HHSC Contact Information" for a list of DSHS regional offices.

Nursing services are not reimbursed if provided in conjunction with the administration of total parenteral nutrition (TPN). The reimbursement for TPN is an all-inclusive fee.

**Referto:** Section 26.6, "Total Parenteral Nutrition (TPN)" in Chapter 26, "Medical Nutrition Services" for more detailed information.

Skilled nursing for in-home administration of blood or blood products is not a benefit.

### **22.2.1 Authorization Requirements**

Skilled nursing services must be authorized. The number of skilled nursing hours that may be authorized or reimbursed is limited to 200 hours per calendar year per client.

Requests for skilled nursing hours must be submitted in writing to TMHP within 95 days of the date of service using the [CSHCN Services Program Home Health Skilled Nursing Request and Plan of Care Form](#).

**Note:** *Fax transmittal confirmations are not accepted as proof of timely authorization submissions.*

An additional 200 hours of service per client, per calendar year may be prior authorized with documented justification of medical necessity.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for additional information about authorization and prior authorization requirements.

### **22.3 Claims Information**

Home health services claims must be submitted to TMHP in an approved electronic format or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web](#)

[page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Services and supplies that exceed the 28-items-per-page limitation must be submitted on separate UB-04 CMS-1450 paper claim forms.

## 22.4 Reimbursement

Skilled nursing care may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 22.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **HOSPICE**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# HOSPICE

## Table of Contents

- 23.1 Enrollment .....3**
- 23.2 Benefits, Limitations, and Authorization Requirements .....3**
  - 23.2.1 Prior Authorization Requirements ..... 4
    - 23.2.1.1 The client’s demographic information ..... 4
    - 23.2.1.2 The requested services ..... 4
    - 23.2.1.3 Required provider information and signature ..... 4
- 23.3 Claims Information .....5**
- 23.4 Reimbursement .....6**
- 23.5 TMHP-CSHCN Services Program Contact Center .....6**

## 23.1 Enrollment

The Children with Special Health Care Needs (CSHCN) Services Program enrolls hospice organizations and home health agencies licensed to provide hospice services. These agencies are not required to be actively enrolled in Texas Medicaid. However, they must be licensed by the Texas Health and Human Commission (HHSC), have a valid provider agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state hospice providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 23.2 Benefits, Limitations, and Authorization Requirements

Hospice services are benefits of the CSHCN Services Program. Hospice care includes palliative care for clients with a prognosis of 6 months or less.

Services must be related to palliative care for the terminal diagnosis and may include any or all of the following services: direct care, respite, durable medical equipment (DME), supplies, and medications prescribed for the terminal illness.

Direct care services may include:

- Skilled nursing services.
- Social work services.
- Home health aide services.
- Pastoral care services.
- Medical supervision by the hospice medical director.
- Physical therapy and occupational therapy.
- Speech therapy.
- Dietitian services.



The hospice benefit does not cover curative care for the terminal diagnosis.

Coverage for conditions unrelated to the terminal illness is unaffected.

If nutritional supplements are the client's sole source of nutrition, the supplements are included in the per diem rate.

Total parenteral nutrition (TPN) provided to a client on hospice services may be reimbursed separately.

**Referto:** Section 26.6.2, "Benefits, Limitations, and Authorization Requirements" in Chapter 26, "Medical Nutrition Services" for TPN benefits, limitations, and authorization requirements.

Hospice and home health services may not be reimbursed on the same date of service, with the exception of the initial date of service when the client is being discharged from home health service and admitted to hospice service.

### **23.2.1 Prior Authorization Requirements**

Prior authorization is required for hospice services. The TMHP-CSHCN Services Program medical review staff review requests for hospice services. Hospice services may be prior authorized up to a maximum of 6 months per request.

Providers must submit the [CSHCN Services Program Prior Authorization Request for Hospice Services Form](#) or the provider's plan of care (POC) if it includes the same information as the [CSHCN Services Program Prior Authorization Request for Hospice Services Form](#) and the provider and physician signatures. All of the fields on the prior authorization form must be completed. A copy of the POC, signed and dated by a physician, must be maintained by the physician and hospice provider in the client's medical record.

The [CSHCN Services Program Prior Authorization Request for Hospice Services Form](#) must include the client's demographic information, the requested services, and required provider information and signature as follows:

#### **23.2.1.1 The client's demographic information**

- First and last name
- CSHCN Services Program number/client identifier
- Date of birth
- Hospice diagnosis codes
- Address

#### **23.2.1.2 The requested services**

- Start of care and end of care dates
- Type of hospice care to be delivered (i.e., routine home care, continuous home care, inpatient hospice care, or respite care)
- The criteria used to assess appropriateness of hospice for this client
- A specific description of all direct care to be provided, durable medical equipment, supplies, and medications anticipated for the care of the client

#### **23.2.1.3 Required provider information and signature**

- Provider name
- CSHCN Services Program National Provider Identifier (NPI)
- Taxonomy and benefit codes

- Telephone and fax numbers
- Address
- Dated signature

If the client requires hospice care beyond the initial 6-month period, authorization for additional 6-month periods may be considered with a new request that includes the following documentation:

- An updated [CSHCN Services Program Prior Authorization Request for Hospice Services Form](#) or a POC that includes the same information as the CSHCN Services Program Prior Authorization Request for Hospice Services Form.
- A current date with the hospice provider and the attending physician.
- An updated description of all direct care, DME, supplies, and medications anticipated for the client’s care.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

### 23.3 Claims Information

Claims for hospice services must be billed using the following revenue codes:

| Revenue Code | Description  |
|--------------|--|
| 651          | Hospice services—home care   |
| 652          | Hospice services—continuous home care - ½ (at least 8 but less than 16 hrs care) |
| 655          | Hospice services—inpatient respite care  |
| 656          | Hospice services—general inpatient care/non-respite                              |

Hospice services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 23.4 Reimbursement

Hospice services are limited to one of any hospice procedure per day, by any provider. Hospice services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid up to the maximum allowed per diem rate. The per diem rate does not cover care for conditions or illnesses unrelated to the terminal diagnosis.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 23.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# HOSPITAL

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# HOSPITAL

## Table of Contents

- 24.1 Enrollment .....4**
  - 24.1.1 Continuity of Hospital Eligibility Through Change of Ownership..... 4
  - 24.1.2 Specialty Team or Center ..... 5
- 24.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements .....5**
  - 24.2.1 Chemotherapy ..... 6
  - 24.2.2 Cochlear Implants ..... 6
  - 24.2.3 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies) ..... 6
  - 24.2.4 Fluocinolone Acetonide Intravitreal Implant (*Retisert*) ..... 6
  - 24.2.5 Laboratory Services\_ ..... 6
  - 24.2.6 Magnetoencephalography (MEG) Services ..... 7
- 24.3 Inpatient Services .....7**
  - 24.3.1 Benefits, Limitations, and Authorization Requirements..... 7
    - 24.3.1.1 Initial Inpatient Prior Authorization Requests ..... 7
    - 24.3.1.2 Emergency Inpatient Hospital Admissions..... 8
    - 24.3.1.3 Inpatient Behavioral Health ..... 8
      - 24.3.1.3.1 *Inpatient Behavioral Health Prior Authorization Requirements* .....8
    - 24.3.1.4 Inpatient Rehabilitation Services ..... 9
      - 24.3.1.4.1 *Inpatient Rehabilitation Prior Authorization Requirements* ..... 10
      - 24.3.1.4.2 *Treatment for Acute Medical Episodes*..... 10
    - 24.3.1.5 Renal (Kidney) Transplants ..... 10
      - 24.3.1.5.1 *Reimbursement for Renal Transplants*..... 11
      - 24.3.1.5.2 *Renal Transplant Authorization Requirements* ..... 12
    - 24.3.1.6 Transplants - Nonsolid Organ ..... 12
      - 24.3.1.6.1 *Stem Cell Transplant Prior Authorization Requirements*..... 13
    - 24.3.1.7 Neonatal Level of Care Designation for Inpatient Services..... 13
      - 24.3.1.7.1 *Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation* ..... 13
      - 24.3.1.7.2 *Other Requirements* ..... 14
      - 24.3.1.7.3 *Transfers* ..... 14
  - 24.3.2 Hospital Reimbursement ..... 14
  - 24.3.3 Prospective Payment Methodology ..... 14
  - 24.3.4 Client Transfers..... 15
    - 24.3.4.1 Admission Dates..... 15
    - 24.3.4.2 Continuous Stays - Client Transfers and Readmissions ..... 15
  - 24.3.5 Observation Status to Inpatient Admission ..... 15
  - 24.3.6 Outlier Adjustments ..... 16
    - 24.3.6.1 24.3.5.1 Day Outliers ..... 16
  - 24.3.7 Payment Window Reimbursement Guidelines ..... 16
    - 24.3.7.1 Exceptions ..... 17
    - 24.3.7.2 Professional and Outpatient Claims for Services Related to the Inpatient Admission ..... 18
    - 24.3.7.3 Professional and Outpatient Claims for Services Unrelated to the

|   |           |
|---|-----------|
| Inpatient Admission .....   | 18        |
| <b>24.4 Outpatient Services .....</b>   | <b>18</b> |
| 24.4.1 Benefits, Limitations, and Authorization Requirements.....                                   | 18        |
| 24.4.1.1 Hospital-Based Outpatient Behavioral Health Services .....                                 | 19        |
| 24.4.1.2 Hospital-Based Emergency Services Department .....   | 19        |
| 24.4.1.2.1 <i>Hospital-Based Emergency Services Authorization</i> .....                             | 19        |
| 24.4.1.3 Outpatient Observation.....  | 20        |
| 24.4.1.3.1 <i>Direct Outpatient Observation Admission</i> .....                                     | 21        |
| 24.4.1.3.2 <i>Observation Following Emergency Room</i> .....  | 21        |
| 24.4.1.3.3 <i>Observation Following Outpatient Day Surgery</i> .....                                | 21        |
| 24.4.1.3.4 <i>Observation Following Outpatient Diagnostic Testing or Therapeutic Services</i> ..... | 21        |
| 24.4.1.3.5 <i>Documentation Requirements for Outpatient Observation</i> .....                       | 22        |
| 24.4.1.3.6 <i>Reporting Hours of Observation</i> .....  | 22        |
| 24.4.1.3.7 <i>Client Status Change</i> .....  | 23        |
| 24.4.1.3.8 <i>Outpatient Observation Authorization</i> .....  | 24        |
| 24.4.1.3.9 <i>Observation Services that are Not a Benefit</i> .....                                 | 24        |
| 24.4.1.3.10 <i>Outpatient Observation Authorization</i> .....                                       | 24        |
| 24.4.1.4 Sleep Studies .....  | 24        |
| 24.4.1.5 Hyperbaric Oxygen Therapy (HBOT) .....   | 25        |
| 24.4.2 Reimbursement Information.....   | 25        |
| 24.4.2.1 Hospital-Based Emergency Services Department .....   | 26        |
| 24.4.2.2 One-day Payment Window Reimbursement Guidelines .....                                      | 26        |
| <b>24.5 Ambulatory Surgical Centers .....</b>   | <b>26</b> |
| 24.5.1 Benefits, Limitations, and Authorization Requirements.....                                   | 26        |
| 24.5.1.1 Freestanding Surgical Centers.....   | 26        |
| 24.5.2 Reimbursement Information.....   | 27        |
| <b>24.6 Claims Information.....</b>   | <b>27</b> |
| 24.6.1 Inpatient Claims .....   | 27        |
| 24.6.2 Outpatient Claims .....  | 28        |
| 24.6.2.1 Revenue Code and Procedure Code Requirements for All Outpatient Services .....             | 29        |
| 24.6.2.1.1 <i>Revenue Codes That Require a Procedure Code</i> .....                                 | 29        |
| 24.6.2.1.2 <i>Clarification for Non-Hospital Facility Claims</i> .....                              | 30        |
| 24.6.3 HASC Claims .....  | 31        |
| 24.6.4 Inpatient Stays Following Scheduled Day Surgeries.....                                       | 32        |
| 24.6.5 Inpatient Stays Following Unscheduled (Emergency) Day Surgeries .....                        | 32        |
| <b>24.7 TMHP-CSHCN Services Program Contact Center .....</b>  | <b>32</b> |

## 24.1 Enrollment

To enroll in the CSHCN Services Program, a hospital must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state hospitals must meet all of these conditions and be located in New Mexico, Oklahoma, Arkansas, or Louisiana within 50 miles of the Texas state border. Hospital providers must be Medicare-certified.

Freestanding ambulatory surgical centers (ASCs) and hospital ambulatory surgical centers (HASCs) are subject to the same enrollment requirements as hospitals. HASCs must enroll separately from the hospitals in which they are based.

To be eligible for participation in the CSHCN Services Program, a psychiatric hospital or facility must be enrolled in Texas Medicaid as a freestanding inpatient psychiatric facility. Out-of-state psychiatric hospitals or facilities must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA) of 1988.

**Referto:** Section 25.1.1, “Clinical Laboratory Improvement Amendments (CLIA) of 1988” in Chapter 25, “Laboratory Services” for more information.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession or facility standards, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

### 24.1.1 Continuity of Hospital Eligibility Through Change of Ownership

When a hospital changes ownership, the new owner must take the following actions:

- Obtain recertification as a Medicare facility under the new ownership.
- Complete a Texas Medicaid Provider Enrollment Application. The provider must be enrolled with Texas Medicaid before applying for the CSHCN Services Program.

- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in a 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).
- Supply a listing of all the providers identified by the change of ownership.

### **24.1.2 Specialty Team or Center**

In addition to requiring prior authorization, the following services require that the physicians or facilities be approved by the TMHP-CSHCN Services Program as specialty team or center providers:

- For kidney transplant services, the facility must be specialty center-approved.
- Stem cell transplant services must be provided in a Texas facility that is a designated Children’s Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). The provider must attest to compliance with the required criteria when the prior authorization form is completed and submitted. TMHP maintains a current list of approved centers.

**Referto:** Section 2.1.7, “Transplant Specialty Centers” in Chapter 2, “Provider Enrollment and Responsibilities” for more information about stem cell and kidney transplant facility designation.

## **24.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements**

Facilities are responsible for knowing which services require authorization or prior authorization and whether they are a benefit in the inpatient or outpatient setting. The services listed below are not all-inclusive. Refer to the appropriate sections of the provider manual for specific benefit information.

The benefits, limitations, and authorization requirements in this section apply to both inpatient and outpatient services. Additional information specific to inpatient services can be found in Section 24.3, “Inpatient Services” in this chapter. Additional information specific to outpatient services can be found in Section 24.4, “Outpatient Services” in this chapter and information on ASCs can be found in Section 24.5, “Ambulatory Surgical Centers” in this chapter.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program.

Some procedures require prior authorization or specialty team or center approval. If prior authorization is not obtained as required, the procedures or hospital stay are denied. Authorization is a condition of reimbursement; it is not a guarantee of payment. Faxed transmittal confirmations are not accepted as proof of timely authorization submission.

Authorization or prior authorization is not given if the client is not eligible for the CSHCN Services Program benefits when the request is received by the TMHP-CSHCN Services Program. All claims for these services must meet the 95-day filing deadline.

Providers can fax or mail their written requests along with all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership  
TMHP-CSHCN Services Program Authorization Department  
12365-A Riata Trace Parkway, Suite 100  
Austin, TX 78727  
Fax: 1-512-514-4222

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for more information, including deadlines and appeal procedures.



### 24.2.1 Chemotherapy

Inpatient and outpatient hospitals must use revenue code 636 for reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

*Referto:* Section 31.2.11, “Chemotherapy” in Chapter 31, “Physician” for additional information.

### 24.2.2 Cochlear Implants

Cochlear implant devices are payable to the facility where the cochlear implantation surgery takes place. Hospitals must submit procedure code L8614 when billing for cochlear implant devices. ASCs and HASCs must submit procedure code L8614 with modifier NU when billing for cochlear implant devices.

*Referto:* Section 20.3.2, “Cochlear Implants” in Chapter 20, “Hearing Services” for additional information.

### 24.2.3 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies)

Electromyography (EMG) and nerve conduction studies (NCS) are benefits of the CSHCN Services Program when medically indicated. EMG and NCS are diagnosis restricted and may require prior authorization.

*Referto:* Section 31.2.18, “Evaluation and Management (E/M) Services” in Chapter 31, “Physician.”

### 24.2.4 Fluocinolone Acetonide Intravitreal Implant (*Retisert*)

Fluocinolone acetonide intravitreal implant is a corticosteroid indicated for the treatment of chronic noninfectious uveitis affecting the posterior segment of the eye. The surgical implant is designed to release fluocinolone acetonide over approximately 30 months.

Procedure code J7311 is a benefit for the CSHCN Services Program for clients 12 years of age or older in a hospital, HASC, or ASC setting. Procedure code J7311 is only considered for reimbursement with a posterior uveitis diagnosis of more than 6 months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

*Referto:* Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information on prior authorization requirements.

### 24.2.5 Laboratory Services

Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient, but whose laboratory services are performed by the hospital.

All clinical laboratory services may be reimbursed at a percentage of the Medicare rate set by the Centers for Medicare and Medicaid Services (CMS), except for those hospitals that have been identified by Medicare as sole community hospitals. These hospitals may be reimbursed at 103.35 percent of the clinical lab rate.

Outpatient and nonpatient claims for laboratory services must only reflect tests actually performed by the hospital laboratory; however, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim.

Hospitals may bill a handling fee (procedure code 99001) for collecting and forwarding a specimen collected by venipuncture or catheterization and sent to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories. In order to bill a handling fee, the receiving laboratory’s name and address and unique National Provider Identifier (NPI) number must be included on the claim in Blocks 17 and 17B.

To be eligible for reimbursement by the CSHCN Services Program, all laboratories must be certified according to the Clinical Laboratory Improvement Amendments (CLIA) regulations.

**Referto:** Section 25.1, “Enrollment” in Chapter 25, “Laboratory Services.”

### 24.2.6 Magnetoencephalography (MEG) Services

Inpatient and outpatient hospitals must use revenue code 860 or 861 for reimbursement of magnetoencephalography (MEG) services. The appropriate MEG procedure code must be listed on the claim.

**Note:** Reimbursement to an outpatient hospital will be based on the submitted procedure code.

**Referto:** Section 31.2.29, “Magnetoencephalography (MEG)” in Chapter 31, “Physician” for additional information.

## 24.3 Inpatient Services

### 24.3.1 Benefits, Limitations, and Authorization Requirements

Inpatient hospital services include medically necessary items and services ordinarily furnished by a CSHCN Services Program hospital or by an approved, enrolled, out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Hospital services must be medically necessary, prior authorized, and are subject to the utilization review requirements of the CSHCN Services Program.

Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year and may accrue intermittently or consecutively. Once 60 days of inpatient care are provided, reimbursement for additional inpatient care is not considered until the next calendar year, except as noted below.

**Exception:** A benefit of up to 60 additional inpatient days may be granted to a client, to begin on the date of hospital admission, for an approved stem cell transplant.

Inpatient hospital services include the following items and services:

- Room and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services. Room and board in private accommodations, including meals, special diets, and general nursing services may be reimbursed up to the hospital’s charge for the most prevalent semiprivate accommodations. Private accommodations are not subject to the semiprivate rate if they are documented by the physician as medically necessary. The hospital must keep this documentation in the client’s record and document the information on the claim.
- Whole blood and packed red blood cells that are reasonable and necessary for the treatment of illness or injury provided they are not available without cost.
- All medically necessary ancillary services and supplies ordered by a physician.
- Medically necessary emergency and non-emergency ambulance transportation of the client during the inpatient stay.

**Note:** Items for personal comfort or convenience, such as a telephone or television, are not a benefit of the CSHCN Services Program and are not reimbursed, even if they are ordered by a physician.

#### 24.3.1.1 Initial Inpatient Prior Authorization Requests

All inpatient admissions must be prior authorized before the date of service or the entire hospital stay will be denied. Partial approvals for a hospital stay will not be approved. Friday and weekend admissions may be authorized when an emergency exists or when the required medical services will not be delayed due to the timing of the admission. The [CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only](#) must be completed and submitted to obtain authorization.

All prior authorization request forms must be complete and must include either the surgeon's or the attending physician's name and NPI on the authorization request form. These physicians and the hospital must be actively enrolled in the CSHCN Services Program to obtain authorization.

If an initial request for prior authorization of an inpatient hospitalization is received for a CSHCN Services Program-enrolled client from a nonenrolled provider, the request is denied. If that provider subsequently enrolls as a CSHCN Services Program provider and submits a claim for these previously denied services within the 95-day claims filing deadline, then the claim may be considered for reimbursement based on the medical necessity of the services. If a provider does not complete the request, or if an initial request for prior authorization was not received from an enrolled provider, then the claim(s) cannot be considered for payment and are denied. All providers must be enrolled in order to receive reimbursement.

### **24.3.1.2 Emergency Inpatient Hospital Admissions**

All inpatient admissions must be prior authorized. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admissions - For Use by Facilities Only Form must be submitted to the claims contractor for review and approval before the date of service, or the entire hospital stay will be denied. Partial approvals for a hospital stay will no longer be reimbursed.

Requests for emergency hospital admissions must be received within 48 hours of an admission or by the next business day for weekend admissions. Late submitted requests for emergency admissions will be denied for the entire hospital stay.

*Note: Partial approvals for a hospital stay will not be granted.*

If the initial prior authorization request meets the deadline requirements and is denied for incomplete or inaccurate information, the provider may correct and resubmit the prior authorization request. The corrected request is a one-time resubmission only and must be received within 5 business days following the denial of the initial request. If the corrected request still contains incomplete or inaccurate information, then the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after 5 business days following the initial denial will be denied for the entire hospital stay.

All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.

*Referto:* Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization and prior authorization requirements.

### **24.3.1.3 Inpatient Behavioral Health**

The intent in providing inpatient services is to provide resources for behavioral health crisis stabilization while efforts are made to transfer the clients to a more appropriate outpatient program where they may receive the necessary psychiatric/psychological treatment required. Benefits are limited to inpatient assessment and crisis stabilization and must be followed by referral to the Texas Department of State Health Services (DSHS) or other appropriate behavioral health programs. Inpatient behavioral health services are limited to five days per calendar year, which count toward the inpatient hospital limitation of 60 days per calendar year.

Revenue code 124 may be a benefit of the CSHCN Services Program for inpatient behavioral health services.

#### **24.3.1.3.1 Inpatient Behavioral Health Prior Authorization Requirements**

Inpatient admissions for behavioral health crisis stabilization must be prior authorized. A completed [CSHCN Services Program Prior Authorization Request for Inpatient Psychiatric Care Form](#) must be submitted. Requests must be received by the TMHP-CSHCN Services Program before or on the day of the client's admission, unless the admission is after 5 p.m., or on a holiday, or a weekend. In these cases,

the TMHP-CSHCN Services Program must receive it by 5 p.m. on the next business day following admission. The TMHP-CSHCN Services Program will notify the provider of the decision in writing by fax. There may be no extensions to the 5-day limit.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information on prior authorization requirements.

Chapter 29, “Outpatient Behavioral Health” for more information about behavioral health services.

Inpatient psychiatric hospitals may be reimbursed at 80 percent of the TEFRA rate for CSHCN services.

#### **24.3.1.4 Inpatient Rehabilitation Services**

Inpatient rehabilitation programs must include medical management, two or more therapies (e.g., respiratory therapy, speech-language pathology [SLP] services, physical therapy [PT], occupational therapy [OT]), and rehabilitation nursing. The CSHCN Services Program may reimburse inpatient rehabilitation services if the client meets one of the following criteria:

- The client is 5 years of age or older, sufficiently alert to respond to interventions and to participate with the rehabilitation team in setting treatment goals, and is an active participant in therapeutic activities.
- The client is 4 years of age or younger, sufficiently alert to respond to interventions and to participate with the rehabilitation team, and the parent or caregiver can actively participate in setting treatment goals and learning therapeutic management.

In addition, at least one of the following criteria must be met for the client to be eligible for reimbursement of inpatient rehabilitation services:

- The client developed a recent onset of illness or trauma (within the last 12 months) without previous comprehensive rehabilitation efforts.
- There is no documentation of previous inpatient comprehensive rehabilitation effort.
- The client experienced a loss of previous level of functional independence through complications or recurrent illness, and the recovery of functional independence is feasible.

The following are examples of conditions that may be considered for coverage of inpatient rehabilitation:

- Spinal cord injuries
- Traumatic amputation of upper or lower extremities
- Rheumatoid arthritis and other inflammatory polyarthropathies
- Burns
- Postpolio syndrome
- Neoplasms
- Head or brain injuries
- Late effects of infections (i.e., Guillain-Barré syndrome)
- Cerebrovascular diseases
- Congenital conditions (e.g., spina bifida and cerebral palsy) may be considered when there is a recent change in medical and functional status, such as postspinal surgery

#### 24.3.1.4.1 Inpatient Rehabilitation Prior Authorization Requirements

Prior authorization is required for inpatient rehabilitation services. An inpatient rehabilitation provider must be enrolled in the CSHCN Services Program as an inpatient hospital before a prior authorization may be approved.

Prior authorization may be approved in 14-day increments, not to exceed a maximum of 90 days per calendar year. Requests must be submitted in writing with documentation of medical necessity, including the diagnosis or condition of the client and progress toward goals (request for additional days) along with a copy of the treatment plan. The [CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission form](#) must be submitted for the initial request and each extension. Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

A statement explaining the medical necessity of inpatient versus outpatient rehabilitation services must be included with the documentation submitted for prior authorization. The justification must state the client's current condition and why inpatient rehabilitation, as opposed to outpatient therapy, is required for optimal care. The client's need for daily, intense, focused, team-directed therapy must be substantiated by the circumstances of the case.

If the prior authorization request for additional days documents that the client has made progress toward treatment goals, an additional 14 days may be approved up to a maximum of 90 days per calendar year.

Requests for additional days must be received for prior authorization before the last inpatient rehabilitation day previously prior authorized.

Requests for extensions are *not* approved if one of the following conditions applies:

- The client has met treatment goals, as determined by the rehabilitation team or the CSHCN Services Program medical director or designee.
- The client has failed to make progress toward remaining treatment goals during the currently authorized period.
- The client no longer requires inpatient rehabilitation, and therapeutic goals can be met on an outpatient basis.
- The request was received after the last prior authorized inpatient day.
- The 90-day calendar maximum is exhausted.

#### 24.3.1.4.2 Treatment for Acute Medical Episodes

If a client has been admitted for inpatient rehabilitation and develops an acute medical condition that prevents participation in rehabilitation program activities, then the CSHCN Services Program must not be billed for inpatient rehabilitation services. Acute care services (whether inpatient or outpatient) that are a benefit of the CSHCN Services Program may require authorization or prior authorization and must be billed as acute care services.

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

#### 24.3.1.5 Renal (Kidney) Transplants

Renal transplants will only be approved for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant facility that is certified by the United Network of Organ Sharing (UNOS) by a Medicaid-approved, CSHCN-enrolled transplant team. All transplant facilities who wish to perform transplants for CSHCN Services Program clients must have current certification and be in continuous compliance with the criteria set forth by UNOS.

Renal transplants and post-transplant care will only be covered if the organ procurement is in alignment with the National Organ Transplant Act (NOTA). Only kidneys harvested voluntarily from within the United States under the oversight of the Health Resources and Services Administration (HRSA) and UNOS will be covered. Kidneys harvested for a fee or sponsorship and kidneys obtained from any country outside of the United States will not be covered for transplant or post-transplant care.

The CSHCN Services Program may reimburse renal transplants when the projected costs of the transplant and follow-up care is less than continuing dialysis treatments. The estimated cost of the renal transplant over a 1-year period versus the cost of renal dialysis for 1 year at the requesting facility must be both documented and reviewed. Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

For any client who is 18 years of age or older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for services through the CSHCN Services Program.

Renal transplants must be prior authorized, and approval is subject to the availability of funds. Only one initial and one subsequent renal transplant may be reimbursed per lifetime.

Some renal transplant procedure codes are subject to a global surgical period of 90 days, with postoperative care included in the reimbursement of the surgical fee.

**Referto:** Section 31.2.39.6, “Global Fees” in Chapter 31, “Physician.”

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6-week postoperative period will be denied for the surgeon, assistant surgeon, and facility. The anesthesiologist may be reimbursed.

#### 24.3.1.5.1 Reimbursement for Renal Transplants

A maximum amount of \$200,000 per client may be reimbursed for a renal transplant hospitalization. Hospitals may be reimbursed 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment rate, up to the maximum of \$200,000. All hospital charges, including donor costs, are included in the \$200,000 limit.

Reimbursement for renal transplants includes:

- The cost of the transplant services.
- One of the following:
  - The cost of the procurement of a cadaveric organ and services associated with the organ procurement, when the organ is obtained from an organ procurement organization designated by the U.S. Department of Health and Human Services. Documentation validating the organ’s source must accompany the claim.
  - The cost associated with living donors. The donor costs must be included on the client’s inpatient hospital claim and may be reimbursed only if another source of payment is not available. Donor costs for CSHCN Services Program clients who also have Medicaid benefits are not reimbursed.

The costs related to the donor-matching process will not be reimbursed.

If the cost related to a living donor will be paid by the client’s other insurance carrier, the Other Insurance information must be completed on the claim form. If these costs will be paid by the donor’s insurance carrier, the claim must be submitted using a paper claim form with attachments documenting the donor’s insurance information.

**Referto:** Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

Renal transplant recipients are eligible for follow-up care (outside the \$200,000 limit) immediately following hospital discharge for the renal transplant.

#### 24.3.1.5.2 Renal Transplant Authorization Requirements

Prior authorization must be obtained by both the facility and the physician.

Documentation supporting the transplant prior authorization request must include:

- The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant form
- A recent and complete history and physical.
- A statement of the client's status, including why a transplant is being recommended at this time.
- Documentation of the cost effectiveness of the transplant vs. continued dialysis.

Nationally, stays for renal transplants in hospital are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program are authorized without an appeal documenting medical necessity.

#### 24.3.1.6 Transplants - Nonsolid Organ

The CSHCN Services Program may cover only autologous and matched related and matched nonrelated allogenic transplants.

Stem cell transplants include the initial transplant and one subsequent retransplant. This allows a total of two transplants per lifetime regardless of payer. The subsequent transplant must be prior authorized separately from the initial transplant.

Indications for re-transplantation will include the following:

- Relapse of disease
- Failure to engraft or poor graft function
- Graft rejection

Services must be provided in a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). TMHP maintains a current list of approved centers.

If a stem cell transplant has been prior authorized, a maximum of 60 days of inpatient hospital services may be a benefit beginning with the actual first day of the transplant. Any days remaining from the standard 60 inpatient day limit may be added to the 60 days for the transplant if the \$200,000 limit for the transplant maximum amount has not been exceeded. This 60-day period is considered a separate inpatient hospital admission for reimbursement purposes.

A maximum amount of \$200,000 per client may be reimbursed for a stem cell transplant hospitalization. All hospital charges for patient care and donor costs (inpatient hospital only) during the time of the hospital stay are applied to the \$200,000 limit. Donor costs must be included on the client's inpatient hospital claim for the transplant. Donor costs will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.

When a second stem cell transplant is prior authorized an additional maximum of \$200,000 may be reimbursed for the second prior authorization period. All hospital charges for patient care and donor cost (inpatient hospital only) will be applied to the additional \$200,000 limit. Donor cost must be included on the client's inpatient hospital claim for the transplant. Donor cost will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.

If a second cell transplant has been prior authorized, a maximum of 60 days of inpatient hospital services may be a benefit beginning with the actual first day of the second transplant.

Claims are accumulated systematically and payments that exceed \$200,000 are cut back, denied, or recouped.

Clients receiving a stem cell transplant are eligible for follow-up care (outside the \$200,000 limit) immediately following hospital discharge for the stem cell transplant event. This includes reimbursement for anti-rejection drugs.

#### 24.3.1.6.1 Stem Cell Transplant Prior Authorization Requirements

Prior authorization is required for all stem cell transplants and must be obtained by both the facility and the physician.

**Referto:** Section 31.2.42.2, “Transplants - Nonsolid Organ” in Chapter 31, “Physician” for additional benefit information.

#### 24.3.1.7 Neonatal Level of Care Designation for Inpatient Services

Hospitals enrolled in Texas Medicaid and the CSHCN Services Program may be reimbursed for inpatient neonatal services only if the hospitals have received a neonatal level of care designation from DSHS in accordance with Title 25 Texas Administrative Code §§133.181-133.190.

A neonatal service is any inpatient hospital service rendered to a client who is 28 days of age and younger.

**Referto:** The [DSHS website](#) for more information on Neonatal Level of Care Designation.

#### 24.3.1.7.1 Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for neonatal services will not be reimbursed for inpatient neonatal services rendered to Texas Medicaid and CSHCN Services Program clients. Hospitals without a neonatal level of care designation may be reimbursed for emergency services to stabilize an infant prior to transport to a facility capable of providing the appropriate level of care.

Claims for inpatient neonatal services submitted by hospitals that do not have a neonatal level of care designation on file will be denied. Providers can appeal claims by providing documentation that emergency services were required.

If neonatal inpatient services are rendered by a facility that has applied for (but not yet received) a neonatal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge). While awaiting neonatal level of care designation the facility is responsible for maintaining active claims appeals to adhere to the 120-day claim appeal deadline.

Requirements to obtain a neonatal level of care designation only apply to facilities located in Texas. Those entities that are physically located outside of Texas and enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a neonatal level of care designation for inpatient services rendered to neonatal clients.

**Note:** *When submitting paper claims for inpatient neonatal services rendered at a facility with an address that is different from the provider’s physical address, providers must enter the address of the facility where services were rendered in the remarks field.*

**Referto:** Chapter 7, “Appeals and Administrative Review” for more information.



#### 24.3.1.7.2 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a neonatal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a neonatal level of care designation by DSHS.

**Important:** *The hospital address on the health facilities license must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on file. Providers should refer to the DSHS approval letter to verify the correct address.*

**Referto:** The [DSHS website](#) for more information on address updates.

#### 24.3.1.7.3 Transfers

When Texas Medicaid or CSHCN Services Program clients are 28 days of age or younger on the date of admission and are subsequently transferred to another facility, neonatal level of care designation requirements will apply to all facilities involved in that client's continuous inpatient stay.

### 24.3.2 Hospital Reimbursement

The reimbursement methodology for many CSHCN Services Program facilities that are reimbursed based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) has changed to the prospective payment methodology based on All Patient Refined Diagnosis Related Groups (APR-DRG) payment system.

Hospitals that are enrolled in the CSHCN Services Program must first be enrolled in Texas Medicaid. The CSHCN Services Program reimbursement methodology has changed from TEFRA to APR-DRG. The reimbursement methodology for hospitals that are reimbursed by Texas Medicaid using APR-DRG also applies for the CSHCN Service Program.

The reimbursement method will not affect inpatient benefits and limitations. Inpatient admissions will continue to require prior authorization.

**Note:** *The 20 percent payment reduction that is currently applied to inpatient claims by the CSHCN Services Program will remain in effect.*

### 24.3.3 Prospective Payment Methodology

The prospective payment methodology is based on a diagnosis related groups (DRG) payment system. Reimbursement based on DRG includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. Claims may not be submitted for technical services.

The CSHCN Services Program does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, providers may submit only one claim for each inpatient stay. The claim must include appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 claim form or electronic equivalent, to be considered for payment.

The number of days of care charged for a client for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission and day on which a client returns from leave of absence, counts as a full day. However, the day of discharge, death, or day on which a client begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to \$200,000 per client, per benefit year (January 1 through December 31) for clients who are 21 years of age and older. Claims may be subject to retrospective review, which may result in recoupment. Hospital reimbursement is made in accordance with TAC §351.10 (6).

### **24.3.4 Client Transfers**

#### **24.3.4.1 Admission Dates**

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

#### **24.3.4.2 Continuous Stays - Client Transfers and Readmissions**

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The CSHCN Services Program does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the NPI. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S Report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to the CSHCN Services Program's UR requirements.

The claims contractor performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS-1450. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of admission.

### **24.3.5 Observation Status to Inpatient Admission**

When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 48 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are submitted on the inpatient claim (TOB 111).

### 24.3.6 Outlier Adjustments

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 21 years of age or younger as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The ER&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information, providers, facilities, and third party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data exchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on this website.

#### 24.3.6.1 24.3.5.1 Day Outliers

The following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length to stay for the DRG.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

### 24.3.7 Payment Window Reimbursement Guidelines

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

CSHCN Services Program inpatient hospital providers must submit, as part of the client's inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client's inpatient admission or one of the following dates immediately before the client's inpatient admission:

- Within three calendar days before the client's inpatient admission for hospitals that receive DRG reimbursement
- Within one calendar day before the client's inpatient admission for hospitals that receive reimbursement other than DRG

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

- **Diagnostic services.** Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.

- **Non-diagnostic services.** Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

**Important:** *Related professional and outpatient services that were rendered within one day of the inpatient admission and related to the inpatient admission must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.*

### 24.3.7.1 Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health center (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

| Emergency Renal Dialysis Services Procedure Codes |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| G0257   |  |  |  |  |  |  |  |  |  |

| Maintenance Renal Dialysis Services Procedure Codes              |       |       |       |       |       |       |       |       |       |  |  |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|--|--|
| ESRD Physician Services  |       |       |       |       |       |       |       |       |       |  |  |
| 90951  | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |  |  |
| 90961  | 90962 | 90963 | 90964 | 90965 | 90966 | 90967 | 90968 | 90969 | 90970 |  |  |
| Physician Services for Hemodialysis or Other Dialysis Procedures |       |       |       |       |       |       |       |       |       |  |  |
| 71010  | 71020 | 78300 | 78305 | 78306 | 80069 | 81050 | 82040 | 82310 | 82374 |  |  |
| 82435  | 82565 | 83615 | 83735 | 84075 | 84100 | 84132 | 84155 | 84295 | 84450 |  |  |
| 84520  | 85004 | 85007 | 85008 | 85014 | 85018 | 85025 | 85027 | 85041 | 85345 |  |  |
| 85347  | 85610 | 87340 | 90935 | 90937 | 90945 | 90947 | 93005 |       |       |  |  |
| Equipment and Supplies   |       |       |       |       |       |       |       |       |       |  |  |
| A4216  | A4217 | A4651 | A4652 | A4657 | A4660 | A4663 | A4670 | A4680 | A4690 |  |  |
| A4706  | A4707 | A4708 | A4709 | A4714 | A4719 | A4720 | A4721 | A4722 | A4723 |  |  |
| A4724  | A4725 | A4726 | A4730 | A4736 | A4737 | A4740 | A4750 | A4755 | A4760 |  |  |
| A4765  | A4766 | A4772 | A4773 | A4774 | A4802 | A4860 | A4911 | A4913 | A4918 |  |  |
| A4927  | A4928 | A4929 | A4930 | A4931 | A4932 | E0424 | E0431 | E0434 | E0439 |  |  |
| E0441  | E0442 | E0443 | E0444 | E1510 | E1520 | E1530 | E1540 | E1550 | E1560 |  |  |
| E1570  | E1575 | E1580 | E1590 | E1592 | E1594 | E1600 | E1620 | E1630 | E1632 |  |  |
| E1635  | E1637 | E1639 | E1699 | J0360 | J1160 | J1200 | J1265 | J1642 | J1644 |  |  |
| J1720  | J1800 | J1955 | J2150 | J2720 | Q4081 | 36000 | 36430 | 36591 | 36593 |  |  |
| 49421  | 93040 | 93041 |       |       |       |       |       |       |       |  |  |

Procedure code Q4081 is limited to three injections per calendar week (Sunday through Saturday).

### **24.3.7.2 Professional and Outpatient Claims for Services Related to the Inpatient Admission**

Professional and outpatient services that are rendered on the date of admission or within one calendar day of the admission date by the hospital, or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

*Note: The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.*

### **24.3.7.3 Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission**

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.
- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and the referenced professional diagnosis is a three- to seven-digit match to the principal inpatient diagnosis.
- Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and the referenced outpatient diagnosis is a three- to seven-digit match to the principal inpatient diagnosis.

Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

*Note: Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.*

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

## **24.4 Outpatient Services**

### **24.4.1 Benefits, Limitations, and Authorization Requirements**

Outpatient services are ambulatory services provided to an individual who is in a hospital, but not admitted for inpatient care. Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services provided on an outpatient basis that are deemed medically necessary and are provided

by a CSHCN Services Program hospital or under the direction of a physician. Supplies provided by a hospital supply room for use in physician's offices in the treatment of clients are not reimbursable as outpatient services.

#### **24.4.1.1 Hospital-Based Outpatient Behavioral Health Services**

Outpatient behavioral health services are limited to no more than 30 encounters by all providers per eligible client per calendar year. Laboratory and radiological services do not count toward the 30 outpatient encounters. The CSHCN Services Program does not provide outpatient behavioral health benefits for clients who are also enrolled in the Texas Medicaid, the Medicaid Comprehensive Care Program (CCP), or Children's Health Insurance Program (CHIP).

Hospitals may be reimbursed for psychological testing (procedure codes 96130, 96131\*, 96136, and 96137\*) and neuropsychological testing (procedure codes 96132, 96133\*, 96136, and 96137\*) in the outpatient setting. Psychological and neuropsychological testing are limited to a total of 4 hours per day and 8 hours per calendar year, per client, by any provider. Time for interpretation and documentation, including time to document test results in the client's medical record, is included in procedure codes 96121\*, 96130, 96131\*, 96136, and 96137\* and not reimbursed separately. Procedure codes 96130, 96131\*, 96136, and 96137\* will be denied if performed on the same day as procedure codes 96132, 96133\*, 96136, and 96137\*.

*Note:* Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code

Authorization is not required.

*Referto:* Chapter 29, "Outpatient Behavioral Health."

#### **24.4.1.2 Hospital-Based Emergency Services Department**

The CSHCN Services Program may cover emergency room visits for program eligible clients when provided in a CSHCN-enrolled facility. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

According to the federal *Emergency Medical Transportation and Labor Act* (EMTALA), if any individual presents at the hospital emergency department requesting an examination or treatment the hospital must provide for an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

An 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 an individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The medical records must reflect continued monitoring according to the client's needs and must continue until the client is discharged, stabilized, or appropriately transferred.

EMTALA medical screening revenue code 451 may be considered for reimbursement when billed as a stand alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement when billed with revenue code 451. Services beyond screening can be billed with the appropriate corresponding emergency services revenue code 450, 456, 459, 761, or 762.

##### **24.4.1.2.1 Hospital-Based Emergency Services Authorization**

Authorization is not required for emergency medical services. Emergency department services are subject to retroactive review.

### 24.4.1.3 Outpatient Observation

Outpatient observation services are a benefit of the CSHCN Services Program and do not require prior authorization. Observation care is defined by the Centers for Medicare & Medicaid Services (CMS) as “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital’s nursing or other ancillary staff to evaluate the client’s condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services are a benefit only when medically necessary and when provided under a practitioner’s order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
  - Laboratory, radiology, or other testing is necessary to assess the client’s need for an inpatient admission.
  - The treatment plan is not established or, based on the client’s condition, is anticipated to be completed within a period not to exceed 48 hours.
  - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
  - The medical necessity for inpatient treatment is unclear, that is:
    - The client’s medical condition requires monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
    - There is a delayed or slow progression of the client’s signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
    - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner’s expectation of the care that the client will require.

#### 24.4.1.3.1 Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner's office without being seen in the emergency room by a hospital-based practitioner. The practitioner's order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for "direct admission" will be considered an inpatient admission unless otherwise specified by the practitioner's orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

#### 24.4.1.3.2 Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client's medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit.

#### 24.4.1.3.3 Observation Following Outpatient Day Surgery

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

#### 24.4.1.3.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.



#### 24.4.1.3.5 Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client's medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner's admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client's condition, treatment, and response to treatment.
- Nurse's notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any preadmission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse's notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 24-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner's order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

#### 24.4.1.3.6 Reporting Hours of Observation

Providers must submit the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client's medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner's order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner's order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. Time spent for the diagnostic or therapeutic procedure must not be included in the total amount of observation time submitted on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

#### 24.4.1.3.7 Client Status Change

If a practitioner determines that a client in observation status meets criteria for an inpatient admission, the observation service becomes part of the inpatient stay and is not separately reimbursed.

Both the outpatient observation service (revenue code 760) and the inpatient admission must be submitted as separate details on the same inpatient claim. When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. The practitioner's order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the outpatient observation claim is submitted for reimbursement.

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client's status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under the CSHCN Services Program if all of the following conditions are met:

- The change in client status is made before the claim is submitted.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR determination to change to outpatient status.
- The practitioner's concurrence with the UR determination is documented in the client's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

#### 24.4.1.3.8 Outpatient Observation Authorization

Authorization is not required for outpatient observation services. Prior authorization is required in the following situations:

- An outpatient observation stay is converted to an inpatient hospitalization.
- A completed CSHCN Services Program Authorization Request for Inpatient Hospital Admission - For Use by Facilities Only form must be completed and submitted to the CSHCN claims contractor.
- Documentation supporting the medical necessity of the outpatient observation services must be submitted with the request for the inpatient hospital admission and must include the beginning and end times of the outpatient observation services.
- For the practitioner's professional services related to a diagnostic, therapeutic, or surgical procedure performed during the time the client is in observation status.

#### 24.4.1.3.9 Observation Services that are Not a Benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of the CSHCN Services Program, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner's order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.
- For clients awaiting transfer to another facility.
- For clients with lack of or delay in transportation.
- As a convenience to the client, client's family, the practitioner, hospital, or hospital staff.
- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.
- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.

#### 24.4.1.3.10 Outpatient Observation Authorization

Authorization is not required for outpatient observation services.

**Important:** *All inpatient admissions require prior authorization. Providers must submit the prior authorization request immediately upon determining that the patient's status is changing from observation to inpatient.*

#### 24.4.1.4 Sleep Studies

Polysomnography, multiple sleep latency tests, and pediatric pneumograms may be a benefit of the CSHCN Services Program.

Sleep facilities that perform services for CSHCN Services Program clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Documentation of accreditation must be maintained in the facility and be available for review. Sleep facilities must also follow current AASM practice parameters and clinical guidelines. Providers may refer to the AASM website at [www.aasmnet.org](http://www.aasmnet.org) for AASM facility certification requirements or to the JCAHO website at [www.jointcommission.org](http://www.jointcommission.org) for JCAHO facility accreditation information.

Sleep facility technicians and technologists must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

The sleep facility must have one or more supervision physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of the non-physician staff who use the equipment.

*Referto:* Section 31.2.38, “Sleep Studies” in Chapter 31, “Physician.”

#### **24.4.1.5 Hyperbaric Oxygen Therapy (HBOT)**

Hyperbaric oxygen therapy services may be a benefit of the CSHCN Services Program when reimbursed in the outpatient setting to hospital providers when using procedure code G0277. Procedure code G0277 requires prior authorization.

Claims for procedure code G0277 must be submitted with revenue code 413 on the same claim. Claims that are submitted without revenue code 413 will be denied.

The number of billable units that may be submitted for procedure code G0277 will be based on the length of time during which the patient receives treatment with hyperbaric oxygen.

The number of billable units of procedure code G0277 is based upon the time that the patient receives treatment with hyperbaric oxygen. In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbrakes and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.
- To bill for a second (or subsequent unit), all previous units of time must have been for the full 30 minutes, and the last unit must be for 16-30 minutes.

*Referto:* Section 31.2.24, “Hyperbaric Oxygen Therapy (HBOT)” in Chapter 31, “Physician” for more information on benefit and prior authorization criteria.

#### **24.4.2 Reimbursement Information**

Outpatient hospital services may be reimbursed 72 percent of the billed amount multiplied by the hospital’s Medicaid interim rate. The CSHCN Services Program does not have a separate cost settlement process.

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed 125 percent of the adult, physician office visit fee for procedure code 99202.

Imaging services rendered by outpatient hospital providers are reimbursed at the flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code. Rural hospitals are eligible for a different rate for outpatient imaging. The CSHCN Services Program Online Fee Lookup (OFL) will display imaging rates for rural outpatient hospitals with a note code of “RH.”

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

### 24.4.2.1 Hospital-Based Emergency Services Department

Hospital-based emergency departments may be reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Texas Medicaid cost settlement report. The reasonable cost is reduced by a percentage determined by the state.

### 24.4.2.2 One-day Payment Window Reimbursement Guidelines

According to the one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within 1 day of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

*Referto:* Section 24.3.7, "Payment Window Reimbursement Guidelines" in this chapter for additional information about the one-day payment window reimbursement guidelines.

## 24.5 Ambulatory Surgical Centers

### 24.5.1 Benefits, Limitations, and Authorization Requirements

Covered services in a freestanding surgical center (ASC) or a hospital ambulatory surgical center (HASC) are billed as one inclusive charge. It is not appropriate to bill separately for any supplies or other services related to the surgery. Routine X-ray and laboratory services directly related to the surgical procedure are not reimbursed separately. All nonroutine laboratory and X-ray services should be billed separately using the hospital's full care NPI and taxonomy code.

Day surgery payment represents a global payment. Physician services must be billed separately.

Day surgery services include prosthetic devices, such as an intraocular lens (IOL), when supplied by the day surgery facility and implanted, inserted, or otherwise applied during a surgical procedure that is a benefit. Certain devices, such as cochlear implants and neurostimulator devices, may be reimbursed separately from the global rate.

#### 24.5.1.1 Freestanding Surgical Centers

To be considered for payment, all surgeries performed in a freestanding surgical center must meet the following requirements:

- Child must be 24 months of age or older.
- The client's current state of health, using the American Society of Anesthesiologists (ASA) physical state classification, must be Level I or II:
  - ASA I or P1: a normal health patient.
  - ASA II or P2: a patient with mild systemic disease.

Services for a client with physical status P3, P4, P5, or P6 cannot be authorized in a freestanding surgical center.

| ASA Designation | Physical Status Modifier |
|-----------------|--------------------------|
| ASA I           | P1                       |
| ASA II          | P2                       |
| ASA III         | P3                       |
| ASA IV          | P4                       |
| ASA V           | P5                       |
| ASA VI          | P6                       |

Documentation of the client's physical status must be on the surgery authorization request form.

A CSHCN Services Program-enrolled provider must perform the surgical procedure.

### 24.5.2 Reimbursement Information

Reimbursement of ASC procedures, whether HASC or free-standing, is based on the Centers for Medicare & Medicaid Services (CMS)-approved Ambulatory Surgical Code Groupings (Groups 1 through 9 per CMS and group 10 per the Texas Health and Human Services Commission [HHSC]) payment schedule. ASC and HASC procedure code group information can be obtained from the fee schedules on the TMHP website at [www.tmhp.com](http://www.tmhp.com). When two or more procedures are performed at the same surgical event, reimbursement is based on the procedure with the highest group payment.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

## 24.6 Claims Information

Inpatient, outpatient, and HASC claims must be submitted to TMHP in an approved electronic format or on a UB-04-CMS-1450 paper claim form. Freestanding ASC claims must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The total number of details allowed for a UB-04 CMS-1450 paper claim form is 28. The TMHP claims processing system accepts a total of 71 details, and merges like revenue codes together to reduce the lines to 28 or less. If the 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.

All claims that require prior authorization must include the prior authorization number.

When completing the claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for additional information about claims filing.

Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims filing.

**Important:** *All CSHCN Services Program paper hospital claims must include benefit code CSN.*

### 24.6.1 Inpatient Claims

Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays. The itemized charges must be retained by the facility for a period of at least 5 years from the date of service.

Medical or surgical supplies (e.g., infusion pumps, traction setups, and crutches only for inpatient use) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or NPI of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

The date of admission must reflect the date that the client was admitted to the hospital as an inpatient.

The from date of service must reflect the date that the client first presented at the hospital for services including but not limited to, emergency room, observation, labor and delivery, or inpatient services.

If services that are rendered before the inpatient admission must be submitted on the inpatient claim, the number of pre-admission days that are related to the inpatient admission cannot exceed the days allowed for the rendered services:

| Services                     | Days Allowed   | Units              |
|------------------------------|--|--------------------|
| Emergency Room (ER) services | One day (24 hours) before the inpatient admission        | Submitted per day  |
| Observation Services         | Up to two days (48 hours) before the inpatient admission | Submitted in hours |
| Labor and Delivery           | Up to three days before the inpatient admission          | Submitted per day  |

Diagnosis-Related Group (DRG) hospital claims allow for a total of three days of pre-admit services. Non-DRG hospital claims are allowed one day of pre-admit services and a second day if additional observations hours occurred.

### 24.6.2 Outpatient Claims

Medical or surgical supplies (e.g., infusion pumps and traction setups) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or NPI of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

Emergency department services by facilities for the room charges may be billed using the following revenue codes:

| Revenue Code | Description                                     |
|--------------|---|
| 450          | Emergency room                                  |
| 451          | Emergency room - EMTALA                         |
| 456          | Emergency room, urgent care                     |
| 459          | Emergency room, other                           |
| 761          | Treatment or observation room, treatment room   |
| 762          | Treatment or observation room, observation room |

Emergency room ancillary services by facilities include laboratory services, radiology services, respiratory therapy services, and diagnostic studies such as electrocardiogram (EKG), computed tomography (CT) scans, and supplies. Facilities billing outpatient claims (claim type 023) bill for ancillary services must use the appropriate procedure code such as the CPT code or the HCPCS code that indicates the procedure or service performed.

If the client visits the emergency room more than once in a day, the time must be given for each visit. The time of the first visit must be identified in Block 18 of the UB-04 CMS-1450 paper claim form, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity of the drug. Take home drugs and supplies are not a benefit of the CSHCN Services Program.

**24.6.2.1 Revenue Code and Procedure Code Requirements for All Outpatient Services**

The *Health Insurance Portability and Accountability Act* (HIPAA) of 1996, requires that a revenue code be billed for outpatient services that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent. All revenue codes (except for those in the table below) must be billed with the most appropriate corresponding procedure code.

Claims must be submitted with the revenue code in Block 42 and the corresponding procedure code in Block 44 for each line item submitted. The revenue code and corresponding procedure code must be on the same line for the claim to process correctly. The procedure code and revenue code combination that is submitted on the claim must reflect the services that were provided to the client. All claims are subject to retrospective review.

**24.6.2.1.1 Revenue Codes That Require a Procedure Code**

The following revenue codes must be billed with an applicable procedure code:

| Revenue Codes That Require Procedure Code  |     |      |      |      |      |     |     |     |     |
|--|-----|------|------|------|------|-----|-----|-----|-----|
| 220  | 278 | 279  | 300  | 301  | 302  | 303 | 304 | 305 | 306 |
| 307  | 309 | 310  | 311  | 312  | 314  | 319 | 320 | 321 | 322 |
| 323  | 324 | 329  | 330  | 331  | 332  | 333 | 335 | 339 | 340 |
| 341  | 342 | 349  | 350  | 351  | 352  | 359 | 380 | 381 | 382 |
| 383  | 384 | 385  | 386  | 387  | 389  | 400 | 401 | 402 | 403 |
| 404  | 409 | 413  | 419  | 420  | 421  | 422 | 423 | 424 | 429 |
| 430  | 431 | 432  | 433  | 434  | 439  | 440 | 441 | 442 | 443 |
| 444  | 449 | 450* | 452* | 456* | 459* | 460 | 469 | 470 | 471 |
| 472  | 479 | 480  | 481  | 482  | 483  | 489 | 540 | 550 | 551 |
| 552  | 559 | 560  | 561  | 562  | 569  | 570 | 571 | 572 | 579 |
| 580  | 581 | 582  | 589  | 610  | 611  | 612 | 619 | 620 | 630 |
| 631  | 632 | 633  | 634  | 635  | 636  | 730 | 731 | 732 | 739 |
| 740  | 749 | 770  | 771  | 779  | 780  | 789 | 860 | 861 | 880 |
| 920  | 921 | 922  | 923  | 924  | 925  | 929 | 943 |     |     |
| * For revenue codes 450, 452, 456, and 459, refer to Section 5.8.5, “Physician Services in Hospital Outpatient Setting” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for additional information about the 40-percent reduction for non-emergent and non-urgent services rendered in the emergency room. |     |      |      |      |      |     |     |     |     |

Claims that are submitted with a revenue code in the above table will be priced based on the procedure code pricing methodology. All limitations, guidelines, and pricing that apply to the procedure code will be applied to the line item. If the procedure code is not a benefit when rendered by outpatient hospital



providers, the line item will be denied. The procedure code must be a benefit when rendered by outpatient hospital providers, and the provider must follow the benefit guidelines and restrictions for the procedure code in order to be reimbursed.

The following list provides examples of claim submissions and appropriate processing:

- Example 1: If the provider bills a revenue code from the above table and chooses a procedure code that requires a modifier, the appropriate modifier must be billed with the revenue code/procedure code combination.
- Example 2: If the provider bills a revenue code from the above table and chooses a procedure code that is not a benefit when rendered by outpatient hospital providers, the line item will be denied.
- Example 3: If the provider bills a revenue code from the above table and chooses a procedure code that must be submitted to the client’s other insurance, the line item will be denied with an indication that the other insurance must be billed first.
- Example 4: If the provider bills a revenue code from the above table and chooses a procedure code with a CMS MUE limitation, the line item will be processed to determine whether the limitation for the procedure code has been exceeded.

The following revenue codes are the only codes that providers can submit without a corresponding procedure code:

| Revenue Codes Exceptions List |     |     |     |     |     |     |     |     |     |
|-------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 250                           | 251 | 252 | 254 | 255 | 257 | 258 | 259 | 260 | 261 |
| 262                           | 263 | 264 | 269 | 270 | 271 | 272 | 275 | 276 | 280 |
| 289                           | 360 | 361 | 369 | 370 | 371 | 372 | 374 | 379 | 390 |
| 410                           | 412 | 413 | 451 | 510 | 511 | 512 | 513 | 514 | 515 |
| 516                           | 517 | 519 | 520 | 523 | 526 | 529 | 621 | 622 | 623 |
| 650                           | 651 | 652 | 655 | 656 | 657 | 659 | 700 | 709 | 710 |
| 719                           | 720 | 721 | 722 | 723 | 724 | 729 | 750 | 759 | 760 |
| 761                           | 762 | 769 | 881 |     |     |     |     |     |     |

**24.6.2.1.2 Clarification for Non-Hospital Facility Claims**

Claims that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent by non-hospital facility or other non-hospital providers must be submitted with a revenue code for correct processing. The following guidelines apply to determine reimbursement based on the information submitted on the claim.

Claims submitted with one of the following revenue codes on the same detail line as the procedure code will be reimbursed based on the submitted procedure code:

| Revenue Codes that Require a Procedure Code |     |     |     |     |     |     |     |     |     |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 278   | 279 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 |
| 309   | 310 | 311 | 312 | 314 | 319 | 320 | 321 | 322 | 323 |
| 324   | 329 | 330 | 331 | 332 | 333 | 335 | 339 | 340 | 341 |
| 342   | 349 | 350 | 351 | 352 | 359 | 380 | 381 | 382 | 383 |
| 403   | 404 | 409 | 419 | 420 | 421 | 422 | 423 | 424 | 429 |
| 430   | 431 | 432 | 433 | 434 | 439 | 440 | 441 | 442 | 443 |
| 444   | 449 | 460 | 469 | 470 | 471 | 472 | 479 | 480 | 481 |
| 482   | 483 | 489 | 550 | 551 | 552 | 559 | 560 | 561 | 562 |

| Revenue Codes that Require a Procedure Code |     |     |     |     |     |     |     |     |     |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 569   | 570 | 571 | 572 | 579 | 580 | 581 | 582 | 589 | 610 |
| 611   | 612 | 619 | 620 | 630 | 631 | 632 | 633 | 634 | 635 |
| 636   | 730 | 731 | 732 | 739 | 740 | 749 | 770 | 771 | 779 |
| 920   | 921 | 922 | 923 | 924 | 925 | 929 | 943 |     |     |

Claims that are submitted with a revenue code in the above table will be processed and priced based on the procedure code processing guidelines and pricing methodology. The reimbursement for the line item will not reflect the submitted revenue code even though the revenue code is required for correct claims processing. All limitations, guidelines, and pricing that apply to the procedure code will be applied to the line item.

For all revenue codes that are not in the above table, the following reimbursement guidelines will apply:

- If the revenue code is submitted without a procedure code, the claim will process using the limitations, guidelines, and pricing for the submitted revenue code.
- If the revenue code is submitted with a procedure code (i.e., on the same line item as the revenue code), the claim will process using the limitations, guidelines, and pricing for the submitted procedure code.

**Note:** *If the submitted procedure code is not a benefit when rendered by the provider that submits the claim, the line item will be denied. The procedure code must be a benefit when rendered by the provider that submits the claim, and the provider must follow the benefit guidelines and restrictions for the procedure code in order to be reimbursed.*

**Referto:** The Online Fee Lookup (OFL) on this website to determine whether a procedure code is a benefit when rendered by the provider that submits the claim.

### 24.6.3 HASC Claims

All surgical procedures performed in an ASC or HASC must be billed using the appropriate national procedure code. Day surgery payment represents a global payment. Physician services must be billed separately.

Claims for scheduled outpatient day surgeries performed in an HASC must be filed using the HASC NPI and type of bill (TOB) 131 for outpatient hospitals in Block 4 of the UB-04 CMS-1450 paper claim form. Surgical procedures performed in the hospital's outpatient departments (emergency room, treatment rooms) are to be billed under the hospital's NPI and taxonomy code and not under the ASC NPI.

Claims for emergency, unscheduled outpatient surgical procedures should be filed with separate charges for all services using TOB 131 and the hospital's outpatient NPI and taxonomy code. If a client is admitted for a day surgery procedure, whether scheduled or emergency, and has either an ASA Classification of Physical Status of III, IV, or V or Classification of Heart Disease IV, the surgical procedure must be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the full care NPI and taxonomy code. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the surgical procedure must be included on one inpatient claim.

**Referto:** Section 24.6.2.1, "Revenue Code and Procedure Code Requirements for All Outpatient Services" in this chapter for more information about the revenue code and procedure code claim requirements for outpatient services.

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#### **24.6.4 Inpatient Stays Following Scheduled Day Surgeries**

If a client suffers a complication following an elective day surgery procedure and requires an inpatient admission, the surgery must be billed as an outpatient service. All inpatient charges must be submitted on a second claim as inpatient services. The diagnosis on the inpatient claim must be the complication that resulted in the admission. The ambulatory surgical procedure must not be listed on the inpatient claim. All inpatient admissions require prior authorization.

Providers must bill the scheduled day surgery using the ASC or HASC NPI and taxonomy code. If a condition of the scheduled day surgery requires additional care beyond the recovery period, the patient may be placed in outpatient observation (stay less than 24 hours). This outpatient observation stay must be billed using the hospital NPI and taxonomy code. Care required beyond the outpatient observation period (stay of 24 hours or more) must be billed as an inpatient stay. The admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement must be included on the claim. The principal diagnosis to be used is the complication of surgery that necessitated the extended stay.

#### **24.6.5 Inpatient Stays Following Unscheduled (Emergency) Day Surgeries**

Providers must bill the unscheduled day surgery as an outpatient claim using the hospital's NPI and taxonomy code. If a complication occurs, the same guidelines presented in Section 24.6.4, "Inpatient Stays Following Scheduled Day Surgeries" in this chapter must be followed with the following exception: the date of admission on the outpatient claim must reflect the date of first contact with the client.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program. Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity.

### **24.7 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **LABORATORY SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# LABORATORY SERVICES

## Table of Contents

- 25.1 Enrollment .....3**
- 25.1.1 Clinical Laboratory Improvement Amendments (CLIA) of 1988 ..... 4
  - 25.1.1.1 Waiver and Physician-Performed Microscopy Procedure (PPMP) Certificates ..... 5
- 25.2 Benefits, Limitations, and Authorization Requirements.....5**
- 25.2.1 Hospital Laboratory Services ..... 5
- 25.2.2 Independent Laboratory Services ..... 6
- 25.2.3 Physician-Owned Laboratory Services ..... 6
  - 25.2.3.1 Other Physician Laboratory-Related Services ..... 6
- 25.2.4 Clinical Pathology Services ..... 6
- 25.2.5 Other Laboratory Procedures ..... 7
  - 25.2.5.1 Drug Testing and Therapeutic Drug Assays ..... 7
  - 25.2.5.2 Cytogenetics Testing ..... 8
  - 25.2.5.3 Genetic Testing for Colorectal Cancer ..... 12
    - 25.2.5.3.1 Authorization Requirements ..... 13
    - 25.2.5.3.2 Familial Adenomatous Polyposis (FAP) ..... 13
    - 25.2.5.3.3 Hereditary Nonpolyposis Colorectal Cancer (HNPCC) ..... 13
  - 25.2.5.4 Genetic Testing for Hereditary Breast and Ovarian Cancers ..... 14
    - 25.2.5.4.1 Authorization Requirements ..... 15
- 25.2.6 Cytopathology of Vaginal, Cervical, and Uterine Sites ..... 15
- 25.2.7 Cytopathology Studies Other Than Vaginal, Cervical, or Uterine ..... 16
- 25.2.8 Evocative and Suppression Testing ..... 16
- 25.2.9 Helicobacter pylori (H. pylori) ..... 17
- 25.2.10 Hematology and Coagulation ..... 18
- 25.2.11 \* Microbiology ..... 19**
  - 25.2.11.1 Zika Virus Testing ..... 19
- 25.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing ..... 20
- 25.2.13 Organ or Disease-Oriented Panels ..... 20
- 25.2.14 \* Urinalysis and Chemistry ..... 21**
- 25.2.15 Other Laboratory Services ..... 22
- 25.2.16 Repeated Procedures ..... 23
  - 25.2.16.1 Modifier 91 ..... 23
- 25.2.17 Receiving Labs and Lab Handling Fees ..... 23
- 25.3 Claims Information.....24**
- 25.3.1 Modifiers To Use When Billing Laboratory Procedures ..... 24
- 25.4 Reimbursement.....24**
- 25.4.1 Clinical Laboratory Fee Schedule ..... 25
- 25.4.2 One-day Payment Window Reimbursement Guidelines ..... 25
- 25.5 TMHP-CSHCN Services Program Contact Center .....25**

## 25.1 Enrollment

To enroll in the CSHCN Services Program, laboratories must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, be certified according to the Clinical Laboratory Improvement Amendments (CLIA) of 1988, and comply with all applicable state laws and requirements. Out-of-state laboratory providers must meet all of these conditions and be located in the United States within 50 miles of the Texas state border.

The following laboratories are eligible for enrollment in the CSHCN Services Program:

- A physician's office
  - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
  - Medicare-certified and enrolled as a Medicaid provider
  - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS

**Note:** *If a physician performs more than 100 laboratory tests per year for other providers in their laboratory, the laboratory must be certified by Medicare, and the provider must enroll as an independent laboratory with TMHP.*

- A hospital laboratory for inpatient, outpatient, and nonpatient client claims (a hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory)
  - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
  - Medicare-certified and enrolled as a Medicaid provider
  - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS
- An independent (freestanding) laboratory
  - An independent (freestanding) laboratory enrolled in the CSHCN Services Program is defined as a facility that meets all of the following criteria:
    - Facility independent from a physician's office, ASC, or hospital
    - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
    - Medicare-certified and enrolled as a Medicaid provider
    - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** The CMS website at [www.cms.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp](http://www.cms.gov/CLIA/10_Categorization_of_Tests.asp) for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

### 25.1.1 Clinical Laboratory Improvement Amendments (CLIA) of 1988

To be eligible for reimbursement by the CSHCN Services Program, all providers performing laboratory tests must:

- Pay the applicable fee to Centers for Medicare & Medicaid Services (CMS).
- Contact HHSC at 1-512-834-6650 to receive a CLIA registration or certification number.

Submit CLIA applications to the following address:

Health Facility and Licensing Certification Division HHSC  
1100 West 49th Street  
Austin, TX 78756

CLIA updates can be submitted through a PEMS Maintenance - Licenses Transaction.

CMS implemented CLIA. The CLIA regulations were published in the February 28, 1992, *Federal Register* and have been amended several times since.

Copies of the CLIA rules and regulations are located at the CMS website at [www.cms.hhs.gov](http://www.cms.hhs.gov). These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. CLIA regulations set standards designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing. Under CLIA 88, all clinical laboratories (including those located in physician’s offices), regardless of location, size, or type of laboratory must meet standards based on the complexity of the test(s) they perform.

**Important:** *The CSHCN Services Program monitors claims submitted by clinical laboratories for CLIA numbers. Claims submitted for laboratory services are denied if there is not a CLIA number on file with the CSHCN Services Program.*

**Referto:** The CMS website at [www.cms.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp](http://www.cms.gov/CLIA/10_Categorization_of_Tests.asp) for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

### 25.1.1.1 Waiver and Physician-Performed Microscopy Procedure (PPMP) Certificates

Providers are responsible for practicing within the limits of their certificates and maintaining awareness of the most current information regarding enforcement of CLIA provisions.

*Note:* Providers may refer to the CMS website at [www.cms.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp](http://www.cms.gov/CLIA/10_Categorization_of_Tests.asp) for a list of waived test and provider-performed microscopy procedures (PPMP) procedure codes.

CSHCN Services Program bills must accurately reflect only those services authorized by CLIA regulations.

## 25.2 Benefits, Limitations, and Authorization Requirements

Authorization is not required for laboratory services.

The CSHCN Services Program may reimburse the following laboratories for services when the laboratory is certified according to the CLIA regulations and enrolled in the CSHCN Services Program:

- A hospital laboratory for outpatient and nonpatient client claims
- A physician's office
- An independent laboratory

Providers must bill the most specific diagnosis and procedure codes that describes the services provided.

Laboratory tests generally performed as a panel and performed on the same day by the same provider, must be billed as a panel, regardless of the method used to perform the tests (automated or manual).

The CSHCN Services Program pays only the amount allowed for the total component for the same procedure, same client, same date of service, and any provider.

- Providers who perform both the technical service and interpretation must bill for the total component.
- Providers who perform only the technical service must bill for the technical component.
- Providers who perform only the interpretation must bill for the interpretation component.

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied.

Claims are paid based on the order in which they are received. For example, if a claim is received for the total component, and if payment has been made for the technical and interpretation component for the same procedure, same dates of service, same client, from any provider, the claim for the total component is denied as previously paid to another provider. The same is true if a total component is paid and subsequent claims are received for the individual components.

### 25.2.1 Hospital Laboratory Services

Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory.

Outpatient and nonpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory. However, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim. If the specimen is collected by venipuncture or catheterization, hospitals may bill procedure code 99001 for collecting and forwarding a specimen to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique NPI number must be included on the claim in Blocks 17 and 17B.



In order to bill nonpatient claims for laboratory services, the complete name and address and unique NPI of the attending, ordering, designated, or performing (freestanding ASCs only) provider must be included on the claim in Blocks 17 and 17B.

### **25.2.2 Independent Laboratory Services**

Independent laboratories that provide laboratory tests to clients registered as hospital inpatients or hospital outpatients are not directly reimbursed. Reimbursement must be obtained from the hospital.

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for laboratory tests. An independent laboratory may bill the CSHCN Services Program for tests referred to another laboratory (independent or hospital) only if the independent laboratory performs at least one test and forwards a portion of the same specimen to another laboratory to have one or more tests performed. In this instance, the referring laboratory may bill for tests it performs and all tests the receiving laboratory performs on the specimen. In both instances, an independent laboratory that forwards a specimen to another laboratory may bill a handling fee (procedure code 99001) for collection and forwarding the specimen if the specimen is collected by venipuncture or catheterization.

In order to bill a handling fee, the receiving laboratory's name and address and unique NPI number must be included on the claim in Blocks 17 and 17B.

The CSHCN Services Program covers professional and technical services that an independent laboratory is certified by Medicare to perform.

### **25.2.3 Physician-Owned Laboratory Services**

The CSHCN Services Program reimburses laboratory services ordered by a physician and provided under the provider's personal supervision in a setting other than an inpatient or outpatient hospital.

#### **25.2.3.1 Other Physician Laboratory-Related Services**

Physicians may only bill for those laboratory tests that are actually performed in their offices. Clinical laboratory services performed in a physician's office may be reimbursed at 60 percent of the prevailing charge levels. A laboratory handling fee (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside laboratory. Only one lab handling fee per day, per client, may be billed, unless multiple specimens are obtained and sent to different laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique NPI must be included on the claim in Blocks 17 and 17B.

Laboratory services must be documented in clients' medical records as medically necessary and reference an appropriate diagnosis.

Laboratory tests generally performed as a panel (chemistries, complete blood counts [CBCs], or urinalyses [UAs]) and performed on the same day by the same provider must be billed as a panel regardless of the method used to perform the test.

Interpretation of laboratory tests for the physician's patients in the hospital, office, or emergency rooms are considered part of the physician's professional services and should not be billed separately.

### **25.2.4 Clinical Pathology Services**

Clinical pathology consultations are a benefit when performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80503, 80504, 80505, and 80506 using their National Provider Identifier (NPI).

Independent laboratories may submit claims for procedure codes 80503, 80504, 80505, and 80506 when services are performed in the independent laboratory setting.

Routine conversations between a consultant and an attending physician about test orders or results are not considered consultations.

The service does not qualify as a consultation if the information could ordinarily be furnished by a non-physician laboratory specialist.

Claims for clinical pathology consultations must be submitted with the following documentation:

- The name and address of the physician requesting the consultation, must be included on the claim. The NPI of the physician requesting the consultation should also be included.
- A copy of the written narrative report describing the consultation findings.
- Documented interaction that clearly outlines that the consultant interpreted the test results and made specific recommendations to the ordering physician.

**Important:** *If the claim does not include all of this information, the clinical pathology consultation will be denied.*

### 25.2.5 Other Laboratory Procedures

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| 1 per lifetime  |       |       |       |
| S3840           | S3841 | S3842 | S3846 |

#### 25.2.5.1 Drug Testing and Therapeutic Drug Assays

The following procedure codes for drug testing and therapeutic drug assays are benefits of the CSHCN Services Program:

| Procedure Codes         |       |        |       |       |       |       |       |       |       |
|-------------------------|-------|--------|-------|-------|-------|-------|-------|-------|-------|
| Drug Testing            |       |        |       |       |       |       |       |       |       |
| 80305^                  | 80306 | 80307  | 80320 | 80321 | 80322 | 80323 | 80324 | 80325 | 80326 |
| 80327                   | 80328 | 80329  | 80330 | 80331 | 80332 | 80333 | 80334 | 80335 | 80336 |
| 80337                   | 80338 | 80339  | 80340 | 80341 | 80342 | 80343 | 80344 | 80345 | 80346 |
| 80347                   | 80348 | 80349  | 80350 | 80351 | 80352 | 80353 | 80354 | 80355 | 80356 |
| 80357                   | 80358 | 80359  | 80360 | 80361 | 80362 | 80363 | 80364 | 80365 | 80366 |
| 80367                   | 80368 | 80369  | 80370 | 80371 | 80372 | 80373 | 80374 | 80375 | 80376 |
| 80377                   | G0480 | G0481  | G0482 | G0483 | G0659 |       |       |       |       |
| Therapeutic Drug Assays |       |        |       |       |       |       |       |       |       |
| 80143                   | 80150 | 80151  | 80155 | 80156 | 80157 | 80158 | 80159 | 80161 | 80162 |
| 80163                   | 80164 | 80165  | 80167 | 80168 | 80169 | 80170 | 80171 | 80173 | 80175 |
| 80176                   | 80177 | 80178^ | 80179 | 80180 | 80181 | 80183 | 80184 | 80185 | 80186 |
| 80188                   | 80189 | 80190  | 80192 | 80193 | 80194 | 80195 | 80197 | 80198 | 80199 |
| 80200                   | 80201 | 80202  | 80203 | 80204 | 80210 | 80299 |       |       |       |
| ^ QW Modifier           |       |        |       |       |       |       |       |       |       |

**Note:** *The procedure codes above do not require prior authorization.*

Procedure codes G0480, G0481, G0482, G0483, and G0659 are limited to once per day by any provider.

Procedure codes 82540, 82550, 82552, 82553, 82554, 83986, and 84311 used for specimen validity testing will be denied when billed on the same date of service, by the same provide, as procedure codes G0480, G0481, G0482, G0483 and G0659.

The following CPT drug assay procedure codes will deny when billed on the same date of service, by the same provider with the corresponding HCPCS drug assay procedure codes identified by an “X” in the following table:

| <b>CPT Drug Assay Procedure Codes to HCPCS Procedure Codes limitations</b>   |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|
|  | G0480 | G0481 | G0482 | G0483 | G0659 |
| 80320  | X     |       | X     | X     | X     |
| 80321  | X     | X     | X     | X     |       |
| 80323  | X     | X     | X     | X     | X     |
| 80324  | X     | X     | X     | X     |       |
| 80325  | X     |       |       |       |       |
| 80326  | X     | X     | X     | X     | X     |
| 80327  | X     |       |       |       |       |
| 80328  | X     |       |       |       |       |
| 80329  | X     |       | X     | X     | X     |
| 80330  | X     |       |       | X     |       |
| 80332  | X     |       | X     | X     | X     |
| 80333  | X     |       |       | X     |       |
| 80335  | X     |       |       |       |       |
| 80336  | X     |       |       |       |       |
| 80337  | X     |       | X     | X     | X     |
| 80338  | X     |       |       |       | X     |
| 80339  | X     |       |       |       | X     |
| 80342  | X     |       |       |       | X     |
| 80345  | X     |       |       |       | X     |
| 80358  | X     |       |       |       | X     |
| 80363  | X     |       |       |       | X     |
| 80365  | X     |       |       |       | X     |
| 80368  | X     |       |       |       | X     |
| 80369  | X     |       |       |       | X     |
| 80370  | X     |       |       |       | X     |
| 80375  | X     |       |       |       | X     |
| 80377  | X     |       |       |       | X     |
| <b>X - The “8000” CPT procedure code will be denied if billed with the HCPCS “G” procedure code indicated with an “X”.</b> |       |       |       |       |       |
| <b>^QW Modifier</b>  |       |       |       |       |       |

**25.2.5.2 Cytogenetics Testing**

When billed with an appropriate diagnosis code, cytogenetics testing procedure codes have the following limitations:

| <b>Procedure Code</b> | <b>Quantity Allowed</b> |
|-----------------------|-------------------------|
| Tissue Culture        |                         |
| 88230                 | 1 per day, any provider |

| Procedure Code         | Quantity Allowed         |
|------------------------|--------------------------|
| 88233                  | 1 per day, any provider  |
| 88237                  | 1 per day, any provider  |
| 88239                  | 1 per day, any provider  |
| 88240                  | 1 per day, any provider  |
| 88241                  | 1 per day, any provider  |
| Chromosome Analysis    |                          |
| 88245                  | 1 per day, any provider  |
| 88248                  | 1 per day, any provider  |
| 88249                  | 1 per day, any provider  |
| 88261                  | 1 per day, any provider  |
| 88262                  | 1 per day, any provider  |
| 88263                  | 1 per day, any provider  |
| 88264                  | 1 per day, any provider  |
| 88280                  | 1 per day, any provider  |
| 88283                  | 1 per day, any provider  |
| 88285                  | 1 per day, any provider  |
| 88289                  | 1 per day, any provider  |
| Molecular Cytogenetics |                          |
| 88271                  | 16 per provider, per day |
| 88272                  | 10 per provider, per day |
| 88273                  | 3 per provider, per day  |
| 88274                  | 5 per provider, per day  |
| 88275                  | 10 per provider, per day |

Providers must bill procedure code 88291 for the interpretation and report of cytogenetics testing.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

| Diagnosis Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| C8280           | C8281 | C8282 | C8283 | C8284 | C8285 | C8286 | C8287 |
| C8288           | C8289 | C8291 | C8292 | C8293 | C8294 | C8295 | C8296 |
| C8297           | C8298 | C8299 | C8310 | C8311 | C8312 | C8313 | C8314 |
| C8315           | C8316 | C8317 | C8318 | C8319 | C8380 | C8381 | C8382 |
| C8383           | C8384 | C8385 | C8386 | C8387 | C8388 | C8389 | C8440 |
| C8441           | C8442 | C8443 | C8444 | C8445 | C8446 | C8447 | C8448 |
| C8449           | C8461 | C8462 | C8463 | C8464 | C8465 | C8466 | C8467 |
| C8468           | C8469 | C8471 | C8472 | C8473 | C8474 | C8475 | C8476 |
| C8477           | C8478 | C8479 | C847A | C8581 | C8582 | C8584 | C8585 |
| C8586           | C8587 | C8588 | C8589 | C884  | C888  | C9012 | C9100 |
| C9101           | C9102 | C9110 | C9111 | C9112 | C9190 | C9191 | C9192 |
| C91Z0           | C91Z1 | C91Z2 | C9200 | C9201 | C9202 | C9210 | C9211 |
| C9212           | C9220 | C9221 | C9222 | C9230 | C9231 | C9232 | C9240 |

| Diagnosis Codes |        |        |        |        |       |        |       |
|-----------------|--------|--------|--------|--------|-------|--------|-------|
| C9241           | C9242  | C9250  | C9251  | C9252  | C9260 | C9261  | C9262 |
| C9290           | C9291  | C9292  | C92A0  | C92A1  | C92A2 | C92Z0  | C92Z1 |
| C92Z2           | C9300  | C9301  | C9302  | C9310  | C9311 | C9312  | C9330 |
| C9331           | C9390  | C9391  | C9392  | C93Z0  | C93Z1 | C93Z2  | C9400 |
| C9401           | C9402  | C9420  | C9421  | C9422  | C9430 | C9431  | C9432 |
| C9480           | C9481  | C9482  | C9500  | C9501  | C9502 | C9510  | C9511 |
| C9512           | C9590  | C9591  | C9592  | D45    | D821  | E230   | E291  |
| E300            | E3430  | E3431  | E34328 | E34329 | E3439 | E83110 | E8359 |
| F70             | F71    | F72    | F73    | F78A1  | F78A9 | F800   | F801  |
| F802            | F804   | F8089  | F810   | F812   | F8181 | F8189  | F819  |
| F82             | F840   | F88    | F900   | F901   | F902  | F908   | H0589 |
| H9325           | I77810 | I77811 | I77812 | I77819 | M2600 | M2601  | M2602 |
| M2603           | M2604  | M2605  | M2606  | M2607  | M2609 | N6482  | P2930 |
| P2938           | Q000   | Q001   | Q002   | Q010   | Q011  | Q012   | Q018  |
| Q02             | Q030   | Q031   | Q038   | Q040   | Q041  | Q042   | Q045  |
| Q046            | Q048   | Q050   | Q051   | Q052   | Q054  | Q055   | Q056  |
| Q057            | Q058   | Q062   | Q064   | Q068   | Q0701 | Q0702  | Q0703 |
| Q078            | Q079   | Q100   | Q101   | Q102   | Q103  | Q104   | Q106  |
| Q107            | Q110   | Q111   | Q112   | Q113   | Q120  | Q121   | Q123  |
| Q124            | Q128   | Q129   | Q130   | Q131   | Q132  | Q133   | Q134  |
| Q135            | Q1381  | Q1389  | Q140   | Q141   | Q142  | Q143   | Q148  |
| Q150            | Q158   | Q159   | Q160   | Q161   | Q162  | Q163   | Q164  |
| Q165            | Q169   | Q170   | Q171   | Q172   | Q173  | Q174   | Q175  |
| Q178            | Q179   | Q180   | Q181   | Q182   | Q183  | Q184   | Q185  |
| Q186            | Q187   | Q188   | Q189   | Q200   | Q201  | Q202   | Q203  |
| Q204            | Q205   | Q206   | Q208   | Q209   | Q210  | Q2110  | Q2111 |
| Q2112           | Q2113  | Q2114  | Q2115  | Q2116  | Q2119 | Q2120  | Q2121 |
| Q2122           | Q2123  | Q213   | Q214   | Q218   | Q219  | Q220   | Q221  |
| Q222            | Q223   | Q224   | Q225   | Q228   | Q230  | Q231   | Q232  |
| Q233            | Q234   | Q238   | Q240   | Q241   | Q242  | Q243   | Q244  |
| Q245            | Q246   | Q248   | Q249   | Q250   | Q251  | Q2521  | Q2529 |
| Q253            | Q2540  | Q2541  | Q2542  | Q2543  | Q2544 | Q2545  | Q2546 |
| Q2547           | Q2548  | Q2549  | Q2572  | Q259   | Q260  | Q261   | Q262  |
| Q263            | Q265   | Q266   | Q268   | Q269   | Q270  | Q271   | Q272  |
| Q2730           | Q2731  | Q2732  | Q2733  | Q2734  | Q274  | Q278   | Q279  |
| Q280            | Q281   | Q282   | Q283   | Q288   | Q289  | Q300   | Q301  |
| Q302            | Q303   | Q308   | Q309   | Q310   | Q311  | Q312   | Q313  |
| Q315            | Q318   | Q320   | Q321   | Q322   | Q323  | Q324   | Q330  |
| Q331            | Q332   | Q333   | Q334   | Q335   | Q336  | Q338   | Q339  |
| Q348            | Q349   | Q351   | Q353   | Q359   | Q360  | Q369   | Q370  |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| Q371            | Q372   | Q373   | Q374   | Q375   | Q380   | Q381   | Q382   |
| Q383            | Q384   | Q385   | Q386   | Q387   | Q388   | Q391   | Q392   |
| Q393            | Q394   | Q395   | Q396   | Q398   | Q400   | Q401   | Q402   |
| Q408            | Q409   | Q410   | Q411   | Q412   | Q419   | Q420   | Q421   |
| Q422            | Q423   | Q428   | Q430   | Q431   | Q432   | Q433   | Q434   |
| Q435            | Q437   | Q438   | Q440   | Q441   | Q442   | Q443   | Q444   |
| Q445            | Q446   | Q4470  | Q4471  | Q4479  | Q450   | Q451   | Q452   |
| Q453            | Q458   | Q459   | Q5001  | Q5002  | Q501   | Q502   | Q5031  |
| Q5032           | Q5039  | Q504   | Q505   | Q506   | Q510   | Q5110  | Q5111  |
| Q5121           | Q5122  | Q5128  | Q515   | Q516   | Q517   | Q51811 | Q51821 |
| Q51828          | Q520   | Q5210  | Q522   | Q523   | Q524   | Q525   | Q526   |
| Q5270           | Q5271  | Q5279  | Q528   | Q529   | Q5300  | Q5301  | Q5302  |
| Q5310           | Q53111 | Q53112 | Q5312  | Q5313  | Q5320  | Q53211 | Q53212 |
| Q5322           | Q5323  | Q539   | Q540   | Q541   | Q542   | Q543   | Q544   |
| Q548            | Q550   | Q551   | Q5521  | Q5522  | Q5523  | Q5529  | Q553   |
| Q554            | Q555   | Q5561  | Q5562  | Q5563  | Q5564  | Q5569  | Q558   |
| Q559            | Q560   | Q561   | Q562   | Q563   | Q564   | Q600   | Q601   |
| Q603            | Q604   | Q606   | Q6101  | Q6119  | Q612   | Q613   | Q614   |
| Q615            | Q618   | Q619   | Q6211  | Q6212  | Q622   | Q6231  | Q6239  |
| Q624            | Q625   | Q6261  | Q6262  | Q6263  | Q628   | Q630   | Q631   |
| Q632            | Q633   | Q638   | Q640   | Q6410  | Q6411  | Q6412  | Q6419  |
| Q642            | Q6431  | Q6432  | Q6433  | Q6439  | Q644   | Q645   | Q646   |
| Q6471           | Q6472  | Q6473  | Q6474  | Q6475  | Q649   | Q6501  | Q6502  |
| Q651            | Q6531  | Q6532  | Q654   | Q6581  | Q6582  | Q6589  | Q6600  |
| Q6601           | Q6602  | Q6610  | Q6611  | Q6612  | Q66211 | Q66212 | Q66219 |
| Q66221          | Q66222 | Q66229 | Q6630  | Q6631  | Q6632  | Q6640  | Q6641  |
| Q6642           | Q6651  | Q6652  | Q666   | Q6670  | Q6671  | Q6672  | Q6681  |
| Q6682           | Q6689  | Q6690  | Q6691  | Q6692  | Q670   | Q671   | Q672   |
| Q673            | Q674   | Q675   | Q676   | Q677   | Q678   | Q680   | Q681   |
| Q682            | Q683   | Q684   | Q688   | Q690   | Q691   | Q692   | Q699   |
| Q7001           | Q7002  | Q7003  | Q7011  | Q7012  | Q7013  | Q7021  | Q7022  |
| Q7023           | Q7031  | Q7032  | Q7033  | Q709   | Q7101  | Q7102  | Q7103  |
| Q7111           | Q7112  | Q7113  | Q7131  | Q7132  | Q7133  | Q7141  | Q7142  |
| Q7143           | Q7151  | Q7152  | Q7153  | Q7161  | Q7162  | Q7163  | Q71811 |
| Q71812          | Q71813 | Q71891 | Q71892 | Q71893 | Q7191  | Q7192  | Q7193  |
| Q7201           | Q7202  | Q7203  | Q7211  | Q7212  | Q7213  | Q7231  | Q7232  |
| Q7233           | Q7241  | Q7242  | Q7243  | Q7251  | Q7252  | Q7253  | Q7261  |
| Q7262           | Q7263  | Q7271  | Q7272  | Q7273  | Q72811 | Q72812 | Q72813 |
| Q72891          | Q72892 | Q72893 | Q7291  | Q7292  | Q7293  | Q730   | Q731   |
| Q738            | Q740   | Q742   | Q743   | Q748   | Q749   | Q75001 | Q75002 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| Q75009          | Q7501  | Q75021 | Q75022 | Q75029 | Q7503  | Q75041 | Q75042 |
| Q75049          | Q75051 | Q75052 | Q75058 | Q7508  | Q751   | Q752   | Q753   |
| Q754            | Q755   | Q758   | Q759   | Q760   | Q761   | Q762   | Q763   |
| Q76411          | Q76412 | Q76413 | Q76414 | Q76415 | Q76425 | Q76426 | Q76427 |
| Q76428          | Q7649  | Q765   | Q766   | Q767   | Q768   | Q770   | Q771   |
| Q772            | Q774   | Q775   | Q776   | Q777   | Q780   | Q781   | Q782   |
| Q783            | Q784   | Q788   | Q789   | Q790   | Q791   | Q792   | Q793   |
| Q794            | Q7959  | Q7960  | Q7961  | Q7962  | Q7963  | Q7969  | Q798   |
| Q799            | Q800   | Q801   | Q802   | Q803   | Q804   | Q808   | Q820   |
| Q821            | Q822   | Q823   | Q824   | Q825   | Q826   | Q828   | Q830   |
| Q831            | Q832   | Q833   | Q838   | Q840   | Q841   | Q842   | Q843   |
| Q844            | Q845   | Q846   | Q848   | Q849   | Q8503  | Q851   | Q8581  |
| Q8582           | Q8583  | Q8589  | Q859   | Q870   | Q8711  | Q8719  | Q87410 |
| Q87418          | Q8742  | Q8743  | Q8782  | Q8783  | Q8784  | Q8785  | Q8901  |
| Q8909           | Q891   | Q892   | Q893   | Q894   | Q897   | Q898   | Q899   |
| Q900            | Q901   | Q902   | Q917   | Q920   | Q921   | Q922   | Q925   |
| Q914            | Q915   | Q916   | Q917   | Q920   | Q921   | Q922   | Q925   |
| Q9261           | Q9262  | Q927   | Q928   | Q930   | Q931   | Q932   | Q933   |
| Q934            | Q9351  | Q9352  | Q9359  | Q937   | Q9381  | Q9382  | Q9388  |
| Q9389           | Q950   | Q952   | Q958   | Q960   | Q961   | Q962   | Q963   |
| Q964            | Q968   | Q969   | Q970   | Q971   | Q972   | Q973   | Q978   |
| Q980            | Q981   | Q984   | Q985   | Q986   | Q987   | Q988   | Q990   |
| Q991            | Q992   | Q998   | Q999   | Z31430 | Z31438 | Z315   | Z810   |
| Z8279           | Z8482  | Z8489  |        |        |        |        |        |

### 25.2.5.3 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer is provided to clients that have a known preposition (having a first-or-second degree relative) to colorectal cancer. Results of the testing may indicate whether the individual has an increased risk of developing colorectal cancer. A first-degree relative is defined as: sibling, parent, or offspring. A second-degree relative is defined as: uncle, aunt, grandparent, nephew, niece, or half-sibling.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client and/or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing.

Providers must bill the following procedure codes for genetic testing for colorectal cancer:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81201           | 81202 | 81203 | 81210 | 81233 | 81275 | 81288 | 81292 | 81293 | 81294 |
| 81295           | 81296 | 81297 | 81298 | 81299 | 81300 | 81301 | 81317 | 81318 | 81319 |
| 81327           |       |       |       |       |       |       |       |       |       |

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results. Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the Physical Evaluation and Management (E/M service).

Genetic testing for colorectal cancer is limited to once per lifetime. Additional tests will not be authorized.

**25.2.5.3.1 Authorization Requirements**

Prior authorization is required for genetic testing for colorectal cancer.

A completed CSHCN Services Program Authorization and Prior Authorization Request form, signed and dated by the referring providers, must be submitted:

- Any provider’s signature, including the prescribing provider’s, on a submitted document indicates the provider certifies, to the best of the provider’s knowledge, the information in the document is true, accurate and complete.
- All documentation submitted with a provider’s signature must have a date next to the signature and must be kept in the client’s medical record.
- Stamped signatures will not be accepted.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. The client’s medical record must include documentation of formal pre-test counseling, including assessment of the client’s ability to understand the risks and limitations of the test, and the client’s informed choice to proceed with the genetic testing for colorectal cancer. The medical record is subject to retrospective review.

Requisition forms from the laboratory are not sufficient documentation for verification of the personal and family history. Medical documentations submitted by the physician must verify the client’s diagnosis or family history.

**25.2.5.3.2 Familial Adenomatous Polyposis (FAP)**

Prior authorization for testing Familial Adenomatous Polyposis (FAP) (procedure codes 81201, 81202, and 81203) may be offered to individuals who have well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care.

Documentation must include one of the following:

- Client with greater than 20 polyps.
- Client with a first-degree relative with FAP and a documented mutation.
- Clients who are seven years of age or younger must have rationale for testing and documentation of medical necessity included in the client’s medical record and submitted with the prior authorization request.

**25.2.5.3.3 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)**

The following procedure codes require prior authorization for testing Hereditary Nonpolyposis Colorectal Cancer (HNPCC) to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81292           | 81293 | 81294 | 81295 | 81296 | 81297 | 81298 | 81299 | 81300 | 81301 |
| 81317           | 81318 | 81319 |       |       |       |       |       |       |       |

Results of the test may influence clinical management decisions.



Documentation of medical necessity must include one of the following:

- Client has three or more family members (one of whom is a first-degree relative) with colorectal cancer and two successive generations are affected and one or more of the colorectal cancers were diagnosed at 50 years of age or younger and FAP has been ruled out.
- A client has had two HNPCC cancers.
- A client has colorectal cancer and a first-degree relative with either colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger.
- A client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- A client has had right-sided colorectal cancer with an undifferentiated pattern or histology at 50 years of age or younger.
- A client has had signet-cell type colorectal cancer at 50 years of age or younger.
- A client has had colorectal adenoma at 40 years of age or younger.
- A client is an asymptomatic individual with a first or second-degree relative with a documented HNPCC mutation.
- A client has a family history of malignant neoplasm in the gastrointestinal tract.

Clients who are twenty years of age or younger must have a clear rationale for testing and documentation of medical necessity from the client’s record must be submitted with the prior authorization request.

**25.2.5.4 Genetic Testing for Hereditary Breast and Ovarian Cancers**

Genetic testing for hereditary breast and ovarian cancers is provided to clients who are at least 18 years of age with an inherited increased risk (having a first-, second- or third-degree relative) for developing breast and certain other cancers.

Genetic testing of mutations in BRCA1 and BRCA2, the genes associated with hereditary breast and ovarian cancer, is based on the National Comprehensive Cancer Network (NCCN) guidelines. These guidelines highly recommend genetic counseling to clients when genetic testing is offered and after test results are disclosed.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client and/or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing.

Providers must bill the following procedure codes genetic testing for hereditary breast and ovarian cancers:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81162           | 81163 | 81164 | 81165 | 81166 | 81167 | 81212 | 81215 | 81216 | 81217 |

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results only if the test results will affect treatment decisions or provide prognostic information. Interpretation of genetic testing results is not separately reimbursable. Interpretation is part of the physician evaluation and management (E/M) service.

Genetic testing for hereditary breast and ovarian cancers is limited to once per lifetime. Additional tests will not be authorized.

Genetic testing for hereditary breast and ovarian cancer predisposition is not covered as a screening test in the general population.

#### 25.2.5.4.1 Authorization Requirements

Prior authorization is required for all BRCA1/BRCA2 genetic testing for susceptibility to breast and ovarian cancer.

A completed CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form, signed and dated by the ordering practitioner, must be submitted and approved prior to the date of service. The form must include:

- The physician's signature on a submitted document that indicates that the physician certifies, to the best of the physician's knowledge, the information in the document is true, accurate, and complete.
- All documentation must be submitted with a physician's signature with a date next to the signature and must be kept in the client's medical record.
- No stamped signatures will be accepted.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the service(s) requested. Documentation supporting the medical need for genetic testing of hereditary breast and ovarian cancers must include:

- The client's diagnosis and prognosis, including the age of onset and the specific location of cancer
- The client's family history, if applicable, including the specifics about the relationship to the client, cancer site, and the age of cancer diagnosis
- The NCCN criterion met supporting the need for the specific test requested
- Documentation of how the result of the test will directly impact the plan of treatment delivered to the client.

Requisition forms from the laboratory are not sufficient documentation for verification of the personal and family history.

To complete the prior authorization process, the provider must complete and submit the prior authorization request and required documentation to the TMHP CSHCN Services Program Authorization Department.

If the service is medically necessary and is provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete PA requests.

The client's medical record must include a copy of the prior authorization request, all submitted documentation, and an assessment of the client's ability to understand the risks and limitations of the test as well as the client's informed choice to proceed with the genetic testing. The medical record is subject to retrospective review.

#### 25.2.6 Cytopathology of Vaginal, Cervical, and Uterine Sites

Because of the technical nature of processing and interpreting a Pap smear or specimen for cytopathology, pathologists are the only physician specialty reimbursed with the following exception:

**Exception:** *Other physician specialties equipped to perform Pap smears in their offices must have modifier SU on the claim form.*

Procurement and handling of the Pap smear or specimen for cytopathology is considered part of the evaluation and management of the client and is not reimbursed separately.

A pathologist must report the place of service (POS) according to where the Pap smear is interpreted: office (POS 1), inpatient (POS 3), outpatient (POS 5), or independent laboratory (POS 6).

The following procedure codes are payable for gynecological cytopathology services and may be reimbursed only to pathologists and CLIA-certified laboratories whose directors providing technical supervision of cytopathology services are pathologists:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 88142           | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 | 88155 | 88164 | 88165 |
| 88166           | 88167 | 88174 | 88175 |       |       |       |       |       |       |

Procedure codes 88155 is an add-on code to be used in conjunction with the following cytopathology procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 88142           | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 | 88164 | 88165 | 88166 |
| 88167           | 88174 | 88175 |       |       |       |       |       |       |       |

The interpretation portion of any gynecological cytopathology test must be reported using only procedure code 88141 and type of service “I.” Reimbursement is restricted to laboratories and pathologists. The interpretation portion may be reimbursed in addition to the following cytopathology procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 88142           | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 | 88164 | 88165 | 88166 |
| 88167           | 88174 | 88175 |       |       |       |       |       |       |       |

**25.2.7 Cytopathology Studies Other Than Vaginal, Cervical, or Uterine**

Procurement and handling of the specimen is not reimbursed separately for cytopathology of sites other than vaginal, cervical, or uterine and is considered part of the evaluation and management of the client. These procedures may be reimbursed according to the POS where the cytopathology smear is interpreted.

Procedure codes 88160, 88161, and 88162 are payable for the total component and technical component in the office (place of service [POS] 1), outpatient setting (POS 5), or independent laboratory (POS 6). Procedure codes 88160, 88161, and 88162 are payable for the interpretation in the inpatient (POS 3) or outpatient (POS 5) settings.

Procedure codes 88160, 88161, and 88162 are payable to a pathologist for the interpretation in the inpatient hospital (POS 3) and outpatient (POS 5) settings.

Procedure codes 88160 or 88161 total components and interpretations are denied as part of the total component and interpretation for procedure code 88162.

Procedure code 88160 total component and interpretation is denied as part of the total component and interpretation for procedure code 88161.

Reimbursement for the total component or interpretation and technical component for procedure codes 88160, 88161, and 88162 is limited to pathologists (doctor of medicine [MD] and doctor of osteopathy [DO]) and laboratories (CLIA-certified to provide pathology services).

**25.2.8 Evocative and Suppression Testing**

Evocative and suppression testing is a benefit when billed for the total component.

Providers must bill the following procedure codes for evocative suppression testing:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 80400           | 80402 | 80406 | 80408 | 80410 | 80412 | 80414 | 80415 | 80416 | 80417 |
| 80418           | 80420 | 80422 | 80424 | 80426 | 80428 | 80430 | 80432 | 80434 | 80435 |
| 80436           | 80438 | 80439 |       |       |       |       |       |       |       |

### 25.2.9 Helicobacter pylori (H. pylori)

H. pylori testing is a benefit. Serology testing for H. pylori is a noninvasive diagnostic procedure preferred for initial diagnosis but is not indicated once a diagnosis is made.

H. pylori testing is not indicated or a benefit for any of the following:

- New onset uncomplicated dyspepsia
- New onset dyspepsia that is responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAIDs] or use of antisecretory agents) (If conservative treatment does not eliminate the symptoms, further testing may be indicated to determine the presence of H. pylori.)
- Screening for H. pylori in asymptomatic clients
- Dyspeptic clients who require endoscopy and biopsy
- A negative endoscopy in the previous 90 days
- A planned endoscopy
- New onset H. pylori that is still being treated

Serology testing is not indicated or a benefit for monitoring response to therapy.

The following procedure codes may be reimbursed by the CSHCN Services Program:

- Serology testing, procedure codes 83009 and 86677
- Stool testing, procedure code 87338 with QW Modifier
- Breath testing, procedure codes 78267, 78268, 83013, and 83014

These procedure codes are considered a clinical lab service and must be billed using type of service (TOS) 5. The interpretation/professional component TOS I is not separately reimbursed.

H. pylori testing may be indicated for symptomatic clients with a documented history of chronic or recurrent duodenal ulcers, gastric ulcers, or chronic gastritis. The history should delineate the failed conservative treatment for the condition.

Procedure codes 83009 and 86677 are allowed once per lifetime when submitted by any provider. A second test may be considered on appeal with documentation that indicates the original test result was negative for H. pylori.

If a follow-up breath or stool test is used to document the eradication of H. pylori, the medical record should contain evidence of one of the following:

- The patient remains symptomatic after a treatment regimen for H. pylori.
- The patient is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The patient has a history of ulcer on chronic nonsteroidal anti-inflammatory drug (NSAID) or anticoagulant therapy.

Providers cannot be reimbursed for testing for the eradication of H. pylori, procedure codes 78267, 78268, 83013, 83014, and 87338 within 35 days of the initial test.

H. pylori testing will be denied if it is performed within 90 days of the following procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 43200           | 43201 | 43202 | 43216 | 43217 | 43229 | 43231 | 43232 | 43235 | 43236 |
| 43237           | 43238 | 43239 | 43241 | 43242 | 43250 | 43251 | 43259 | 43270 |       |

Procedure codes 78267, 78268, 83013, 83014, and 87338 may be reimbursed within 90 days of the procedure codes in the preceding table if the provider submits documentation that indicates the client was tested for eradication after treatment.

### 25.2.10 Hematology and Coagulation

The following hematology and coagulation procedure codes are benefits of the CSHCN Services Program:

| Procedure Codes    |       |       |        |       |        |        |        |        |       |
|--------------------|-------|-------|--------|-------|--------|--------|--------|--------|-------|
| 85002              | 85004 | 85007 | 85008  | 85009 | 85013* | 85014^ | 85018^ | 85025^ | 85027 |
| 85032              | 85041 | 85044 | 85045  | 85046 | 85048  | 85049  | 85055  | 85060  | 85097 |
| 85130              | 85170 | 85175 | 85210  | 85220 | 85230  | 85240  | 85244  | 85245  | 85246 |
| 85247              | 85250 | 85260 | 85270  | 85280 | 85290  | 85291  | 85292  | 85293  | 85300 |
| 85301              | 85302 | 85303 | 85305  | 85306 | 85307  | 85335  | 85337  | 85345  | 85347 |
| 85348              | 85360 | 85362 | 85366  | 85370 | 85378  | 85379  | 85380  | 85384  | 85385 |
| 85390              | 85396 | 85397 | 85400  | 85410 | 85415  | 85420  | 85421  | 85441  | 85445 |
| 85475              | 85520 | 85525 | 85530  | 85536 | 85540  | 85547  | 85549  | 85555  | 85557 |
| 85576^             | 85597 | 85598 | 85610^ | 85611 | 85612  | 85613  | 85635  | 85651* | 85652 |
| 85660              | 85670 | 85675 | 85705  | 85730 | 85732  | 85810  | 85999  | G0306  | G0307 |
| * CLIA Waived test |       |       |        |       |        |        |        |        |       |
| ^QW Modifier       |       |       |        |       |        |        |        |        |       |

The following procedure codes may be reimbursed once per day by the same provider:

| Procedure Codes |       |       |       |        |        |       |
|-----------------|-------|-------|-------|--------|--------|-------|
| 85027           | 85347 | 85397 | 85520 | 85576^ | 85610^ | 85730 |
| ^QW Modifier    |       |       |       |        |        |       |

Procedure code 85027 will deny if billed on the same date of service by the same provider as procedure codes 85007 and 85009.

Procedure code 85660 may be reimbursed once per lifetime by any provider. An additional test may be considered on appeal with documentation indicating the provider was unaware the client was tested previously or was unable to obtain the client’s medical records.

### 25.2.11 \* Microbiology

The following microbiology procedure codes are benefits of the CSHCN Services Program:

| [Revised] Procedure Codes                           |        |        |        |        |        |        |        |        |        |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 86790   | 86794  | 87003  | 87015  | 87040  | 87045  | 87046  | 87070  | 87071  | 87073  |
| 87075   | 87076  | 87077^ | 87081  | 87084  | 87086  | 87088  | 87101  | 87102  | 87103  |
| 87106   | 87107  | 87109  | 87110  | 87116  | 87118  | 87140  | 87143  | 87147  | 87149  |
| 87150   | 87152  | 87153  | 87154  | 87158  | 87164  | 87166  | 87168  | 87169  | 87172  |
| 87176   | 87177  | 87181  | 87184  | 87185  | 87186  | 87187+ | 87188  | 87190  | 87197  |
| 87205   | 87206  | 87207  | 87209  | 87210^ | 87220  | 87230  | 87250  | 87252  | 87253  |
| 87254   | 87255  | 87260  | 87265  | 87267  | 87269  | 87270  | 87271  | 87272  | 87273  |
| 87274   | 87275  | 87276  | 87278  | 87279  | 87280  | 87281  | 87283  | 87285  | 87290  |
| 87299   | 87300  | 87301  | 87305  | 87320  | 87324  | 87327  | 87328  | 87329  | 87332  |
| 87335   | 87336  | 87337  | 87338^ | 87339  | 87340  | 87341  | 87350  | 87380  | 87385  |
| 87389^  | 87390  | 87391  | 87400  | 87420  | 87425  | 87427  | 87430  | 87449^ | 87451  |
| 87467   | 87468  | 87469  | 87471  | 87472  | 87475  | 87476  | 87478  | 87480  | 87481  |
| 87482   | 87484  | 87485  | 87486  | 87487  | 87490  | 87491  | 87492  | 87493  | 87495  |
| 87496   | 87497  | 87498  | 87500  | 87501  | 87502^ | 87503+ | 87505  | 87506  | 87507  |
| 87510   | 87511  | 87512  | 87516  | 87517  | 87520  | 87521  | 87522  | 87523  | 87525  |
| 87526   | 87527  | 87528  | 87529  | 87530  | 87531  | 87532  | 87533  | 87534  | 87535  |
| 87536   | 87537  | 87538  | 87539  | 87540  | 87541  | 87542  | 87550  | 87551  | 87552  |
| 87555   | 87556  | 87557  | 87560  | 87561  | 87562  | 87563  | 87580  | 87581  | 87582  |
| 87590   | 87591  | 87592  | 87593  | 87623  | 87624  | 87625  | 87631^ | 87632  | 87633^ |
| 87634^  | 87640  | 87641  | 87650  | 87651^ | 87652  | 87653  | 87660  | 87661  | 87662  |
| 87797   | 87798  | 87799  | 87800  | 87801^ | 87802  | 87803  | 87804^ | 87806^ | 87807^ |
| 87808^  | 87809^ | 87810  | 87850  | 87880^ | 87899^ | 87900  | 87901  | 87902  | 87903  |
| 87904+  | 87905* | 87906  | 87910  | 87912  | 87999  | G0499  |        |        |        |
| * CLIA Waived test<br>+ Add-on code<br>^QW Modifier |        |        |        |        |        |        |        |        |        |

**Note:** The procedure codes above do not require prior authorization.

The following procedure codes may be reimbursed once per day by the same provider:

| Procedure Codes |       |        |       |        |        |        |        |       |        |
|-----------------|-------|--------|-------|--------|--------|--------|--------|-------|--------|
| 86790           | 86794 | 87015  | 87046 | 87071  | 87075  | 87076  | 87077^ | 87081 | 87088  |
| 87101           | 87102 | 87106  | 87107 | 87140  | 87147  | 87149  | 87150  | 87152 | 87153  |
| 87154           | 87181 | 87184  | 87185 | 87186  | 87188  | 87190  | 87206  | 87209 | 87210^ |
| 87252           | 87254 | 87634^ | 87300 | 87801^ | 87809^ | 87899^ | 87904  |       |        |
| ^QW Modifier    |       |        |       |        |        |        |        |       |        |

#### 25.2.11.1 Zika Virus Testing

Procedure codes 86794 and 87662 may be used to bill for Zika virus testing.

Procedure code 87662 may be reimbursed up to two times on the same day by the same provider.

### 25.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing

Standard treatment regimens for HIV therapy require a combination of three or more drugs. Standard therapy continues if a reduction in viral load is achieved. Incomplete virus suppression favors the development of a drug resistance and jeopardizes the success of future therapy. Testing for drug resistance as a prerequisite to further therapy is indicated under such circumstances.

To ensure accurate testing results, the client must be on appropriate antiretroviral therapy at the same time of testing or have discontinued the drug regimen within the past four weeks.

Testing for antiretroviral drug resistance is indicated in certain clinical situations. These indications include any of the following:

- Individuals who have an initial (new onset) acute HIV infection, to determine if a drug-resistant viral strain was transmitted, and to plan a drug regimen accordingly; or
- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500, and less than 1000 copies/ml.

Documentation must be maintained in the client’s medical record to support medical necessity for drug-resistance testing. Specific documentation requirements are dependent upon testing rationale.

Documentation must include, but is not limited to, the date the drug regimen was initiated, the dosage and frequency of the prescribed medication, and laboratory tests which support all of the following:

- Acute HIV infection, with identification of the specific viral strain; and
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1000 copies/ml.

Drug resistance testing is not recommended if one of the following criteria is met:

- The drug regimen has been discontinued for more that four weeks; or
- The viral load is less than 500 copies/ml.

### 25.2.13 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes are benefits of the CSHCN Services Program:

| Procedure Codes |        |       |        |        |        |        |       |       |
|-----------------|--------|-------|--------|--------|--------|--------|-------|-------|
| 80047^          | 80048^ | 80050 | 80051^ | 80053^ | 80061^ | 80069^ | 80074 | 80076 |
| ^QW Modifier    |        |       |        |        |        |        |       |       |

For all procedure codes listed in the organ or disease-oriented panels table above, refer to the Current Procedural Terminology (CPT) manual for information regarding laboratory panels and appropriate modifiers.

Reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined with any other automated tests that are billed for the client for the same date of service. Reimbursement for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same date of service.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test performed may be billed.

**25.2.14 \* Urinalysis and Chemistry**

The following urinalysis and chemistry procedure codes are benefits of the CSHCN Services Program:

| <b>[Revised] Procedure Codes</b>                  |             |        |        |        |        |        |        |        |        |
|---|-------------|--------|--------|--------|--------|--------|--------|--------|--------|
| <b>Urinalysis</b>                                 |             |        |        |        |        |        |        |        |        |
| 81000   | 81001       | 81002* | 81003^ | 81005  | 81015  | 81020  | 81050  | 81099  |        |
| <b>Chemistry</b>                                  |             |        |        |        |        |        |        |        |        |
| 82009   | 82010^      | 82013  | 82016  | 82017  | 82024  | 82030  | 82040^ | 82042* | 82043^ |
| 82044^  | 82045       | 82075  | 82077  | 82085  | 82088  | 82103  | 82104  | 82105  | 82107  |
| 82108   | 82120^      | 82127  | 82128  | 82131  | 82135  | 82136  | 82139  | 82140  | 82150^ |
| 82154   | 82157       | 82160  | 82163  | 82164  | 82166  | 82172  | 82175  | 82180  | 82190  |
| 82232   | 82239       | 82240  | 82247^ | 82248  | 82252  | 82261  | 82270* | 82271^ | 82272* |
| 82274^  | 82286       | 82300  | 82306  | 82308  | 82310^ | 82330^ | 82331  | 82340  | 82355  |
| 82360   | 82365       | 82370  | 82373  | 82374^ | 82375  | 82376  | 82378  | 82379  | 82380  |
| 82382   | 82383       | 82384  | 82387  | 82390  | 82397  | 82415  | 82435^ | 82436  | 82438  |
| 82441   | 82465^      | 82480  | 82482  | 82485  | 82495  | 82507  | 82523^ | 82525  | 82528  |
| 82530   | 82533       | 82540  | 82542  | 82550^ | 82552  | 82553  | 82554  | 82565^ | 82570^ |
| 82575   | 82585       | 82595  | 82600  | 82607  | 82608  | 82610  | 82615  | 82626  | 82627  |
| 82633   | 82634       | 82638  | 82642  | 82652  | 82653  | 82656  | 82657  | 82658  | 82664  |
| 82668   | 82670       | 82671  | 82672  | 82677  | 82679^ | 82681  | 82693  | 82696  | 82705  |
| 82710   | 82715       | 82725  | 82726  | 82728  | 82735  | 82746  | 82747  | 82757  | 82759  |
| 82760   | 82775       | 82776  | 82784  | 82785  | 82787  | 82800  | 82803  | 82805  | 82810  |
| 82820   | 82930       | 82938  | 82941  | 82943  | 82945  | 82946  | 82947^ | 82948  | 82950^ |
| 82951^  | 82952+<br>^ | 82955  | 82960  | 82963  | 82965  | 82977^ | 82978  | 82979  | 82985^ |
| 83001^  | 83002^      | 83003  | 83009  | 83010  | 83012  | 83013  | 83014  | 83015  | 83018  |
| 83020   | 83021       | 83026* | 83030  | 83033  | 83036^ | 83037^ | 83045  | 83050  | 83051  |
| 83060   | 83065       | 83068  | 83069  | 83070  | 83080  | 83088  | 83090  | 83150  | 83491  |
| 83497   | 83498       | 83500  | 83505  | 83516^ | 83518  | 83519  | 83520* | 83525  | 83527  |
| 83528   | 83540       | 83550  | 83570  | 83582  | 83586  | 83593  | 83605^ | 83615  | 83625  |
| 83630   | 83631       | 83632  | 83633  | 83655^ | 83670  | 83690  | 83695  | 83698  | 83700  |
| 83701   | 83704       | 83718^ | 83719  | 83721^ | 83722  | 83727  | 83735  | 83775  | 83785  |
| 83825   | 83835       | 83857  | 83864  | 83872  | 83873  | 83874  | 83880^ | 83883  | 83885  |
| 83915   | 83916       | 83918  | 83919  | 83921  | 83930  | 83935  | 83937  | 83945  | 83950  |
| 83951   | 83970       | 83986^ | 83992  | 83993  | 84035  | 84060  | 84066  | 84075^ | 84078  |
| 84080   | 84081       | 84085  | 84087  | 84100  | 84105  | 84106  | 84110  | 84119  | 84120  |
| 84126   | 84132^      | 84133  | 84134  | 84135  | 84138  | 84140  | 84143  | 84144  | 84145  |
| 84146   | 84150       | 84152  | 84153  | 84154  | 84155^ | 84156  | 84157* | 84160  | 84165  |
| 84166   | 84181       | 84182  | 84202  | 84203  | 84206  | 84207  | 84210  | 84220  | 84228  |
| 84233   | 84234       | 84235  | 84238  | 84244  | 84252  | 84255  | 84260  | 84270  | 84275  |
| *CLIA Waived test<br>+Add-on code<br>^QW Modifier |             |        |        |        |        |        |        |        |        |



| <b>[Revised] Procedure Codes</b>                  |        |        |        |        |       |        |       |        |        |
|---|--------|--------|--------|--------|-------|--------|-------|--------|--------|
| 84285   | 84295^ | 84300  | 84302  | 84305  | 84307 | 84311  | 84315 | 84375  | 84376  |
| 84377   | 84378  | 84379  | 84392  | 84402  | 84403 | 84425  | 84430 | 84431  | 84432  |
| 84436   | 84437  | 84439  | 84442  | 84443^ | 84445 | 84446  | 84449 | 84450^ | 84460^ |
| 84466   | 84478^ | 84479  | 84480  | 84481  | 84482 | 84484  | 84485 | 84488  | 84490  |
| 84510   | 84512  | 84520^ | 84525  | 84540  | 84545 | 84550^ | 84560 | 84577  | 84578  |
| 84580   | 84583  | 84585  | 84586  | 84588  | 84590 | 84591  | 84597 | 84600  | 84620  |
| 84630   | 84681  | 84702  | 84703^ | 84999  |       |        |       |        |        |
| <b>Molecular Testing</b>                          |        |        |        |        |       |        |       |        |        |
| 83006   |        |        |        |        |       |        |       |        |        |
| <b>Ophthalmology and Optometry</b>                |        |        |        |        |       |        |       |        |        |
| 83861^  |        |        |        |        |       |        |       |        |        |
| *CLIA Waived test<br>+Add-on code<br>^QW Modifier |        |        |        |        |       |        |       |        |        |

Procedure codes 81099, 82105, 82107, 82803, 82805, 82948, 84703, and 84999 are limited to one per day when billed by any provider.

Procedure code 84583 will be denied if billed on the same day by the same provider as procedure codes 81000, 81001, 81002, 81003, 81005, or 81020.

Procedure code 82270 is limited to one per rolling year when billed by any provider.

Procedure code 83698 is limited to two per rolling year when billed by any provider. Claims submitted for procedure code 83698 that are in excess of two per year may be considered on appeal with documentation of any of the following:

- Medical necessity for the additional test.
- The provider was unable to obtain the previous records from a different provider.
- The provider was new to treating the client and was not aware the client had received the test.

**Referto:** Section 25.2.9, “*Helicobacter pylori* (*H. pylori*)” in this chapter for information about limitations on procedure codes 83009, 83013, and 83014.

### 25.2.15 Other Laboratory Services

The following procedure codes are denied for pathologists as noncovered for specialty type

| <b>Procedure Codes</b> |       |       |       |
|------------------------|-------|-------|-------|
| <b>Surgery</b>         |       |       |       |
| 36430                  | 36440 | 36455 |       |
| <b>Consultation</b>    |       |       |       |
| 99252                  | 99253 | 99254 | 99255 |

Payment may be considered on appeal if the pathologist can document the medical necessity of performing the procedures.

## 25.2.16 Repeated Procedures

### 25.2.16.1 Modifier 91

Modifier 91 must be used for clinical diagnostic laboratory tests performed more than one time per day as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures must be documented on the appeal.
- Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each analyte. Documentation of time is required. If no time documentation is received, the claim will be denied. Providers may appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 91 continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier including documentation of times for each repeated procedure.

*Referto:* Chapter 7, “Appeals and Administrative Review.”

## 25.2.17 Receiving Labs and Lab Handling Fees

An independent laboratory may not bill for laboratory tests when the specimen is forwarded to another laboratory without performing any tests on that specimen. An independent laboratory may bill the CSHCN Services Program for tests referred to another laboratory (independent or hospital) only if the independent laboratory performs at least one test and forwards a portion of the same specimen to another laboratory (receiving laboratory) to have one or more tests performed. In this instance, the receiving laboratory may bill for tests it performs and all tests the receiving laboratory performs on the specimen. When billing, the *YES* box in Block 20 of the CMS-1500 paper claim form must be marked, the complete name, NPI, address, and ZIP code of the outside receiving laboratory where the specimen was forwarded must be entered in Block 32, and the taxonomy code of the receiving laboratory must be indicated in Block 24j next to each procedure to be performed by the receiving laboratory. Enter the taxonomy code in the shaded area of the field. Enter the NPI in the unshaded area of the field.

Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories.

In order to bill a handling fee, the receiving laboratory’s name and address and unique NPI number must be included on the claim in Blocks 17 and 17B.

In both situations, if a specimen is collected by venipuncture or catheterization, an independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (procedure code 99001) for collecting and forwarding the specimen to the other laboratory.

When billing for laboratory services, providers should use the date the specimen is collected as the date of service. If the specimen is sent to a receiving laboratory and the client is an inpatient, the hospital is responsible for payment of these services to the receiving laboratory.

## 25.3 Claims Information

Independent laboratory services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

Laboratory services providers must indicate the specific laboratory procedure codes that are being submitted for claims filing.

The Healthcare Common Procedure Coding System (HCPCS)/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

### 25.3.1 Modifiers To Use When Billing Laboratory Procedures

Providers may use an appropriate modifier to bill for laboratory procedures as needed.

Providers may refer to the CMS website at [www.cms.gov](http://www.cms.gov) for guidelines on which modifier to use when submitting claims for laboratory services.

## 25.4 Reimbursement

In compliance with state and federal law, the CSHCN Services Program reimburses laboratories for most services according to maximum fees established by federal law, Medicare, or HHSC. Clinical laboratory services may be reimbursed the lower of the national fee schedule amount, the billed amount, or the amount allowed by Texas Medicaid. Some services (e.g., anatomical pathology) may be reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM). For automated lab tests, the fees that are paid are calculated by compiling the number of automated tests on the date of service and assigning an automated test panel payment code.

Physicians may be reimbursed for laboratory services the lower of the billed amount or the amount allowed by Texas Medicaid. Outpatient hospitals may be reimbursed for laboratory services at 72 percent of the rate equivalent to the hospital’s Medicaid interim rate.

As the result of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982, independent laboratories are not directly reimbursed by the CSHCN Services Program when providing tests to clients registered as hospital inpatients or hospital outpatients. Reimbursement must be obtained from the hospital. These services cannot be billed to the client.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note:* Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

#### **25.4.1 Clinical Laboratory Fee Schedule**

The *Deficit Reduction Act* (DEFRA) of 1984 requires clinical diagnostic laboratory tests that are performed in a physician’s office by an independent laboratory or a hospital laboratory for its outpatients be reimbursed on the basis of maximum fee schedules. The Texas Medicare carrier publishes the fee schedules on an annual basis. By federal law, the CSHCN Services Program payment *cannot* exceed that allowed by Medicare.

#### **25.4.2 One-day Payment Window Reimbursement Guidelines**

According to the one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within 1 day of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

The one-day payment window reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

*Referto:* Section 24.3.7, “Payment Window Reimbursement Guidelines” in Chapter 24, “Hospital” for additional information about the one-day payment window reimbursement guidelines.

### **25.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **MEDICAL NUTRITION SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# MEDICAL NUTRITION SERVICES

## Table of Contents

|             |   |           |
|-------------|---|-----------|
| <b>26.1</b> | <b>Enrollment</b>                                     | <b>3</b>  |
| <b>26.2</b> | <b>Vitamins and Minerals</b>                          | <b>3</b>  |
| 26.2.1      | Enrollment  | 3         |
| 26.2.2      | Benefits, Limitations, and Authorization Requirements | 4         |
| 26.2.3      | Prior Authorization Requirements                      | 8         |
| 26.2.4      | Claims Information                                    | 9         |
| 26.2.5      | Reimbursement   | 9         |
| <b>26.3</b> | <b>Medical Foods</b>                                  | <b>9</b>  |
| 26.3.1      | Enrollment  | 9         |
| 26.3.2      | Benefits, Limitations, and Authorization Requirements | 10        |
| 26.3.2.1    | Prior Authorization Requirements                      | 10        |
| 26.3.3      | Claims Information                                    | 11        |
| 26.3.4      | Reimbursement   | 11        |
| <b>26.4</b> | <b>Medical Nutritional Counseling Services</b>        | <b>11</b> |
| 26.4.1      | Enrollment  | 11        |
| 26.4.2      | Benefits, Limitations, and Authorization Requirements | 12        |
| 26.4.2.1    | Prior Authorization Requirements                      | 13        |
| 26.4.3      | Claims Information                                    | 13        |
| 26.4.4      | Reimbursement   | 13        |
| <b>26.5</b> | <b>Medical Nutritional Products</b>                   | <b>14</b> |
| 26.5.1      | Enrollment  | 14        |
| 26.5.2      | Benefits, Limitations, and Authorization Requirements | 14        |
| 26.5.2.1    | Prior Authorization Requirements                      | 15        |
| 26.5.3      | Claims Information                                    | 16        |
| 26.5.4      | Reimbursement   | 16        |
| <b>26.6</b> | <b>Total Parenteral Nutrition (TPN)</b>               | <b>17</b> |
| 26.6.1      | Enrollment  | 17        |
| 26.6.2      | Benefits, Limitations, and Authorization Requirements | 17        |
| 26.6.2.1    | Prior Authorization                                   | 18        |
| 26.6.3      | Claims Information                                    | 19        |
| 26.6.4      | Reimbursement   | 19        |
| <b>26.7</b> | <b>TMHP-CSHCN Services Program Contact Center</b>     | <b>20</b> |

## 26.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical nutrition services (medical foods, medical nutritional counseling services, medical nutritional products, and total parenteral nutrition) must meet the conditions outlined in the enrollment sections provided in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical foods are in Section 26.3.1, “Enrollment” in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutritional counseling services are in Section 26.4.1, “Enrollment” in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of medical nutrition products are in Section 26.5.1, “Enrollment” in this chapter.

Detailed information about CSHCN Services Program provider enrollment procedures for providers of total parenteral nutrition are in Section 26.6.1, “Enrollment” in this chapter.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 26.2 Vitamins and Minerals

### 26.2.1 Enrollment

Vitamins and minerals may be reimbursed to Durable Medical Equipment (DME) providers, home health providers, and Custom DME providers.

**Referto:** Section 17.1, “Enrollment” in Chapter 17, “Durable Medical Equipment (DME)” for more detailed information about CSHCN Services Program provider enrollment procedures for DME and Custom DME providers and Section 21.1, “Enrollment” in Chapter 21, “Home Health Services” for more detailed information about CSHCN Services Program provider enrollment procedures for home health providers

### 26.2.2 Benefits, Limitations, and Authorization Requirements

Vitamin and mineral supplements with a prescription are a benefit of the CSHCN Services Program. The client's diagnosis and a prescription for the requested vitamin(s) and mineral(s) is required to determine coverage.

The following procedure codes for vitamin and mineral products are manually priced, and are benefits when prior authorized and submitted with the corresponding procedure code and state modifier:

| Vitamin or Mineral                             | Procedure Code | State Modifier |
|--|----------------|----------------|
| Beta-carotene                                  | A9152          | U1             |
| Vitamin A (retinol)                            | A9152          |                |
| Biotin   | A9152          | U2             |
| Boric acid                                     | A9152          | U3             |
| Copper   | A9152          |                |
| Iodine   | A9152          |                |
| Phosphorous                                    | A9152          |                |
| Zinc   | A9152          |                |
| Calcium  | A9152          | U4             |
| Chloride                                       | A9152          | U5             |
| Iron   | A9152          | U6             |
| Magnesium                                      | A9152          | U7             |
| Vitamin B1 (thiamin)                           | A9152          | U8             |
| Vitamin B2 (riboflavin)                        | A9152          |                |
| Vitamin B3 (niacin)                            | A9152          |                |
| Vitamin B5 (panthothenic acid)                 | A9152          |                |
| Vitamin B6 (pyridoxine, pyridoxal 5-phosphate) | A9152          |                |
| Vitamin B9 (folic acid)                        | A9152          |                |
| Vitamin B12 (cyanocobalamin)                   | A9152          |                |
| Vitamin C (ascorbic acid)                      | A9152          | U9             |
| Vitamin D (ergocalciferol)                     | A9152          | UA             |
| Vitamin E (tocopherols)                        | A9152          | UB             |
| Vitamin K (phytonadione)                       | A9152          | UC             |
| Multi-minerals                                 | A9153          | U1             |
| Multi-vitamins                                 | A9153          | U2             |
| Trace elements                                 | A9153          | U3             |
| Miscellaneous                                  | A9152 or A9153 | UD             |

**Note:** Claims for multivitamins with any combination of additives must be submitted with modifier U2.



Vitamin and mineral products may be indicated for, but are not limited to, treatment of the following conditions:

| <b>Vitamin or Mineral</b> | <b>Condition</b>   |
|---------------------------|--|
| Beta-carotene             | <ul style="list-style-type: none"> <li>• Vitamin A deficiency</li> <li>• Cystic fibrosis</li> <li>• Disorders of porphyrin metabolism</li> <li>• Intestinal malabsorption</li> </ul>   |
| Biotin                    | <ul style="list-style-type: none"> <li>• Biotin deficiency</li> <li>• Biotinidase deficiency</li> <li>• Carnitine deficiency</li> <li>• Cystic fibrosis</li> </ul>   |
| Boric acid                | <ul style="list-style-type: none"> <li>• Recalcitrant vulvovaginitis</li> </ul>  |
| Calcium                   | <ul style="list-style-type: none"> <li>• Calcium deficiency</li> <li>• Disorders of calcium metabolism</li> <li>• Chronic renal disease</li> <li>• Pituitary dwarfism, isolated growth hormone deficiency</li> <li>• Cystic fibrosis</li> <li>• Intestinal disaccharidase deficiencies and disaccharide malabsorption</li> <li>• Allergic gastroenteritis and colitis</li> </ul> |
| Chloride                  | <ul style="list-style-type: none"> <li>• Hypochloremia</li> <li>• Hypercapnia with mixed acid-base disorder</li> </ul>   |
| Copper                    | <ul style="list-style-type: none"> <li>• Disorders of copper metabolism</li> </ul>   |
| Iodine                    | <ul style="list-style-type: none"> <li>• Iodine deficiency</li> <li>• Simple and unspecified goiter and nontoxic nodular goiter</li> <li>• Cystic fibrosis</li> </ul>  |
| Iron                      | <ul style="list-style-type: none"> <li>• Disorders of iron metabolism</li> <li>• Iron deficiency anemia</li> <li>• Cystic fibrosis</li> </ul>  |
| Magnesium                 | <ul style="list-style-type: none"> <li>• Magnesium deficiency</li> <li>• Hypoparathyroidism</li> <li>• Cystic fibrosis</li> </ul>  |
| Phosphorous               | <ul style="list-style-type: none"> <li>• Disorders of phosphorous metabolism</li> </ul>  |
| Vitamin A (retinol)       | <ul style="list-style-type: none"> <li>• Vitamin A deficiency</li> <li>• Intestinal malabsorption</li> <li>• Disorders of the biliary tract</li> <li>• Cystic fibrosis</li> </ul>  |

| Vitamin or Mineral                             | Condition  |
|--|--|
| Vitamin B1 (thiamin)                           | <ul style="list-style-type: none"> <li>• Vitamin B1 deficiency</li> <li>• Disturbances of branched-chain amino-acid metabolism (e.g. maple syrup urine disease)</li> <li>• Disorders of mitochondrial metabolism</li> <li>• Wernicke-Korsakoff syndrome</li> <li>• Cystic fibrosis</li> </ul>                                |
| Vitamin B2 (riboflavin)                        | <ul style="list-style-type: none"> <li>• Vitamin B2 deficiency</li> <li>• Disorders of fatty acid oxidation</li> <li>• Riboflavin deficiency, ariboflavinosis</li> <li>• Disorders of mitochondrial metabolism</li> <li>• Cystic fibrosis</li> </ul>   |
| Vitamin B3 (niacin)                            | <ul style="list-style-type: none"> <li>• Vitamin B3 deficiency</li> <li>• Disorders of lipid metabolism (e.g. pure hypercholesterolemia)</li> <li>• Cystic fibrosis</li> </ul>   |
| Vitamin B5 (pantothenic acid)                  | <ul style="list-style-type: none"> <li>• Vitamin B5 deficiency</li> </ul>  |
| Vitamin B6 (pyridoxine, pyridoxal 5 phosphate) | <ul style="list-style-type: none"> <li>• Vitamin B6 deficiency</li> <li>• Sideroblastic anemia</li> <li>• Cystic fibrosis</li> </ul>   |
| Vitamin B9 (folic acid)                        | <ul style="list-style-type: none"> <li>• Vitamin B9 deficiency</li> <li>• Folate-deficiency anemia</li> <li>• Combined B12 and folate-deficiency anemia</li> <li>• Disorders of mitochondrial metabolism</li> <li>• Sickle-cell disease</li> <li>• Pernicious anemia</li> <li>• Cystic fibrosis</li> </ul>                   |
| Vitamin B12 (cyanocobalamin)                   | <ul style="list-style-type: none"> <li>• Vitamin B12 deficiency</li> <li>• Disturbances of sulphur-bearing amino-acid metabolism (e.g., homocystinuria and disturbances of metabolism of methionine)</li> <li>• Pernicious anemia</li> <li>• Combined B12 and folate-deficiency anemia</li> <li>• Cystic fibrosis</li> </ul> |
| Vitamin C (ascorbic acid)                      | <ul style="list-style-type: none"> <li>• Vitamin C deficiency</li> <li>• Anemia due to disorders of glutathione metabolism</li> <li>• Disorders of mitochondrial metabolism</li> <li>• Cystic fibrosis</li> </ul>  |

| Vitamin or Mineral         | Condition   |
|----------------------------|---|
| Vitamin D (ergocalciferol) | <ul style="list-style-type: none"> <li>• Vitamin D deficiency</li> <li>• Galactosemia</li> <li>• Glycogenosis</li> <li>• Disorders of magnesium metabolism</li> <li>• Intestinal malabsorption</li> <li>• Chronic renal disease</li> <li>• Cystic fibrosis</li> <li>• Disorders of phosphorous metabolism</li> <li>• Hypocalcemia</li> <li>• Disorders of the biliary tract</li> <li>• Hypoparathyroidism</li> <li>• Intestinal disaccharidase deficiencies and disaccharide malabsorption</li> <li>• Allergic gastroenteritis and colitis</li> </ul> |
| Vitamin E (tocopherols)    | <ul style="list-style-type: none"> <li>• Vitamin E deficiency</li> <li>• Inflammatory bowel disease (e.g. Crohn’s disease and ulcerative colitis)</li> <li>• Disorders of mitochondrial metabolism</li> <li>• Chronic liver disease</li> <li>• Intestinal malabsorption</li> <li>• Disorders of the biliary tract</li> <li>• Cystic fibrosis</li> </ul>   |
| Vitamin K (phytonadione)   | <ul style="list-style-type: none"> <li>• Vitamin K deficiency</li> <li>• Congenital deficiency of other clotting factors</li> <li>• Intestinal malabsorption</li> <li>• Acquired coagulation factor deficiency</li> <li>• Cystic fibrosis</li> <li>• Disorders of the biliary tract</li> <li>• Chronic liver disease</li> </ul>   |
| Zinc                       | <ul style="list-style-type: none"> <li>• Zinc deficiency</li> <li>• Wilson’s disease</li> <li>• Acrodermatitis enteropathica</li> <li>• Cystic fibrosis</li> </ul>  |
| Multimineral               | <ul style="list-style-type: none"> <li>• Other and unspecified protein-calorie malnutrition</li> </ul>  |
| Multivitamins              | <ul style="list-style-type: none"> <li>• Cystic fibrosis</li> <li>• Other and unspecified protein-calorie malnutrition</li> </ul>   |
| Trace elements             | <ul style="list-style-type: none"> <li>• Mineral deficiency</li> </ul>  |

### 26.2.3 Prior Authorization Requirements

Prior authorization for vitamin and mineral products must be requested using the [CSHCN Services Program Authorization and Prior Authorization Request Form](#) and be submitted on or before the date that the products are dispensed. Vitamin and mineral products that are dispensed before the date that the prior authorization request is received, or before the date of the physician’s order, will not be approved.

- A physician’s prescription with the name of the vitamin or mineral product, dosage, frequency, duration, and route of administration.
- The manufacturer’s suggested retail price (MSRP) or average wholesale price (AWP) (whichever is applicable) with the calculated price per dose or the providers’ documented invoice price.

Requests for additional vitamin and mineral products must be submitted before the current authorized period expires, but no more than 30 days before the expiration. Prior authorization of vitamin and mineral products may be considered for up to 6 months and for a quantity up to a 30-day supply.

*Note: Liquid formulations of vitamin and mineral products may be considered for quantities that exceed the 30-day supply to allow for variance in container sizes.*

If a client’s eligibility expires, all prior authorizations for the client become invalid and benefits may be denied. If eligibility is renewed, a new prior authorization request must be submitted.

The following sample tables taken from the [CSHCN Services Program Authorization and Prior Authorization Request Form](#), are examples of the information that is required to submit a request for vitamin and mineral products:

- Example 1: Vitamin D

| Requested Procedure or Service Information  |   |
|---|---|
| Type of Request: _____ Authorization <input checked="" type="checkbox"/> Prior Authorization  |   |
| <b>Procedure requested:</b> A9152 UA (per CPT code)   | <b>Service requested:</b> Vitamin D (ergocalciferol) 10 ml bottle (8000 units/ml) |
| <b>Other:</b> \$40.00/bottle  | Diagnosis:  |
| \$0.20/dose   |   |
| <b>Additional information:</b> (Refer to the appropriate manual section for specific authorization requirements): Dose: 400 units (0.05 ml), Route: PO, Frequency: QD |   |

- Example 2: Multivitamin Tablets

| Requested Procedure or Service Information   |   |
|--|---|
| Type of Request: _____ Authorization <input checked="" type="checkbox"/> Prior Authorization   |   |
| <b>Procedure requested:</b> A9153 U2 (per CPT code)  | <b>Service requested:</b> Centrum Kids (80 tablets/ bottle) |
| <b>Other:</b> \$8.99/bottle  | Diagnosis:  |
| \$0.11/dose  |   |
| <b>Additional information:</b> (Refer to the appropriate manual section for specific authorization requirements): Dose: 1 tablet, Route: PO, Frequency: QD |   |

- Example 3: Poly-Vi-Sol Drops with Iron

| Requested Procedure or Service Information   |  |
|--|--|
| Type of Request: _____ Authorization <input checked="" type="checkbox"/> Prior Authorization |  |

| Requested Procedure or Service Information   |  |
|--|--|
| <b>Procedure requested:</b> A9153 U1 (per CPT code)  | <b>Service requested:</b> Poly-Vi-Sol with Iron (50 ml bottle) |
| <b>Other:</b> \$10.05/bottle   | Diagnosis:   |
| \$0.20/dose  |  |
| <b>Additional information:</b> (Refer to the appropriate manual section for specific authorization requirements): Dose: 1 ml, Route: PO, Frequency: QD |  |

- Example 4: Fer-In-Sol Iron Supplement

| Requested Procedure or Service Information   |   |
|--|---|
| Type of Request: _____ Authorization <input checked="" type="checkbox"/> Prior Authorization   |   |
| <b>Procedure requested:</b> A9153 U1 (per CPT code)  | <b>Service requested:</b> Fer-In-Sol (50 ml bottle) 30 mg BID |
| <b>Other:</b> \$10.75/bottle   | Diagnosis:  |
| \$0.43/dose  |   |
| <b>Additional information:</b> (Refer to the appropriate manual section for specific authorization requirements): Dose: 2 ml (15 mg/ml), Route: PO, Frequency: BID |   |

*Note: Vitamin and mineral supplements are not diagnosis restricted.*

### 26.2.4 Claims Information

Claims for vitamin and mineral products must be submitted with procedure code A9152 or A9153, the appropriate modifier, and the corresponding National Drug Code (NDC). Units must be based on the quantity dispensed for up to a 30-day supply.

### 26.2.5 Reimbursement

The CSHCN Services Program reimburses vitamin and mineral products at the lesser of:

- The provider’s billed charges.
- The published fee determined by the Texas Health and Human Services Commission (HHSC).
- Manual price as determined by HHSC, which is based on one of the following:
  - MSRP less 18 percent or AWP less 10.5 percent with the calculated price per dose, whichever is applicable.
  - The provider’s documented invoice cost.

A maximum of \$100.00 per 30 days may be reimbursed for all vitamin and mineral products. Providers must dispense the most cost-effective product in accordance with a prescription from a licensed physician. Organic products will not be reimbursed unless medical documentation is provided to substantiate the need for that formulation.

## 26.3 Medical Foods

### 26.3.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical foods are not required to be actively enrolled in Texas Medicaid. However, they must have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state medical food providers may enroll and must meet all these conditions. The 50-mile within the Texas state border limitation does not apply to providers of medical foods.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

**26.3.2 Benefits, Limitations, and Authorization Requirements**

Medical foods are a benefit of the CSHCN Services Program for clients with inborn errors of metabolism that prohibit them from eating a regular diet.

Medical foods are defined as:

- Lacking in the compounds which cause complications of the metabolic disorder.
- Not generally available in grocery stores, health food stores, or pharmacies.
- Not used as food by the general population.
- Not foods covered under the Food Stamps program.
- Approved products listed in enrolled provider’s catalogs.

The CSHCN Services Program only pays for foods with nutritional value.

Foods with minimal nutritional value, including, but not limited to the following, are not a benefit of the CSHCN Services Program:

| Foods with Minimal Nutritional Value |                         |         |                     |               |
|--------------------------------------|-------------------------|---------|---------------------|---------------|
| Cakes                                | Cake mixes              | Candy   | Candy covered items | Chips         |
| Chocolate                            | Chocolate covered items | Cookies | Cookie dough        | Dessert items |
| Gum                                  | Onion rings             | Pies    |                     |               |

Foods described as gluten-free are not a benefit of the CSHCN Services Program.

A maximum of \$200.00 per month may be reimbursed for all medical foods. Clients may order up to a three-month supply of food at one time.

Claims for medical foods must be submitted with procedure code S9434 or S9435.

**26.3.2.1 Prior Authorization Requirements**

Authorization or prior authorization is not required if the client has one of the diagnoses listed below and the request is for covered items (i.e., foods with nutritional value):

| Diagnosis Codes |        |        |       |       |       |        |        |
|-----------------|--------|--------|-------|-------|-------|--------|--------|
| E700            | E701   | E7020  | E7021 | E7029 | E7030 | E70329 | E70330 |
| E70331          | E70338 | E70339 | E7039 | E705  | E709  | E710   | E7119  |
| E7201           | E7202  | E7203  | E7204 | E7211 | E7212 | E7219  | E7221  |
| E7222           | E7223  | E724   | E7229 | E723  | E7289 | H3120  |        |

Prior authorization and documentation of medical necessity is required for all other diagnoses, new products, or products not listed as approved.

Prior authorization requests for products, conditions, quantities, or dollar amounts beyond the limits described in this chapter will be considered with medical necessity on a case-by-case basis after review by the DSHS-CSHCN Medical Director or a designee.

**Note:** *Prior authorization requests that were approved before August 1, 2012, will remain valid until the authorized period expires; services must be billed as authorized.*

Providers must complete the [CSHCN Services Program Prior Authorization Request for Medical Foods Form](#) for medical foods prior authorization requests.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

### 26.3.3 Claims Information

For purposes of billing, one unit is equal to one dose. The total billable units are equal to the total doses requested on the prior authorization.

Services by providers of medical foods must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The Texas Vendor Drug Program website at [www.txvendordrug.com](http://www.txvendordrug.com) for information about the VDP.

### 26.3.4 Reimbursement

The CSHCN Services Program implemented rate reductions for certain services. The Online Fee Lookup (OFL) includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 26.4 Medical Nutritional Counseling Services

### 26.4.1 Enrollment

To enroll in the CSHCN Services Program, providers of nutritional counseling services must be dietitians licensed by the Texas State Board of Examiners of Dietitians, actively enrolled in Texas Medicaid, and must be enrolled as licensed dietitians, have a valid Provider Agreement with the CSHCN Services

Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state medical nutritional counseling services providers must meet all of these conditions, and be located in the United States within 50 miles of the Texas state border.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

#### **26.4.2 Benefits, Limitations, and Authorization Requirements**

The CSHCN Services Program provides coverage for nutritional assessment and counseling to prevent, treat, or minimize the effects of illness, injury, or other impairments.

Medical nutritional counseling services are a benefit of the CSHCN Services Program when all of the following criteria are met:

- Prescribed by a physician
- Considered medically necessary or medically appropriate, as supported by documentation
- Completed by a CSHCN Services Program-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians
- Provided in the home, office, or in the outpatient hospital setting

Medical nutrition therapy (procedure codes 97802 and 97803) and medical nutritional counseling services, dietitian visit (procedure code S9470) may be beneficial for disease states in which dietary adjustment has a therapeutic role. These include, but are not limited to, the following conditions:

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders
- Gastrointestinal disorders
- Hypertension
- Inherited metabolic disorders
- Kidney disease
- Lack of normal weight gain
- Nutritional deficiencies

Nutrition intervention for chronic fatigue syndrome, attention-deficit hyperactivity disorder, idiopathic environmental intolerances, and multiple food and chemical sensitivities is considered experimental and investigational and is not a benefit of the CSHCN Services Program.

Medical nutritional counseling service for the diagnosis of obesity without a comorbid condition is not a benefit of the CSHCN Services Program.

Nutrition counseling, dietitian visit (procedure code S9470) is a less comprehensive service and does not include an assessment or reassessment. This is limited to four nutritional counseling visits (procedure code S9470) per rolling year.

Procedure codes 97802, 97803, and S9470 are not restricted to clients 20 years of age or younger; they may be submitted for clients of any age. Services may be provided in the home, office, or outpatient hospital settings.



The CSHCN Services Program reimburses procedure codes 97802, 97803, and S9470. If procedure codes 97802 or 97803 are billed for the same date of service as S9470, procedure code 97802 or 97803 is paid and procedure code S9470 is denied.

#### **26.4.2.1 Prior Authorization Requirements**

Authorization or prior authorization is not required for the following nutritional counseling services:

- One hour (four units) for nutrition assessment, and intervention for procedure code 97802 per rolling year and three hours (12 units) per rolling year for nutrition reassessment and intervention for procedure code 97803
- Four nutritional counseling visits (procedure code S9470) per rolling year

Providers are responsible for maintaining documentation to support medical necessity of nutritional counseling services in the clinical record.

Prior authorization is required for additional visits. Requests for additional visits require medical review and must be submitted in writing on the [CSHCN Services Program Request for Authorization and Prior Authorization Request Form](#) with documentation to support medical necessity or appropriateness.

Use procedure codes 97802, 97803, or S9470 when requesting prior authorization or submitting claims.

**Note:** *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

#### **26.4.3 Claims Information**

Medical nutritional counseling services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

#### **26.4.4 Reimbursement**

Nutritional assessment and counseling services may be reimbursed the lower of either the billed amount or the amount allowed by Texas Medicaid.

Providers must use the following procedure codes when requesting prior authorization or submitting claims:

| Procedure Codes |       |       |
|-----------------|-------|-------|
| 97802           | 97803 | S9470 |

If either procedure code 97802 or 97803 is billed with procedure code S9470 for the same date of service, then either procedure code 97802 or 97803 is paid, and procedure code S9470 is denied. Procedure code 97803 is denied as part of another service when billed for the same date of service as procedure code 97802 by any provider.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 26.5 Medical Nutritional Products

### 26.5.1 Enrollment

To enroll in the CSHCN Services Program, providers of medical nutritional products must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state medical nutritional products providers may enroll and must meet all these conditions, and be approved by DSHS. The 50-mile within the Texas state border limitation does not apply to providers of medical nutritional products.

*Referto:* Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

### 26.5.2 Benefits, Limitations, and Authorization Requirements

Medical nutritional products including enteral formulas, food thickeners, and nutritional supplements are a benefit of the CSHCN Services Program when the client has a specialized nutritional requirement. Medical nutritional products are those nutritional products that serve as a therapeutic agent for life and health and are part of a treatment regimen.

The CSHCN Services Program does not cover the following:

- Nutritional products that are traditionally used for infant feeding
- Pudding products
- Nutritional bars
- Nutritional products for individuals who can be sustained on an age-appropriate diet.

Oral electrolyte solutions are reimbursed through VDP and will not be approved as a nutritional product.

Claims for medical nutritional products must be submitted with one of the procedure codes listed in the following table:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| B4100           | B4149 | B4150 | B4152 | B4100 | B4153 | B4154 | B4155 | B4157 | B4158 |
| B4159           | B4160 | B4161 | B4162 | B9002 | B9998 | T1999 |       |       |       |

**Note:** Appropriate limitations for miscellaneous procedure code B9998 and T1999 are determined on a case-by-case basis through prior authorization and must be based on medical necessity.

The following limitations apply for the rental or purchase of an enteral nutrition infusion pump, any type (procedure code B9002):

- Rental may be reimbursed once per calendar month, same procedure, any provider.
- Purchase may be reimbursed once every five rolling years, same procedure, any provider.

The feeding pump is considered purchased after 10 months of lease within the same year with the same provider.

**26.5.2.1 Prior Authorization Requirements**

Prior authorization is required every six months for nutritional products. Documentation must be submitted indicating that the client has a medical condition that is expected to be permanent or of indefinite duration that prevents the individual from being sustained on an age-appropriate diet and has manifested in nutritional deficiencies.

Prior authorization is not required for nutritional formulas administered via an enteral feeding tube.

Prior authorization requests must be submitted on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form. The form must be signed by the physician within 90 days prior to the requested start of service. All claims with dates of service prior to the prescribing provider’s signature will be denied.

The following information must be provided on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form:

- The full name of the product
- The appropriate procedure code(s)
- The recommended total caloric intake from all sources ordered for nutritional products, except food thickeners
  - The percentage of the total caloric intake from formula or the total number of calories from formula each day
- Identification or explanation of the medical condition resulting in the requirement for a special nutritional product. Additional documentation may be submitted to supplement the information provided on the CSHCN Services Program Prior Authorization Request for Medical Nutritional Products Form. Documentation should be current (within the past 12 months.) Documentation must include:
  - The client’s height and weight
  - The client’s growth history, growth charts, or both (for clients who are 18 years of age or older, only a weight history is required)
  - Documentation to support why the client cannot be maintained on an age-appropriate diet

Food thickener may be considered for clients with a diagnosis of dysphagia. Documentation of the findings of a swallow study indicating a recommended thickness must be submitted.

Enteral feeding pumps may be considered for prior authorization for lease or purchase with documentation that gravity or syringe feedings are not medically indicated. Requests must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Procedure code B4105 may be considered for prior authorization for clients who are 5 years of age or older with documentation of the following:

- The client's diagnoses of both exocrine pancreatic insufficiency and cystic fibrosis
- The client's body mass index (BMI) below 18.5 for initial requests and a BMI below 25 for renewal requests
- The client's use of an enteral feeding pump for overnight feedings
- The amount of formula (mL) the client receives during overnight feedings
- An attestation that the client uses a compatible formula

**Note:** *One cartridge can be used with up to 500mL of formula with a maximum of two cartridges per day.*

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

### 26.5.3 Claims Information

In order to be considered for reimbursement, providers should not submit claims for procedure code B9998 with modifiers U1 - U5.

The quantity billed should always be the number of cans, not units or calories.

Medical nutritional services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

### 26.5.4 Reimbursement

Reimbursement for medical nutritional products is determined by using the lesser of the following:

- The billed amount
- The amount allowed by the CSHCN Services Program

Reimbursement for prescribed products that are included in the current edition of the *Drug Reference* is the listed AWP, less 10.5 percent.

Reimbursement for prescribed products that are not included in the current edition is the AWP that is supplied by the manufacturer of the product, less 10.5 percent.

Reimbursement for miscellaneous procedure code B9998 will be determined by prior authorization, based upon the average wholesale price (AWP) less 10.5%, the manufacturer's suggested retail price (MSRP) less 18%, or the documented invoice cost which must be submitted with the appropriate code to be considered for reimbursement.

A prior authorization request for pure amino acids, including, but not limited to, glycine, L-arginine, and L-orthinine, will be considered using procedure code B9998.

Enteral formula is reimbursed on the number of "units" of a specific formula provided to a client. A "unit" is defined as 100 calories of formula. The supplier must submit claims for reimbursement with "units" per day that are prescribed for the client and not the number of cans or cases used.

In the case of enteral formulas, the HCPCS code assignments and reimbursement rates are based on the composition and source of ingredients in each individual formula, as well as the intended therapeutic benefit of the formula.

Enteral formulas are reimbursed using the appropriate covered HCPCS code, which must be submitted in order to be reimbursed.

All claims for medical nutritional products may be subject to retrospective review and recoupment.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note:* Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

## 26.6 Total Parenteral Nutrition (TPN)

### 26.6.1 Enrollment

To enroll in the CSHCN Services Program, a provider of TPN must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state TPN providers must be located in the United States, within 50 miles of the Texas state border, and approved by DSHS.

*Referto:* Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

### 26.6.2 Benefits, Limitations, and Authorization Requirements

TPN is a benefit of the CSHCN Services Program and is reimbursed at a global fee. Services included in the global fee include, but are not limited to, the following:

Parenteral solutions and additives, with the exception of lipids (procedure codes B4185 and B4187).

- Supplies and equipment, including refrigeration if necessary.
- Education of the client or caregiver regarding the administration of the TPN. Education must include the use and maintenance of supplies and required equipment.

- Visits by a registered nurse appropriately trained in the administration of TPN. The nurse must visit the client at least one time each month to monitor the client’s status and to provide ongoing education.
- Customary and routine laboratory work required to monitor the client’s status.
- No more than a one-week supply of solutions and additives may be reimbursed even if the solutions and additives are shipped and not used. Any days that the client is an inpatient in a hospital or other medical facility or institution must be subtracted from the daily billing. Payment for partial months is prorated based on actual days of administration.

Lipids solution (procedure codes B4185 and B4187) will be considered for separate reimbursement when billed for the same date of service as any other TPN procedure code (S9364, S9365, S9366, S9367, or S9368) with a valid prior authorization.

Procedure code B4187 is a benefit for clients who are birth through 18 years of age.

Providers can use the following procedure codes to request prior authorization and submit claims:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| B4185           | B4187 | B9004 | B9006 | S9364 | S9365 | S9366 | S9367 | S9368 |

Procedure codes B9004 and B9006 are a benefit of the CSHCN Services Program when the item is purchased new or rented monthly. Procedure codes B9004 and B9006 will no longer be a benefit of the CSHCN Services Program when purchased as used durable medical equipment (DME).

Procedure codes B9004 and B9006 are denied as included in another procedure when they are submitted for the same date of service as related procedure codes S9364, S9365, S9366, S9367 or S9368 by any provider.

When purchased as new, procedure code B9004 will be limited to one service every five rolling years, any provider.

**Note:** Procedure codes B9004 and B9006 when purchased new or rented monthly require prior authorization.

The procedure codes in the above table are a benefit only in the home setting when provided by a home health DME provider, medical supplier (DME), or a medical supply company.

If the rental of a parenteral nutrition infusion pump is expected to exceed a period of 6 months, purchase of the equipment will be considered with prior authorization.

A client whose eligibility expires will no longer receive benefits for prior authorized services. If the client renews eligibility, the provider must submit a new prior authorization request in order to receive reimbursement for the services.

TPN contains all the nutrients needed to sustain the client’s life development. The administration of intravenous fluids and electrolytes alone is not TPN.

**26.6.2.1 Prior Authorization**

Prior authorization is required for all TPN services, including lipids solution.

Providers must complete the [CSHCN Services Program Authorization and Prior Authorization Request Form](#) for TPN authorization requests. Documentation must include the following items:

- Diagnosis
- Start date of TPN
- Estimated time TPN is needed

- Documentation to support medical necessity of TPN. If lipids are medically necessary, the prior authorization request must also include documentation supporting the need for procedure code B4185 and B4187.

Prior authorization will be considered for clients with one of the following conditions.

- Anatomical, physiological, or motility disorder of the gastrointestinal tract.
- Prolonged bowel rest
- Gastrointestinal fistula
- Malignancies
- Inborn errors of amino acid metabolism
- Cystic Fibrosis
- Major trauma and burns
- Severe malnutrition, significant weight loss and/or hypoproteinaemia when enteral therapy is not possible
- Other disease states or conditions in which oral or enteral feeding are not an option

TPN may be approved up to a six-month duration.

**Note:** *Prior authorization requests for clients with conditions other than those listed will be forwarded to the CSHCN Services Program Medical Director or designee for consideration.*

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

### 26.6.3 Claims Information

TPN services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

### 26.6.4 Reimbursement

TPN services may be reimbursed a global daily rate based on the lower of the amount billed or the fee allowed by Texas Medicaid. TPN is payable only once per day, per client.

For fee information, providers can refer to the OFL on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## **26.7 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **NEUROSTIMULATORS AND NEUROMUSCULAR STIMULATORS**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# NEUROSTIMULATORS AND NEUROMUSCULAR STIMULATORS

## Table of Contents

|                  |  |           |
|------------------|--|-----------|
| <b>27.1</b>      | <b>Enrollment .....</b>  | <b>3</b>  |
| <b>27.2</b>      | <b>Benefits, Limitations, and Authorization Requirements .....</b> | <b>3</b>  |
| 27.2.1           | Dorsal Column Neurostimulation (DCN) .....                         | 4         |
| 27.2.2           | Intracranial Neurostimulation (ICN) .....                          | 5         |
| 27.2.3           | Neuromuscular Electrical Stimulation (NMES) .....                  | 6         |
| 27.2.3.1         | NMES for Muscle Atrophy .....                                      | 6         |
| 27.2.3.2         | NMES for Walking in Clients with Spinal Cord Injury .....          | 7         |
| 27.2.4           | Percutaneous Electrical Nerve Stimulation (PENS) .....             | 7         |
| 27.2.5           | Sacral Nerve Stimulation (SNS) .....                               | 8         |
| <b>27.2.6</b>    | <b>* Transcutaneous Electrical Nerve Stimulation (TENS) .....</b>  | <b>9</b>  |
| 27.2.6.1         | TENS Rental .....  | 9         |
| 27.2.6.2         | TENS Purchase .....  | 9         |
| 27.2.7           | Pelvic Floor Stimulation .....                                     | 10        |
| 27.2.8           | Vagal Nerve Stimulation (VNS) .....                                | 10        |
| 27.2.9           | Hypoglossal Nerve Stimulators (HNS) .....                          | 10        |
| 27.2.10          | Electronic Analysis for Implantable Neurostimulators .....         | 11        |
| 27.2.11          | Electrocorticogram .....   | 11        |
| 27.2.12          | Revision or Removal of Implantable Neurostimulators .....          | 11        |
| 27.2.13          | Implantable Neurstimulators and Neuromuscular Stimulators .....    | 12        |
| 27.2.13.1        | NMES and TENS Garments .....                                       | 12        |
| <b>27.2.13.2</b> | <b>*NMES and TENS Supplies .....</b>                               | <b>12</b> |
| <b>27.3</b>      | <b>Claims Information .....</b>                                    | <b>13</b> |
| <b>27.4</b>      | <b>Reimbursement .....</b>   | <b>13</b> |
| <b>27.5</b>      | <b>TMHP-CSHCN Services Program Contact Center .....</b>            | <b>14</b> |

## 27.1 Enrollment

To enroll in the CSHCN Services Program, providers of neurostimulators and neuromuscular stimulator devices and supplies must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services program enrollment process, and comply with all applicable state laws and requirements. Out-of-state providers of neurostimulator and neuromuscular stimulator devices and supplies must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 27.2 Benefits, Limitations, and Authorization Requirements

As outlined in this chapter, neurostimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting garments, are a benefit of the CSHCN Services Program.

All procedures and related devices for the initial application or surgical implantation of neurostimulators and neuromuscular stimulators require prior authorization with documentation that supports medical necessity with one of the approved diagnoses listed in this section.

Prior authorization requests for neurostimulator and neuromuscular stimulator procedures and related devices may be considered for clients without one of the approved diagnoses and with documentation of medical conditions which will be reviewed by the Department of State Health Services (DSHS)-CSHCN Services Program Medical Director or a designee.

Neurostimulator and neuromuscular stimulator supplies, including leads and electrodes, do not require prior authorization.

Neurostimulator and neuromuscular stimulator supplies may be considered for reimbursement on appeal with documentation of a prior neurostimulator or neuromuscular stimulator procedure for clients with a history greater than five years or for those who did not receive a neurostimulator procedure through the CSHCN Services Program.

The revision or removal of implantable neurostimulators or neuromuscular stimulators does not require prior authorization; however, if the neurostimulator or neuromuscular stimulator device must be replaced, the device itself requires prior authorization with documentation that supports medical necessity with one of the approved diagnoses.

Prior authorization requests, including supporting documentation, must be submitted on the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

### 27.2.1 Dorsal Column Neurostimulation (DCN)

DCN (procedure codes 63650, 63655, and 63685) involves the surgical implantation of neurostimulator electrodes within the dura mater or the percutaneous insertion of electrodes in the epidural space. The neurostimulation system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

DCN electrode implantation and the purchase of devices may be a benefit of the CSHCN Services Program when medically necessary for the treatment of chronic intractable pain. Permanent implantation will be considered when criteria are met, including completion of a one-month trial period demonstrating that an implantable device is needed.

Prior authorization for the implantation and purchase of DCN or ICN devices may be considered with one of the diagnosis codes listed in the table below:

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| G1223           | G1224   | G1225   | G129    | G20A1   | G20A2   | G20B1   | G20B2   |
| G20C            | G250    | G251    | G252    | G500    | G501    | G5771   | G5772   |
| G5773           | G5783   | G5793   | G8921   | G8928   | G8929   | G893    | M4321   |
| M4322           | M4323   | M4324   | M4325   | M4326   | M4327   | M4328   | M438X9  |
| M4800           | M4801   | M4802   | M4803   | M4804   | M4805   | M48061  | M48062  |
| M4807           | M4808   | M50020  | M50021  | M50022  | M50023  | M50120  | M50121  |
| M50122          | M50123  | M5020   | M5021   | M50220  | M50221  | M50222  | M50223  |
| M5023           | M5410   | M792    | S48011S | S48012S | S48021S | S48022S | S48111S |
| S48112S         | S48121S | S48122S | S48911S | S48912S | S48921S | S48922S | S58011S |
| S58012S         | S58021S | S58022S | S58111S | S58112S | S58121S | S58122S | S58911S |
| S58912S         | S58921S | S58922S | S68011S | S68012S | S68021S | S68022S | S68110S |
| S68111S         | S68112S | S68113S | S68114S | S68115S | S68116S | S68117S | S68120S |
| S68121S         | S68122S | S68123S | S68124S | S68125S | S68126S | S68127S | S68128S |
| S68411S         | S68412S | S68421S | S68511S | S68512S | S68521S | S68522S | S68610S |
| S68611S         | S68612S | S68613S | S68614S | S68615S | S68616S | S68617S | S68621S |
| S68622S         | S68623S | S68624S | S68625S | S68626S | S68627S | S68712S | S68721S |
| S68722S         | S78011S | S78012S | S78021S | S78022S | S78111S | S78112S | S78121S |
| S78122S         | S78911S | S78912S | S78921S | S78922S | S78929S | S88011S | S88012S |
| S88021S         | S88022S | S88111S | S88112S | S88121S | S88122S | S88911S | S88912S |
| S88921S         | S88922S | S98011S | S98012S | S98021S | S98022S | S98111S | S98112S |
| S98121S         | S98122S | S98131S | S98132S | S98141S | S98211S | S98221S | S98222S |
| S98311S         | S98312S | S98321S | S98322S | S98911S | S98912S | S98921S | T879    |

Prior authorization for the implantation and purchase of DCN or ICN devices may be considered with a condition indicating chronic pain that is refractory to conventional therapy. Covered diagnosis codes are listed in the above table.

Documentation submitted with the request for permanent implantation and purchase of the DCN device must also demonstrate that:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and were shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- The facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the client are available.
- There has been demonstrated evidence of pain relief during a trial period of DCN with a temporarily implanted electrode or electrodes preceding the permanent implantation. The trial period must be a minimum of 30 days in duration.

**Note:** *The trial period including device and supplies is considered part of DCN procedure and will not be separately reimbursed.*

Providers may request prior authorization for clients who do not meet the criteria listed for DCN or ICN in the table above. The provider must submit documentation of medical necessity with the request which will be reviewed by the DSHS-CSHCN Services Program Medical Director or a designee.

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of a DCN device:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| E0740           | L8681 | L8682 | L8683 | L8684 | L8685 | L8686 | L8687 | L8688 | L8689 |

### 27.2.2 Intracranial Neurostimulation (ICN)

ICN involves the stereotactic implantation of electrodes in the brain.

The surgical implantation, revision, and removal of intracranial deep-brain stimulators (DBS) are a benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS, or pharmacological management, have failed or were contraindicated.

ICN is also covered for the treatment of intractable tremors due to idiopathic Parkinson's disease or essential tremors.

Prior authorization for the implantation and purchase of DCN or ICN devices may be considered with one of the diagnosis codes listed in the table below:

| Diagnosis Codes |        |        |         |         |         |         |         |
|-----------------|--------|--------|---------|---------|---------|---------|---------|
| G1223           | G1224  | G1225  | G129    | G20A1   | G20A2   | G20B1   | G20B2   |
| G20C            | G250   | G251   | G252    | G500    | G501    | G5771   | G5772   |
| G5773           | G5783  | G5793  | G8921   | G8928   | G8929   | G893    | M4321   |
| M4322           | M4323  | M4324  | M4325   | M4326   | M4327   | M4328   | M438X9  |
| M4800           | M4801  | M4802  | M4803   | M4804   | M4805   | M48061  | M48062  |
| M4807           | M4808  | M50020 | M50021  | M50022  | M50023  | M50120  | M50121  |
| M50122          | M50123 | M5020  | M5021   | M50220  | M50221  | M50222  | M50223  |
| M5023           | M5410  | M792   | S48011S | S48012S | S48021S | S48022S | S48111S |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| S48112S         | S48121S | S48122S | S48911S | S48912S | S48921S | S48922S | S58011S |
| S58012S         | S58021S | S58022S | S58111S | S58112S | S58121S | S58122S | S58911S |
| S58912S         | S58921S | S58922S | S68011S | S68012S | S68021S | S68022S | S68110S |
| S68111S         | S68112S | S68113S | S68114S | S68115S | S68116S | S68117S | S68120S |
| S68121S         | S68122S | S68123S | S68124S | S68125S | S68126S | S68127S | S68128S |
| S68411S         | S68412S | S68421S | S68511S | S68512S | S68521S | S68522S | S68610S |
| S68611S         | S68612S | S68613S | S68614S | S68615S | S68616S | S68617S | S68621S |
| S68622S         | S68623S | S68624S | S68625S | S68626S | S68627S | S68712S | S68721S |
| S68722S         | S78011S | S78012S | S78021S | S78022S | S78111S | S78112S | S78121S |
| S78122S         | S78911S | S78912S | S78921S | S78922S | S78929S | S88011S | S88012S |
| S88021S         | S88022S | S88111S | S88112S | S88121S | S88122S | S88911S | S88912S |
| S88921S         | S88922S | S98011S | S98012S | S98021S | S98022S | S98111S | S98112S |
| S98121S         | S98122S | S98131S | S98132S | S98141S | S98211S | S98221S | S98222S |
| S98311S         | S98312S | S98321S | S98322S | S98911S | S98912S | S98921S | T879    |

ICN procedures may be reimbursed using the following procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 61781           | 61850 | 61860 | 61863 | 61864 | 61867 | 61868 | 61885 | 61886 |

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of an ICN device:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| E0740           | L8681 | L8682 | L8683 | L8684 | L8685 | L8686 | L8687 | L8688 | L8689 |

### 27.2.3 Neuromuscular Electrical Stimulation (NMES)

NMES (procedure code 64580) is used for the treatment of muscle atrophy or to enhance the functional activity of neurologically impaired clients as described in Section 27.2.3.1, “NMES for Muscle Atrophy” in this chapter and Section 27.2.3.2, “NMES for Walking in Clients with Spinal Cord Injury” in this chapter.

NMES requires prior authorization. The prior authorization request form must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

The following procedure codes may be reimbursed for the rental or purchase of an NMES device:

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| E0720           | E0730 | E0731 | E0745 | E0762 | E0764 |

The purchase of an NMES device is limited to once every 5 years.

#### 27.2.3.1 NMES for Muscle Atrophy

NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other non-neurological reasons. Examples of NMES treatment for non-neurological reasons include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

### 27.2.3.2 NMES for Walking in Clients with Spinal Cord Injury

The type of NMES used to enhance an SCI client's ability to walk is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. Reimbursement for NMES and FES is limited to SCI clients who have completed a training program consisting of at least 32 physical therapy sessions with the device over a period of 3 months.

The trial period of physical therapy will enable the physician treating the client for SCI to properly evaluate the client's ability to use NMES and FES devices frequently and for the long term.

Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.

***Note:** The goal of physical therapy must be to train SCI clients on the use of NMES and FES devices to achieve walking, not to reverse or retard muscle atrophy.*

NMES and FES used for walking is a benefit for clients with SCI who have all of the following characteristics:

- Intact lower motor unit (L1 and below; both muscle and peripheral nerve)
- Muscle and joint stability for weight bearing at upper and lower extremities, and the balance and control necessary to maintain an upright support posture independently
- Demonstrated brisk muscle contraction with NMES and have sensory perception electrical stimulation sufficient for muscle contraction
- High motivation, commitment, and cognitive ability necessary to use such devices for walking
- Ability to transfer independently and demonstrated independent standing tolerance for at least 3 minutes
- Demonstrated hand and finger function to manipulate controls
- At least 6-month recovery post spinal cord injury and restorative surgery
- Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis
- Demonstrated a willingness to use the device in the long term

NMES and FES used for walking is not a benefit for clients with any of the following conditions:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dysflexia

### 27.2.4 Percutaneous Electrical Nerve Stimulation (PENS)

Implantation of PENS and electrodes is a benefit of the CSHCN Services Program. PENS (procedure codes 64553, 64555, and 64590) is a diagnostic service and may be covered for a 1-month trial to determine if an implantable device is needed. The medical necessity for such diagnostic services which are furnished beyond the first month must be documented, including the rationale for not considering an implantable device.

Because PENS is an office or outpatient therapy, the rental or purchase of the PENS devices, accessories, and supplies is not a benefit of the CSHCN Services Program.

Providers may request prior authorization for clients who do not meet the criteria listed for PENS in the table below. The provider must submit documentation of medical necessity with the request which will be reviewed by the DSHS-CSHCN Services Program Medical Director of a designee.

- Treatment with TENS must have failed or have been contraindicated for the client.
- The client must have a diagnosis indicating chronic pain that is refractory to conventional therapy. The covered diagnosis codes include the following:

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| G1223           | G1224   | G1225   | G129    | G20A1   | G20A2   | G20B1   | G20B2   |
| G20C            | G250    | G251    | G252    | G500    | G501    | G5771   | G5772   |
| G5773           | G5783   | G5793   | G8921   | G8928   | G8929   | G893    | M4321   |
| M4322           | M4323   | M4324   | M4325   | M4326   | M4327   | M4328   | M438X9  |
| M4800           | M4801   | M4802   | M4803   | M4804   | M4805   | M4807   | M4808   |
| M50020          | M50021  | M50022  | M50023  | M50120  | M50121  | M50122  | M50123  |
| M5020           | M5021   | M50220  | M50221  | M50222  | M50223  | M5023   | M5410   |
| M792            | S48011S | S48012S | S48021S | S48022S | S48111S | S48112S | S48121S |
| S48122S         | S48911S | S48912S | S48921S | S48922S | S58011S | S58012S | S58021S |
| S58022S         | S58111S | S58112S | S58121S | S58122S | S58911S | S58912S | S58921S |
| S58922S         | S68011S | S68012S | S68021S | S68022S | S68110S | S68111S | S68112S |
| S68113S         | S68114S | S68115S | S68116S | S68117S | S68120S | S68121S | S68122S |
| S68123S         | S68124S | S68125S | S68126S | S68127S | S68128S | S68411S | S68412S |
| S68421S         | S68511S | S68512S | S68521S | S68522S | S68610S | S68611S | S68612S |
| S68613S         | S68614S | S68615S | S68616S | S68617S | S68621S | S68622S | S68623S |
| S68624S         | S68625S | S68626S | S68627S | S68712S | S68721S | S68722S | S78011S |
| S78012S         | S78021S | S78022S | S78111S | S78112S | S78121S | S78122S | S78911S |
| S78912S         | S78921S | S78922S | S78929S | S88011S | S88012S | S88021S | S88022S |
| S88111S         | S88112S | S88121S | S88122S | S88911S | S88912S | S88921S | S88922S |
| S98011S         | S98012S | S98021S | S98022S | S98111S | S98112S | S98121S | S98122S |
| S98131S         | S98132S | S98141S | S98211S | S98221S | S98222S | S98311S | S98312S |
| S98321S         | S98322S | S98911S | S98912S | S98921S | T879    |         |         |

All equipment and supplies for PENS are considered part of the service and are not reimbursed separately.

### 27.2.5 Sacral Nerve Stimulation (SNS)

SNS (procedure codes 64561, 64581, and 64590) is a benefit of the CSHCN Services Program. Prior authorization for the implantation and purchase of SNS devices may be considered with one of the following medical conditions:

- Urinary incontinence secondary to urethral instability and/or detrusor muscle instability
- Chronic voiding dysfunction
- Non-obstructive urinary retention
- Fecal Incontinence



The client's medical record must include documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

Providers may request prior authorization for clients who do not meet the criteria listed above. The provider must submit documentation of medical necessity with the request that will be reviewed by the DSHS-CSHCN Services Program Medical Director or designee.

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of an SNS device:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| L8681           | L8682 | L8683 | L8684 | L8685 | L8686 | L8687 | L8688 | L8689 |

### 27.2.6 \* Transcutaneous Electrical Nerve Stimulation (TENS)

TENS (procedure code 64580) is a benefit of the CSHCN Services Program. Rental of the TENS device, accessories, and supplies is a benefit for the treatment of acute postoperative pain or to determine if TENS will benefit a client with chronic pain.

The following procedure codes may be reimbursed for the rental or purchase of a TENS device:

| [Revised] Procedure Codes |       |       |       |       |       |       |  |  |  |
|---------------------------|-------|-------|-------|-------|-------|-------|--|--|--|
| E0720                     | E0730 | E0731 | E0733 | E0745 | E0762 | E0764 |  |  |  |

[Revised] Procedure code E0733 is restricted to diagnosis code G500.

Once it has been determined that TENS should be continued for chronic pain and the client has been trained to use the stimulator, the CSHCN Services Program will no longer reimburse TENS therapy as an outpatient or office service.

#### 27.2.6.1 TENS Rental

The rental of a TENS device may be considered for prior authorization with documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS may be considered before purchase and is limited to a trial period of 1 month. One additional month's rental of the TENS device may be considered with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be reimbursed separately. Garments may be reimbursed during the rental period when medically necessary.

Rental reimbursement may not exceed the purchase price. Purchase is justified when the estimated duration of need multiplied by the rental rate exceeds the purchase price of the equipment.

#### 27.2.6.2 TENS Purchase

The purchase of a TENS device, accessories, and supplies may be considered only after a 1-month trial period. In addition, the purchase of a TENS device will be considered for prior authorization with documentation of all of the following:

- Acute postoperative pain or chronic pain that is refractory to conventional therapy
- Successful test stimulation (during the rental or other therapeutic period) that shows improvement as measured by a demonstrated increase in range of motion
- Improved ability to complete activities of daily living or perform activities outside the home

The purchase of a TENS device is limited to once every 5 years.

### 27.2.7 Pelvic Floor Stimulation

Prior authorization is not required for the purchase of a pelvic floor stimulator (procedure code E0740) when the criteria listed below are met:

- Has a diagnosis of stress or urge incontinence.
- Has completed a six-month trial of conservative treatment with no significant clinical improvement, such as Kegel exercises, behavior management, bladder training or medication.

Providers may request prior authorization for clients who do not meet the criteria listed above. The provider must submit documentation of medical necessity with the request, which will be reviewed by the DSHS-CSHCN Services Program Medical Director or a designee.

### 27.2.8 Vagal Nerve Stimulation (VNS)

The implantation, revision, programming, and removal of the VNS device are a benefit of the CSHCN Services Program for clients with medically intractable seizures who are not candidates for surgical intervention. VNS (procedure codes 61885, 61886, 64553, 64568, 64569, and 64570) may be reimbursed only when the diagnosis reflects medically refractory partial-onset seizures.

Prior authorization is required for the implantation and purchase of VNS devices. Prior authorization for the implantation and purchase of VNS devices may be considered for clients with partial onset intractable seizures when there is failure, contraindication or intolerance to all suitable medical and pharmacological management.

VNS is not a benefit in the following cases:

- Treatment of clients with an absent left vagus nerve
- Treatment of clients with depression
- Treatment of clients with a progressively terminal illness or a medical disease that imparts a poor diagnosis

Prior Authorization is not required for procedure codes 64569 and 64570.

Incapacities that are due to intellectual disabilities (ID) or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of ID or cerebral palsy exists, the treating physician must document in the medical record how VNS will measurably benefit the client in spite of ID or cerebral palsy.

Providers may request prior authorization for clients who do not meet the criteria listed above. The provider must submit documentation of medical necessity with the request that will be reviewed by the DSHS-CSHCN Services Program Medical Director or designee.

Only one similar device code may be reimbursed per date of service for any provider. The following procedure codes may be reimbursed for the purchase of a VNS device:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| E0740           | L8681 | L8682 | L8683 | L8684 | L8685 | L8686 | L8687 | L8688 | L8689 |

### 27.2.9 Hypoglossal Nerve Stimulators (HNS)

HNS (procedure code 64582) is a benefit of the CSHCN Services Program when medically necessary and prior authorized, for the treatment of obstructive sleep apnea (OSA) and seizures.

The revision or removal of an HNS may be reimbursed using procedure codes 64583 and 64584. Procedure codes 64583 and 64584 do not require prior authorization.

The surgical implantation of HNS and purchase of a device may be considered for prior authorization with documentation of the following:

- Client has a documented diagnosis of obstructive OSA or seizures by a qualified health-care provider.
- For OSA diagnosis, requests must include documentation that the client's compliant use of continuous positive airway pressure (CPAP) for a minimum of 1 month (5 nights per week for at least 4 hours per night) has not been successful or is unable to be tolerated.
- For OSA diagnosis, absence of complete concentric collapse at the soft palate level as seen on a drug-induced sleep endoscopy (DISE) procedure.

### 27.2.10 Electronic Analysis for Implantable Neurostimulators

The following procedure codes may be reimbursed for the electronic analysis of the implanted neurostimulator:

| Procedure Codes |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|
| 95970           | 95971 | 95972 | 95976 | 95977 | 95983 | 95984 |

### 27.2.11 Electrocardiogram

Electrocardiogram (procedure code 95836) is a benefit of the CSHCN Services Program and may be reported only once for each 30 day period.

### 27.2.12 Revision or Removal of Implantable Neurostimulators

The revision or removal of implantable neurostimulators (DCN, ICN, SNS, or VNS) may be reimbursed as a surgery or assistant surgery using the following procedure codes:

| Device                                | Procedure Codes                      |
|---------------------------------------|--------------------------------------|
| DCN                                   | 63661, 63662, 63663, 63664, or 63688 |
| ICN                                   | 61781, 61880 or 61888*               |
| SNS                                   | 64585 or 64595                       |
| VNS                                   | 61888*, 64569 or 64570               |
| *Not a benefit for assistant surgery. |                                      |

Ambulatory surgical centers may be reimbursed using the procedure codes listed in the table above, except for procedure code 61781. These procedure codes are not a benefit for ambulatory surgical centers.

Supplies for the implantable devices listed in this policy may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the last 5 years.

**Note:** Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the initial device may be required.

Supplies for implantable devices as listed in this policy may be considered for reimbursement on appeal with documentation of a prior neurostimulator or neuromuscular stimulator implantation procedure for clients with a history greater than 5 years or for those who did not receive a neurostimulator procedure through CSHCN Services Program.

The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed using procedure code 64595.

### 27.2.13 Implantable Neurostimulators and Neuromuscular Stimulators

Implantable neurostimulator services may be reimbursed using procedure code 64575. Implantable supply (procedure codes A4290, L8680, and L8696) will be denied if they are not submitted for clients with a purchased device and a claims history within 5 years of related procedure code 64575 by any provider.

One of the following implantable neurostimulator device procedure codes must be billed on the same date of service as related procedure code 64575 by any provider.

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| L8681           | L8682 | L8683 | L8684 | L8685 | L8686 | L8687 | L8688 | L8689 |

Neurostimulator supplies, including leads and electrodes, may be benefits for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator procedure within the last five years.

Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the initial device may be required.

#### 27.2.13.1 NMES and TENS Garments

The prior authorization request form for the purchase of the NMES and TENS conductive garments must include supporting documentation that shows:

- The garment has been prescribed by a physician for use in delivering covered NMES and TENS treatment.
- The client has successfully completed a 1-month trial period.
- The conductive garment is necessary for one of the medical indications outlined below:
  - The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  - The client cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  - The client has a documented medical condition, such as a skin problem, that precludes the application of conventional electrodes, adhesive tapes, and lead wires.

The rental of the NMES and TENS garment is not a benefit during the trial rental period unless the client has a documented skin problem prior to the start of the trial period; and DSHS or its designee is satisfied that the use of such an item is medically necessary for the client.

#### 27.2.13.2 \* NMES and TENS Supplies

[Revised] NMES and TENS supplies may be reimbursed with procedure code A4541, A4556, A4557, or A4595.

Supplies for purchased devices are limited as follows:

- If additional electrodes are required, procedure code A4556 may be reimbursed at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be reimbursed at a maximum of two per month.
- [Revised] Procedure codes A4541 and A4595 are limited to one per month.

- [Revised] Procedure code A4541 is restricted to diagnosis code G500.

The purchase of supplies for NMES/TENS may only be considered for reimbursement for clients with a purchased device and a claims history of a NMES/TENS procedure within the last 5 years.

The physician or physical therapist providing the services may furnish the equipment necessary for assessment. When the physician or physical therapist advises the client to rent the TENS from a supplier during the trial period rather than supplying it, program payment may be made for the rental of the TENS as well as for the services of the physician or physical therapist who is evaluating its use. However, the combined program payment made for the physician's or physical therapist's services and rental of the stimulator from a supplier should not exceed the amount which would be a benefit for the total service, including the stimulator, furnished by the physician or physical therapist alone.

## 27.3 Claims Information

To avoid claim denials, providers billing as a group must use the performing National Provider Identifier (NPI) number on their claims.

Neurostimulator devices and supplies must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

All claims and authorization requests submitted by CSHCN Services Program home health durable medical equipment (DME) providers must be submitted with benefit code DM3.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 27.4 Reimbursement

Neuromuscular devices and the implantation codes must be billed on the same day by any provider.

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Inpatient hospitals may be reimbursed at 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment for all CSHCN services.

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

DME suppliers may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Advanced practice registered nurses (APRNs) and physician assistants (PAs) may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service performed by a physician.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## **27.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **ORTHOTIC AND PROSTHETIC DEVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# ORTHOTIC AND PROSTHETIC DEVICES

## Table of Contents

- 28.1 Enrollment .....4**
- 28.2 Benefits, Limitations, and Authorization Requirements .....4**
  - 28.2.1 General Authorization Requirements ..... 5
  - 28.2.2 Orthoses and Prostheses (Not All-Inclusive) ..... 5
    - 28.2.2.1 Repairs, Replacements, and Modifications to Orthoses and Prostheses ..... 6
    - 28.2.2.2 Mechanical Stretching Devices ..... 6
    - 28.2.2.3 Orthoses and Prostheses Training ..... 7
- 28.3 Orthoses and Related Services .....7**
  - 28.3.1 Prior Authorization and Documentation Requirements ..... 7
  - 28.3.2 Orthotic and Orthopedic Devices Procedure Codes ..... 8
  - 28.3.3 Noncovered Orthotic and Prosthetic Services ..... 10
  - 28.3.4 Spinal Orthoses ..... 11
  - 28.3.5 Thoracic-Hip-Knee-Ankle (THKA) Orthoses ..... 11
  - 28.3.6 Lower-Limb Orthoses ..... 11
    - 28.3.6.1 Ankle-Foot Orthoses (AFO) ..... 11
    - 28.3.6.2 Reciprocating Gait Orthoses (RGO) ..... 11
  - 28.3.7 Foot Orthoses ..... 12
    - 28.3.7.1 Foot Inserts ..... 12
    - 28.3.7.2 Prescription Shoes ..... 13
    - 28.3.7.3 Noncovered Shoes or Shoe Inserts ..... 13
    - 28.3.7.4 Wedges and Lifts ..... 13
  - 28.3.8 Upper-Limb Orthoses ..... 13
  - 28.3.9 Other Orthopedic Devices ..... 14
    - 28.3.9.1 Protective Helmets ..... 14
    - 28.3.9.2 Cranial Molding Orthosis ..... 14
      - 28.3.9.2.1 *Definitions of Plagiocephaly* ..... 14
      - 28.3.9.2.2 *Authorization Requirements* ..... 15
    - 28.3.9.3 Static and Dynamic Mechanical Stretching Devices ..... 16
- 28.4 Prostheses and Related Services .....16**
  - 28.4.1 Prior Authorization and Documentation Requirements ..... 16
  - 28.4.2 \* Prostheses Procedure Codes ..... 17**
  - 28.4.3 Preparatory or Temporary Prostheses ..... 19
  - 28.4.4 Upper-Limb Prostheses ..... 19
    - 28.4.4.1 Myoelectric Prostheses ..... 19
  - 28.4.5 Lower-Limb Prostheses ..... 19
    - 28.4.5.1 Microprocessor-Controlled Lower-Limb Prostheses ..... 20
    - 28.4.5.2 Foot Prostheses ..... 20
    - 28.4.5.3 Knee Prosthesis ..... 20
    - 28.4.5.4 Ankle Prosthesis ..... 21
    - 28.4.5.5 Sockets ..... 21



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|             |  |           |
|-------------|--|-----------|
| 28.4.5.6    | Accessories.....   | 21        |
| <b>28.5</b> | <b>Repairs, Replacements, and Modifications to Orthoses and Prostheses .....</b> | <b>21</b> |
| 28.5.1      | Other Artificial Devices .....   | 21        |
| <b>28.6</b> | <b>CSHCN Services Program Documentation of Receipt.....</b>                      | <b>22</b> |
| <b>28.7</b> | <b>Claims Information.....</b>   | <b>22</b> |
| <b>28.8</b> | <b>Reimbursement.....</b>  | <b>23</b> |
| <b>28.9</b> | <b>TMHP-CSHCN Services Program Contact Center.....</b>                           | <b>23</b> |

## 28.1 Enrollment

To enroll in the CSHCN Services Program, an orthotics and prosthetics provider must be actively enrolled in Texas Medicaid as a durable medical equipment (DME) provider or as a licensed prosthetist and/or orthotist, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process by enrolling as an individual or as a group of performing providers, and comply with all applicable state laws and requirements. The CSHCN Services Program does not enroll orthotists and prosthetists as facilities. Out-of-state orthotics and prosthetics providers must meet all of these conditions, and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 28.2 Benefits, Limitations, and Authorization Requirements

Orthoses, prostheses, and prescription shoes may be a benefit of the CSHCN Services Program. These benefits are solely for external orthoses and prostheses. Items must be prescribed by a licensed physician or podiatrist (for conditions below the ankle) and fitted by an orthotist or prosthetist enrolled in the CSHCN Services Program, even if the device is supplied by another enrolled provider type. Noncustom commercial products may be supplied through a physician’s office. Licensed occupational therapists may provide upper extremity splints and inhibitive casting, and licensed physical therapists may provide lower extremity inhibitive casts.

Training in the use of an orthotic or prosthetic device for a client who has not worn one previously, has not worn one for a prolonged time period, or is receiving a different type may be reimbursed when provided by a licensed PT or OT. Therapy for the purpose of training a client in the use of an orthotic or prosthetic device will be approved for up to five times a week for 1 month; then three times a week for 2 months. Additional request forms require documentation of medical necessity.

### 28.2.1 General Authorization Requirements

All orthoses and prostheses procedures addressed in this chapter require prior authorization. Requests for prior authorization must be in writing on a completed [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#) with all procedure codes included. Documentation that supports the medical necessity of the requested item must be included with the prior authorization request.

Modifications of orthotic and prosthetic systems, due to growth or a change in medical status, may be prior authorized. Repairs required due to normal wear may be prior authorized. Additional information may be requested to determine if repairs and modifications are cost-effective.

### 28.2.2 Orthoses and Prostheses (Not All-Inclusive)

The following listed conditions are a guide. Additional documentation of medical necessity must be provided if orthoses, prostheses (artificial limbs), or other orthopedic devices are requested for an unlisted condition:

| Orthoses   | Applicable Condition   |
|--|--|
| Helmet   | Neoplasms of the brain, subarachnoid hemorrhage, subdural hemorrhage, hemophilia, epilepsy, cerebral palsy   |
| Spinal orthosis, collar, corset, body jacket (thoracic-lumbar-sacral orthoses [TLSO], lumbar-sacral orthoses [LSO], cervical thoracic-lumbar-sacral orthoses [CTLSO])          | Scoliosis, spinal injuries, paraplegia, kyphosis, neurofibromatosis, cerebral palsy, spina bifida, spinal tumor  |
| Hip orthosis (HO), Pavlik harness, Ilfeld, Craig   | Dislocated hip, cerebral palsy, spina bifida, congenital deformities of hip  |
| Thoracic-hip-knee-ankle orthosis (THKAO), parapodium (standing frame), swivel walker   | Spina bifida, spinal injuries, spinal tumor, cerebral palsy, paraplegia  |
| Hip-knee-ankle-foot orthosis (HKAFO), knee-ankle-foot orthosis (KAFO) (also known as a long leg brace), knee orthosis (KO), knee immobilizer                                   | Spina bifida, cerebral palsy, paraplegia, late effects of CVA, spinal cord lesions, arthrogryposis, club foot, varus deformities of feet, genu varus and genu valgus if due to growth deformity, arthropathy associated with hematological disorders related to lower extremity conditions |
| Ankle foot orthosis (AFO)  | Foot anomalies, cerebral palsy, hemiplegia, spina bifida, club foot, arthrogryposis, arthropathy associated with extremity conditions  |
| Inhibitive casting   | Cerebral palsy, increased muscle tone related to central nervous system lesions/disorders  |
| Foot orthosis, Dennis Brown splint, counter-rotation system  | Foot anomalies, tibial torsion, club foot, varus deformities of feet, cerebral palsy, spina bifida, arthrogryposis, arthritic conditions (medical justification needed for valgus deformities of the feet)   |
| Upper extremity orthosis, shoulder orthosis (SO), elbow orthosis (EO), wrist-hand-finger orthosis (WHFO), mobile arm support (MAS: shoulder-elbow-wrist-hand orthoses [SEWHO]) | Cerebral palsy, spinal cord injury, brachial plexus lesions, nerve lesions, paralysis, juvenile rheumatoid arthritis, reduction of deformities   |
| Static or Dynamic Mechanical Stretching Device   | Cerebral palsy, increased muscle tone related to central nervous system lesions/disorders  |
| University of California–Berkeley (UCB) shoe   | Valgus deformity and significant congenital pes planus with pain, a structural problem that results in significant pes planus, acute plantar fasciitis, or a diagnosis of hemophilia   |

| Orthoses   | Applicable Condition  |
|--|---|
| Reciprocating gait orthosis (RGO)  | Spina bifida or similar functional disabilities   |
| Partial foot, ankle, below knee, above knee, hip disarticulation, hemipelvectomy, immediate postsurgical | Congenital absence, surgical revision, or traumatic amputation of lower extremity or hip      |
| Partial hand, wrist disarticulation, below elbow, above elbow, elbow disarticulation                     | Congenital absence, surgical revision, or traumatic amputation of upper extremity or shoulder |
| Myoelectric prostheses (powered limbs)   | Congenital absence of limb, traumatic amputation limb, bilateral shoulder disarticulation     |

### 28.2.2.1 Repairs, Replacements, and Modifications to Orthoses and Prostheses

Repairs, replacements, and modifications to orthoses and prostheses are a benefit of the CSHCN Services Program when medically necessary criteria are met.

Repairs due to normal wear and modifications due to growth or change in medical status will be considered for prior authorization when the repair or modification is more cost-effective than the replacement of the device.

- Additional information from the provider may be requested to determine cost-effectiveness.
- Documentation supporting medical necessity must be provided when requesting prior authorization.

Replacement of orthotic or prosthetic devices will be considered for prior authorization with medical justification.

- Orthotic devices are anticipated to last a minimum of 6 months from the receipt of the initial system.
- Prosthetic devices are anticipated to last a minimum of one year from the receipt of the initial definitive/permanent system.
- Preparatory or temporary prostheses may be replaced in less than 12 months of their receipt, but they will undergo medical review if the permanent prosthesis is requested less than 6 months after provision of the preparatory or temporary prosthesis.
- Replacement of an orthosis or prosthesis will be considered when loss or irreparable damage has occurred due to a traumatic event such as a vehicle accident, a residential fire, or theft. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent a repeat of similar loss.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

### 28.2.2.2 Mechanical Stretching Devices

Mechanical stretching devices are a benefit of the CSHCN Services Program. Mechanical stretching devices are not motorized and may be prefabricated or custom fabricated. The following are Classifications of Stretching Devices:

- Dynamic low-load prolonged-duration stretch (LLPS) devices
- Static progressive stretch (SPS) device
- Patient-actuated serial stretch (PASS) device

### **28.2.2.3 Orthoses and Prostheses Training**

Training in the use of an orthosis or prosthesis for a client who has not worn one previously, has not worn one for a prolonged time period, or is receiving a different type is a benefit when the training is provided by a licensed physical or occupational therapist.

Therapy for the purpose of training a client in the use of an orthosis or prosthesis may be approved for up to 5 times per week for 1 month; then 3 times per week for 2 months. Additional requests will require medical review.

RGO and dynamic splints require medical review at the onset of training therapy.

## **28.3 Orthoses and Related Services**

All requests for prior authorization must include documentation of medical necessity including documentation that the client meets one of the following general indications for the requested device:

- Reducing pain by restricting mobility of the affected body part
- Facilitating healing following injury or surgery to the affected body part
- Supporting weak muscles or a deformity of the affected body part

The provider must maintain written documentation in the client's medical record including the prescription for the device and accurate diagnostic information supporting the medical necessity for the requested device.

### **28.3.1 Prior Authorization and Documentation Requirements**

Prior authorization is required for all orthoses and related services. All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets all of the following general indications for the requested device.

Orthoses will be considered for prior authorization with documentation that the device is needed for one of the following indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles and/or a deformity of the affected body part.

The provider must maintain the following written documentation in the client's medical record:

- The prescription for the device.
- Orthotic and devices must be prescribed by a physician (M.D., D.O.) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
- Accurate diagnostic information supporting the medical necessity for the requested device.
- The prior authorization is valid for a maximum period of six months from the prescription signature date. At the end of the six-month authorization period, a new prescription is required for prior authorization of additional services.
- Other orthopedic devices will be considered for prior authorization with documentation of medical necessity as outlined for the specific orthotic device.

### 28.3.2 Orthotic and Orthopedic Devices Procedure Codes

The following orthoses procedure codes may be reimbursed in the home setting to an orthotist, prosthetist, medical supplier (DME), and custom DME provider:

| <b>Orthoses Procedure Codes</b>                          |                       |       |                       |       |       |       |       |       |       |
|--|-----------------------|-------|-----------------------|-------|-------|-------|-------|-------|-------|
| <b>Protective Helmets</b>                                |                       |       |                       |       |       |       |       |       |       |
| A8000  | A8001                 | A8002 | A8003                 | A8004 |       |       |       |       |       |
| <b>Static and Dynamic Devices (Purchased and Rental)</b> |                       |       |                       |       |       |       |       |       |       |
| E1800  | E1801                 | E1802 | E1805                 | E1806 | E1810 | E1811 | E1812 | E1815 | E1816 |
| E1818  | E1820 (purchase only) |       | E1821 (purchase only) |       | E1825 | E1830 | E1840 | E1841 |       |
| <b>Cervical Orthoses</b>                                 |                       |       |                       |       |       |       |       |       |       |
| L0112  | L0113                 | L0120 | L0130                 | L0140 | L0150 | L0160 | L0170 | L0172 | L0174 |
| L0180  | L0190                 | L0200 |                       |       |       |       |       |       |       |
| <b>Thoracic Rib Belts</b>                                |                       |       |                       |       |       |       |       |       |       |
| L0220  |                       |       |                       |       |       |       |       |       |       |
| <b>Thoracic-Lumbar-Sacral Orthoses</b>                   |                       |       |                       |       |       |       |       |       |       |
| L0450  | L0452                 | L0454 | L0455                 | L0456 | L0457 | L0458 | L0460 | L0462 | L0464 |
| L0466  | L0467                 | L0468 | L0469                 | L0470 | L0472 | L0480 | L0482 | L0484 | L0486 |
| L0488  | L0490                 | L0491 | L0492                 |       |       |       |       |       |       |
| <b>Sacroiliac Orthoses</b>                               |                       |       |                       |       |       |       |       |       |       |
| L0621  | L0622                 | L0623 | L0624                 |       |       |       |       |       |       |
| <b>Lumbar Orthoses</b>                                   |                       |       |                       |       |       |       |       |       |       |
| L0625  | L0626                 | L0627 |                       |       |       |       |       |       |       |
| <b>Lumbar-Sacral Orthoses</b>                            |                       |       |                       |       |       |       |       |       |       |
| L0628  | L0629                 | L0630 | L0631                 | L0632 | L0633 | L0634 | L0635 | L0636 | L0637 |
| L0638  | L0639                 | L0640 | L0641                 | L0642 | L0643 | L0648 | L0649 | L0650 | L0651 |
| <b>Cervical-Thoracic-Lumbar-Sacral Orthoses</b>          |                       |       |                       |       |       |       |       |       |       |
| L0700  | L0710                 |       |                       |       |       |       |       |       |       |
| <b>Halo Procedures</b>                                   |                       |       |                       |       |       |       |       |       |       |
| L0810  | L0820                 | L0830 | L0859                 | L0861 |       |       |       |       |       |
| <b>Spinal Corset Orthoses</b>                            |                       |       |                       |       |       |       |       |       |       |
| L0970  | L0972                 | L0974 | L0976                 |       |       |       |       |       |       |
| <b>Miscellaneous Devices</b>                             |                       |       |                       |       |       |       |       |       |       |
| L0978  | L0980                 | L0982 | L0984                 | L0999 |       |       |       |       |       |
| <b>Spinal Orthosis-Milwaukee Brace</b>                   |                       |       |                       |       |       |       |       |       |       |
| L1000  |                       |       |                       |       |       |       |       |       |       |
| <b>CTLSO- Infant Size Immobilizer</b>                    |                       |       |                       |       |       |       |       |       |       |
| L1001  |                       |       |                       |       |       |       |       |       |       |
| <b>Spinal Orthoses for Scoliosis</b>                     |                       |       |                       |       |       |       |       |       |       |
| L1005  | L1010                 | L1020 | L1025                 | L1030 | L1040 | L1050 | L1060 | L1070 | L1080 |
| L1085  | L1090                 | L1100 | L1110                 | L1120 |       |       |       |       |       |

| <b>Orthoses Procedure Codes</b>  |         |       |       |       |       |         |       |       |       |
|--|---------|-------|-------|-------|-------|---------|-------|-------|-------|
| <b>Thoracic–Lumbar–Sacral Orthoses–Initial and Additions</b>                             |         |       |       |       |       |         |       |       |       |
| L1200  | L1210   | L1220 | L1230 | L1240 | L1250 | L1260   | L1270 | L1280 | L1290 |
| <b>Other Spinal Orthoses</b>   |         |       |       |       |       |         |       |       |       |
| L1300  | L1310   | L1499 |       |       |       |         |       |       |       |
| <b>Hip Orthoses</b>  |         |       |       |       |       |         |       |       |       |
| L1600  | L1610   | L1620 | L1630 | L1640 | L1650 | L1652   | L1660 | L1680 | L1685 |
| L1686  | L1690   | L1700 |       |       |       |         |       |       |       |
| <b>Legg Perthes Orthoses</b>   |         |       |       |       |       |         |       |       |       |
| L1710  | L1720   | L1730 | L1755 |       |       |         |       |       |       |
| <b>Knee Orthoses</b>   |         |       |       |       |       |         |       |       |       |
| L1810  | L1812   | L1820 | L1830 | L1831 | L1832 | L1833   | L1834 | L1836 | L1840 |
| L1843  | L1844   | L1845 | L1846 | L1847 | L1848 | L1850   | L1851 | L1852 | L1860 |
| <b>Ankle-Foot Orthoses/Ankle Orthoses</b>  |         |       |       |       |       |         |       |       |       |
| L1900  | L1902   | L1904 | L1906 | L1907 | L1910 | L1920   | L1930 | L1932 | L1940 |
| L1945  | L1950   | L1951 | L1960 | L1970 | L1971 | L1980   | L1990 |       |       |
| <b>Knee-Ankle-Foot Orthoses</b>  |         |       |       |       |       |         |       |       |       |
| L2000  | L2005   | L2006 | L2010 | L2020 | L2030 | L2034   | L2035 | L2036 | L2037 |
| L2038  |         |       |       |       |       |         |       |       |       |
| <b>Hip-Knee-Ankle-Foot Orthoses</b>  |         |       |       |       |       |         |       |       |       |
| L2040  | L2050   | L2060 | L2070 | L2080 | L2090 |         |       |       |       |
| <b>Fracture Orthoses–Lower Limb</b>  |         |       |       |       |       |         |       |       |       |
| L2106  | L2108   | L2112 | L2114 | L2116 | L2126 | L2128   | L2132 | L2134 | L2136 |
| <b>Additions to Lower–Limb Orthoses</b>  |         |       |       |       |       |         |       |       |       |
| <b>* May also be reimbursed in the outpatient hospital setting to hospital providers</b> |         |       |       |       |       |         |       |       |       |
| L2180  | L2182   | L2184 | L2186 | L2188 | L2190 | L2192   | L2200 | L2210 | L2220 |
| L2230  | L2232 * | L2240 | L2250 | L2260 | L2265 | L2270 * | L2275 | L2280 | L2300 |
| L2310  | L2320   | L2330 | L2335 | L2340 | L2350 | L2360   | L2370 | L2375 | L2380 |
| L2385  | L2387   | L2390 | L2395 | L2397 | L2405 | L2415   | L2425 | L2430 | L2492 |
| L2500  | L2510   | L2520 | L2525 | L2526 | L2530 | L2540   | L2550 | L2570 | L2580 |
| L2600  | L2610   | L2620 | L2622 | L2624 | L2627 | L2628   | L2630 | L2640 | L2650 |
| L2660  | L2670   | L2680 | L2750 | L2755 | L2760 | L2768   | L2780 | L2785 | L2795 |
| L2800  | L2810   | L2820 | L2830 | L2840 | L2850 | L2861   |       |       |       |
| <b>Miscellaneous Lower–Limb Orthosis</b>   |         |       |       |       |       |         |       |       |       |
| L2999  |         |       |       |       |       |         |       |       |       |
| <b>Foot Orthoses/Inserts and Arch Supports</b>   |         |       |       |       |       |         |       |       |       |
| L3000  | L3001   | L3002 | L3003 | L3010 | L3020 | L3030   | L3031 | L3040 | L3050 |
| L3060  | L3070   | L3080 | L3090 | L3100 | L3140 | L3150   | L3160 | L3170 |       |
| <b>Orthopedic Shoes and Surgical Boots</b>   |         |       |       |       |       |         |       |       |       |
| L3201  | L3202   | L3203 | L3204 | L3206 | L3207 | L3208   | L3209 | L3211 | L3212 |
| L3213  | L3214   | L3215 | L3216 | L3217 | L3219 | L3221   | L3222 | L3224 | L3225 |

| <b>Orthoses Procedure Codes</b>   |       |       |       |       |       |       |       |       |       |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L3230   | L3250 | L3251 | L3252 | L3253 | L3254 | L3255 | L3257 | L3260 | L3265 |
| <b>Heel Lifts and Wedges</b>  |       |       |       |       |       |       |       |       |       |
| L3300   | L3310 | L3320 | L3330 | L3332 | L3334 | L3340 | L3350 | L3360 | L3370 |
| L3380   | L3390 | L3400 | L3410 | L3420 | L3430 | L3440 | L3450 | L3455 | L3460 |
| L3465   | L3470 | L3480 | L3485 |       |       |       |       |       |       |
| <b>Additions to Orthopedic Shoes</b>                                    |       |       |       |       |       |       |       |       |       |
| L3500   | L3510 | L3520 | L3530 | L3540 | L3550 | L3560 | L3570 | L3580 | L3590 |
| L3595   |       |       |       |       |       |       |       |       |       |
| <b>Transfer of Orthosis</b>   |       |       |       |       |       |       |       |       |       |
| L3600   | L3610 | L3620 | L3630 | L3640 | L3649 |       |       |       |       |
| <b>Shoulder Orthoses</b>  |       |       |       |       |       |       |       |       |       |
| L3650   | L3660 | L3670 | L3671 | L3674 | L3675 | L3677 | L3678 |       |       |
| <b>Elbow/Elbow–Wrist–Hand/Elbow–Wrist–Hand–Finger Orthoses</b>          |       |       |       |       |       |       |       |       |       |
| L3702   | L3710 | L3720 | L3730 | L3740 | L3760 | L3761 | L3762 | L3763 | L3764 |
| L3765   | L3766 |       |       |       |       |       |       |       |       |
| <b>Wrist–Hand/Wrist–Hand–Finger/Hand–Finger Orthoses</b>                |       |       |       |       |       |       |       |       |       |
| L3806   | L3807 | L3808 | L3809 | L3891 | L3900 | L3901 | L3904 | L3905 | L3906 |
| L3908   | L3912 | L3913 | L3915 | L3916 | L3917 | L3918 | L3919 | L3921 | L3923 |
| L3924   | L3925 | L3927 | L3929 | L3930 | L3931 | L3933 | L3935 |       |       |
| <b>Additions to Upper–Limb Joint</b>                                    |       |       |       |       |       |       |       |       |       |
| L3956   |       |       |       |       |       |       |       |       |       |
| <b>Shoulder–Elbow/Shoulder–Elbow–Wrist–Hand Orthoses</b>                |       |       |       |       |       |       |       |       |       |
| L3960   | L3961 | L3962 | L3967 | L3971 | L3973 | L3975 | L3976 | L3977 | L3978 |
| <b>Fracture Orthoses–Upper Limb</b>                                     |       |       |       |       |       |       |       |       |       |
| L3980   | L3981 | L3982 | L3984 | L3995 |       |       |       |       |       |
| <b>Miscellaneous Upper–Limb Orthosis</b>                                |       |       |       |       |       |       |       |       |       |
| L3999   |       |       |       |       |       |       |       |       |       |
| <b>Orthoses Replacement Procedures</b>                                  |       |       |       |       |       |       |       |       |       |
| L4000   | L4002 | L4010 | L4020 | L4030 | L4040 | L4045 | L4050 | L4055 | L4060 |
| L4070   | L4080 | L4090 | L4100 | L4110 | L4130 |       |       |       |       |
| <b>Repair of Orthoses</b>   |       |       |       |       |       |       |       |       |       |
| L4205   | L4210 |       |       |       |       |       |       |       |       |
| <b>Walking Boots, Foot Drop Splints, and Static Ankle–Foot Orthoses</b> |       |       |       |       |       |       |       |       |       |
| L4350   | L4360 | L4361 | L4370 | L4386 | L4387 | L4392 | L4394 | L4396 | L4397 |
| L4398   | L4631 |       |       |       |       |       |       |       |       |

**28.3.3 Noncovered Orthotic and Prosthetic Services**

The following services are not a benefit of the CSHCN Services Program:

- Replacement or repair of an orthotic or prosthetic device due to confirmed misuse or abuse by the client, the client’s family, or the vendor
- Orthoses primarily used for athletic or recreational purposes



### **28.3.4 Spinal Orthoses**

Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervical-thoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

Spinal orthoses will be considered for prior authorization with documentation of one of the general indications in Section 28.3.1, “Prior Authorization and Documentation Requirements” in this chapter.

### **28.3.5 Thoracic-Hip-Knee-Ankle (THKA) Orthoses**

THKA orthoses will be considered for prior authorization with documentation of one of the general indications outlined in Section 28.3.1, “Prior Authorization and Documentation Requirements” in this chapter.

### **28.3.6 Lower-Limb Orthoses**

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle-foot orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the general indication requirements, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

#### **28.3.6.1 Ankle-Foot Orthoses (AFO)**

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle
- A need for stabilization for medical reasons
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least ten degrees.
  - The contracture is interfering or is expected to interfere significantly with the client’s functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

#### **28.3.6.2 Reciprocating Gait Orthoses (RGO)**

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.

The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the physical therapy treatment plan, and documentation that the client or family is willing to comply with the treatment plan.

### 28.3.7 Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including physical therapy, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion
  - Structural deformities
  - Hallux valgus deformities
  - In-toe or out-toe gait
  - Musculoskeletal weakness

In addition to the general indication requirements, foot orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices.

#### 28.3.7.1 Foot Inserts

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus
- History of amputation of the opposite foot or part of either foot
- History of foot ulceration or pre-ulcerative calluses of either foot
- Peripheral neuropathy with evidence of callus formation of either foot
- Deformity of either foot
- Poor circulation of either foot

The CSHCN Services Program may authorize removable foot inserts independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A University of California–Berkeley (UCB) removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus, which is symptomatic for pain
- A structural problem which results in significant pes planus
- Acute plantar fasciitis
- A diagnosis of hemophilia

Authorization requests for removable shoe insert must be submitted on the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

**Referto:** Section 4.3, “Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

### **28.3.7.2 Prescription Shoes**

Prescription shoes (corrective or orthopedic shoes) must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.

Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is custom modified by an orthotist or prosthetist/orthotist at the direction of the prescribing physician.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot.
- Casting (does not have to be attached to a brace). A prescription shoe may be prior authorized up to one year from the date of the surgical procedure.
- Documented by a physician as to specific medical rationale. Lifts for unequal leg length greater than one-half inch will be covered with documentation of medical need; the prescription shoe itself and the lift may be reimbursable.

Only one pair of prescription shoes will be prior authorized every three months. Two pairs of shoes may be purchased at the same time; in such situations, however, additional requests for shoes will not be considered for coverage for another six months.

If the primary diagnosis is valgus deformities of the feet, medical justification is required.

### **28.3.7.3 Noncovered Shoes or Shoe Inserts**

The following are not considered a prescription shoe:

- A tennis shoe, even if prescribed by a physician and worn with a removable brace.
- A shoe insert when it is not a part of a modified shoe or when the shoe in which it is inserted is not attached to a brace (other than University of California–Berkeley-type, Healthcare Common Procedure Coding System [HCPCS] procedure code L3000).

### **28.3.7.4 Wedges and Lifts**

Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

Prior authorization is required with justification of medical necessity for wedges and lifts.

### **28.3.8 Upper-Limb Orthoses**

Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO), shoulder-elbow orthoses (SEO), and fracture orthoses.

In addition to the general indication requirements, upper-limb orthoses will be considered for prior authorization with documentation of one of the general indications outlined in Section 28.3.1, “Prior Authorization and Documentation Requirements” in this chapter.

## 28.3.9 Other Orthopedic Devices

### 28.3.9.1 Protective Helmets

Protective helmets used for conditions such as neoplasm of the brain, subarachnoid subdural hemorrhage, epilepsy, or cerebral palsy may be reimbursed by the CSHCN Services Program with prior authorization using the following procedure codes:

| Procedure Codes |       |       |       |       |
|-----------------|-------|-------|-------|-------|
| A8000           | A8001 | A8002 | A8003 | A8004 |

Protective helmets will be considered for prior authorization for clients with a documented medical condition that makes the client susceptible to injury during ADLs. Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional documentation that supports the medical necessity of the requested device.

### 28.3.9.2 Cranial Molding Orthosis

The CSHCN Services Program may cover cranial molding orthosis (procedure code S1040) for positional plagiocephaly with documentation supporting the use of the cranial molding orthosis to modify or prevent an associated functional impairment. Cranial molding orthosis may only be approved for children who are 3 through 18 months of age.

The CSHCN Services Program may cover cranial molding orthosis for use after surgery for cranial deformities, including craniosynostosis.

Studies indicate repositioning and physical therapy can be effective treatment for positional plagiocephaly. If detected early, repositioning combined with prone positioning while awake can correct the condition in the majority of children. For infants with a diagnosis of positional plagiocephaly who do not meet the criteria described in this chapter, the use of a cranial molding orthosis is considered cosmetic and, therefore, not medically necessary.

The effective use of cranial molding orthosis for the treatment of brachycephaly or a high cephalic index without cranial asymmetry has not been clearly documented, is not medically necessary, and, therefore, is not a benefit of the CSHCN Services Program.

#### 28.3.9.2.1 Definitions of Plagiocephaly

Plagiocephaly is defined as an asymmetric skull deformity that is generally characterized by occipital flattening giving the head an oblique configuration.

Synostotic plagiocephaly occurs when there is a premature union of cranial sutures (coronal or lamboid). This pathological condition generally requires surgical intervention, with or without postoperative use of a cranial orthosis.

Positional plagiocephaly results from external pressure (molding) that causes the cranium, in which the premature union of the cranial sutures (coronal or lamboid) has not occurred, to become asymmetrical.

### 28.3.9.2.2 Authorization Requirements

Prior authorization is required for cranial molding orthosis which will be reviewed by the CSHCN medical director or designee. Prior authorization requests must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

Cranial molding orthosis may be considered for prior authorization when they are part of a treatment plan for shaping the skull in cases of post-operative synostotic plagiocephaly or positional plagiocephaly with an associated functional impairment. Documentation that the use of the cranial molding orthosis will modify or prevent the development of such impairment is required.

Documentation supporting medical necessity must include all of the following:

- Plan of treatment and/or follow up schedule
- The assessment and recommendations of the appropriate primary care physician, pediatric subspecialist, craniofacial team, or pediatric neurosurgeon
- A full description of the physical findings, precise diagnosis, age of onset and the etiology of the deformity
- Reports of any radiological procedures used in making the diagnosis
- Client is at least 3 months of age, but not greater than 18 months of age
- Anthropometric measurements documenting greater than 10 mm of cranial asymmetry

The written documentation of medical necessity must also include that aggressive repositioning interventions was attempted, with or without physical therapy, of at least three months' duration without improvement in cranial asymmetry. The attempted aggressive repositioning interventions may include, but is not limited to:

- Repositioning the client's head to the opposite side of the preferred position when the infant is either lying down, reclined, or sitting.
- Gently turning and stretching the client's neck at each diaper change.
- Repositioning the client's bed, thus encouraging the infant to look away from the flattened side to view other objects of interest.
- The trial of repositioning intervention has failed to improve the deformity and is judged to be unlikely to do so.

Repositioning may not be indicated for children who are over 6 months of age. Repositioning therapy for this age group may be waived with documentation of medical necessity.

Requests for clients with a comorbid diagnosis that prohibits repositioning will be evaluated on an individual basis.

Prior authorization requests for subsequent cranial molding orthosis must include documentation of medical necessity including new measurements.

Muscular torticollis (wry neck) characterized by tight or shortened neck muscles that result in a head tilt or turn, is often associated with the secondary development of positional plagiocephaly. Therefore, clients with muscular torticollis and positional plagiocephaly must have documentation of early, aggressive treatment (stretching, positioning and/or physiotherapy) prior to consideration of prior authorization for cranial orthosis.

### 28.3.9.3 Static and Dynamic Mechanical Stretching Devices

Static and dynamic mechanical stretching devices will be considered for prior authorization for a 3-month trial period when the request is submitted with the following documentation supporting medical necessity:

- Client's condition
- Client's current course of therapy
- Rationale for the use of the static or dynamic mechanical stretching device
- Agreement by the client or family that the client will comply with the prescribed use of the static or dynamic mechanical stretching device

Requests for purchase of the device must include documentation of successful completion of the 3-month trial period, with improvement in the client's condition as measured by one of the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADLs or perform activities outside the home

*Note: If the cost of the rental is expected to exceed the purchase price, purchase of the device should be considered.*

Authorization requests for static or dynamic mechanical stretching devices must be submitted on the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

**Referto:** Section 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

## 28.4 Prostheses and Related Services

### 28.4.1 Prior Authorization and Documentation Requirements

Prior authorization is required for all prostheses and related services. All requests for prior authorization must include a valid prescription for the prosthetic device that is prescribed by a physician (M.D., D.O.).

*Note: The prescription must be maintained in the client's medical record, and is valid for a maximum period of 6 months. At the end of the 6-month prescription period, additional prior authorization is required for any repairs, replacements, or related services.*

Documentation of medical necessity must include, but is not limited to, documentation that the client meets the following general indications for the device:

- The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb.
- The prosthesis is required for activities of daily living and/or for rehabilitation purposes.

The provider must maintain the following documentation in the client's medical record:

- The prescription for the requested prosthetic device
- Written documentation of a rehabilitation program prescribed by the treating physician, including expected goals with the use of the prosthesis
- Written documentation that the client or client's family/caregiver is willing to comply with the rehabilitation program

**28.4.2 \* Prostheses Procedure Codes**

The following prostheses procedure codes may be reimbursed in the home setting to an orthotist, prosthetist, medical supplier (DME), and custom DME provider:

| <b>[Revised] Prostheses Procedure Codes</b>   |        |        |        |        |        |        |        |        |        |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| L3161   | L5615  |        |        |        |        |        |        |        |        |
| <b>Partial Foot, Ankle, and Knee Disarticulation Sockets</b>  |        |        |        |        |        |        |        |        |        |
| L5000   | L5010  | L5020  | L5050  | L5060  | L5100  | L5105  | L5150  | L5160  |        |
| <b>Above-Knee Short Prostheses</b>  |        |        |        |        |        |        |        |        |        |
| L5200   | L5210  | L5220  | L5230  |        |        |        |        |        |        |
| <b>Hip and Knee Disarticulation Prostheses</b>  |        |        |        |        |        |        |        |        |        |
| L5250   | L5270  | L5280  | L5301  | L5312  | L5321  | L5331  | L5341  |        |        |
| <b>Postsurgical Prostheses</b>  |        |        |        |        |        |        |        |        |        |
| L5400   | L5410  | L5420  | L5430  | L5450  | L5460  | L5500  | L5505  |        |        |
| <b>Preparatory Prostheses</b>   |        |        |        |        |        |        |        |        |        |
| L5510   | L5520  | L5530  | L5535  | L5540  | L5560  | L5570  | L5580  | L5585  | L5590  |
| L5595   | L5600  |        |        |        |        |        |        |        |        |
| <b>Additions to Lower-Limb Prostheses</b>   |        |        |        |        |        |        |        |        |        |
| L5610*  | L5611* | L5613* | L5614* | L5616* | L5617  | L5618  | L5620  | L5622  | L5624  |
| L5626   | L5628  | L5629  | L5630  | L5631  | L5632  | L5634  | L5636  | L5637  | L5638  |
| L5639   | L5640  | L5642  | L5643  | L5644  | L5645  | L5646  | L5647  | L5648  | L5649  |
| L5650   | L5651  | L5652  | L5653  | L5654  | L5655  | L5656  | L5658  | L5661  | L5665  |
| L5666   | L5668  | L5670  | L5671  | L5672  | L5673  | L5676  | L5677  | L5678  | L5679  |
| L5680   | L5681  | L5682  | L5683  | L5684  | L5685  | L5686  | L5688  | L5690  | L5692  |
| L5694   | L5695  | L5696  | L5697  | L5698  | L5699  |        |        |        |        |
| <b>Replacement Sockets</b>  |        |        |        |        |        |        |        |        |        |
| L5700   | L5701  | L5702  | L5703  |        |        |        |        |        |        |
| <b>Protective Covers</b>  |        |        |        |        |        |        |        |        |        |
| L5704   | L5705  | L5706  | L5707  |        |        |        |        |        |        |
| <b>Additions to Lower-Limb Prosthesis-Exoskeletal and Endoskeletal</b>  |        |        |        |        |        |        |        |        |        |
| L5710*  | L5711* | L5712* | L5714* | L5716* | L5718* | L5722* | L5724* | L5726* | L5728* |
| L5780*  | L5781  | L5785  | L5790  | L5795  | L5810* | L5811* | L5812* | L5814* | L5816  |
| L5818*  | L5822* | L5824* | L5826* | L5828* | L5830* | L5840* | L5845  | L5848* | L5850  |
| L5855   | L5856* | L5857* | L5858  | L5859* | L5910  | L5920  | L5925  | L5926  | L5930* |
| L5940   | L5950  | L5960  | L5961* | L5962  | L5964  | L5966  | L5968  |        |        |
| <b>All Lower-Limb Prostheses</b>  |        |        |        |        |        |        |        |        |        |
| L5970*  | L5971* | L5972* | L5973* | L5974* | L5975* | L5976* | L5978* | L5979* | L5980* |
| L5981*  | L5982* | L5984  | L5985  | L5986  | L5987* |        |        |        |        |
| <b>Additions to Lower-Limb Prostheses</b>   |        |        |        |        |        |        |        |        |        |
| L5988   | L5990  | L5999  |        |        |        |        |        |        |        |
| <b>Partial Hand, Wrist, and Elbow Disarticulation Prostheses</b>  |        |        |        |        |        |        |        |        |        |
| <b>* Must be billed with the functional modifiers in Section 28.4.5, "Lower-Limb Prostheses" in this chapter.</b> |        |        |        |        |        |        |        |        |        |

| <b>[Revised] Prostheses Procedure Codes</b>   |       |       |       |       |       |       |       |       |       |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L6000   | L6010 | L6020 | L6026 | L6050 | L6055 | L6100 | L6110 | L6120 | L6130 |
| L6200   | L6205 | L6250 |       |       |       |       |       |       |       |
| <b>Shoulder Disarticulation and Interscapular Thoracic Prostheses</b>   |       |       |       |       |       |       |       |       |       |
| L6300   | L6310 | L6320 | L6350 | L6360 | L6370 |       |       |       |       |
| <b>Immediate Postsurgical Wrist, Elbow, or Shoulder Disarticulation Prostheses</b>                                |       |       |       |       |       |       |       |       |       |
| L6380   | L6382 | L6384 | L6386 | L6388 |       |       |       |       |       |
| <b>Endoskeletal Elbow, Shoulder, and Interscapular Thoracic Prostheses</b>  |       |       |       |       |       |       |       |       |       |
| L6400   | L6450 | L6500 | L6550 | L6570 |       |       |       |       |       |
| <b>Preparatory Wrist, Elbow, and Shoulder Disarticulation Prostheses</b>  |       |       |       |       |       |       |       |       |       |
| L6580   | L6582 | L6584 | L6586 | L6588 | L6590 |       |       |       |       |
| <b>Additions to Upper-Limb Prostheses</b>   |       |       |       |       |       |       |       |       |       |
| L6600   | L6605 | L6610 | L6611 | L6615 | L6616 | L6620 | L6621 | L6623 | L6624 |
| L6625   | L6628 | L6629 | L6630 | L6632 | L6635 | L6637 | L6638 | L6640 | L6641 |
| L6642   | L6645 | L6646 | L6647 | L6648 | L6650 | L6655 | L6660 | L6665 | L6670 |
| L6672   | L6675 | L6676 | L6677 | L6680 | L6682 | L6684 | L6686 | L6687 | L6688 |
| L6689   | L6690 | L6691 | L6692 | L6693 | L6694 | L6695 | L6696 | L6697 | L6698 |
| <b>Terminal Devices</b>   |       |       |       |       |       |       |       |       |       |
| L6703   | L6704 | L6706 | L6707 | L6708 | L6709 | L6711 | L6712 | L6713 | L6714 |
| L6715   | L6721 | L6722 | L6805 | L6810 | L6880 | L6881 | L6882 |       |       |
| <b>Replacement Sockets</b>  |       |       |       |       |       |       |       |       |       |
| L6883   | L6884 | L6885 |       |       |       |       |       |       |       |
| <b>Additions – Glove for Terminal Devices</b>   |       |       |       |       |       |       |       |       |       |
| L6890   | L6895 |       |       |       |       |       |       |       |       |
| <b>Hand Restoration</b>   |       |       |       |       |       |       |       |       |       |
| L6905   | L6910 | L6915 |       |       |       |       |       |       |       |
| <b>Wrist, Elbow, and Shoulder Inner Sockets – Externally Powered</b>  |       |       |       |       |       |       |       |       |       |
| L6920   | L6925 | L6930 | L6935 | L6940 | L6945 | L6950 | L6955 | L6960 | L6965 |
| L6970   | L6975 |       |       |       |       |       |       |       |       |
| <b>Electronic Hand, Elbow and Wrist Prosthetic Device</b>   |       |       |       |       |       |       |       |       |       |
| L7007   | L7008 | L7009 | L7040 | L7045 | L7170 | L7180 | L7181 | L7185 | L7186 |
| L7190   | L7191 | L7259 |       |       |       |       |       |       |       |
| <b>Additions to Upper-Limb Prostheses</b>   |       |       |       |       |       |       |       |       |       |
| L7400   | L7401 | L7402 | L7403 | L7404 | L7405 |       |       |       |       |
| <b>Miscellaneous Upper-Limb Prosthesis</b>  |       |       |       |       |       |       |       |       |       |
| L7499   |       |       |       |       |       |       |       |       |       |
| <b>Repair of Prosthetic Device</b>  |       |       |       |       |       |       |       |       |       |
| L7510   | L7520 |       |       |       |       |       |       |       |       |
| <b>Prosthetic Donning Sleeve</b>  |       |       |       |       |       |       |       |       |       |
| L7600   | L7700 |       |       |       |       |       |       |       |       |
| <b>* Must be billed with the functional modifiers in Section 28.4.5, “Lower-Limb Prostheses” in this chapter.</b> |       |       |       |       |       |       |       |       |       |



| <b>[Revised] Prostheses Procedure Codes</b> |       |       |       |       |       |       |       |       |       |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| <b>Prosthetic Sheath, Shrinker, or Sock</b> |       |       |       |       |       |       |       |       |       |
| L8400                                       | L8410 | L8415 | L8417 | L8420 | L8430 | L8435 | L8440 | L8460 | L8465 |
| L8470                                       | L8480 | L8485 | L8499 |       |       |       |       |       |       |

**\* Must be billed with the functional modifiers in Section 28.4.5, “Lower-Limb Prostheses” in this chapter.**

**28.4.3 Preparatory or Temporary Prostheses**

Preparatory or temporary prostheses are a benefit of the CSHCN Services Program.

A preparatory or temporary prosthesis allows for extensive gait training for lower-limb amputees and extensive functional training for upper-limb amputees. A preparatory prosthesis is intended as the final step before the permanent or definitive application. A client with a preparatory prosthesis does not need to be in the hospital, may be involved in chemotherapy or other medical or rehabilitative treatment that affects the size or healing of the residual limb, and may be undergoing changes to the residual limb that would preclude the fitting of the permanent or definitive prosthesis. A preparatory prosthesis is used by the client for varying time periods (4 to 12 months) before the permanent or definitive prosthesis needs to be ordered.

**28.4.4 Upper-Limb Prostheses**

Upper-limb prostheses will be considered for prior authorization with documentation of all of the indications defined in the Prostheses and Related Services section above. In addition, the following criteria apply for specific prosthetic devices.

**28.4.4.1 Myoelectric Prostheses**

Myoelectric upper extremity prostheses will be considered for prior authorization for clients with bilateral shoulder disarticulation.

Myoelectric hand prostheses will be considered for prior authorization for clients with traumatic or congenital absence of forearm(s) and hand(s).

**28.4.5 Lower-Limb Prostheses**

Lower-limb prostheses will be considered for prior authorization with documentation of all of the indications defined in Section 28.4.1, “Prior Authorization and Documentation Requirements” in this chapter. In addition, the following documentation is required for all lower-limb prostheses:

- Written documentation of the client’s current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist, and may include the following:
  - The client’s history, including prior use of a prosthesis, if applicable
  - The client’s current condition, including the status of the residual limb, and any co-existing medical conditions
  - The client’s desire to ambulate

The following functional modifiers and levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

| <b>Functional Modifier</b> | <b>Functional Level</b> | <b>Description</b>   |
|----------------------------|-------------------------|--|
| K0                         | Level 0                 | Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility. |

| Functional Modifier | Functional Level | Description  |
|---------------------|------------------|--|
| K1                  | Level 1          | Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.   |
| K2                  | Level 2          | Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.   |
| K3                  | Level 3          | Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. |
| K4                  | Level 4          | Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high-impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.   |

A client whose functional level is zero is not a candidate for a prosthetic device; the device is not considered medically necessary. Advanced knee, ankle, or foot prostheses procedure codes must be submitted with the appropriate functional modifier in the table above.

#### **28.4.5.1 Microprocessor-Controlled Lower-Limb Prostheses**

Microprocessor-controlled lower-limb prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor, and a functional level of 3 or above.

The licensed prosthetist or orthotist who provides the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

#### **28.4.5.2 Foot Prostheses**

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot
- An external keel SACH foot or single axis ankle/foot

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

A flex foot system, energy storing foot, multi-axial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

#### **28.4.5.3 Knee Prosthesis**

A single-axis, constant-friction knee or other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above.

A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above.

A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.

#### **28.4.5.4 Ankle Prosthesis**

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.

#### **28.4.5.5 Sockets**

Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets.

Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two.

Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

#### **28.4.5.6 Accessories**

Accessories to prostheses, such as stump stockings and harnesses, will be considered for prior authorization when they are essential to the effective use of the artificial limb.

### **28.5 Repairs, Replacements, and Modifications to Orthoses and Prostheses**

Repairs, replacements, and modifications to orthoses and prostheses are a benefit of the CSHCN Services Program when medically necessary criteria are met.

Repairs due to normal wear and modifications due to growth or change in medical status will be considered for prior authorization when the repair or modification is more cost-effective than the replacement of the device.

- Additional information from the provider may be requested to determine cost-effectiveness.
- Documentation supporting medical necessity must be provided when requesting prior authorization.
- Replacement of orthotic or prosthetic devices will be considered for prior authorization with medical justification.
- Orthotic devices are anticipated to last a minimum of 6 months from the receipt of the initial system.
- Prosthetic devices are anticipated to last a minimum of one year from the receipt of the initial definitive/permanent system.
- Preparatory or temporary prostheses may be replaced in less than 12 months of their receipt, but they will undergo medical review if the permanent prosthesis is requested less than 6 months after provision of the preparatory or temporary prosthesis.
- Replacement of an orthosis or prosthesis will be considered when loss or irreparable damage has occurred due to a traumatic event such as a vehicle accident, a residential fire, or theft. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent a repeat of similar loss.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

#### **28.5.1 Other Artificial Devices**

A prosthesis is defined as “a custom-fabricated or fitted medical device that is not surgically implanted and is used to replace a missing limb, appendage, or other external human body part, including an artificial limb, hand, or foot.”

The term “prosthesis” does not include an artificial eye, ear, finger, or toe, a dental appliance, a cosmetic device, including an artificial breast, eyelash, or wig, or other device that does not have a significant impact on the musculoskeletal functions of the body.

**Referto:** Section 40.2.1.9, “Eye Prostheses” in Chapter 40, “Vision Services” for information about eye prostheses.

Section 31.2.40, “Diagnostic and Surgical/Reconstructive Breast Therapies” in Chapter 31, “Physician” and Chapter 17, “Durable Medical Equipment (DME)” for information about breast prostheses.

Chapter 14, “Dental” for information about dental services.

## 28.6 CSHCN Services Program Documentation of Receipt

The [CSHCN Services Program Documentation of Receipt form](#) is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. Providers must retain individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to the CSHCN Services Program or its designee upon request.

The documentation of receipt form is available in both [English](#) and [Spanish](#).

Documentation of delivery must include one of the following:

- Delivery slip or invoice signed and dated by client/caregiver. The delivery slip or invoice must contain the client’s full name and address to which the supplies were delivered, the item description and the numerical quantities that were delivered to the client.
- A dated carrier tracking document with shipping date and delivery date. The dated carrier tracking document must be attached to the delivery slip or invoice. The dated delivery slip or invoice must include an itemized list of goods that includes the descriptions and numerical quantities of the supplies delivered to the client. This document could also include prices, shipping weights, shipping charges, and any other description.

## 28.7 Claims Information

Orthotic and prosthetic services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The HCPCS/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 28.8 Reimbursement

Orthotics and prosthetics services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 28.9 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **OUTPATIENT BEHAVIORAL HEALTH**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# OUTPATIENT BEHAVIORAL HEALTH

## Table of Contents

|             |  |           |
|-------------|--|-----------|
| <b>29.1</b> | <b>Enrollment</b> .....  | <b>3</b>  |
| 29.1.1      | Provisionally Licensed Psychologist (PLP).....   | 3         |
| <b>29.2</b> | <b>Benefits, Limitations, and Authorization Requirements</b> .....                       | <b>3</b>  |
| 29.2.1      | Authorization Requirements .....   | 4         |
| 29.2.2      | Documentation Requirements .....   | 4         |
| 29.2.3      | Pharmacological Management Services Documentation .....                                  | 5         |
| 29.2.4      | Reimbursement—The 12-Hour System Limitation .....  | 5         |
| 29.2.5      | Procedure Codes Included in the 12-Hour System Limitation.....                           | 6         |
| 29.2.6      | Psychological Testing, Neuropsychological Testing, and Neurobehavioral Status Exams..... | 7         |
| 29.2.7      | Psychotherapy and Counseling .....   | 8         |
| 29.2.7.1    | Treatment for Alzheimer’s and Dementia.....  | 8         |
| 29.2.8      | Psychiatric Diagnostic Evaluations .....   | 9         |
| 29.2.9      | Noncovered Services .....  | 9         |
| 29.2.10     | National Correct Coding Initiative (NCCI) Guidelines .....                               | 10        |
| <b>29.3</b> | <b>Claims Information</b> .....  | <b>10</b> |
| <b>29.4</b> | <b>Reimbursement</b> .....   | <b>10</b> |
| <b>29.5</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....                                  | <b>11</b> |

## 29.1 Enrollment

To enroll in the CSHCN Services Program, outpatient behavioral health providers are required to be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state outpatient behavioral health providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

The CSHCN Services Program enrolls the following types of providers of outpatient behavioral health services:

- Licensed marriage and family therapist (LMFT)
- Licensed clinical social worker (LCSW, formerly LMSW-ACP)
- Licensed professional counselor (LPC)
- Licensed psychologist or neuropsychologist (PhD)
- Psychiatrist (doctor of medicine [MD] or doctor of osteopathy [DO])

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

### 29.1.1 Provisionally Licensed Psychologist (PLP)

The Texas State Board of Examiners of Psychologist (TSBEP) requires the provisionally licensed psychologist (PLP) to work under the direct supervision of a licensed psychologist and does not allow a PLP to engage in independent practice. Therefore, a PLP will not be independently enrolled in the CSHCN Services Program and must provide services under the delegating psychologist’s National Provider Identifier (NPI).

## 29.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program does not provide outpatient behavioral health services to clients who are also enrolled in Texas Medicaid, Comprehensive Care Program (CCP), or Children’s Health Insurance Program (CHIP).



Outpatient behavioral health services are limited to no more than 30 encounters by all practitioners per client, per calendar year. Benefits include, but are not limited to, psychological testing, neuropsychological testing, psychotherapy, and counseling.

Laboratory and radiology services do not count toward the 30 outpatient encounters per client, per calendar year limitation. Pharmacological management does not count toward the 30 encounters per client, per calendar year limitation.

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with potentially significant side effects. Pharmacological management represents a skilled aspect of client care and is intended for use by clients who are being managed primarily by psychotropics or other types of psychopharmacologic medications that are part of the billable E/M visit.

The focus of a pharmacological management encounter is the use of medication for relief of a client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness, which necessitates a discussion beyond minimal psychotherapy or counseling in a given day, the focus of the service is broader and is considered outpatient psychotherapy or counseling rather than pharmacological management.

Visits for the sole purpose of pharmacological management should be billed as a regular physician visit, not as a behavioral health visit using the appropriate E/M procedure code. Pharmacological management visits should be conducted on the basis of medical necessity.

### **29.2.1 Authorization Requirements**

Authorization is not required for outpatient behavioral health services. The CSHCN Services Program may reimburse a maximum of 30 outpatient behavioral health services encounters by any practitioner per client, per calendar year.

### **29.2.2 Documentation Requirements**

Services not supported by documentation in the client's medical record are subject to recoupment. All entries must be clear and concise, legible to individuals other than the author, and dated (month/date/year) and signed by the performing provider.

Documentation must include all of the following:

- Beginning and ending times for each counseling session or test administered
- Diagnosis
- Support for the medical necessity of the chosen treatment
- All pertinent information about the client's condition that substantiates the need for services, including, but not limited to, the following:
  - Reason for referral or the presenting problem
  - Prior history, including prior treatment
  - Other pertinent medical, social, and family history
  - Clinical observations and mental status examinations
  - The name of each test (e.g., WAIS-R, Rorschach, MMPI) administered
  - The scoring of the test
  - Narrative descriptions of the test findings
  - An explanation to substantiate the necessity of retesting, if testing is repeated
  - Background, symptoms, impression
  - Narrative description of the assessment

- Behavioral observations during the counseling session
- Narrative description of the counseling session
- Treatment plan and recommendations, including expected long-term and short-term benefits

The original testing material must be maintained by the provider and readily available for retrospective review by the Department of State Health Services (DSHS) or its designee.

### **29.2.3 Pharmacological Management Services Documentation**

Documentation for pharmacological management services must include the following:

- Complete diagnosis
- Medication history
- Current psychiatric symptoms and problems (including the presenting mental status or physical symptoms) that indicate the client requires a medication adjustment
- Problems, reactions, and side effects (if any) to medications or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Reasons for medication adjustments, changes, or continuation with anticipated outcomes
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Treatment goals

### **29.2.4 Reimbursement—The 12-Hour System Limitation**

The following provider types are limited to a maximum combined total of 12 hours per provider, per day for inpatient or outpatient behavioral health services:

- Psychologist
- Advanced practice registered nurse (APRN)
- Physician Assistant (PA)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)

Each hour of testing counts towards the 12 hour limit. Doctors of medicine (MDs) and doctors of osteopathy (DOs) are not subject to the 12-hour system limitation because they can delegate services and, as a result, may submit claims in excess of 12 hours per day.

Doctors of medicine (MDs) and doctors of osteopathy (DOs) are not subject to the 12-hour system limitation because they can delegate services, and, as a result, may submit claims in excess of 12 hours per day. Additionally, because a psychologist can delegate to multiple PLPs and may submit claims for PLP services in excess of 12 hours per day, PLPs are not subject to the 12-hour system limitation. PLPs who perform delegated psychology services under the delegating psychologist's NPI are subject to retrospective review.

No single behavioral health services provider may be reimbursed for more than 12 hours of behavioral health services per day. As a result, all providers who are not subject to the 12-hour system limitation, and each provider to whom they delegate, are subject to retrospective review and recoupment.

### 29.2.5 Procedure Codes Included in the 12-Hour System Limitation

The following table lists the outpatient behavioral health procedure codes included in the system limitation. The table also includes the time increments that the system applies based on the billed procedure code. The system uses the “time applied” time increments to determine whether the 12-hour-per-day system limitation has been exceeded.

| Procedure Code | Time Assigned by Procedure Code Description  | Time Applied |
|----------------|--|--------------|
| 90791          | N/A  | 60 minutes   |
| 90792          | N/A  | 60 minutes   |
| 90832          | 30 minutes   | 30 minutes   |
| 90833          | 30 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.) | 30 minutes   |
| 90834          | 45 minutes   | 45 minutes   |
| 90836          | 45 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.) | 45 minutes   |
| 90837          | 60 minutes   | 60 minutes   |
| 90838          | 60 minutes with an evaluation and management service. (List separately in addition to the code for primary procedure.) | 60 minutes   |
| 90846          | N/A  | 50 minutes   |
| 90847          | N/A  | 50 minutes   |
| 96116          | 60 minutes   | 60 minutes   |
| 96121*         | 60 minutes   | 60 minutes   |
| 96130          | 60 minutes   | 60 minutes   |
| 96131*         | 60 minutes   | 60 minutes   |
| 96132          | 60 minutes   | 60 minutes   |
| 96133*         | 60 minutes   | 60 minutes   |
| 96136          | 60 minutes   | 30 minutes   |
| 96137*         | 60 minutes   | 30 minutes   |

**N/A = Not Applicable**  
**\*Add-on procedure codes must be billed with their corresponding primary procedure code.**

*Note: Procedure code 90853 is not included in the 12-hour system limitation, so it is not shown in the table.*

LCSWs, LMFTs, or LPCs may use only the following procedure codes when filing claims:

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| 90832           | 90834 | 90837 | 90846 | 90847 | 90853 |

LMFT services require the U8 modifier.

Only physicians, APRNs, and PAs may use the following procedure codes when filing claims:

| Procedure Codes |       |       |       |       |
|-----------------|-------|-------|-------|-------|
| 90791           | 90792 | 90833 | 90836 | 90838 |

Procedure codes 90833, 90836, and 90838 are add on codes and must be billed with a primary E/M code in order to be considered for reimbursement.

Physicians and psychologists may use the following procedure codes when filing claims:

| Procedure Codes |       |        |       |       |       |       |       |        |       |
|-----------------|-------|--------|-------|-------|-------|-------|-------|--------|-------|
| 90791           | 90832 | 90834  | 90837 | 90846 | 90847 | 90853 | 96116 | 96121* | 96130 |
| 96131*          | 96132 | 96133* | 96136 | 96137 |       |       |       |        |       |

**\*Add-on procedure codes must be billed with their corresponding primary procedure code.**

Clinical psychologist services must be submitted with the AH modifier.

PLP services may be reimbursed using procedure code 90791 with modifier U9.

### 29.2.6 Psychological Testing, Neuropsychological Testing, and Neurobehavioral Status Exams

Psychological testing (procedure codes 96130, 96131\*, 96136, and 96137\*), neurobehavioral status exams (procedure codes 96116 and 96121\*), and neuropsychological testing (procedure codes 96132, 96133\*, 96136, and 96137\*) are limited to a total of 4 hours per day and 8 hours per calendar year, per client, for any provider. Claims submitted for an amount greater than 4 hours per day or 8 hours per year must be submitted with documentation of medical necessity. All supporting documentation must be maintained by the provider in the client’s medical record.

**Note:** *\*Add-on procedure codes must be billed with their corresponding primary procedure code.*

Reimbursement of psychological testing, neurobehavioral status exams, and neuropsychological testing includes testing, scoring, and interpretation of results.

The number of units on the claim must reflect the time spent face-to-face testing with the client plus the time spent scoring and interpreting the results in one hour increments.

If the performance, interpretation, and reporting of the testing span more than one day, the date of service on the claim must reflect the date and the time spent for each service performed.

- Providers must submit only one claim for each psychological or neuropsychological testing or neurobehavioral status exam performed, even if the scoring and interpretation cannot be completed on the same date as the testing.
- A claim must not be submitted until testing is complete. Providers can submit one claim with multiple details on separate claims for each date of service.

Psychological testing, neurobehavioral status exams, and neuropsychological testing are not reimbursed to an APRN or physician assistant. Behavioral health testing and neurobehavioral status exams may be performed during an assessment by an APRN or physician assistant, but is not reimbursed separately. The most appropriate office encounter code must be used.

Psychological testing (procedure codes 96130, 96131\*, 96136, and 96137\*) and neuropsychological testing (procedure codes 96132, 96133\*, 96136, 96137\*) may be reimbursed on the same date of service as a psychiatric diagnostic evaluation (procedure code 90791 or 90792).

Testing procedure codes 96116, 96121\*, 96130, 96131, 96132, 96133\*, 96136, and 96137\* count toward the 30 per calendar year limitation.

Psychological testing (procedure codes 96130, 96131\*, 96136, and 96137\*), neurobehavioral testing (procedure codes 96116 and 96121\*), and neuropsychological testing (procedure codes 96132, 96133\*, 96136, and 96137\*) will not be reimbursed on the same date of service when performed by the same provider.

*Note: Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code.*

## **29.2.7 Psychotherapy and Counseling**

Reimbursement for outpatient psychotherapy or counseling is limited to no more than 4 hours per client, per day.

Providers must bill the units of each half hour of psychotherapy and indicate that number of units on the claim form.

When more than one type of session (individual, group, or family outpatient psychotherapy or counseling) is provided by any provider on the same date of service, each session type will be reimbursed individually. Services are reimbursed only for clients who are eligible for the CSHCN Services Program.

Only the LMFT, LCSW, LPC, APRN, or PA provider actually performing the behavioral health service may bill the CSHCN Services Program. These providers must not bill for services performed by individuals under their supervision. A psychiatrist may bill for services performed by individuals under their supervision.

A psychologist may also bill for services performed by a PLP under their direct supervision.

Interpretation and documentation time is not reimbursed separately for psychotherapy or counseling procedures.

Psychotherapy and counseling services count toward the 30 per calendar year limitation.

Psychotherapy services must not be continued if no longer beneficial to the client.

Professional services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Hospitals are reimbursed 80 percent of the rate allowed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital's Medicaid interim rate.

### **29.2.7.1 Treatment for Alzheimer's and Dementia**

Treatment for CSHCN Services Program clients with Stage 1, 2, or 3 Alzheimer's disease or dementia may be reimbursed with prior authorization as follows:

#### **Stage 1- No impairment (normal function)**

The person does not experience any memory problems. An interview with a medical professional does not show any evidence of symptoms of dementia

#### **Stage 2- Very mild cognitive decline (may be normal age-related changes or earliest signs of Alzheimer's disease)**

The person may feel as if he or she is having memory lapses - forgetting familiar words or the location of everyday objects. But no symptoms of dementia can be detected during a medical examination or by friends, family or co-workers

#### **Stage 3- Mild cognitive decline (early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms)**

Friends, family or co-workers begin to notice difficulties. During a detailed medical interview, doctors may be able to detect problems in memory or concentration. Common stage 3 difficulties include:

- Noticeable problems coming up with the right word or name
- Trouble remembering names when introduced to new people

- Having noticeably greater difficulty performing tasks in social or work settings.
- Forgetting material that one has just read
- Losing or misplacing a valuable object
- Increasing trouble with planning or organizing

Psychotherapy services must not be continued if no longer beneficial to the client.

Psychotherapy for clients with Alzheimer’s disease or dementia is limited to the diagnoses listed below and must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

The following psychotherapy procedure codes for clients with Alzheimer’s disease or dementia may be reimbursed for clients who meet one of the stages listed above and are diagnosed with one of the diagnosis codes listed below:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90832           | 90833 | 90834 | 90836 | 90837 | 90838 | 90846 | 90847 | 90853 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F0390           | F03911 | F03918 | F0392  | F0393  | F0394  | F03A0  | F03A11 |
| F03A18          | F03A2  | F03A3  | F03A4  | F03B0  | F03B11 | F03B18 | F03B2  |
| F03B3           | F03B4  | F03C0  | F03C11 | F03C18 | F03C2  | F03C3  | F03C4  |
| G3184           | R41841 |        |        |        |        |        |        |

Documentation to support the treatment for Alzheimer’s disease or dementia must be maintained in the client’s medical record and may be subject to retrospective review.

Supporting documentation (certification of need) must be documented in the individual client’s record. This documentation must be maintained by each facility, as applicable to state and federal guidelines, and be available upon request.

**29.2.8 Psychiatric Diagnostic Evaluations**

Psychiatric diagnostic evaluations (procedure codes 90791 or 90792) are limited to once per day per client, any provider, regardless of the number of professionals involved in the interview.

Psychiatric diagnostic evaluations count toward the 30 per calendar year limitation.

**29.2.9 Noncovered Services**

The following behavioral health services are not benefits of the CSHCN Services Program:

- Services provided by a psychiatric nurse (registered nurse [RN] or licensed vocational nurse [LVN]), mental health worker, or licensed psychological associate (LPA)
- Thermogenic therapy
- Recreational therapy
- Psychiatric day care
- Psychiatric day treatment
- Psychiatric day hospital
- Partial hospitalization
- Neurofeedback including, but not limited to, electroencephalography (EEG) feedback
- Music therapy

- Dance therapy
- Hypnosis
- Services provided to clients residing in residential treatment centers
- Services provided to clients in an acute-care hospital
- Educationally related services provided in a school setting
- Multiple family group psychotherapy
- Narcosynthesis
- Psychoanalysis
- Unlisted psychiatric services or procedures
- “Adult activity” or “individual activity” (These services are payable only if guidelines for group therapy are met and termed “group therapy.”)

The CSHCN Services Program does not reimburse procedure code 90849.

### **29.2.10 National Correct Coding Initiative (NCCI) Guidelines**

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

### **29.3 Claims Information**

Outpatient behavioral health services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

### **29.4 Reimbursement**

Outpatient behavioral health services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRNs and PAs will be reimbursed the lesser of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for services performed by APRNs is 92 percent of the physician’s Texas Medicaid reimbursement for the same service. The reimbursement methodology for these services is contained in the specific policy for each service.

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The PLP, LPC, and LMSW providers will be reimbursed the lesser of the billed amount or the amount allowed by Texas Medicaid. Reimbursement for PLP, LPC, and LMSW services is 70 percent of the physician's Texas Medicaid reimbursement for the same service.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

***Note:** Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## **29.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **PHYSICAL MEDICINE AND REHABILITATION**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# PHYSICAL MEDICINE AND REHABILITATION

## Table of Contents

|             |   |           |
|-------------|---|-----------|
| <b>30.1</b> | <b>Enrollment .....</b>   | <b>3</b>  |
| <b>30.2</b> | <b>Benefits, Limitations, and Authorization Requirements .....</b>                | <b>3</b>  |
| 30.2.1      | Osteopathic Manipulative Treatment (OMT) .....                                    | 3         |
| 30.2.2      | Physical Therapy (PT), and Occupational Therapy (OT) .....                        | 4         |
| 30.2.3      | Time-based PT and OT Treatment Procedure Codes .....                              | 5         |
| 30.2.4      | Untimed PT and OT Treatment Procedure Codes .....                                 | 6         |
| 30.2.5      | Method for Counting Minutes for Timed Procedure Codes in 15-Minute<br>Units ..... | 6         |
| 30.2.6      | Group Therapy .....   | 7         |
| 30.2.6.1    | Group Therapy Guidelines .....  | 7         |
| 30.2.6.2    | Group Therapy Documentation Requirements .....                                    | 7         |
| 30.2.7      | Noncovered Services .....   | 8         |
| 30.2.8      | Authorization Requirements .....  | 8         |
| 30.2.8.1    | Initial Prior Authorization Requests .....  | 9         |
| 30.2.8.2    | Extension of Services Requests .....  | 10        |
| 30.2.8.3    | Discontinuation of Therapy or Change of Provider .....                            | 10        |
| <b>30.3</b> | <b>Coordination with the Public School System .....</b>                           | <b>11</b> |
| <b>30.4</b> | <b>Claims Information .....</b>   | <b>11</b> |
| <b>30.5</b> | <b>Reimbursement .....</b>  | <b>12</b> |
| <b>30.6</b> | <b>TMHP-CSHCN Services Program Contact Center .....</b>                           | <b>12</b> |

## 30.1 Enrollment

To enroll in the CSHCN Services Program, physical medicine and rehabilitation providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state physical medicine and rehabilitation providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 30.2 Benefits, Limitations, and Authorization Requirements

Physical therapy (PT) and occupational therapy (OT) services are benefits of the CSHCN Services Program for clients with an acute or chronic medical condition when documentation from the prescribing physician and the treating therapist shows there is or will be progress made toward goals.

**Note:** *An advanced practice registered nurse (APRN) or physician assistant (PA) may sign and date all documentation related to the provision of PT or OT services on behalf of the client’s physician when the client’s physician delegates this authority to the APRN or PA. The APRN or PA provider’s signature and license number must appear on the forms where the physician signature and license number are required.*

The CSHCN Services Program reimburses licensed physical or occupational therapists, physicians, home health agencies, hospitals, and outpatient facilities based on the procedure codes listed in this chapter. Therapy sessions include the time span the therapist is with the client, time spent preparing the client for the session, and the time spent completing documentation.

### 30.2.1 Osteopathic Manipulative Treatment (OMT)

OMT services provided by a licensed physician are benefits when they are performed with the expectation of restoring the client’s level of function that has been lost or reduced due to injury or illness.

Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

OMT may be considered for reimbursement by the CSHCN Services Program in the following situations:

- Acute musculoskeletal condition
- Acute exacerbation of a chronic condition
- Acute treatment pre- or postsurgery that is directly related to the surgery

Procedure codes 98925, 98926, 98927, 98928, and 98929 must be used when billing for OMT.

### **30.2.2 Physical Therapy (PT), and Occupational Therapy (OT)**

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

PT and OT evaluations and treatment must be ordered or prescribed by the client's physician, APRN, or PA and be based on medical necessity.

A client may receive any combination of physical, occupational, or speech therapy in the office, home, or outpatient setting, up to the limits outlined in this chapter for each type of therapy.

Therapy evaluations and re-evaluations are limited to 180 days, any provider. Therapy re-evaluations are a benefit when documentation supports one of the following:

- A change in the client's status
- A request for extension of services
- A change of provider

Additional therapy evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
  - The date that the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation of why providers were changed

An evaluation or re-evaluation will be denied when billed by any provider on the same date of service as therapy treatment from the same discipline.

An evaluation or re-evaluation performed on the same day as therapy treatment from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If an initial evaluation and a re-evaluation from the same therapy discipline are billed for the same date of service by any provider, the re-evaluation will be denied.

Outpatient OT or PT treatment services will deny if billed on the same date of service as procedure codes G0152 or G0151, respectively.

PT and OT services must be rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners or performed by a physician within their scope of practice.

**Note:** *Therapy services provided by a licensed therapist assistant must be submitted by the licensed supervising provider.*

All documentation that is related to the therapy services that were prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. Each therapy discipline provided must be of the level of complexity that requires the judgment, knowledge, and skill of a licensed physical or occupational therapist, or physician. The documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

Providers must use the following procedure codes for claim submission when billing for physical and occupational therapy services:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 97012           | 97016 | 97018 | 97022 | 97024 | 97026 | 97028 | 97032 | 97033 | 97034 |
| 97035           | 97036 | 97110 | 97112 | 97113 | 97116 | 97124 | 97140 | 97150 | 97161 |
| 97162           | 97163 | 97164 | 97165 | 97166 | 97167 | 97168 | 97530 | 97535 | 97537 |
| 97542           | 97750 | 97755 | 97760 | 97761 | 97763 | 97799 |       |       |       |

Physical therapists must use procedure code 97161, 97162, or 97163 for evaluations and procedure code 97164 for re-evaluations. Occupational therapists must use procedure code 97165, 97166, or 97167 for evaluations and procedure code 97168 for re-evaluations. These codes are untimed and do not require modifiers.

The following modifiers must be used to indicate when treatment services have been rendered by a licensed therapist or physician, or by a licensed therapy assistant under supervision of a licensed therapist:

| Modifier | Description   |
|----------|---|
| U5       | Services delivered by a licensed therapist or physician                             |
| UB       | Services delivered by a therapy assistant under supervision of a licensed therapist |

**Note:** These modifiers are not required for evaluation and re-evaluation procedure codes because those services may not be rendered by licensed therapy assistants.

### 30.2.3 Time-based PT and OT Treatment Procedure Codes

PT and OT time-based treatment procedure codes are payable as 15-minute units for all provider types.

Time-based treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour.

All time-based PT and OT treatment procedure codes listed in the table below will be cumulatively limited to four units (one hour) per date of service, per discipline:

| Procedure Codes  |       |       |       |       |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| <b>Limited to a combined total of 4 units (one hour) per date of service per discipline</b>  |       |       |       |       |       |       |       |       |       |
| 97032  | 97033 | 97110 | 97112 | 97113 | 97116 | 97124 | 97140 | 97530 | 97535 |
| 97537  | 97542 | 97750 | 97755 | 97760 | 97761 | 97763 |       |       |       |
| <b>Limited to a total of 3 units (45 minutes) per date of service per discipline; may be combined with other time-based codes; not payable in the home setting</b> |       |       |       |       |       |       |       |       |       |
| 97036  |       |       |       |       |       |       |       |       |       |
| <b>Limited to a combined total of 2 units (30 minutes) per date of service per discipline; may be combined with other time-based codes</b>                         |       |       |       |       |       |       |       |       |       |
| 97034  | 97035 |       |       |       |       |       |       |       |       |

**30.2.4 Untimed PT and OT Treatment Procedure Codes**

The following PT and OT treatment procedure codes are limited to one each, one time per day, per discipline.

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 97012           | 97016 | 97018 | 97022 | 97024 | 97026 | 97028 | 97150 | 97799 |

The following untimed procedure codes may only be reimbursed when billed on the same date of service with one or more time-based procedure codes listed in the Time-Based PT and OT Treatment Procedure Codes table above.

| Procedure Codes |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|
| 97012           | 97016 | 97018 | 97022 | 97024 | 97026 | 97028 |

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

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service.

If the total billable minutes are not divisible by 15 and are greater than seven, the minutes are converted to one (1) unit of service. If the total billable minutes are not divisible by 15 and are seven minutes or fewer, the minutes are converted to zero (0) units.

*Example: 68 total billable minutes/15 = four units + eight minutes. Since eight minutes are more than seven minutes, those eight minutes are converted to one unit. Therefore, 68 total billable minutes equals five units of service.*

Time intervals for one through eight units are as follows:

| Units   | Number of Minutes             |
|---------|-------------------------------|
| 0 units | 0 minutes through 7 minutes   |
| 1 unit  | 8 minutes through 22 minutes  |
| 2 units | 23 minutes through 37 minutes |
| 3 units | 38 minutes through 52 minutes |

| Units   | Number of Minutes               |
|---------|---------------------------------|
| 4 units | 53 minutes through 67 minutes   |
| 5 units | 68 minutes through 82 minutes   |
| 6 units | 83 minutes through 97 minutes   |
| 7 units | 98 minutes through 112 minutes  |
| 8 units | 113 minutes through 127 minutes |

### 30.2.6 Group Therapy

Group therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or giving the same instructions to two or more clients at the same time, the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

#### 30.2.6.1 Group Therapy Guidelines

In order to meet CSHCN Services Program criteria for group therapy, all of the following applies:

- Physician prescription for group therapy.
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements.
- The licensed therapist involved in group therapy services must be in constant attendance (meaning in the same room) and active in the therapy.
- Each client participating in the group must have an individualized treatment plan for group treatment, including interventions, short- and long-term goals, and measurable outcomes.

*Note: The CSHCN Services Program does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standards regarding group therapy.*

#### 30.2.6.2 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals

Documentation for each group therapy session must include the following:

- Name and signature of the licensed therapist providing supervision over the group therapy session
- Treatment goal addressed in the group
- Specific treatment technique(s) utilized during the group therapy session
- How the treatment technique will restore function
- Start and stop times for each session
- Group therapy setting or location
- Number of clients in the group

The client's medical record must be made available upon request.

Group therapy procedure code 97150 must be reported for each member of the group.

### **30.2.7 Noncovered Services**

The following services are not a benefit of the CSHCN Services Program:

- Therapy services provided by the following:
  - Unlicensed physical therapy aides, orderlies, students, or technicians
  - Unlicensed occupational therapy aides, interns, orderlies, students, or technicians
- Unattended electrical stimulation, as unattended services are not covered
- Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment
- Treatment solely for the instruction of other agency or professional personnel in the client's physical or occupational therapy program
- Procedure code 98960
- Procedure code 97010 (This does not require special medical training)
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- VitalStim therapy for dysphagia
- Services and procedures that are investigational or experimental

### **30.2.8 Authorization Requirements**

PT and OT evaluations and re-evaluations do not require prior authorization. All other PT and OT services require prior authorization.

Prior authorization for therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition that results in a significant decrease in functional ability and will benefit from therapy services in an office or outpatient setting.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

An initial prior authorization may be granted for a period not to exceed 180 days. Requests for extensions of ongoing treatment services may be granted up to an additional 180 days for chronic conditions with documentation of medical necessity.

Time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour.

PT and OT services that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Untimed PT and OT treatment procedure codes are limited to one each, one time per date of service, per discipline.

Each supervised modality code must be requested on the prior authorization form and may only be reimbursed when billed with one or more time-based PT/OT procedure codes.

To complete the prior authorization process by paper, the provider must submit the prior authorization requirements documentation through fax or mail and must retain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.



To complete the prior authorization process electronically, the provider must submit the prior authorization requirements documentation through any approved method and must retain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician, APRN, or PA must submit correct and complete information including documentation of medical necessity for the service requested. The ordering practitioner must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request for therapy.

### **30.2.8.1 Initial Prior Authorization Requests**

The initial request for prior authorization must be approved before therapy treatments are initiated. Requests that are received after therapy initiation will be denied for dates of service that occurred before the date that the request was approved.

***Note:** If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day.*

The following medical necessity documentation is required when submitting a request for PT or OT therapy services:

- A completed [CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy \(TP1\) Form](#). The request form must be signed and dated by the ordering physician, APRN, or PA, and the therapy provider. A request form that is missing required information is considered incomplete.

***Note:** The ordering practitioner must sign and date the treatment plan and request form on or after the date the evaluation was performed.*

- A current evaluation and comprehensive treatment plan with all of the following:
  - Date of evaluation
  - Diagnoses
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals for the therapy discipline, and associated disciplines, requested related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested dates of service
  - Date and signature of the licensed therapist

***Note:** A therapy evaluation is current when performed within 60 days before the initiation of therapy treatment services.*

### 30.2.8.2 Extension of Services Requests

A prior authorization request for extension of ongoing treatment services must be received and approved no earlier than 30 days prior to the expiration of the current prior authorization period. Requests received after the current prior authorization expires will be denied for dates of service occurring before the request's approval date.

Prior authorization requests for extension of ongoing treatment services may be considered for increments up to 180 days for chronic conditions with documentation of medical necessity and includes all of the following:

- A completed [CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy \(TP2\) Form](#) signed and dated by the ordering physician, APRN, or PA, and the therapy provider. A request form that is missing required information is considered incomplete.

*Note: The ordering practitioner must sign and date the updated treatment plan and request form on or after the date the evaluation or re-evaluation was performed.*

- A current therapy evaluation or re-evaluation, and updated treatment plan with all of the following:
  - Date of evaluation or re-evaluation
  - Diagnoses
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Prior and new short- and long-term treatment goals documenting the client's progress towards prior treatment goals
  - A description of the specific treatment modalities that are being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested date of service
  - Dated signature of licensed therapist

*Note: A therapy evaluation or re-evaluation is current when performed within 60 days before the request for extension of ongoing services.*

### 30.2.8.3 Discontinuation of Therapy or Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit evidence of the following, including all documentation required for an initial request for therapy services:

- A change-of-provider letter, which has been signed and dated by the client, parent, or guardian and documents the date that the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.

A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined above.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

[CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy \(TP1\) Form](#)

[CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy \(TP2\) Form](#)

**Note:** Fax transmittal confirmations are not accepted as proof of timely authorization submission.

### 30.3 Coordination with the Public School System

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses different client needs. If the client is of school age, therapy provided through the CSHCN Services Program is not intended to duplicate, replace, or supplement services that are the legal responsibility of other entities or institutions.

The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client’s ability to progress.

### 30.4 Claims Information

To be considered for reimbursement, claims must identify the specific therapy type. Claims for PT treatment services must include modifier GP, and claims for OT treatment services must include modifier GO. Evaluation and re-evaluation procedure codes do not require the modifiers.

Outpatient therapy services provided by a physical or occupational therapist or by an outpatient facility must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Note:** NCCI guidelines do not apply to therapy procedure codes if a valid prior authorization number is submitted on the claim.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 30.5 Reimbursement

PT or OT providers may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 30.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# PHYSICIAN

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# PHYSICIAN

## Table of Contents

- 31.1 Enrollment ..... 8**
  - 31.1.1 Group Practices ..... 9
  - 31.1.2 Changes in Provider Enrollment..... 9
  - 31.1.3 Substitute Physician ..... 9
- 31.2 Benefits, Limitations, and Authorization Requirements ..... 9**
  - 31.2.1 Authorization and Prior Authorization Requirements ..... 10
  - 31.2.2 Aerosol Treatments/Inhalation Therapy ..... 11
  - 31.2.3 Allergy Services ..... 13
    - 31.2.3.1 Collagen Skin Tests ..... 13
    - 31.2.3.2 Prior Authorization Requirements..... 13
  - 31.2.4 Ambulatory Blood Pressure Monitoring ..... 14
  - 31.2.5 Anesthesia Services..... 15
    - 31.2.5.1 Medical Direction..... 16
    - 31.2.5.2 Monitored Anesthesia Care ..... 17
    - 31.2.5.3 Anesthesia Modifiers..... 17
      - 31.2.5.3.1 *State-Defined Modifiers*..... 18
      - 31.2.5.3.2 *Anesthesiologist Services and Modifier Combinations* ..... 18
      - 31.2.5.3.3 *CRNA, AA, or Other Qualified Professional Services* ..... 19
      - 31.2.5.3.4 *Monitored Anesthesia Care* ..... 20
    - 31.2.5.4 Dental General Anesthesia ..... 20
    - 31.2.5.5 Epidural and Subarachnoid Infusion (Not including Labor and Delivery) .... 20
    - 31.2.5.6 Reimbursement ..... 20
    - 31.2.5.7 Conversion Factor ..... 20
    - 31.2.5.8 Time-Based Fees..... 21
  - 31.2.6 Audiometry/Hearing Services ..... 21
  - 31.2.7 Augmentative Communication Devices (ACDs)..... 21
  - 31.2.8 Biofeedback Services ..... 21
    - 31.2.8.1 Medical Record Documentation..... 22
    - 31.2.8.2 Provider Certification ..... 22
    - 31.2.8.3 Authorization Requirements ..... 22
    - 31.2.8.4 Noncovered Services ..... 23
  - 31.2.9 Bone Growth Stimulators ..... 23
    - 31.2.9.1 Prior Authorization Requirements for Bone Growth Stimulators ..... 23
      - 31.2.9.1.1 *Low-Intensity Ultrasound Bone Growth Stimulators* ..... 24
      - 31.2.9.1.2 *Non-Invasive Bone Growth Stimulators* ..... 24
      - 31.2.9.1.3 *Invasive Bone Growth Stimulators* ..... 25
    - 31.2.9.2 Authorization Requirements for Bone Growth Stimulation ..... 25
  - 31.2.10 Casting..... 25
  - 31.2.11 Chemotherapy ..... 26
  - 31.2.12 Clinician-Directed Care Coordination Services ..... 27
    - 31.2.12.1 Face-to-Face Clinician-Directed Care Coordination Services ..... 28
    - 31.2.12.2 Non-Face-to-Face Clinician-Directed Care Coordination Services ..... 28

|              |   |    |
|--------------|---|----|
| 31.2.12.2.1  | Care Plan Oversight   | 30 |
| 31.2.12.2.2  | Medical Team Conference   | 31 |
| 31.2.12.2.3  | Non-Face-to-Face Specialist or Subspecialist Telephone Consultations                | 31 |
| 31.2.12.2.4  | Non-Face-to-Face Prolonged Services   | 31 |
| 31.2.12.2.5  | Authorization for Non-Face-to-Face Clinician-Directed Care<br>Coordination Services | 32 |
| 31.2.13      | Cochlear Implants   | 33 |
| 31.2.14      | Colon Capsule Endoscopy   | 33 |
| 31.2.15      | Colorectal Cancer Screening   | 34 |
| 31.2.16      | Critical Care Services  | 34 |
| 31.2.16.1    | General Limitations   | 35 |
| 31.2.16.2    | Critical Care Services  | 36 |
| 31.2.16.3    | Pediatric Critical Care   | 37 |
| 31.2.16.4    | Neonatal Critical Care  | 37 |
| 31.2.16.5    | Intensive Care (Noncritical) Services   | 37 |
| 31.2.16.6    | Newborn Resuscitation   | 37 |
| 31.2.17      | Echoencephalography   | 38 |
| 31.2.17.1    | Ambulatory Electroencephalogram   | 41 |
| 31.2.18      | Evaluation and Management (E/M) Services  | 41 |
| 31.2.18.1    | New or Established Patient Visits   | 41 |
| 31.2.18.2    | Inpatient Professional Services   | 42 |
| 31.2.18.2.1  | Initial and Subsequent Hospital Care (Nonintensive Care)                            | 42 |
| 31.2.18.2.2  | Hospital Discharge Day Management   | 43 |
| 31.2.18.2.3  | Concurrent Inpatient Care   | 43 |
| 31.2.18.3    | Emergency Services  | 43 |
| 31.2.18.3.1  | Hospital-Based Emergency Department Professional Services                           | 43 |
| 31.2.18.4    | Consultations   | 44 |
| 31.2.18.5    | Services Outside of Business Hours  | 45 |
| 31.2.18.6    | Prolonged Physician Services  | 45 |
| 31.2.18.7    | Observation Room Services   | 45 |
| 31.2.18.8    | Preventive Care Services  | 46 |
| 31.2.18.9    | Preventive Care Medical Checkups and Developmental Testing                          | 47 |
| 31.2.18.9.1  | Laboratory Tests  | 47 |
| 31.2.18.9.2  | Medical Checkup Follow-up Visit   | 47 |
| 31.2.18.9.3  | Denied Medical Checkups   | 48 |
| 31.2.18.9.4  | Developmental Screening and Testing   | 48 |
| 31.2.18.9.5  | Developmental Screening   | 48 |
| 31.2.18.9.6  | Developmental Testing   | 49 |
| 31.2.18.10   | Preventive Care Medical Checkup Components  | 50 |
| 31.2.18.10.1 | Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV)                     | 50 |
| 31.2.18.10.2 | Mental Health Screening   | 51 |
| 31.2.18.10.3 | Postpartum Depression Screening   | 51 |
| 31.2.18.10.4 | Sensory Screening   | 53 |
| 31.2.18.11   | Teaching Physicians   | 53 |
| 31.2.19      | Evoked Response Tests and Neuromuscular Procedures                                  | 53 |
| 31.2.19.1    | Autonomic Function Tests (AFTs)   | 54 |
| 31.2.19.2    | Electromyography and Nerve Conduction Studies                                       | 54 |
| 31.2.19.2.1  | EMG   | 59 |
| 31.2.19.2.2  | NCS   | 59 |
| 31.2.19.3    | Evoked Potential Procedures   | 60 |
| 31.2.19.3.1  | Vestibular Evoked Myogenic Potentials (VEMP)  | 61 |

|              |  |           |
|--------------|--|-----------|
| 31.2.19.3.2  | <i>Intraoperative Neurophysiology Monitoring (IONM)</i> .....      | 62        |
| 31.2.19.4    | Motion Analysis Studies (MAS) .....                                | 62        |
| 31.2.19.5    | Prior Authorization for Unlisted Procedure Code 95999 .....        | 63        |
| 31.2.20      | Extracapsular Cataract Removal .....                               | 63        |
| 31.2.21      | Extracorporeal Shock Wave Lithotripsy (ESWL) .....                 | 63        |
| 31.2.22      | Gastrostomy Devices .....  | 64        |
| 31.2.23      | Genetics .....   | 64        |
| 31.2.23.1    | Family History .....   | 64        |
| 31.2.23.2    | Genetic Tests .....  | 65        |
| 31.2.23.3    | Laboratory Practices .....   | 65        |
| 31.2.23.4    | Genetic Counselors .....   | 66        |
| 31.2.24      | Hyperbaric Oxygen Therapy (HBOT) .....                             | 66        |
| 31.2.24.1    | Prior Authorization Requirements .....                             | 67        |
| 31.2.25      | Immunizations (Vaccines and Toxoids) .....                         | 70        |
| 31.2.25.1    | Texas Vaccines for Children (TVFC) Program .....                   | 70        |
| 31.2.25.2    | Documentation Recommendations .....                                | 70        |
| 31.2.25.3    | Vaccine Reporting to the DSHS .....                                | 71        |
| 31.2.25.3.1  | <i>Vaccine Adverse Event Reporting System (VAERS)</i> .....        | 71        |
| 31.2.25.4    | Authorization Requirements .....                                   | 71        |
| 31.2.25.5    | Vaccine Reimbursement .....  | 71        |
| 31.2.25.6    | Vaccine Administration .....                                       | 72        |
| 31.2.25.6.1  | <i>Administration With Counseling</i> .....                        | 72        |
| 31.2.25.6.2  | <i>Administration Without Counseling</i> .....                     | 73        |
| 31.2.25.7    | <b>*Vaccine and Toxoid Procedure Codes</b> .....                   | <b>74</b> |
| 31.2.25.8    | Influenza Vaccines .....   | 75        |
| 31.2.25.9    | Bacille Calmette-Guerin (BCG) Vaccine .....                        | 76        |
| 31.2.25.10   | Botulinum Antitoxin .....  | 76        |
| 31.2.25.11   | Hepatitis B Vaccine .....  | 76        |
| 31.2.25.12   | Rabies Postexposure Prophylaxis .....                              | 76        |
| 31.2.25.13   | Respiratory Syncytial Virus (RSV) Prophylaxis .....                | 77        |
| 31.2.26      | Injections and Oral Medications .....                              | 77        |
| 31.2.26.1    | Reimbursement for the Unused Portion of the Single-Dose Vial ..... | 78        |
| 31.2.26.2    | Injection Administration Billed by a Physician .....               | 78        |
| 31.2.26.3    | Unit Calculations for Billing Drugs .....                          | 78        |
| 31.2.26.4    | JW Modifier Claims Filing Instructions .....                       | 79        |
| 31.2.26.5    | <b>*Injection Procedure Codes</b> .....                            | <b>80</b> |
| 31.2.26.6    | Adalimumab .....   | 84        |
| 31.2.26.7    | Ado-Trastuzumab Emtansine .....                                    | 85        |
| 31.2.26.8    | Bevacizumab .....  | 86        |
| 31.2.26.9    | Botulinum Toxin (Type A and Type B) .....                          | 86        |
| 31.2.26.9.1  | <i>Prior Authorization Requirements</i> .....                      | 89        |
| 31.2.26.9.2  | <i>Reimbursement</i> .....   | 90        |
| 31.2.26.10   | Epirubicin Hydrochloride .....                                     | 90        |
| 31.2.26.11   | Erythropoietin Alfa (EPO) and Darbepoetin .....                    | 90        |
| 31.2.26.12   | Growth Hormone .....   | 93        |
| 31.2.26.12.1 | <i>Prior Authorization Requirements</i> .....                      | 93        |
| 31.2.26.13   | Immune Globulins .....   | 94        |
| 31.2.26.13.1 | <i>Authorization Requirements</i> .....                            | 95        |
| 31.2.26.14   | Infliximab, Inflectra, and Renflexis .....                         | 95        |
| 31.2.26.15   | Inotuzumab ozogamicin (Besponsa) .....                             | 96        |
| 31.2.26.16   | Leuprolide Acetate Injection .....                                 | 97        |



|               |  |     |
|---------------|--|-----|
| 31.2.26.17    | Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria.....                                       | 97  |
| 31.2.26.17.1  | <i>Omalizumab</i> .....  | 97  |
| 31.2.26.17.2  | <i>Benralizumab</i> .....  | 97  |
| 31.2.26.17.3  | <i>Mepolizumab</i> .....   | 97  |
| 31.2.26.17.4  | <i>Reslizumab</i> .....  | 97  |
| 31.2.26.17.5  | <i>Prior Authorization Requirements</i> .....  | 98  |
| 31.2.26.17.6  | <i>Chronic Idiopathic Urticaria</i> .....  | 98  |
| 31.2.26.17.7  | <i>Asthma Moderate to Severe (Omalizumab) and Severe (Benralizumab, Mepolizumab, and Reslizumab)</i> ..... | 98  |
| 31.2.26.17.8  | <i>Omalizumab</i> .....  | 99  |
| 31.2.26.17.9  | <i>Benralizumab</i> .....  | 99  |
| 31.2.26.17.10 | <i>Mepolizumab</i> .....   | 99  |
| 31.2.26.17.11 | <i>Reslizumab</i> .....  | 100 |
| 31.2.26.17.12 | <i>Requirements for Continuation of Therapy</i> .....  | 100 |
| 31.2.26.18    | Trastuzumab .....  | 101 |
| 31.2.26.19    | Triamcinolone Acetonide.....   | 101 |
| 31.2.27       | Intracranial Pressure Monitoring .....   | 101 |
| 31.2.28       | Laboratory Services.....   | 102 |
| 31.2.28.1     | Clinical Pathology Services and Pathology Consultations.....   | 102 |
| 31.2.28.2     | Claims Filing for Laboratory Tests .....   | 102 |
| 31.2.28.3     | Reimbursement .....  | 102 |
| 31.2.28.4     | Cytopathology Studies (Gynecological, Pap Smears) .....  | 102 |
| 31.2.28.5     | Cytogenetics Testing .....   | 103 |
| 31.2.28.6     | Helicobacter pylori (H. pylori) .....  | 103 |
| 31.2.28.7     | CLIA Requirement .....   | 103 |
| 31.2.29       | Magnetoencephalography (MEG) .....   | 103 |
| 31.2.29.1     | Authorization Requirements .....   | 103 |
| 31.2.29.2     | Documentation Requirements .....   | 104 |
| 31.2.29.3     | Exclusions.....  | 104 |
| 31.2.30       | Neurostimulator Devices and Supplies .....   | 104 |
| 31.2.31       | Ophthalmological Services.....   | 104 |
| 31.2.31.1     | Intraocular Lenses (IOL) .....   | 104 |
| 31.2.31.2     | Vitrasert Ganciclovir Implant .....  | 105 |
| 31.2.32       | Osteopathic Manipulative Treatment (OMT) .....   | 105 |
| 31.2.33       | Physical Medicine and Physical Therapy (PT) Services .....   | 105 |
| 31.2.34       | Podiatry.....  | 105 |
| 31.2.35       | Psychological Testing.....   | 106 |
| 31.2.36       | Sign Language Interpreting Services .....  | 106 |
| 31.2.37       | Skin Therapy .....   | 107 |
| 31.2.38       | Sleep Studies.....   | 108 |
| 31.2.38.1     | Polysomnography .....  | 108 |
| 31.2.38.2     | Multiple Sleep Latency Test .....  | 110 |
| 31.2.38.3     | Pediatric Pneumogram .....   | 110 |
| 31.2.38.4     | Home Sleep Study Test .....  | 110 |
| 31.2.39       | Surgery .....  | 111 |
| 31.2.39.1     | Anesthesia Administered by Surgeon .....   | 111 |
| 31.2.39.2     | Primary Surgeons.....  | 111 |
| 31.2.39.3     | Assistant Surgeons .....   | 111 |
| 31.2.39.4     | Cosurgery .....  | 112 |
| 31.2.39.5     | Bilateral Procedures .....   | 113 |
| 31.2.39.6     | Global Fees.....   | 113 |

|             |   |     |
|-------------|---|-----|
| 31.2.39.6.1 | <i>Modifiers</i> .....  | 114 |
| 31.2.39.6.2 | <i>Documentation Requirements</i> .....   | 114 |
| 31.2.39.6.3 | <i>Preoperative Services</i> .....  | 114 |
| 31.2.39.6.4 | <i>Intraoperative Services</i> .....  | 115 |
| 31.2.39.6.5 | <i>Postoperative Services</i> .....   | 115 |
| 31.2.39.6.6 | <i>Return Trips to the Operating Room</i> .....   | 117 |
| 31.2.39.7   | Multiple Surgeries .....  | 117 |
| 31.2.39.8   | Second Opinions .....   | 117 |
| 31.2.39.9   | Unlisted Surgical Procedure Code Considerations .....   | 118 |
| 31.2.39.10  | Circumcision .....  | 118 |
| 31.2.39.11  | Cleft/Craniofacial Procedures .....   | 119 |
| 31.2.40     | Diagnostic and Surgical/Reconstructive Breast Therapies .....   | 120 |
| 31.2.40.1   | Breast Therapies .....  | 121 |
| 31.2.40.1.1 | <i>Diagnostic Breast Procedures</i> .....   | 121 |
| 31.2.40.2   | Surgical Breast Procedures .....  | 122 |
| 31.2.40.2.1 | <i>Mastectomy</i> .....   | 122 |
| 31.2.40.2.2 | <i>Prophylactic Mastectomy</i> .....  | 123 |
| 31.2.40.2.3 | <i>Mastectomy for Gynecomastia</i> .....  | 123 |
| 31.2.40.2.4 | <i>Breast Reconstruction</i> .....  | 123 |
| 31.2.40.2.5 | <i>Excision or Destruction of Benign Lesions</i> .....  | 125 |
| 31.2.40.2.6 | <i>Treatment for Complications of Breast Reconstruction</i> .....   | 126 |
| 31.2.40.2.7 | <i>Reduction Mammoplasty</i> .....  | 126 |
| 31.2.40.2.8 | <i>External Breast Protheses</i> .....  | 126 |
| 31.2.40.3   | Prior Authorization and Authorization Requirements .....  | 126 |
| 31.2.40.4   | Prior Authorization and Authorization Requirements for Mastectomy,<br>Breast Reconstruction, and External Protheses ..... | 126 |
| 31.2.40.4.1 | <i>Mastectomy and Breast Reconstruction</i> .....   | 127 |
| 31.2.40.4.2 | <i>Breast Reconstruction</i> .....  | 127 |
| 31.2.40.4.3 | <i>Mastectomy for Gynecomastia</i> .....  | 128 |
| 31.2.40.4.4 | <i>Reduction Mammoplasty</i> .....  | 128 |
| 31.2.40.4.5 | <i>Unlisted Procedure</i> .....   | 128 |
| 31.2.40.4.6 | <i>Breast Protheses</i> .....   | 129 |
| 31.2.40.5   | Documentation Requirements .....  | 129 |
| 31.2.40.6   | Reconstructive and Corrective Procedures (Not Related to Breast<br>Therapies) .....                                       | 130 |
| 31.2.40.7   | Prior Authorization and Authorization for Corrective Procedures .....   | 131 |
| 31.2.40.7.1 | <i>Oral Procedures</i> .....  | 131 |
| 31.2.40.7.2 | <i>Dermatological and Blepharoplasty Procedures</i> .....   | 131 |
| 31.2.40.7.3 | <i>Panniculectomy and Abdominoplasty</i> .....  | 131 |
| 31.2.40.7.4 | <i>Noncovered Services</i> .....  | 131 |
| 31.2.40.8   | Rhizotomy .....   | 132 |
| 31.2.40.9   | Septoplasty .....   | 132 |
| 31.2.41     | Therapeutic Apheresis .....   | 132 |
| 31.2.42     | Transplants .....   | 134 |
| 31.2.42.1   | Renal (Kidney) Transplant .....   | 134 |
| 31.2.42.2   | Transplants - Nonsolid Organ .....  | 135 |
| 31.2.42.2.1 | <i>Physician Reimbursement</i> .....  | 137 |
| 31.2.43     | Wound Care Management .....   | 137 |
| 31.2.43.1   | First-Line Wound Care Therapy .....   | 137 |
| 31.2.43.1.1 | <i>Compression</i> .....  | 138 |
| 31.2.43.1.2 | <i>Debridement</i> .....  | 138 |

---

|             |   |            |
|-------------|---|------------|
| 31.2.43.2   | Second-Line Wound Care Therapy .....  | 138        |
| 31.2.43.2.1 | <i>Pulsatile-Jet Irrigation</i> .....   | 139        |
| 31.2.43.2.2 | <i>Application of Metabolically Active Skin Equivalents and Wound Preparation</i> ..... | 139        |
| 31.2.43.3   | Documentation Requirements .....  | 139        |
| <b>31.3</b> | <b>Claims Information</b> .....   | <b>140</b> |
| 31.3.1      | General Medical Record Documentation Requirements.....                                  | 141        |
| <b>31.4</b> | <b>Reimbursement</b> .....  | <b>142</b> |
| 31.4.1      | Physician Services in Outpatient Hospital Setting .....                                 | 143        |
| 31.4.1.1    | Reimbursement Reduction.....  | 143        |
| <b>31.5</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....                                 | <b>143</b> |

## 31.1 Enrollment

Physicians, podiatrists, physician groups, and podiatry groups may enroll as Children with Special Healthcare Needs (CSHCN) Services Program providers by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). Providers may also enroll or reenroll in the CSHCN Services Program online through PEMS. For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Option 2.

In this section the term “physician” means a doctor of medicine (MD), doctor of osteopathy (DO), or doctor of podiatric medicine (DPM).

Physicians must be actively enrolled as a Medicaid provider before enrolling in the CSHCN Services Program. “Actively enrolled” physicians are those that have filed claims for clients of the CSHCN Services Program or Texas Medicaid within the past 24 months, and that do not have any type of payment holds on their enrollment status. Physicians must be licensed by the Texas licensing board. Out-of-state physicians must meet all these conditions and be located in the United States, within 50 miles of the Texas state border.

Requests for medical services provided by an out-of-state provider more than 50 miles from the Texas state border must be submitted for consideration to TMHP at the address in Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities.”

**Referto:** Section 2.1.9, “Out-of-State Providers” in Chapter 2, “Provider Enrollment and Responsibilities” for more information about out-of-state services.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC) Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 2.1.5.1, “Types of Providers” in Chapter 2, “Provider Enrollment and Responsibilities” for additional information.

Section 3.1.4, “Services Provided Outside of Texas” in Chapter 3, “Client Benefits and Eligibility” for more detailed information about services provided outside of Texas.

### 31.1.1 Group Practices

Provider groups that are enrolled in Texas Medicaid can enroll in the CSHCN Services Program by completing an enrollment application. The CSHCN Services Program application must include the Medicaid group provider identifier and performing provider identifiers for all physicians in the group.

### 31.1.2 Changes in Provider Enrollment

If additions or changes occur in the provider's enrollment information after the enrollment process is completed, the provider must notify TMHP of the changes through PEMS.

*Referto:* Section 2.1.2, "Changes in Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for additional information.

### 31.1.3 Substitute Physician

Physicians may bill for the services of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements are limited to a continuous period no longer than 14 days and do not have to be in writing.

A *locum tenens* arrangement is one in which a substitute physician assumes the practice of a billing physician for a temporary period no longer than 90 days when the billing physician is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the Armed Forces. The locum tenens arrangement may be extended for a continuous period longer than 90 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the Armed Forces. *Locum tenens* arrangements must be in writing.

Substitute physicians are required to enroll with the CSHCN Services Program. Substitute physicians are also required to enroll with Texas Medicaid before enrolling in the CSHCN Services Program and cannot be on the Texas Medicaid provider exclusion list.

The billing provider's name, address, and national provider identifier must appear in Block 33 of the claim form. The name and mailing address of the substitute physician must be documented on the claim in Block 19, not Block 33. When a physician bills for a substitute physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a *locum tenens* arrangement.

## 31.2 Benefits, Limitations, and Authorization Requirements

Physician and podiatrist services include reasonable and medically necessary services that are ordered and performed by a physician or under the personal supervision of a physician and that are within the scope of practice of his or her profession, as defined by state law. The physician must examine the client, make a diagnosis, establish a plan of care, and document these tasks on the appropriate client medical records before submitting claims. Payment may be recouped if the documentation is not in the client's medical record.

To be payable by the CSHCN Services Program, services must be personally performed by the physician or by a qualified person working under the personal supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided.

If an attending physician provides personal and identifiable direction to interns or residents who are participating in the care of a CSHCN Services Program client in a teaching setting through an approved and accredited training program by the appropriate accreditation agencies, the attending physician's services are a benefit. For major surgical procedures and other complex and dangerous procedures or

situations, the attending physician must be physically present during the procedure or situation to provide personal and identifiable direction. Payment for services may be recouped if personal and identifiable direction is not provided or is not appropriately documented.

To demonstrate that personal and identifiable direction was provided, the attending physician must have:

- Reviewed the client's history and physical examination and personally examined the client within a reasonable period after the client's admission and before the client's discharge.
- Confirmed or revised the client's diagnosis.
- Determined the course of treatment to be followed.
- Provided appropriate supervision of the interns or residents.
- Entered the appropriate daily documentation of the tasks identified above in the client's medical record before the claim is submitted.

### 31.2.1 Authorization and Prior Authorization Requirements

Some services, as specified throughout this chapter, require authorization or prior authorization as a condition for reimbursement. Authorization and prior authorization is not a guarantee of payment.

- Authorization must occur no later than 95 days after the date of service.
- Prior authorization must be obtained before the service is provided.

Authorization requests received after the authorization deadline are denied.

The 95-day filing deadline is for all services that require authorization (not *prior* authorization), including extensions and emergency situations.

Before submitting an authorization or prior authorization request, the provider must verify the client's eligibility. Any service provided while the client is not eligible cannot be reimbursed. Providers are responsible for knowing which services require authorization or prior authorization.

All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are located on the [Forms](#) page of the TMHP website. Providers may fax their authorization or prior authorization requests to the TMHP-CSHCN Services Program Authorization Department at 1-512-514-4222. This fax number is only for authorization or prior authorization requests.

Fax transmittal confirmations are not accepted as proof of timely authorization or prior authorization submission.

Requests to extend the authorization deadline are not considered except in cases involving retroactive eligibility.

**Exception:** *For clients that receive retroactive eligibility, the authorization and prior authorization requirement may be waived if the client's eligibility had not been determined by the time TMHP received the request. Claims for these services must be received within 95 days of the eligibility add date and must include a completed request for authorization/prior authorization, along with all other applicable documentation.*

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for additional information.

Section 4.3.1, "Services that Require Authorization" in Chapter 4, "Prior Authorizations and Authorizations" for a list of some of the services requiring authorization.

Section 4.4.1, "Services that Require Prior Authorization" in Chapter 4, "Prior Authorizations and Authorizations" for a list of some of the services requiring prior authorization.

### 31.2.2 Aerosol Treatments/Inhalation Therapy

Aerosol therapy is a benefit of the CSHCN Services Program. Continuous inhalation treatment with aerosol medication for acute airway obstruction (procedure codes 94644 and 94645) is a benefit of the CSHCN Services Program.

On physician claims, nebulizers and metered-dose inhaler treatments must be billed with procedure code 94640.

Pentamidine aerosol treatment (procedure codes 94642 and J2545) is a benefit of the CSHCN Services Program for diagnosis codes B20, D8481, D84821, D84822, and D8489 for the treatment of pneumocystis carinii.

Procedure code J7605 may be reimbursed when billed with the following diagnosis codes:

| Diagnosis Codes |        |       |       |        |        |        |        |
|-----------------|--------|-------|-------|--------|--------|--------|--------|
| A150            | E840   | J09X1 | J09X2 | J09X9  | J1000  | J1001  | J1008  |
| J101            | J1100  | J1108 | J111  | J121   | J15212 | J188   | J189   |
| J210            | J211   | J218  | J398  | J410   | J411   | J418   | J42    |
| J430            | J431   | J432  | J438  | J439   | J440   | J441   | J449   |
| J4520           | J4521  | J4522 | J4530 | J4531  | J4532  | J4540  | J4541  |
| J4542           | J4550  | J4551 | J4552 | J45901 | J45902 | J45909 | J45990 |
| J45991          | J45998 | J470  | J471  | J479   | J60    | J61    | J620   |
| J628            | J630   | J631  | J632  | J633   | J634   | J635   | J64    |
| J660            | J661   | J662  | J668  | J670   | J671   | J672   | J673   |
| J674            | J675   | J676  | J677  | J678   | J679   | J680   | J681   |
| J682            | J683   | J684  | J689  | J690   | J691   | J698   | J700   |
| J701            | J705   | J708  | J709  | J9801  | J9809  | Q334   | R051   |
| R052            | R053   | R054  | R058  | R059   | Z7182  |        |        |

Procedure code J7608 may be reimbursed when billed with the following diagnosis codes:

| Diagnosis Codes |        |       |       |        |        |        |        |
|-----------------|--------|-------|-------|--------|--------|--------|--------|
| A150            | E840   | J09X1 | J09X2 | J09X9  | J1000  | J1001  | J1008  |
| J101            | J1100  | J1108 | J111  | J121   | J15212 | J188   | J189   |
| J210            | J211   | J218  | J398  | J410   | J411   | J418   | J42    |
| J430            | J431   | J432  | J438  | J439   | J440   | J441   | J449   |
| J4520           | J4521  | J4522 | J4530 | J4531  | J4532  | J4540  | J4541  |
| J4542           | J4550  | J4551 | J4552 | J45901 | J45902 | J45909 | J45990 |
| J45991          | J45998 | J470  | J471  | J479   | J60    | J61    | J620   |
| J628            | J630   | J631  | J632  | J633   | J634   | J635   | J64    |
| J660            | J661   | J662  | J668  | J670   | J671   | J672   | J673   |
| J674            | J675   | J676  | J677  | J678   | J679   | J680   | J681   |
| J682            | J683   | J684  | J689  | J690   | J691   | J698   | J700   |
| J701            | J708   | J709  | J8281 | J8282  | J9801  | J9809  | Q334   |
| R051            | R052   | R053  | R058  | R059   | Z7182  |        |        |

Procedure codes J7622, J7631, J7639, J7644, and J7682 may be reimbursed when billed with the following diagnosis codes:

| Diagnosis Codes |        |       |       |        |        |        |        |
|-----------------|--------|-------|-------|--------|--------|--------|--------|
| A150            | E840   | J09X1 | J09X2 | J09X9  | J1000  | J1001  | J1008  |
| J101            | J1100  | J1108 | J111  | J121   | J15212 | J188   | J189   |
| J210            | J211   | J218  | J398  | J410   | J411   | J418   | J42    |
| J430            | J431   | J432  | J438  | J439   | J440   | J441   | J449   |
| J4520           | J4521  | J4522 | J4530 | J4531  | J4532  | J4540  | J4541  |
| J4542           | J4550  | J4551 | J4552 | J45901 | J45902 | J45909 | J45990 |
| J45991          | J45998 | J470  | J471  | J479   | J60    | J61    | J620   |
| J628            | J630   | J631  | J632  | J633   | J634   | J635   | J64    |
| J660            | J661   | J662  | J668  | J670   | J671   | J672   | J673   |
| J674            | J675   | J676  | J677  | J678   | J679   | J680   | J681   |
| J682            | J683   | J684  | J689  | J690   | J691   | J698   | J700   |
| J701            | J708   | J709  | J9801 | J9809  | Q334   | R051   | R052   |
| R053            | R054   | R058  | R059  | Z7182  |        |        |        |

Procedure code J7626 may be reimbursed when billed with the following diagnosis codes:

| Diagnosis Codes |        |       |       |        |        |        |        |
|-----------------|--------|-------|-------|--------|--------|--------|--------|
| A150            | E840   | J09X1 | J09X2 | J09X9  | J1000  | J1001  | J1008  |
| J101            | J1100  | J1108 | J111  | J121   | J15212 | J188   | J189   |
| J210            | J211   | J218  | J398  | J410   | J411   | J418   | J42    |
| J430            | J431   | J432  | J438  | J439   | J440   | J441   | J449   |
| J4520           | J4521  | J4522 | J4530 | J4531  | J4532  | J4540  | J4541  |
| J4542           | J4550  | J4551 | J4552 | J45901 | J45902 | J45909 | J45990 |
| J45991          | J45998 | J470  | J471  | J479   | J60    | J61    | J620   |
| J628            | J630   | J631  | J632  | J633   | J634   | J635   | J64    |
| J660            | J661   | J662  | J668  | J670   | J671   | J672   | J673   |
| J674            | J675   | J676  | J677  | J678   | J679   | J680   | J681   |
| J682            | J683   | J684  | J689  | J690   | J691   | J698   | J700   |
| J701            | J708   | J709  | J9801 | J9809  | Q334   | R051   | R052   |
| R053            | R054   | R058  | R059  | Z7182  |        |        |        |

Procedure code J7633 may be reimbursed when billed with the following diagnosis codes:

| Diagnosis Codes |       |       |       |        |        |        |        |
|-----------------|-------|-------|-------|--------|--------|--------|--------|
| A150            | E840  | J09X1 | J09X2 | J09X9  | J1000  | J1001  | J1008  |
| J101            | J1100 | J1108 | J111  | J121   | J15212 | J188   | J189   |
| J210            | J211  | J218  | J398  | J410   | J411   | J418   | J42    |
| J430            | J431  | J432  | J438  | J439   | J440   | J441   | J449   |
| J4520           | J4521 | J4522 | J4530 | J4531  | J4532  | J4540  | J4541  |
| J4542           | J4550 | J4551 | J4552 | J45901 | J45902 | J45909 | J45990 |



| Diagnosis Codes |        |      |       |       |      |       |      |
|-----------------|--------|------|-------|-------|------|-------|------|
| J45991          | J45998 | J470 | J471  | J479  | J60  | J61   | J620 |
| J628            | J630   | J631 | J632  | J633  | J634 | J635  | J64  |
| J660            | J661   | J662 | J668  | J670  | J671 | J672  | J673 |
| J674            | J675   | J676 | J677  | J678  | J679 | J680  | J681 |
| J682            | J683   | J684 | J689  | J690  | J691 | J698  | J700 |
| J701            | J708   | J709 | J9801 | J9809 | Q334 | Z7182 |      |

### 31.2.3 Allergy Services

Allergy testing and desensitization are benefits of the CSHCN Services Program.

Providers must use the following procedure codes to bill for allergy testing:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 86001           | 86003 | 86005 | 86008 | 86486 | 95004 | 95017 | 95018 | 95024 | 95027 |
| 95028           | 95076 | 95180 | 95199 |       |       |       |       |       |       |

Allergy blood testing (procedure codes 86001, 86003, 86005, and 86008) are a benefit of the CSHCN Services Program under the following circumstances:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client because of the following reasons:
  - The client is pediatric
  - The client is disabled
  - The client suffers from a skin condition such as dermatitis

Procedure code 86001 is limited to 20 allergens per rolling year, any provider. Procedure codes 86003 and 86008 are limited to 30 allergens per rolling year, any provider. Procedure code 86005 is limited to 4 screenings per rolling year, same provider.

Providers must indicate the number of allergens tested in the Units field in Block 24G of the CMS-1500 paper claim form. If the number of tests is not indicated in this field, payment is made for only one test.

#### 31.2.3.1 Collagen Skin Tests

Collagen skin tests are a benefit of the CSHCN Services Program and may be reimbursed using procedure code Q3031.

Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure which utilizes collagen.

#### 31.2.3.2 Prior Authorization Requirements

Allergy services generally do not require prior authorization; however, prior authorization is required for unlisted procedure code 95199 and when benefit limitations are exceeded for procedure codes 86001, 86003, 86005, and 86008.

Every effort should be made to use the appropriate Healthcare Common Procedure Coding System (HCPCS) or Current Procedural terminology (CPT) procedure code which describes the procedure being performed. If a procedure code does not exist to describe the service performed, procedure code 95199 should be submitted with appropriate documentation to assist in determining coverage. The documentation submitted must include all of the following:

- The client's diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending the procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that the procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The physician's intended fee for this procedure

Requests for prior authorization of procedure codes 86001, 86003, 86005, and 86008 must be submitted with documentation of medical necessity and include all of the following:

- Results of any previous treatment
- Documentation indicating that the client's treatment could not be completed within the policy limits for the requested procedures
- Client diagnosis and conditions that support the medical necessity for the additional procedures requested
- Explanation of client outcomes that the requested procedures will achieve

Prior authorization requests must be submitted using the [CSHCN Services Program Authorization and Prior Authorization Request Form](#).

### **31.2.4 Ambulatory Blood Pressure Monitoring**

Blood pressure monitoring by either self-measured blood pressure monitoring or ambulatory blood pressure monitoring are benefits of the CSHCN Services Program when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are a benefit for the initial diagnosis of hypertension and should not be used for maintenance monitoring. Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for the evaluation of one of the following conditions:

- White coat hypertension, which includes all of the following:
  - A clinic or office blood pressure measurement greater than 140/90 mm Hg on at least three separate clinic or office visits with two separate measurements made at each visit
  - At least two documented separate blood pressure measurements taken outside the clinic or office, which are less than 140/90 mm Hg
  - No evidence of end-organ damage
- Resistant hypertension
- Evaluation of hypotensive symptoms as a response to hypertension medications

- Nocturnal angina
- Episodic hypertension
- Evaluation of syncope

Providers must document that the self-measured blood pressure monitoring and ambulatory blood pressure monitoring was performed for at least 24 hours.

Providers must use procedure codes 93784, 93786, 93788, and 93790 when billing for ambulatory blood pressure monitoring.

Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Claims that exceed the limitation of two services per lifetime may be considered for reimbursement when documentation of medical necessity is submitted with the claim.

Self-measured blood pressure monitoring procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings - excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs - day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

Self-measured blood pressure monitoring procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

Only one method of blood pressure monitoring (self-measured or ambulatory) may be reimbursed within a rolling 12-month period. Self-measured blood pressure monitoring submitted within the same rolling 12-month period as ambulatory blood pressure monitoring will be denied.

### **31.2.5 Anesthesia Services**

Anesthesia services are a benefit of the CSHCN Services Program and may be reimbursed to anesthesiologists, certified registered nurse anesthetists (CRNAs), anesthesiologist assistants (AA), and other qualified professionals.

Anesthesia must be administered by an anesthesia practitioner. An anesthesia practitioner is defined as the following:

- An anesthesiologist performing the anesthesia service alone or medically directs a CRNA, AA, or other qualified professional
- A CRNA who is not medically directed
- An AA performing delegated services
- A qualified professional as identified by the Texas Medical Board performing delegated services

Authorization is not required for anesthesia services. Specific surgical procedures, however, may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon are denied.

For time-based anesthesiology procedure codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

The anesthesiologist who medically directs the CRNA, AA, or other qualified professional must document the same time that the CRNA, AA, or other qualified professional documents.

Time units are determined on the basis of one time unit for each 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Anesthesia services for obstetrical or family planning procedures are not a benefit of the CSHCN Services Program.

Local, regional, or general anesthesia provided by a surgeon is not a separately payable benefit of the CSHCN Services Program when performed by the operating surgeon. If anesthesia services are provided and modifier 47 is used, the services are included in the global fee for the surgical procedure.

### **31.2.5.1 Medical Direction**

Personal medical direction of an anesthesia practitioner (CRNA, AA, or other qualified professional) by an anesthesiologist is a benefit of the CSHCN Services Program if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.

**Exception:** *Anesthesiologists may simultaneously supervise more than a combination of four CRNAs, AAs, or other qualified professionals, as defined by the Texas Medical Board under emergency circumstances.*

- The anesthesiologist is physically present in the operating suite.

Medical direction is a covered service only if all of the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical and key portions of the anesthesia plan, including induction and emergence, if applicable.
- The anesthesiologist must ensure that a qualified professional, including anesthesiologist assistants, can perform any procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at frequent intervals.
- The anesthesiologist must provide direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides indicated postanesthesia care.
- The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist directing the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:
  - Address an emergency of short duration in the immediate area.
  - Administer an epidural or caudal anesthetic to ease labor pain for a client who is not enrolled in the CSHCN Services Program.

- Provide periodic, rather than continuous, monitoring of an obstetrical client who is not enrolled in the CSHCN Services Program.
- Receive clients entering the operating suite for the next surgery.
- Check or discharge clients in the recovery room.
- Handle scheduling matters.

An anesthesiologist may medically direct up to four concurrent anesthesia procedures. Concurrent medical direction refers to involvement of the anesthesiologist in directing two, three, or four current anesthesia procedures.

Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a CSHCN Services Program client. For example, if three procedures are medically directed but only two involve CSHCN Services Program clients, the CSHCN Services Program claims should be billed as concurrent medical direction of three procedures.

The following information must be available to the state upon request and is subject to retrospective review:

- The name of each CRNA, AA, and other qualified professional concurrently being medically directed or supervised and a description of the procedure that was performed must be documented and maintained on file.
- Signatures of the anesthesiologist, CRNAs, AAs, or other qualified professionals involved in administering anesthesia services must be documented in the client's medical record.
- For medical direction, the anesthesiologist must document in the client's medical record that he or she:
  - Performed the pre-anesthetic exam and evaluation.
  - Provided the indicated post-anesthesia care.
  - Was present during the critical and key portions of the anesthesia procedure including, if applicable, induction and emergence.
  - Was present during the anesthesia procedure to monitor the client's status.

### **31.2.5.2 Monitored Anesthesia Care**

Monitored anesthesia care may include any of the following:

- Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist.
- Monitoring the client's vital physiological signs in anticipation of the need for general anesthesia.
- Monitoring the client to detect development of an adverse physiological reaction to a surgical procedure.

### **31.2.5.3 Anesthesia Modifiers**

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier(s) whether billing as the sole provider or for the medical direction of CRNAs, AAs, or other qualified professionals.

When an anesthesia procedure is billed without the appropriate reimbursement modifiers, or is billed with modifier combinations other than those listed in this section, the claim is denied.

A claim billed with a modifier indicating that the anesthesia was not medically directed or medically supervised (modifier AD, QK, QX, or QY) is denied if a previous claim has been billed with a modifier indicating the service was personally performed (modifier AA or QZ) and is reimbursed for the same client, date of service, and procedure code.

A claim billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) is denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service, and procedure code. The opposite is also true—a CRNA-administered procedure is denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

**31.2.5.3.1 State-Defined Modifiers**

Modifiers U1 (indicating one anesthesia claim is expected) and U2 (indicating two anesthesia claims are expected) are state-defined modifiers that may be billed by an anesthesiologist, CRNA, AA, or other qualified professional.

Modifier U3 indicates that the anesthesia was performed with dental services.

Modifier U1 indicating that only one claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit the modifier U1 or U2 in combination with an appropriate pricing modifier when billing for any payable anesthesia procedure codes.

**31.2.5.3.2 Anesthesiologist Services and Modifier Combinations**

When a single claim per client is billed by the anesthesiologist for personally performing the anesthesia service, the AA and U1 modifier combination must be billed together.

Anesthesiologists may be reimbursed for medical direction of anesthesia practitioners by using one of the following modifier combinations:

| <b>Modifier Combination</b>   |  |                                |
|---|--|--------------------------------|
| <b>Submitted by Anesthesiologist</b>  | <b>When is it used?</b>  | <b>Who will submit claims?</b> |
| <b>Anesthesiologist Providing Medical Direction or Medical Supervision to Other Qualified Professionals</b> |  |                                |
| QY and U1   | When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA, or other qualified professional, the QY + U1 modifier combination must be billed together if the CRNA, AA, or qualified professional are a part of a clinic/group. | Only the anesthesiologist      |
| QK and U1   | When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.   | Only the anesthesiologist      |

| <b>Modifier Combination Submitted by Anesthesiologist</b>                                  | <b>When is it used?</b>  | <b>Who will submit claims?</b>  |
|--|--|---|
| AA, U1, and GC   | When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one resident physician.  | Only the anesthesiologist   |
| AD and U1 (emergency circumstances only)   | When a single claim per client is billed by the anesthesiologist for medically supervising anesthesia services provided by more than four concurrent procedures that are provided by a CRNA, AA, or other qualified professional. The AD modifier must be used in emergency circumstances only and limited to 6 units (90 minutes maximum) per case for each occurrence requiring supervision of five or more concurrent procedures. | Only the anesthesiologist   |
| <b>Anesthesiologist Providing Medical Direction or Medical Supervision of CRNAs or AAs</b> |  |   |
| QY and U2  | When two claims per client are billed, one by the medically directing anesthesiologist and one by the CRNA, AA, or other qualified professional.   | Both the anesthesiologist and CRNA, AA, or other qualified professional       |
| QK and U2  | When two claims per client are billed for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNA(s), AA(s), or other qualified professionals.  | Both the anesthesiologist and CRNA(s), AA(s), or other qualified professional |
| AD and U2 (emergency circumstances only)   | When two claims per client are billed for medically supervising more than four concurrent anesthesia procedures provided by CRNA(s), AA(s), or other qualified professionals. The AD modifier must be used in emergency circumstances only and limited to 6 units (90 minutes maximum) per case for each occurrence requiring supervision of five or more concurrent procedures.   | Both the anesthesiologist and CRNA(s), AA(s), or other qualified professional |

**31.2.5.3.3 CRNA, AA, or Other Qualified Professional Services**

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the physician.

Modifiers QX and U2 must be submitted by a CRNA, AA, or other qualified professional who provided services under the medical direction of an anesthesiologist.

#### 31.2.5.3.4 Monitored Anesthesia Care

Anesthesiologists, CRNAs, AAs, or other qualified professionals may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier, and must be billed with any combination of pricing modifiers for reimbursement.

#### 31.2.5.4 Dental General Anesthesia

Procedure code 00170 with modifier U3 should be used when billing for the appropriate reimbursement of dental general anesthesia.

*Referto:* Chapter 14, “Dental” for more information about dental services.

#### 31.2.5.5 Epidural and Subarachnoid Infusion (Not including Labor and Delivery)

Epidural and subarachnoid infusion for pain management may be reimbursed for acute, chronic, and postoperative pain management.

Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. If procedure code 01996 is billed longer than 30 days medical necessity documentation is required. Cancer diagnoses are excluded from the 30-day limitation.

#### 31.2.5.6 Reimbursement

To be reimbursed, providers of anesthesia services must include the following on submitted claims:

- Appropriate national anesthesia procedure codes
- Correct modifier(s)
- Name of the anesthesiologist, CRNA, or medically directed AA administering the anesthesia
- Exact amount of face-to-face time with the client

If procedure code 01996 is used, it must be reported as a medical service rather than an anesthesia service.

The anesthesiologist’s reimbursement for medical direction of CRNAs, AAs, and other qualified professionals is 50 percent of the maximum allowable fee.

The CRNA’s or AA’s reimbursement for performing an anesthesia service when supervised by a physician other than an anesthesiologist is 92 percent of the maximum allowable fee.

A CRNA or AA under the supervision of an anesthesiologist may be reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

*Referto:* Chapter 12, “Certified Registered Nurse Anesthetist (CRNA)” for more information on CRNA services.

If multiple CRNAs, anesthesiologists, or anesthesiologist assistants under anesthesiologist supervision are providing anesthesia services for a client, only one CRNA or AA and one anesthesiologist may be reimbursed.

Procedure codes 99100, 99116, 99135, and 99140 are qualifying circumstances that impact the character of the anesthesia services provided. These procedures are not payable alone, but are payable in addition to the anesthesia service. Documentation supporting the medical necessity for use of these procedure codes may be subject to retrospective review.

#### 31.2.5.7 Conversion Factor

A conversion factor is the multiplier that transforms relative value into payment amounts. There is a standard conversion factor for anesthesia services that can be obtained from the online fee lookup on the TMHP website at [www.tmhp.com](http://www.tmhp.com).



### 31.2.5.8 Time-Based Fees

Reimbursement of time-based anesthesia services is defined as  $[(\text{Minutes}/15) + \text{Relative Value Units (RVUs)}] \times \text{Conversion Factor} = \text{Anesthesia Reimbursement}$ . It is derived from the following steps:

- 1) Divide the total anesthesia time in minutes (the time of all procedures performed, directed or supervised) by 15.

Add the RVUs for the procedure performed (use the procedure with the highest RVUs when multiple procedures are performed at the same time).

Multiply this sum by the appropriate conversion factor.

Reimbursement of time-based fees requires documentation of exact time in minutes of face-to-face time with the client.

If anesthesia services are performed for two surgical procedures at separate times during the same date of service, both may be reimbursed based on the documentation submitted with the claim.

### 31.2.6 Audiometry/Hearing Services

The CSHCN Services Program may reimburse appropriately-enrolled providers for audiometry and other hearing services.

Authorization is not required for hearing services provided by physicians.

*Referto:* Chapter 20, “Hearing Services” for more information about hearing services.

CSHCN Services Program clients who are 17 years of age or older, legal residents of the state of Texas, and are employable, may be eligible for assistance from the Health and Human Services Commission (HHSC). The CSHCN Services Program is the payer of last resort and may request that clients meeting these requirements apply to HHSC.

### 31.2.7 Augmentative Communication Devices (ACDs)

The purchase, rental, replacement, modification, and repair of ACDs that function independently of any other technology (i.e., may not rely on a computer in any way) are benefits of the CSHCN Services Program when medically necessary.

*Referto:* Chapter 10, “Augmentative Communication Devices (ACDs).”

### 31.2.8 Biofeedback Services

Biofeedback is a form of therapy in which a physiologic activity is monitored, amplified, and conveyed by visual or acoustic signals. Procedure codes 90901, 90912 and 90913 may be benefits of the CSHCN Services Program for biofeedback services.

The CSHCN Services Program will cover biofeedback services with prior authorization for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence (i.e., stress, urge, overflow, mixed)
- Fecal incontinence

Procedure codes 90901, 90912 and 90913 are limited to one procedure code for each date of service by any provider to include all modalities of the services performed during a specific session regardless of the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

### 31.2.8.1 Medical Record Documentation

The physician must provide correct and complete information including documentation establishing medical necessity of the service requested, which must remain in the client's medical record and maintain the record of the performing staff member(s) certification. Claims may be subject to retrospective review.

### 31.2.8.2 Provider Certification

Biofeedback services must be performed by a staff member who is certified by Biofeedback Certification International Alliance (BCIA). The accepted certification types are:

| Certification Type  | Description   |
|---|---|
| General biofeedback certification (BCB)                       | Professionals certified in general biofeedback covering all modalities such as SEMG, Thermal, GSR, HRV, and an overview of neurofeedback. |
| Pelvic muscle dysfunction biofeedback certification (BCB-PMD) | Professionals certified to use SEMG biofeedback to treat elimination disorders including incontinence and pelvic pain.                    |

### 31.2.8.3 Authorization Requirements

Prior authorization is required for biofeedback services. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request Form.

The number of sessions prior authorized will not exceed a total of 12 sessions and will not exceed a total duration of 12 weeks. The following documentation must be submitted for consideration of prior authorization:

- Failure of pharmacotherapy and behavioral training
- Evidence of dyssynergic or non-relaxing detrusor/voluntary sphincter activity based on urodynamic evaluation to include urinary flow testing and complex cystometry
- The client has agreed to actively participate in the biofeedback sessions
- Diagnosis of fecal, stress, urge, overflow, or a mix of stress and urge incontinence
- Medical records indicate that the physician has excluded any underlying medical conditions that could be causing the problem
- For clients who are 21 years of age or older with a diagnosis of stress, urge, overflow, or a mix of stress and urge incontinence, the medical records must indicate failed pelvic muscle exercise (PME) service

**Note:** *A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing 4 weeks of PME exercises.*

After completion of the initial biofeedback treatment course, prior authorization may be considered for a total of 6 follow-up sessions not to exceed 3 sessions per week and total duration not to exceed 8 weeks. Prior authorization documentation submitted must be for the same condition as the original request, must include each original symptom, and how the symptom has objectively improved. The documentation may include, but is not limited to:

- For urinary incontinence, the biofeedback therapy should result in improvement of continence scores. There should be a decrease in high-grade stress incontinence, nocturnal enuresis, and loss of urine during activity. For clients who are 21 years of age and older, the pelvic floor muscle contraction strength should improve with the ability to hold the contractions longer and to increase repetitions.

- For fecal incontinence, the biofeedback therapy should result in improvement of continence scores. Squeeze and anal pressures, squeeze duration, and for clients who are 21 years of age and older, pelvic floor muscle contraction strength should show improvement.

Total authorized sessions for any combination of procedure codes 90901, 90912 and 90913, including the 12 initial sessions and 6 follow-up sessions, will not exceed 18 sessions for urinary or fecal incontinence conditions.

#### **31.2.8.4 Noncovered Services**

Neurofeedback (i.e., EEG biofeedback) is not a benefit of the CSHCN Services Program.

#### **31.2.9 Bone Growth Stimulators**

Internal (implanted) or external (not implanted) bone growth (osteogenic) stimulators are a benefit of the CSHCN Services Program.

Electromagnetic bone growth stimulators promote healthy bone growth and repair by low intensity electrical stimulation. Electrical stimulation is provided by implanting low-voltage electrodes within the tissue surrounding the bone (internal) or by external placement of a device which transmits low-voltage currents through the soft tissue to the bone (external).

Ultrasonic bone growth stimulators promote healthy bone growth and repair through low-intensity pulsed ultrasound waves.

Bone growth stimulators are a benefit for skeletally mature individuals only.

Bone growth stimulation (procedure codes 20974, 20975, and 20979) is limited to one service every six months. Bone growth stimulation for a second fracture that occurs during the six-month limitation period may be considered on appeal with documentation of medical necessity that supports that the criteria have been met for the second fracture.

**Referto:** Section 31.2.9.1, “Prior Authorization Requirements for Bone Growth Stimulators” in this chapter for information about prior authorization requirements for procedure codes 20974, 20975, and 20979.

Due to the short life of the equipment, osteogenic stimulators are purchased.

An ultrasonic bone growth stimulator may not be reimbursed concurrently with other noninvasive bone growth stimulation devices.

Monitoring the effectiveness of bone growth stimulation treatment should be billed as the appropriate evaluation and management (E/M) code.

Physician services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Durable medical equipment (DME) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

#### **31.2.9.1 Prior Authorization Requirements for Bone Growth Stimulators**

Prior authorization is required for bone growth stimulator devices. Inpatient admissions require prior authorization. Ambulatory or day surgery requires authorization.

Prior authorization requests for bone stimulator devices must be submitted on the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#).

A completed [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form](#) prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. All signatures

must be current, stamped signatures will not be accepted. The completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form must be maintained by the requesting provider and the prescribing physician.

To avoid unnecessary authorization denials, the physician must provide correct and complete information, including documentation for medical necessity of the DME or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the bone growth stimulator.

Documentation that supports medical necessity for a bone growth stimulator device must be maintained by the ordering physician and requesting provider in the client's medical record and is subject to retrospective review.

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

The manufacturer will replace the bone growth stimulator device during the course of treatment should the device become nonfunctional. Repairs to purchased equipment will not be prior authorized. All repairs are considered part of the purchase price.

A new bone growth stimulator may be considered for prior authorization with documentation that supports treatment of a different fracture site when the criteria listed in the following sections are met.

#### 31.2.9.1.1 Low-Intensity Ultrasound Bone Growth Stimulators

Documentation of the following is required for prior authorization of the external, low-intensity ultrasound bone growth stimulator device (procedure code E0760):

- Nonunion of a fracture other than the skull or vertebrae in a skeletally mature person, documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days each, including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs
- The fracture is not tumor-related
- The fracture is not fresh (less than 7 days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture)

#### 31.2.9.1.2 Non-Invasive Bone Growth Stimulators

Documentation of the following is required for prior authorization of the external, electromagnetic bone stimulator device (procedure code E0747):

- At least one of the following conditions:
  - Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for 3 months or longer despite appropriate fracture care.
  - Delayed unions of fractures of failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures).
- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with nonweight bearing restrictions.

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator device for spinal application (procedure code E0748):

- One or more failed fusions
- Grade II or worse spondylolisthesis
- A multiple level fusion with extensive bone grafting is required
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability

### 31.2.9.1.3 Invasive Bone Growth Stimulators

Documentation of one of the following is required for prior authorization of the surgically implanted osteogenesis stimulator device (procedure code E0749):

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of 2 sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.
- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.
- Congenital pseudoarthrosis.
- An adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to previously failed spinal fusion at the same site.
- An adjunct to multiple-level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

### 31.2.9.2 Authorization Requirements for Bone Growth Stimulation

Authorization is required for bone growth stimulation professional services (procedure codes 20974, 20975, and 20979). Providers must submit documentation of medical necessity, which includes the appropriate clinical indications for a low-intensity ultrasound, non-invasive, or invasive device, as defined in section Section 31.2.9.1, “Prior Authorization Requirements for Bone Growth Stimulators” in this chapter.

Authorization requests for bone growth stimulation must be submitted on the [CSHCN Services Program Authorization and Prior Authorization Request Form](#).

**Referto:** Section 4.3, “Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

### 31.2.10 Casting

The CSHCN Services Program may reimburse the application of casts, splinting, and strapping in addition to an E/M procedure code when no surgery is performed. Casting, splinting and strapping are subject to global surgery fee guidelines.

Supplies used for casting, splinting, and strapping are not reimbursed separately.

Procedure codes 29450 and 29750 are benefits for the following diagnosis codes:

| Diagnosis Codes |        |        |      |       |       |      |       |
|-----------------|--------|--------|------|-------|-------|------|-------|
| M21541          | M21542 | M21549 | Q662 | Q6651 | Q6652 | Q666 | Q6681 |

**Diagnosis Codes**

|       |       |
|-------|-------|
| Q6682 | Q6689 |
|-------|-------|

The following procedure codes may be reimbursed for surgery when billing for casting, splinting, or strapping services:

**Procedure Codes**

|                                    |       |       |       |       |       |       |       |       |       |
|------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Body and upper extremity casts     |       |       |       |       |       |       |       |       |       |
| 29000                              | 29010 | 29015 | 29035 | 29040 | 29044 | 29046 | 29049 | 29055 | 29058 |
| 29065                              | 29075 | 29085 | 29086 |       |       |       |       |       |       |
| Body and upper extremity splints   |       |       |       |       |       |       |       |       |       |
| 29105                              | 29125 | 29126 | 29130 | 29131 |       |       |       |       |       |
| Body and upper extremity strapping |       |       |       |       |       |       |       |       |       |
| 29200                              | 29240 | 29260 | 29280 | 29799 |       |       |       |       |       |
| Lower extremity casts              |       |       |       |       |       |       |       |       |       |
| 29305                              | 29325 | 29345 | 29355 | 29358 | 29365 | 29405 | 29425 | 29435 | 29440 |
| 29445                              | 29580 |       |       |       |       |       |       |       |       |
| Lower extremity splints            |       |       |       |       |       |       |       |       |       |
| 29505                              | 29515 |       |       |       |       |       |       |       |       |
| Lower extremity strapping          |       |       |       |       |       |       |       |       |       |
| 29520                              | 29530 | 29540 | 29550 |       |       |       |       |       |       |
| Cast removal or repair             |       |       |       |       |       |       |       |       |       |
| 29700                              | 29705 | 29710 | 29720 | 29730 | 29740 |       |       |       |       |

**31.2.11 Chemotherapy**

Chemotherapy services are a benefit of the CSHCN Services Program when they are provided by a physician or under the supervision of a physician.

*Note: Authorization is not required for administration of chemotherapy.*

Providers billing for chemotherapy administration may be reimbursed by using the appropriate procedure codes shown in the following table:

**Procedure Codes**

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95991 | 96401 | 96402 | 96405 | 96406 | 96409 | 96411 | 96413 | 96415 | 96416 |
| 96417 | 96420 | 96422 | 96423 | 96425 | 96440 | 96446 | 96450 | 96521 | 96522 |
| 96523 | 96542 | 96549 | G0498 |       |       |       |       |       |       |

For the first 15 minutes through the first hour of chemotherapy infusion, procedure code 96409 or 96413 must be used for a single or initial chemotherapeutic medication. Procedure code 96411 must be used for each additional chemotherapeutic medication given and must be billed with procedure code 96401, 96402, 96409, 96413, or 96416.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96409, 96413, or 96416.

Procedure code 96416 will be denied if billed with procedure code G0498 on the same date of service, any provider.

Procedure code 96417 must be used for each subsequent infusion up to 1 hour and must be used in conjunction with procedure code 96409, 96413, or 96416 on the same day, by the same provider. Procedure code 96415 must be used for each additional hour.

Procedure codes 96416 and 96425 must be used when initiating an infusion that will take more than 8 hours and requires using an implanted pump or a portable pump.

Procedure code 96422 must be used for the first hour of intra-arterial push administration. Procedure code 96423 must be used for each additional hour in conjunction with procedure code 96422.

The chemotherapy administration procedure codes listed above include charges for intravenous (IV) solutions (such as saline, dextrose and water, Ringer's solution, etc.) and IV equipment (administration sets, needles, extension tubing, etc.).

The chemotherapy administration procedure codes 96440 and 96450 include payment for the surgical procedure. Separate reimbursement for the surgical codes will not be allowed.

The appropriate E/M procedure code may be billed by a physician for a face-to-face visit with the client to review chemotherapy options.

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be reimbursed using the appropriate procedure code. The chemotherapeutic agents should be billed separately, including the name of the drug and actual amount administered for correct reimbursement.

Physicians providing a chemotherapy administration service as an inpatient service on the same day as an E/M service must bill using modifier 25 except for procedure code 99211. A different diagnosis is not required.

When a significant, separately identifiable E/M service is performed, the appropriate E/M code must be submitted with modifier 25 and the chemotherapy procedure code. A different diagnosis is not required for an E/M service provided on the same day. Documentation that supports a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Modifier 25 must be used to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. This modifier may be appended to the E/M code when the services are rendered. Both services must be documented as distinct and documentation must be maintained in the client's medical record and made available upon request by the CSHCN Services Program.

Chemotherapy planning program (procedure code 99213, 99214, or 99215) may be reimbursed.

Inpatient and outpatient hospitals must use revenue code 636 for reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

### **31.2.12 Clinician-Directed Care Coordination Services**

Clinician (physician or APRN)-directed care coordination services are a benefit of the CSHCN Services Program.

Clinician-directed care coordination services are a benefit only when provided by a primary care clinician, specialist, or subspecialist who attests that he or she is providing the medical home for the client.

The medical home is defined as:

- A partnership between the child, the child's family, and the primary care provider (or place where the child receives care).

- A care delivery model that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

In providing a medical home for the client, the primary care clinician directs care coordination together with the child or youth and family. Care coordination is a family-centered process that links children or youths with special health needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following activities, with permission of the client or family:

- Supervising the development and revision of a client's written care plan (a formal document or contained in the client's progress notes) in partnership with the client, family, and other agreed-upon contributors and sharing of this care plan with other providers, agencies, and organizations involved in the care of the client
- Coordinating care among multiple providers
- Maintaining a central record or database that contains all pertinent client medical information, including hospitalizations and specialty care
- Assisting the client and family in communicating clinical issues when a client is referred for a consultation or additional care
- Evaluating, interpreting, and managing consultant recommendations for the client and family in partnership and collaboration with consultants, other providers, the client, and the family

Clinician-directed care coordination services should also include supervision of development and revision of the client's emergency medical plan in partnership with the client, the family, and other providers to be used by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

### **31.2.12.1 Face-to-Face Clinician-Directed Care Coordination Services**

Face-to-face care coordination services are encompassed within the various levels of E/M services and prolonged services.

Providers should use the most appropriate face-to-face E/M procedure codes to bill for care coordination services.

When counseling or care coordination requires more than 50 percent of the client or family encounter (face-to-face time in the office or other outpatient setting, or floor or unit time in the hospital), then time may be considered the key or controlling factor to qualify for a particular level of E/M service.

Counseling is discussion with the client or family, concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

An E/M procedure code for a face-to-face problem-focused care coordination visit may be billed on the same day as a preventive medicine visit. Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of the CSHCN Services Program may be billed on the same day as any non-face-to-face clinician-directed care coordination (procedure codes 99367, 99374, 99375, 99377, and 99378), when the client requires significant, separately identifiable E/M service by the same physician on the same day. Modifiers must be used for appropriate billing.

### **31.2.12.2 Non-Face-to-Face Clinician-Directed Care Coordination Services**

Non-face-to-face care coordination services include:

- Prolonged services (procedure codes 99358 and 99359)



- Medical team conferences (procedure code 99367)
- Care plan oversight/supervision (procedure codes 99374, 99375, 99377, and 99378)

Non-face-to-face specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9) are a benefit for a specialist or subspecialist when the clinician providing the medical home contacts the specialist for advice or a referral and the consultation is at least 15 minutes in duration.

Telephone consultations are defined by the CSHCN Services Program as the process where the specialist or subspecialist receives a telephone call from the clinician providing the medical home. During the telephone call, the specialist or subspecialist assesses and manages the client's condition by providing advice or referral to a more appropriate provider.

Specifically, non-face-to-face clinician supervision of the development or revision of a client's care plan (care plan oversight services) may include the following activities. These services do not have to be contiguous:

- Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results ordered during or associated with a face-to-face encounter
- Telephone calls with other clinicians (not employed in the same practice), including specialists or subspecialists involved in the care of the client
- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (not just ordering a prescription)
- Medical decision making
- Activities to coordinate services (if the coordination activities require the skill of a clinician)
- Documentation of the services provided, including writing a note in the client chart describing services provided, decision making performed, and amount of time spent performing the countable services, including time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies or facilities to the physician, including the start and stop times

The following activities are not covered as non-face-to-face clinician oversight/supervision of the development or revision of the client's care plan (care plan oversight services):

- Time that staff spends getting or filing charts, calling the home health agencies, clients, etc.
- Clinician telephone calls to a client or family, except when necessary to discuss changes in client's care plan
- Clinician time spent telephoning prescriptions to the pharmacist (not a physician service; does not require a physician to perform)
- Clinician time getting or filing the chart, dialing the telephone, or time on hold (these activities do not require clinician work or meaningfully contribute to the treatment of the illness or injury)
- Travel time
- Time spent preparing claims and for claims processing
- Initial interpretation or review of lab or study results that were ordered during, or associated with, a face-to-face encounter
- Services included as part of other E/M service
- Consults with health professionals not involved in the client's case

These services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Clinician-directed care coordination services must be documented in the client's medical record. Documentation must support the services being billed and must include a record of the clinician's time spent performing specific care coordination activities, including start and stop times. The documentation should include a formal care plan and emergency services plan.

The supporting documentation maintained in the client's medical records must be dated and include the following components and requirements:

- A current medical summary containing key information about the client's health (e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.)
- A current list of the main concerns, key strengths and assets, and the related current clinical information
- Planned actions or interventions to address the concerns and to sustain or build strength, with the expected outcomes
- Persons responsible
- Timeframes and due dates

The supporting documentation must be reviewed and updated every 6 months, or more frequently, as needed.

Client medical records are subject to retrospective review.

Payment is made for care coordination to a clinician providing postsurgical care during the postoperative period only if the care coordination is documented to be unrelated to the surgery.

#### 31.2.12.2.1 Care Plan Oversight

Clinician-directed care plan oversight services may be billed with one of the procedure codes listed in the following table.

Clinician supervision of a client in the home or domiciliary or under the care of a home health agency or hospice (care plan oversight) may be billed with the following procedure codes:

| Procedure Codes |       |       |       |
|-----------------|-------|-------|-------|
| 99374           | 99375 | 99377 | 99378 |

The clinician who bills for the care plan oversight must be the same clinician who signed the plan of care for the home health agency (procedure codes 99374 and 99375) or hospice (procedure codes 99377 and 99378).

Care plan oversight may be reimbursed for the clinician time involved in the coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

The following end-stage renal disease procedure codes apply to a full or partial month of services and are inclusive of all the clinicians supervision services described in care plan oversight (procedure codes 99374, 99375, 99377, and 99378):

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 | 90963 | 90964 | 90965 | 90966 | 90967 | 90968 | 90969 | 90970 |

Care plan oversight may not be reimbursed to the same clinician during the same month as end-stage renal disease services.

The clinician may not have a significant financial or contractual relationship with the home health agency as defined in 42 *Code of Federal Regulations* (CFR) 424.

The clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice (including volunteering).

#### 31.2.12.2.2 Medical Team Conference

Medical conferences may be billed with procedure code 99367.

One medical team conference (procedure code 99367) may be reimbursed every 6 months when the coordinating clinician attests that he or she is providing the medical home for the client. The coordinating clinician may be the client's primary care physician or a specialist.

The medical team conference time must be documented in the client's record.

#### 31.2.12.2.3 Non-Face-to-Face Specialist or Subspecialist Telephone Consultations

Non-face-to-face specialist or subspecialist telephone consultations may be billed with procedure code 99499 and modifier U9.

A specialist or subspecialist telephone consultation is limited to two every 6 months by the same provider.

The clinician providing the medical home must maintain the following documentation in the client's medical record:

- The start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name of the consulted specialist or subspecialist

The specialist or subspecialist must maintain documentation of the telephone consultation using the [CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services Form](#) or similar clinical record documentation. These records are subject to retrospective review. The supporting documentation must include, but is not limited to, the following:

- The client's name, date of birth, and CSHCN Services Program identification number
- The start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name and telephone number of the referring clinician providing the medical home
- The specialist's or subspecialist's and referring clinician's National Provider Identifier (NPI) information

#### 31.2.12.2.4 Non-Face-to-Face Prolonged Services

Non-face-to-face prolonged services may be billed with procedure codes 99358 and 99359.

The client must be an established client and must have had a face-to-face encounter at least once during the 6 months immediately preceding provision of the first non-face-to-face prolonged service.

Non-face-to-face prolonged services (procedure code 99358 or 99359) are limited to a maximum of 90 minutes, once per client, for the same provider.

Procedure code 99358 must be used to report the first hour of prolonged services. Prolonged services of less than 30 minutes duration are considered part of the physician E/M service being provided.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Procedure code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Procedure code 99359 must be billed for the same date of service by the same provider as procedure code 99358 or it will be denied.

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

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

#### 31.2.12.2.5 Authorization for Non-Face-to-Face Clinician-Directed Care Coordination Services

Authorization is required for non-face-to-face clinician-directed care coordination services. A [CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services form](#), and the required documentation must be submitted.

Authorization of initial non-face-to-face clinician-directed care coordination services requires at least 1 covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the 6 months preceding the provision of the first non-face-to-face care coordination service.

Authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least 1 covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the previous 12 months, or more frequently as indicated by the client's condition.

Authorization of medical team conferences (procedure code 99367) is limited to once every 6 months. Additional medical team conferences may be considered with documentation of a change in the client's medical home.

Authorization of non-face-to-face prolonged services (procedure codes 99358 and 99359) is limited to a maximum of 90 minutes once per client, per provider. Additional prolonged non-face-to-face services may be authorized (with documentation) if there is one of the following significant changes in the client's clinical condition:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization requiring coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- Documentation of recent trauma resulting in new medical complications that require complex interdisciplinary care.
- The client has a new diagnosis of a medically complex condition requiring additional interdisciplinary care with additional specialists.

Authorization of care plan oversight or supervision (procedure codes 99374, 99375, 99377, and 99378) is limited to one service a month in a 6-month authorization period.

In order for authorization to be considered, the client must require complex and multidisciplinary care modalities involving regular clinician development or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies, such as:

- Medically complex health care: Health care provided by a clinician that requires coordination of various treatment modalities or a multidisciplinary approach due to the client’s moderate or severe health condition, physical or functional limitations, or health risk factors.
- Multidisciplinary health care: The coordination of clinician-ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental, or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For CSHCN Services Program coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.

Documentation of the following components must be submitted with the authorization form to obtain an initial authorization or renewal:

- A current medical summary, containing key information about the client’s health (e.g., conditions, complexity, medications, allergies, past surgical procedures)
- A current list of the main concerns as well as key strengths and assets, and the related current clinical information
- Planned action steps or interventions to address the concerns and to sustain or build strengths, with the expected outcomes
- Persons responsible
- Timeframes or due dates

The supporting documentation can be in the form of the following:

- Formal written care plan
- Progress note detailing the care coordination planning
- Letter of medical necessity detailing the care plan oversight and care coordination

Authorization is limited to a maximum of 6 months. Subsequent periods of authorization require submission of a new request with documentation supporting medical necessity for ongoing services.

Non-face-to-face specialist or subspecialist telephone consultations do not require authorization.

### 31.2.13 Cochlear Implants

Cochlear implants and auditory rehabilitation are benefits for CSHCN Services Program clients.

*Referto:* Section 20.3.2, “Cochlear Implants” in Chapter 20, “Hearing Services” for more information about cochlear implants.

### 31.2.14 Colon Capsule Endoscopy

Colon capsule endoscopy (procedure code 91113) is a benefit of the CSHCN Services Program and limited to the following diagnosis codes:

| Diagnosis Codes |      |      |      |       |      |
|-----------------|------|------|------|-------|------|
| K635            | K921 | K922 | R195 | Z5309 | Z538 |

### 31.2.15 Colorectal Cancer Screening

Procedure codes 74263, 81528, 82270 (CLIA waived test), G0104, G0105, G0121, and G0328 (with modifier QW) are benefits of the CSHCN Services Program. An additional screening may be considered on appeal with documentation that indicates the provider was unable to obtain the previous screening results from a different provider or the provider was new to treating the client and was not aware the client had already received colorectal cancer screening.

Procedure code 81528 may be reimbursed once every 3 years for clients who are 45 years of age or older. Procedure code G0104 may be reimbursed once every 5 years, or as recognized by the ACS or the U.S. Preventive Services Task Force (USPSTF). Procedure code G0121 may be reimbursed once every 10 rolling years.

**Referto:** Chapter 25, “Enrollment” for additional information about laboratory cancer screening or pathology procedures.

High-risk individuals include clients with one or more of the following factors:

- A close relative who has had colorectal cancer or an adenomatous polyp
  - Note:** “Relative” means close blood relatives, including first-degree male or female relatives (parents, siblings, or children), second-degree relatives (aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (first cousins, great grandparents) who are on the same side of the family as the client.
- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of colorectal cancer
- Personal history of adenomatous polyps
- Personal history of inflammatory bowel disease, including Crohn’s disease and ulcerative colitis

During the course of a screening flexible sigmoidoscopy, if a lesion or growth is detected that results in a biopsy or removal of the growth, an appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be reported.

During the course of a screening colonoscopy, if a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported.

### 31.2.16 Critical Care Services

Critical care is a benefit of the CSHCN Services Program. Authorization is not required for these services.

Critical care is the care of a critically ill client who requires constant physician attention. Critical care involves high-complexity decision making to access, manipulate, and support vital system functions. If the physician is not at bedside, he or she must be immediately available to the client. The physician must devote his or her full attention to the client and therefore, cannot render E/M services to any other client during the same period of time. Critical care is usually given in a critical care area, such as a coronary care unit, respiratory care unit, intensive care unit, pediatric intensive care unit, neonatal intensive care unit, or emergency department care facility.

Noncritical intensive care is a benefit for infants who are very low birth weight, low birth weight, or normal weight and do not meet the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services only available in the intensive care setting.

Neonatal critical care is the comprehensive care of the critically ill neonate. The neonatal period is defined as the period from birth through the 28th day of life. Neonatal critical care codes are comprehensive per diem (daily) care codes for providers personally delivering or supervising the delivery of care of the critically ill neonate as an inpatient.

Newborn resuscitation is a benefit for high-risk newborns who require resuscitation.

Physician standby service requiring prolonged physician attendance, each 30 minutes (procedure code 99360), is not a benefit of the CSHCN Services Program.

In accordance with CPT, critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the client, provided that the client's condition continues to require the level of physician attention as described above.

### **31.2.16.1 General Limitations**

Services for a client who is not, or is no longer, critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes, such as continuing intensive care (procedure codes 99478, 99479, and 99480) or subsequent hospital care (procedure codes 99231, 99232, and 99233).

Neonatal critical care (procedure codes 99468 and 99469), pediatric critical care (procedure codes 99471, 99472, 99475, and 99476), and the initial critical care (procedure code 99291) are limited to once per day for the same provider. Subsequent critical care (procedure code 99292) is each additional 30 minutes beyond the first 74 minutes of critical care, and is limited to a quantity of 6 units (3 hours) per day.

Neonatal and pediatric critical care (procedure codes 99468, 99469, 99471, 99472, 99475, and 99476) and continuing intensive care services (procedure codes 99478, 99479, and 99480) are inpatient, per-day charges and only billable once per day by any provider. No other inpatient E/M services may be reimbursed on the same day when billed by the same provider.

When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) should be used.

If the same physician provides critical care for a neonatal or pediatric client in both the outpatient and inpatient settings on the same day, the provider should report only the appropriate inpatient neonatal or pediatric critical care service (procedure codes 99468, 99469, 99471, 99472, 99475, and 99476).

E/M services provided on the same day by the same provider as surgical procedures that meet the definition of separately identifiable and above and beyond usual preoperative and postoperative care may be billed with modifier 25. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Critical care (procedure codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476) is only billable by the provider rendering the critical care service while the client is critically ill. While providers from various specialties (e.g., cardiology or neurology) may be consulted to render an opinion or assist in the management of a particular portion of the care, only the provider managing the care of the critically ill client during a life threatening crisis may bill the critical care.

If a second physician provides critical care services on the same day at a separate and distinct time, the physician should report the appropriate time-based critical care service (procedure code 99291 or 99292).

Critical care totaling less than 30 minutes in duration on a given date should be reported with the appropriate E/M procedure code.

Actual time spent with the individual client should be recorded in the client's record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

The time spent in the following activities may not be included in the time reported as critical care:

- Activities that occur outside of the unit or off the floor because the physician is not immediately available to the client
- Activities that do not directly contribute to the treatment of the client even if they are performed in the critical care unit
- Performing separately reportable procedures or services

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRNs, physician assistants, and CRNAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for physicians for the same service.

### **31.2.16.2 Critical Care Services**

Procedure codes 99291 and 99292 are used to identify critical care services provided to clients who are 6 years of age or older.

Procedure code 99291 should be used per day for the first 30 to 74 minutes of critical care even if the time spent by the physician is not continuous on that day.

Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room) which does not result in admission, must be billed using procedure codes 99291 and 99292.

If outpatient critical care (procedure codes 99291 and 99292) is provided to a client at a distinctly separate time than another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

If critical care (procedure code 99291) is provided by different physicians that meet the initial 30-minute time requirement, and the care is provided at separate distinct times, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be considered on appeal. The time spent by each physician cannot overlap (i.e., two physicians cannot bill critical care for care delivered at the same time). Supporting medical record documentation must be provided by the second physician that includes the time in which the critical care was rendered. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill client during the life-threatening crisis.

If the provider's time exceeds the 74-minute time threshold for procedure code 99291, procedure code 99292 may be billed in addition to procedure code 99291 for each additional 30 minutes.

Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider's group practice.

Procedure code 99292 is limited to six units per day (3 hours), any provider. If the number of units is not stated on the claim, only a quantity of one will be allowed.

Retrospective review may be performed to ensure the documentation supports the medical necessity of the service and any modifier used when billing the claim.



**31.2.16.3 Pediatric Critical Care**

Procedure codes 99471, 99472, 99475, and 99476 are used to identify pediatric critical care services provided to clients who are 29 days through 24 months of age.

Pediatric critical care services are comprehensive per diem (daily) care procedure codes for providers personally delivering or supervising the delivery of care of the critically ill infant or child.

Inpatient pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge.

**31.2.16.4 Neonatal Critical Care**

Procedure codes 99468 and 99469 are used to identify neonatal critical care services provided to clients who are 28 days of age or younger.

Procedure code 99468 is used for the first day of admission for a critically ill neonate, 28 days of age or younger, and may be reimbursed once per day, any provider.

Procedure code 99468 must be billed for the initial day of neonatal critical care irrespective of the time that the provider spends with the client.

Procedure code 99469 must be billed for subsequent neonatal critical care per day, irrespective of the time that the provider spends directing the care of the critically ill neonate or infant that is 28 days of age or younger.

Procedure code 99469 may be reimbursed once per day, any provider.

After the neonate is no longer considered critically ill, the E/M procedure codes for subsequent hospital care (procedure codes 99231, 99232, and 99233) or subsequent intensive care (procedure codes 99478, 99479, and 99480) must be used.

If the infant remains in critical care after the 28th day of age, on the 29th day of age, the provider must bill pediatric critical care codes (procedure codes 99471 and 99472).

Neonatal intensive or critical care procedure codes 99468, 99469, 99477, 99478, 99479, and 99480 are inpatient, per day charges and only billable once per day by any provider.

**31.2.16.5 Intensive Care (Noncritical) Services**

Initial hospital care provided to neonates who require intensive observation, frequent interventions, and other intensive services may be billed using procedure code 99477. Subsequent intensive care provided to very low birth weight, low birth weight, and normal weight infants who do not meet the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services only available in the intensive care setting, may be billed using procedure codes 99478, 99479, and 99480.

**31.2.16.6 Newborn Resuscitation**

Newborn resuscitation may be billed using procedure code 99465.

Procedure code 99465 may be reimbursed for clients birth through 28 days of age. For cardiopulmonary resuscitation performed on clients 29 days of age or older, providers must bill procedure code 92950. Procedure code 92950 may be billed on the same day as critical care (procedure codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476) when reported as a separately identifiable procedure.

Procedure code 99465 must be used by the provider who performs the resuscitation.

**31.2.17 Echoencephalography**

Procedure code 76506 is a benefit of the CSHCN Services Program with the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| A066            | A170   | A171   | A1781  | A1782  | A1789  | C410   | C6961  |
| C6962           | C700   | C710   | C711   | C712   | C713   | C714   | C715   |
| C716            | C717   | C718   | C719   | C7221  | C7222  | C7231  | C7232  |
| C7241           | C7242  | C7259  | C729   | C751   | C752   | C768   | C7931  |
| C7932           | C7940  | C7949  | C7951  | C7952  | C7989  | D075   | D098   |
| D164            | D3161  | D3162  | D320   | D329   | D330   | D331   | D332   |
| D333            | D3500  | D3501  | D3502  | D420   | D421   | D429   | D432   |
| D433            | D434   | D438   | D439   | D47Z1  | D47Z2  | D480   | D487   |
| D492            | D496   | D497   | F0390  | F03911 | F03918 | F0392  | F0393  |
| F0394           | G060   | G062   | G07    | G08    | G132   | G138   | G232   |
| G233            | G300   | G301   | G308   | G309   | G3101  | G3109  | G311   |
| G312            | G3180  | G3183  | G3184  | G3185  | G3186  | G3189  | G319   |
| G910            | G911   | G912   | G930   | G932   | G9340  | G9341  | G9342  |
| G9343           | G9344  | G9349  | G935   | G936   | G937   | G9381  | G9389  |
| G939            | G94    | G988   | G998   | H35361 | H4600  | H4601  | H4602  |
| H4603           | H4610  | H4611  | H4612  | H4613  | H462   | H463   | H468   |
| H469            | H47011 | H47012 | H47013 | H47019 | H47021 | H47022 | H47023 |
| H47029          | H47031 | H47032 | H47033 | H47039 | H47091 | H47092 | H47093 |
| H47099          | H4710  | H4711  | H4712  | H4713  | H47141 | H47142 | H47143 |
| H47149          | H4720  | H47211 | H47212 | H47213 | H47219 | H4722  | H47231 |
| H47232          | H47233 | H47239 | H47291 | H47292 | H47293 | H47299 | H47311 |
| H47312          | H47313 | H47319 | H47321 | H47322 | H47323 | H47329 | H47331 |
| H47332          | H47333 | H47339 | H47391 | H47392 | H47393 | H47399 | H4741  |
| H4742           | H4743  | H4749  | H47511 | H47512 | H47519 | H47521 | H47522 |
| H47529          | H47531 | H47532 | H47539 | H47611 | H47612 | H47619 | H47621 |
| H47622          | H47629 | H47631 | H47632 | H47639 | H47641 | H47642 | H47649 |
| I6000           | I6001  | I6002  | I6010  | I6011  | I6012  | I602   | I6030  |
| I6031           | I6032  | I604   | I6050  | I6051  | I6052  | I606   | I607   |
| I608            | I609   | I610   | I611   | I612   | I613   | I614   | I615   |
| I616            | I618   | I619   | I6200  | I6201  | I6202  | I6203  | I621   |
| I629            | I6330  | I63311 | I63312 | I63319 | I63321 | I63322 | I63323 |
| I63329          | I63331 | I63332 | I63333 | I63339 | I6339  | I6340  | I63411 |
| I63412          | I63419 | I63421 | I63422 | I63429 | I63431 | I63432 | I63439 |
| I6349           | I6350  | I63511 | I63512 | I63513 | I63519 | I63521 | I63522 |
| I63523          | I63529 | I63531 | I63532 | I63533 | I63539 | I63543 | I6381  |
| I6389           | I6601  | I6602  | I6603  | I6609  | I6611  | I6612  | I6613  |
| I6619           | I6621  | I6622  | I6623  | I6629  | I668   | I669   | I671   |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| I6781           | I6782   | I6783   | I67850  | I67858  | I6789   | I680    | I69098  |
| I6921           | I69210  | I69211  | I69212  | I69213  | I69214  | I69215  | I69218  |
| I69219          | I69220  | I69221  | I69222  | I69223  | I69269  | I69290  | I69291  |
| I69292          | I69293  | I69298  | O99411  | O99412  | O99413  | O99419  | O9942   |
| O9943           | P0082   | P0700   | P0701   | P0702   | P0703   | P0710   | P0714   |
| P0715           | P0716   | P0717   | P100    | P101    | P102    | P103    | P104    |
| P108            | P109    | P112    | P119    | P120    | P121    | P122    | P123    |
| P124            | P1281   | P1289   | P129    | P150    | P151    | P152    | P153    |
| P154            | P155    | P156    | P158    | P352    | P370    | P371    | P372    |
| P373            | P374    | P378    | P520    | P521    | P5221   | P5222   | P523    |
| P524            | P525    | P526    | P528    | P529    | P90     | P912    | P91811  |
| P91819          | P91821  | P91822  | P91823  | P91829  | P9188   | Q010    | Q011    |
| Q012            | Q018    | Q02     | Q030    | Q031    | Q038    | Q040    | Q041    |
| Q042            | Q045    | Q046    | Q048    | Q050    | Q051    | Q052    | Q054    |
| Q0701           | Q0702   | Q0703   | Q282    | Q283    | R220    | R221    | R5600   |
| R569            | S0190XA | S0190XD | S0190XS | S060X0A | S060X0D | S060X0S | S060X1A |
| S060X1D         | S060X1S | S060X9A | S060X9D | S060X9S | S060XAA | S060XAD | S060XAS |
| S061X0A         | S061X0D | S061X0S | S061X1A | S061X1D | S061X1S | S061X2A | S061X2D |
| S061X2S         | S061X3A | S061X3D | S061X3S | S061X4A | S061X4D | S061X4S | S061X5A |
| S061X5D         | S061X5S | S061X6A | S061X6D | S061X6S | S061X7A | S061X8A | S061X9A |
| S061X9D         | S061X9S | S061XAA | S061XAD | S061XAS | S06305A | S06305D | S06305S |
| S06306A         | S06306D | S06306S | S06307A | S06308A | S0630AA | S0630AD | S0630AS |
| S06310A         | S06310D | S06310S | S06311A | S06311D | S06311S | S06312A | S06312D |
| S06312S         | S06313A | S06313D | S06313S | S06314A | S06314D | S06314S | S06315A |
| S06315D         | S06315S | S06316A | S06316D | S06316S | S06317A | S06318A | S06319A |
| S06319D         | S06319S | S0631AA | S0631AD | S0631AS | S06320A | S06320D | S06320S |
| S06321A         | S06321D | S06321S | S06322A | S06322D | S06322S | S06323A | S06323D |
| S06323S         | S06324A | S06324D | S06324S | S06325A | S06325D | S06325S | S06326A |
| S06326D         | S06326S | S06327A | S06328A | S06329A | S06329D | S06329S | S0632AA |
| S0632AD         | S0632AS | S06330A | S06330D | S06330S | S06331A | S06331D | S06331S |
| S06332A         | S06332D | S06332S | S06333A | S06333D | S06333S | S06334A | S06334D |
| S06334S         | S06335A | S06335D | S06335S | S06336A | S06336D | S06336S | S06337A |
| S06338A         | S06339A | S06339D | S06339S | S0633AA | S0633AD | S0633AS | S06340A |
| S06340D         | S06340S | S06341A | S06341D | S06341S | S06342A | S06342D | S06342S |
| S06343A         | S06343D | S06343S | S06344A | S06344D | S06344S | S06349A | S06349D |
| S06349S         | S06350A | S06346D | S06346S | S06347A | S06348A | S06349A | S06349D |
| S06349S         | S0634AA | S0634AD | S0634AS | S06350A | S06350D | S06350S | S06351A |
| S06351D         | S06351S | S06352A | S06352D | S06352S | S06353A | S06353D | S06353S |
| S06354A         | S06354D | S06354S | S06355A | S06355D | S06355S | S06356A | S06356D |
| S06356S         | S06357A | S06358A | S06359A | S06359D | S06359S | S0635AA | S0635AD |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| S0635AS         | S06360A | S06360D | S06360S | S06361A | S06361D | S06361S | S06362A |
| S06362D         | S06362S | S06363A | S06363D | S06363S | S06364A | S06364D | S06364S |
| S06365A         | S06365D | S06365S | S06366A | S06366D | S06366S | S06367A | S06368A |
| S06369A         | S06369D | S06369S | S06370A | S06370D | S06370S | S06371A | S06371D |
| S06371S         | S06372A | S06372D | S06372S | S06373A | S06373D | S06373S | S06374A |
| S06374D         | S06374S | S06375A | S06375D | S06375S | S06376A | S06376D | S06376S |
| S06377A         | S06378A | S06379A | S06379D | S06379S | S0637AA | S0637AD | S0637AS |
| S06380A         | S06380D | S06380S | S06381A | S06381D | S06381S | S06382A | S06382D |
| S06382S         | S06383A | S06383D | S06383S | S06384A | S06384D | S06384S | S06385A |
| S06385D         | S06385S | S06386A | S06386D | S06386S | S06387A | S06388A | S06389A |
| S06389D         | S06389S | S0638AA | S0638AD | S0638AS | S064X0A | S064X0D | S064X0S |
| S064X1A         | S064X1D | S064X1S | S064X2A | S064X2D | S064X2S | S064X3A | S064X3D |
| S064X3S         | S064X4A | S064X4D | S064X4S | S064X5A | S064X5D | S064X5S | S064X6A |
| S064X6D         | S064X6S | S064X7A | S064X8A | S064X9A | S064X9D | S064X9S | S064XAA |
| S064XAD         | S064XAS | S065X0A | S065X0D | S065X0S | S065X1A | S065X1D | S065X1S |
| S065X2A         | S065X2D | S065X2S | S065X3A | S065X3D | S065X3S | S065X4A | S065X4D |
| S065X4S         | S065X5A | S065X5D | S065X5S | S065X6A | S065X6D | S065X6S | S065X7A |
| S065X8A         | S065X9A | S065X9D | S065X9S | S065XAA | S065XAD | S065XAS | S066X0A |
| S066X0D         | S066X0S | S066X1A | S066X1D | S066X1S | S066X2A | S066X2D | S066X2S |
| S066X3A         | S066X3D | S066X3S | S066X4A | S066X4D | S066X4S | S066X5A | S066X5D |
| S066X5S         | S066X6A | S066X6D | S066X6S | S066X7A | S066X8A | S066X9A | S066X9D |
| S066X9S         | S066XAA | S066XAD | S066XAS | S06890A | S06890D | S06890S | S06891A |
| S06891D         | S06891S | S06892A | S06892D | S06892S | S06893A | S06893D | S06893S |
| S06894A         | S06894D | S06894S | S06895A | S06895D | S06895S | S06896A | S06896D |
| S06896S         | S06897A | S06898A | S06899A | S06899D | S06899S | S0689AA | S0689AD |
| S0689AS         | S069X0A | S069X0D | S069X0S | S069X1A | S069X1D | S069X1S | S069X2A |
| S069X2D         | S069X2S | S069X3A | S069X3D | S069X3S | S069X4A | S069X4D | S069X4S |
| S069X5A         | S069X5D | S069X5S | S069X6A | S069X6D | S069X6S | S069X7A | S069X8A |
| S069X9A         | S069X9D | S069X9S | S069XAA | S069XAD | S069XAS | S06A0XA | S06A0XD |
| S06A0XS         | S06A1XA | S06A1XD | S06A1XS | S0990xA | S0990xD | S0990xS |         |

### 31.2.17.1 Ambulatory Electroencephalogram

Ambulatory electroencephalographic monitoring is a benefit of the CSHCN Services Program with the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F05             | F060   | F0670  | F0671  | F068   | G253   | G40001 | G40009 |
| G40011          | G40019 | G40101 | G40109 | G40111 | G40119 | G40201 | G40209 |
| G40211          | G40219 | G40301 | G40309 | G40311 | G40319 | G40401 | G40409 |
| G40411          | G40419 | G40501 | G40509 | G40801 | G40802 | G40803 | G40804 |
| G40811          | G40812 | G40813 | G40814 | G4089  | G40901 | G40909 | G40911 |
| G40919          | G40A11 | G40A19 | G40B01 | G40B09 | G40B11 | G40B19 | G40C01 |
| G40C09          | G40C11 | G40C19 | G912   | G9381  | G9389  | P912   | R561   |
| R569            | Z85020 | Z85030 | Z85040 | Z85060 | Z85110 | Z85230 | Z85520 |
| Z85821          | Z85841 | Z85848 | Z86011 | Z8669  | Z87728 | Z87798 |        |

Procedure codes must be used when billing for ambulatory electroencephalograms:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95700           | 95705 | 95706 | 95707 | 95708 | 95709 | 95710 | 95711 | 95712 | 95713 |
| 95714           | 95715 | 95716 | 95717 | 95718 | 95719 | 95720 | 95721 | 95722 | 95723 |
| 95724           | 95725 | 95726 | 95957 |       |       |       |       |       |       |

Authorization is not required for the diagnoses listed above. All other diagnoses require authorization and documentation of medical necessity. Documentation should include the diagnosis and the specific rationale for the request. Claims for ambulatory electroencephalographic monitoring are considered for payment on appeal for diagnoses other than those listed above or if the frequency of testing exceeds the limitation.

Ambulatory electroencephalograms are limited to three every 6 months, per client, same provider. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid for the procedure.

### 31.2.18 Evaluation and Management (E/M) Services

E/M services are benefits of the CSHCN Services Program. When selecting the level of service provided, providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS.

Covered professional services provided by physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. This manual may not list all E/M procedure codes that may be reimbursed by the CSHCN Services Program.

#### 31.2.18.1 New or Established Patient Visits

Home/residence services are those services that are provided in a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship), assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.

New patient visits will be allowed every 3 years for physician E/M services, per client, per provider.

A new patient is defined by the American Medical Association (AMA) as one who has not received any professional services from a physician or physician within the same group practice, of the same specialty, within the past 3 years. An established patient is one who has received professional services from a physician or physician within the same group practice, of the same specialty, within the last 3 years.

Providers may use procedure codes 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office, or in an outpatient or other ambulatory facility.

Providers may use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office, outpatient, or other ambulatory facility during regularly scheduled evening, weekend, holiday, or standard office hours.

Providers may use procedure codes 99341, 99342, 99344, and 99345 when billing for new patient services provided in the home/residence setting.

Providers may use procedure codes 99347, 99348, 99349, and 99350 when billing for established patient services provided in the home/residence setting.

A subsequent home/residence visit (procedure codes 99347, 99348, 99349, and 99350) billed on the same day as a new patient home/residence visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure billed on the same day, regardless of the diagnosis.

Subsequent home/residence evaluation and management procedure codes are limited to one per day regardless of diagnosis.

Office visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same day as a planned procedure (minor or extensive), are included in the cost of the procedure and are not separately reimbursed.

Modifier 25 may be used to identify a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded. The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

### **31.2.18.2 Inpatient Professional Services**

#### **31.2.18.2.1 Initial and Subsequent Hospital Care (Nonintensive Care)**

Initial or subsequent hospital visits (procedure codes 99221, 99222, 99223, 99231, 99232, and 99233), observation (procedure codes 99234, 99235, and 99236), and discharge (procedure codes 99238 and 99239) are limited to one per day for the same provider.

If a subsequent inpatient/observation hospital visit (procedure codes 99231, 99232, and 99233) following admission is billed on the same day by the same provider as an emergency department visit (procedure codes 99281, 99282, 99283, 99284, and 99285), an office visit (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or an outpatient consultation (procedure codes 99242, 99243, 99244, and 99245), the subsequent hospital visit will be paid and the other visits will be denied.

One initial inpatient/observation consultation (procedure code 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Any subsequent consultation that is billed as an initial consultation during this time period will be denied.

A subsequent inpatient/observation hospital visit (procedure codes 99231, 99232, and 99233) may be reimbursed on the same day to the same provider when critical care services (procedure codes 99291 and 99292) are billed.

E/M services provided in a hospital setting following a major procedure, provided by the same provider or in direct follow-up for postsurgical care, are included in the surgeon's global surgical fee and are denied as included in another procedure.

A physician who did not perform the surgery and provides postoperative surgical care in the time frame that is included in the global surgical fee must bill with modifier 55. This may only be done when the surgeon submits a charge for surgical care only and there is an agreement between the physicians and the surgeon to split the care of the client.

#### 31.2.18.2.2 Hospital Discharge Day Management

Discharge management (procedure codes 99238 and 99239) billed on the same date of service as the admission by the same provider will be denied.

Discharge management (procedure codes 99238 and 99239) billed on the same date of service as an emergency room visit by the same provider is denied, but may be considered for reimbursement upon appeal, if provided at a separate time.

Only one discharge management service will be considered for reimbursement per day. Subsequent hospital visits billed on the same day as discharge management, by the same provider, will be denied.

Initial/observation or subsequent hospital visit (procedure codes 99221, 99222, and 99223) billed on the same day as hospital discharge day management (procedure code 99238) is denied as part of another procedure billed on the same day.

#### 31.2.18.2.3 Concurrent Inpatient Care

Concurrent care exists when services are provided to a client by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the client in accordance with accepted standards of good medical practice.

Concurrent care will not be paid to providers of the same specialty for the same or related diagnoses. Diagnoses are considered to be related when up to six digits of the primary diagnosis codes match. Denied concurrent care may be considered on an appeal basis when accompanied by documentation of medical necessity.

Concurrent care may be considered for reimbursement to providers of different specialties when providing services for unrelated diagnoses involving different organ systems.

### 31.2.18.3 Emergency Services

An emergency medical condition is defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that if not immediately treated must reasonably be expected to result in one of the following outcomes:

- Placing the client's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who require immediate medical attention. The facility must be available to provide services 24 hours a day, 7 days a week.

#### 31.2.18.3.1 Hospital-Based Emergency Department Professional Services

Physicians may use procedure codes 99281, 99282, 99283, 99284, and 99285 to bill for services provided in the hospital-based emergency department. Office-based physicians may also use procedure codes 99202, 99203, 99204, and 99205 for new patients or procedure codes 99211, 99212, 99213, 99214, and 99215 for established patients, to bill for services provided in the office or in a hospital-based emergency department. These procedure codes are also appropriate for a physician who is attending a client in an outpatient observation room setting for less than 6 hours. Document the time for multiple visits in Block 24K of the CMS-1500 paper claim form.

Emergency department visits include the components of a diagnostic examination such as a pelvic or rectal examination. These components should not be billed with an unlisted procedure code in addition to the procedure code for the visit. These components are considered part of the examination and no separate reimbursement may be provided.

Multiple emergency department visits on the same day and billed by the same provider must have the times for each visit documented on the claim form. More than one visit on the same day can also be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this charge.

Emergency department visits may be paid to different providers on the same day, when medically necessary, regardless of specialty and diagnosis.

Separate charges are allowed for emergency department treatment room and minor surgery or diagnostic procedures billed on the same day. Use the appropriate procedure code from the CPT manual.

Payment for an additional emergency department visit by an anesthesiologist following a surgical procedure is denied as part of the global anesthesia payment (base plus time). A distinct and separate diagnosis beyond the diagnosis for which the global anesthesia services were provided should be documented in order for payment to be considered on an appeal basis.

If an emergency department visit (procedure codes 99281, 99282, 99283, 99284, and 99285) is billed on the same day, by the same provider, as an office visit (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or outpatient consultation (procedure codes 99242, 99243, 99244, and 99245), the emergency department visit may be considered for reimbursement and the office or consultation visit is denied.

Emergency department visits (procedure codes 99281, 99282, 99283, 99284, and 99285) are denied when billed on the same day as an inpatient/observation service (procedure codes 99238 and 99239) by the same provider.

Binocular microscopy (procedure code 92504) and noninvasive ear or pulse oximetry for oxygen (procedure code 94760) will be denied when billed on the same day, by the same provider, as emergency department visit (procedure code 99281, 99282, 99283, 99284, or 99285).

### **31.2.18.4 Consultations**

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. To be billed as such, a consultation must consist of the following:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating the medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary. If treatment is initiated and the client returns for follow up care, an established patient visit should be billed. If the purpose of the referral is to transfer care, a consultation may not be billed.

The medical records maintained by both the referring and consulting providers must identify their counterpart and reason for consultation.

Consultations may be billed using the following procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 99242           | 99243 | 99244 | 99245 | 99252 | 99253 | 99254 | 99255 |



Office or outpatient consultations will be limited to one consultation every six-month period by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this time period will be denied.

### **31.2.18.5 Services Outside of Business Hours**

The CSHCN Services Program limits reimbursement for after hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours or on an emergency basis.

An office-based provider may bill an after hours charge in addition to a visit for providing services after routine office hours. After hours charges may be billed when the provider's clinical judgment deems it medically necessary to interrupt the routine schedule to care for a client with an emergent condition. A provider's routine office hours are those hours posted at the physician's office as the usual office hours. The CSHCN Services Program may reimburse office-based physicians when any of the following exists:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.
- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.
- After-hours procedure codes are limited to one per day, same provider.

Procedure codes 99050, 99056, and 99060 are not reimbursed separately to emergency department-based physicians or emergency department-based groups.

### **31.2.18.6 Prolonged Physician Services**

Prolonged services may be provided in an office, outpatient, or inpatient setting and involves direct (face-to-face) client contact that is beyond the usual service and exceeds the time threshold of the E/M procedure code (listed in the table below) being billed on that day:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99205           | 99215 | 99223 | 99233 | 99236 | 99245 | 99255 | 99345 | 99350 |

Prolonged services of less than 30 minutes duration should not be reported separately.

Procedure code 99417 should only be used when an outpatient evaluation and management service has been selected using time alone as the basis, and only after the minimum time required to report the addition to the code of the outpatient evaluation and management service has been exceeded by 15 minutes.

Procedure codes 99417 and 99418 are limited to 4 units (1 hour) per day and should not be used to report an additional time increment of less than 15 minutes.

Procedure code 99418 is only used when inpatient or observation evaluation and management service has been selected using time alone as the basis and only after the minimum time required to report the addition to the code of the inpatient and observation evaluation and management service has been exceeded by 15 minutes.

Physician standby service without face-to-face contact (procedure code 99360) is not a benefit of the CSHCN Services Program.

### **31.2.18.7 Observation Room Services**

When a client's status changes from observation to inpatient, the date of inpatient admission is the date the client was admitted to the hospital as an inpatient. Charges are to be billed as specified in Section 24.4, "Outpatient Services" in Chapter 24, "Hospital."

Inpatient/observation care discharge day management (procedure codes 99238 and 99239) may be used to report services provided to a client upon discharge from “observation status” if the discharge date differs from the initial date of admission.

The following limitations apply to these procedure codes:

- Procedure codes 99211, 99212, 99213, 99214, 99215, 99221, 99222, and 99223 are denied if billed on the same day as procedure codes 99238 and 99239 by the same provider.
- If a physician inpatient/observation visit (procedure codes 99221, 99222, 99234, 99235, 99238, and 99239) is billed on the same day as prolonged services (procedure codes 99417 and 99418) by the same provider, the prolonged services are denied as part of another procedure on the same day.
- If procedure codes 99234, 99235, and 99236 are billed on the same day as a subsequent hospital visit (procedure codes 99231, 99232, and 99233) by the same provider, the subsequent visit is denied.
- If procedure codes 99234, 99235, and 99236 are billed on the same day as a consultation by the same provider, the consultation is paid and the physician inpatient hospital observation is denied.
- If a chemotherapy planning program (procedure codes 99213, 99214, or 99215) and physician outpatient hospital observation are billed on the same day by the same provider, the chemotherapy planning is paid and the physician outpatient hospital observation will be denied.
- Procedure codes 99234, 99235, and 99236 are not payable on the same day as procedure codes 99238 and 99239.
- Procedure codes 99234, 99235, and 99236 are subject to the global surgical fee pre-/postcare days assigned to certain surgical procedures.
- E/M services provided at any place of service (POS) other than an inpatient hospital and billed on the same day as a physician observation visit by the same provider are denied.
- If dialysis treatment and physician observation visits are billed the same day by the same provider, same specialty (other than nephrology and internal medicine specialists), the dialysis treatment may be paid and the physician observation visit is denied.

**31.2.18.8 Preventive Care Services**

The CSHCN Services Program may reimburse for preventive health-care services. Providers should submit claims with the following E/M procedure codes and include the appropriate diagnosis code. Diagnosis code Z00121 or Z00129 should be used for children’s preventive care medical checkups. Diagnosis code Z0000 or Z0001 should be used for an adult preventive care medical checkup.

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99381           | 99382 | 99383 | 99384 | 99385 | 99386 | 99387 | 99391 | 99392 | 99393 |
| 99394           | 99395 | 99396 | 99397 |       |       |       |       |       |       |

Providers may be reimbursed for an acute care visit on the same day as a preventive care visit. The acute care visit should be billed as an established patient visit. Modifier 25 must be used to describe circumstances in which a visit was provided at the same time as other separately identifiable services (e.g., preventive visits, minor procedure). Both services must be documented as distinct, and documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to the CSHCN Services Program upon request. This modifier must be appended to the evaluation procedure code when the services rendered are distinct, provided for different diagnosis, or are performed for different reasons.

When the client visit is only for immunization, a preventive care visit will not be reimbursed. The administration fee and any vaccine or toxoid not obtained through Texas Vaccines for Children (TVFC) may be reimbursed when diagnosis code Z23 and the appropriate procedure code referencing an immunization is submitted with the claim.

Vaccinations, vaccine administration procedure codes, and laboratory services may be billed in addition to the preventive care E/M procedure code. Providers must append modifier 25 to one of the preventive care E/M procedure codes listed in the table above to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the vaccine administration.

The CSHCN Services Program reimburses for only one preventive health visit per day per client for any provider. The program does not cover family planning services and inpatient newborn examinations.

Preventive care medical checkups are not a benefit of a telemedicine or telehealth service.

### **31.2.18.9 Preventive Care Medical Checkups and Developmental Testing**

When a new patient acute care E/M visit is billed for the same date of service as a new patient preventive care medical checkup, both new patient services may be reimbursed when billed by the same provider if that provider has not billed other acute care E/M visits or preventive care medical checkups for the client in the preceding 3 years.

Modifier 25 must be used to describe circumstances in which an acute care E/M visit was provided at the same time as a preventive care medical checkup. This modifier must be appended to the E/M procedure code when the services are distinct and provided for a different diagnosis. An appropriate level E/M procedure code must be billed with the diagnosis supporting the acute care claim.

If the provider or provider group has billed for a new patient preventive care medical checkup within the past 3 years, subsequent preventive care medical checkups and acute care visits billed as new patient services will be denied when billed by the same provider. Another new checkup will only be allowed when the client has not received any professional services from the same provider or another provider who belongs to the same group practice in the past 3 years, because subsequent acute care visits after the initial new patient preventive care medical checkup continue the established relationship with the provider. Subsequent preventive care medical checkups and acute care visits after the initial new patient preventive care medical checkup continue the established relationship with the provider.

#### **31.2.18.9.1 Laboratory Tests**

Documented laboratory results obtained prior to the current medical checkup may be used as follows to complete the laboratory testing requirement:

- Results obtained within 30 days before the current medical checkup for clients who are 2 years of age and younger
- Results obtained within 90 days before the current medical checkup for clients who are 3 years of age and older

Documentation must include the date of service and one of the following:

- A clear reference to the previous visit by the same provider
- Results obtained from a different provider

#### **31.2.18.9.2 Medical Checkup Follow-up Visit**

A follow-up checkup is a visit that is scheduled to complete checkup components that could not be completed at the original medical checkup due to circumstances beyond the provider's control. If the parent or guardian did not give consent for a missing component, a follow-up visit is not necessary. The most appropriate procedure code for the follow-up visit will be determined by the components that could not be completed during the original medical checkup.

Procedure code 99211 may be submitted for a follow-up visit that includes a separately identifiable evaluation and management (E/M) component. When the follow-up visit does not include a separately identifiable E/M component, the following procedure codes must be used instead of procedure code 99211:

- Developmental testing (procedure code 96110) and autism screening (procedure code 96110 with modifier U6)
- Hearing screening (procedure code 92551)
- Immunization administration (procedure codes 90460 and 90461)

If a separately identifiable E/M component is required before completing one of the above checkup components, claims for the follow-up visit (procedure code 99211) and the checkup component may be submitted.

### 31.2.18.9.3 Denied Medical Checkups

Providers may be reimbursed for denied medical checkups through the appeal process when all of the following criteria are met for clients who are birth through 3 years of age:

- The client changed to a new provider in a new practice.
- The previous provider billed the maximum number of checkups in the procedure code age range for that client.
- The new provider's claim was denied for exceeding periodicity.

**Note:** *In addition to the criteria listed above, at least 1 year must have elapsed since the last checkup for clients who are 3 years of age or older.*

### 31.2.18.9.4 Developmental Screening and Testing

Developmental screening and testing may be a benefit when the services are provided during a preventive care medical checkup in accordance with accepted guidelines or when a parent expresses concern with a client's developmental progress. If the developmental screening was not completed during a previous checkup, or if the provider is seeing the client for the first time at a checkup for birth through 6 years of age, a standardized developmental screening must be completed.

Standardized developmental screening and testing may also be a benefit when they are performed outside of a preventive care medical checkup.

Clients with abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age with suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) as soon as possible, but no longer than 7 days after identification, even if the client is referred to an appropriate provider for further testing.

### 31.2.18.9.5 Developmental Screening

Developmental screening (procedure code 96110) is a required component of each checkup for clients who are birth through 6 years of age. Procedure code 96110 is a benefit when performed by an APRN or physician in the office, home, or outpatient hospital setting.

Providers must submit modifier U6 with procedure code 96110 to bill for autism screening. Autism screening is required at 18 and 24 months of age.

If the provider administers a standardized developmental screening at an additional checkup, the provider must document the rationale for the additional screen(s), which may be due to provider or parental concern. Retrospective review may be performed to ensure documentation supports medical necessity.

Additional parental or guardian consent may be required if online or web-based screening tools are used, which could result in client data being stored electronically in an outside database other than the provider's electronic medical record system, or if the data is used for purposes other than CSHCN Services Program screening. The provider should seek legal advice regarding the need for this consent.

Procedure code 96110, with or without modifier U6, must be billed with the appropriate E/M procedure code. Providers must use a standardized tool to complete the developmental screening. The CSHCN Services Program recognizes the following standardized tools:

- The Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire: Social - Emotional (ASQ:SE)
- Parents' Evaluation of Developmental Status (PEDS)
- The Modified Checklist for Autism in Toddlers (M-CHAT)
- The Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT - R/F)
- The Survey of Well-being of Young Children (SWYC)

A provider who chooses a standardized developmental screening tool different from those listed above must provide medical documentation that supports the use of the tool.

Developmental screening procedure code 96110 and autism screening procedure code 96110 with modifier U6 may be reported separately when provided as part of a medical checkup or follow up visit. Developmental screening and testing may also be billed with other office visits when medically necessary.

Procedure codes 96110 and 96110 with modifier U6 are each limited to once per day, same provider and will be denied unless a checkup, follow up visit or office visit is paid for the same date of service by the same provider. Providers may be reimbursed for both procedures on the same day.

Developmental screening, which is not expected to last longer than 30 minutes, is included in the limitation of 12 hours of behavioral health services per day, per provider. Physicians are not limited to the 12-hour limitation since they can delegate services and may submit claims in excess of 12 hours per day. The individuals delegated by a physician to perform these services are subject to the 12-hour limitation.

A Mini Mental State Examination is considered part of any E/M service and is not separately reimbursed.

### 31.2.18.9.6 Developmental Testing

Procedure codes 96112 and 96113, which consists of an extended evaluation, require the use of a standardized tool and are limited to clients who are birth through 20 years of age. Procedure codes 96112 and 96113 are a benefit when performed by an APRN, physician, or psychologist in the office, home, or outpatient hospital setting. Developmental testing is medically necessary when there is suspected developmental delay that is supported by the following clinical evidence:

- Suspected developmental delay or atypical development when the diagnosis cannot be clearly identified through clinical interview or standardized screening tools alone
- Retesting of a client to evaluate a change in developmental status that results in a change of treatment plan

The following procedure codes will be denied when billed on the same day as procedure codes 96112 and 96113:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99202           | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 |

Developmental testing procedure codes 96112 and 96113 are included in the system limitation of 12 hours of behavioral health services per day, per provider. Each additional 30 minutes may be reimbursed using add-on procedure code 96113. Retrospective review may be performed on billed hours and total hours worked per day since providers who perform developmental testing may possibly bill in excess of 12 hours per day. Providers must maintain clinical documentation in the client's medical record to support medical necessity.

Developmental testing that is performed when a development delay or change in the client's developmental status is not suspected would constitute developmental screening and is not covered. Providers may not bill clients for developmental testing that is considered developmental screening.

### **31.2.18.10 Preventive Care Medical Checkup Components**

#### Referral to Establish a Dental Home

The American Academy of Pediatric Dentistry's (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In Texas, establishment of a client's dental home begins at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The provider must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the six-month medical checkup visit, the provider must confirm whether a dental home has been established and is on-going. If a dental home has not been established, the provider must make additional referrals at subsequent medical checkup visits until the parent or guardian confirms that a dental home has been established for the client. A parent or guardian of the client may self-refer for dental care at any age, including 12 months of age or younger.

#### 31.2.18.10.1 Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV)

An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients 6 months of age through 35 months of age. Procedure code 99429 must be submitted with modifier U5, and diagnosis code Z00121 or Z00129.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup or an exception to the periodicity visit (procedure codes 99381, 99382, 99391, or 99392) and is limited to six services per lifetime by any provider.

An intermediate oral evaluation with fluoride varnish application is limited to preventive care medical checkup providers who have completed the required benefit education and who are certified by the DSHS Oral Health Program to perform an intermediate oral evaluation with fluoride varnish application.

The intermediate oral evaluation with fluoride varnish application add-on includes the following component:

- Intermediate oral evaluation
- Fluoride varnish application
- Dental anticipatory dental guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
  - Diet, nutrition, and food choices
  - Fluoride needs

- Injury prevention
- Antimicrobials, medications, and oral health
- Referral to a dentist to establish a dental home
- Additional dental anticipatory guidance if the client has no erupted teeth

**Note:** *The provider must complete the intermediate oral evaluation but can delegate all other components.*

#### 31.2.18.10.2 Mental Health Screening

Mental health screening is a benefit at each preventive care medical checkup when it is provided in accordance with accepted guidelines or when a parent expresses concern about the client's mental health.

Mental health screening using one of the following validated, standardized mental health screening tools recognized by the CSHCN Services Program is required once per calendar year, any provider for clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Pediatric Symptom Checklist-17 (PSC-17)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance use])
- Rapid Assessment for Adolescent Preventive Services (RAAPS)

Providers may be reimbursed separately when using one of the required screening tools during a preventive care medical checkup.

Procedure code 96160 or 96161 must be submitted for the required mental health screening. Procedure codes 96160 and 96161 are a benefit for clients who are 12 through 18 years of age.

Mental health screening at other medical checkups does not require the use of a validated, standardized mental health screening tool.

Procedure code 96160 or 96161 must be submitted on the same date of service and by the same provider as procedure code 99384, 99385, 99394, or 99395. Procedure codes 96160 and 96161 are limited to once per calendar year, any provider.

Procedure codes 96160 and 96161 will not be reimbursed for the same client for any date of service.

The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals.

#### 31.2.18.10.3 Postpartum Depression Screening

Postpartum depression screening is a benefit of the CSHCN Services Program. Procedure codes G8431 and G8540 may be reimbursed when billing for postpartum depression screening.

Postpartum depression screening must be submitted under the infant's Medicaid client number.

Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service, by the same provider as the checkup or follow-up visit procedure codes below:

| Procedure Codes |       |       |       |       |
|-----------------|-------|-------|-------|-------|
| 99211           | 99381 | 99382 | 99391 | 99392 |

Providers may receive separate reimbursement for postpartum depression screening in addition to the infant's preventive care medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the checkup or follow-up visit.

Only one procedure code, either G8431 or G8510, may be reimbursed per provider in the 12 months following the infant's birth.

### Postpartum Depression Screening and Referral Services

The American Academy of Pediatrics (AAP) recommends the infant's provider screen mothers for postpartum depression. Postpartum depression is the most common form of postpartum mood disturbance. Screening mothers for postpartum depression is appropriate for the general postpartum population.

*Note: Screening for postpartum depression during the infant's preventive care medical checkup is recommended, not required.*

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, providers should be aware that other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder, and postpartum psychosis.

Postpartum psychosis is a much more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

In addition to postpartum psychosis, immediate or emergent medical attention may be necessary when the risk of imminent harm or danger is present.

### Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the THSteps provider to develop a referral plan with the mother.

### Positive Screenings: Referrals and Follow-Up

Providers must discuss the screening results with the mother, discuss the possibility of depression, and the impact depression may have on the mother, family, and health of the infant.

The provider and mother should discuss the mother's options so the provider can refer her to an appropriate provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

Providers should refer the mother to a provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate providers include, but are not limited to:



- Mental health clinicians
- The mother's primary care provider
- Obstetricians and gynecologists
- Family physicians

Community resources such as Local Mental Health Authorities (LMHAs)

Resources should be provided for support in the interim until the mother is able to access care.

Scheduling a return visit for the infant sooner than the next scheduled visit may be appropriate in some cases.

### **Prior Authorization Requirements**

Screening for postpartum mood disorders at the checkup or follow up visit does not require prior authorization.

While recommended, screening for postpartum depression is not a compulsory requirement of the infant visit.

### **Documentation Requirements**

Documentation in the infant's record must include the name of the screening tool used and date the screening was completed.

If the mother screens positive for depression, at a minimum, the provider must note that a referral plan was discussed with the mother and a referral to a provider was made. Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

#### **31.2.18.10.4 Sensory Screening**

Providers may use test results from a different provider or a school vision and hearing screening program to replace the required visual acuity or hearing screening that requires the use of calibrated electronic equipment as long as the previous screening was performed within 12 months preceding the current medical checkup.

Procedure code 92551 may be reimbursed separately for a hearing screening (for hearing loss) with pure tone audiometric testing that is performed with the use of calibrated electronic equipment.

#### **31.2.18.11 Teaching Physicians**

Teaching physicians who provide E/M services may bill the CSHCN Services Program for lower- and mid-level E/M services (procedure codes 99202, 99203, 99211, 99212, and 99213) that are provided by residents if they meet the primary care exception under Medicare.

### **31.2.19 Evoked Response Tests and Neuromuscular Procedures**

The following services are a benefit of the CSHCN Services Program:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) procedures
- Motion analysis (MAS) studies

All procedures must be medically indicated and testing must be performed using appropriate equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening, rather than diagnosis, are not benefits of the CSHCN Services Program.

Client medical records must clearly document the medical necessity for all procedures and must reflect the actual results of specific procedures. All client medical records are subject to retrospective review.

**31.2.19.1 Autonomic Function Tests (AFTs)**

AFTs are a benefit of the CSHCN Services Program when submitted with procedure codes 95921, 95922, 95923, and 95924. Prior authorization is not required for AFTs.

Procedure codes 95921, 95922, 95923, and 95924 are limited to once per date of service, by the same provider.

Autonomic disorders may be congenital or acquired (primary or secondary). Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy
- Excessive sweating
- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure
- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjogren’s syndrome

**31.2.19.2 Electromyography and Nerve Conduction Studies**

EMG and NCS are a benefit of the CSHCN Services Program when billed with the following procedure codes:

| EMG Procedure Codes |       |       |       |       |       |       |       |       |       |
|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 51784               | 51785 | 95860 | 95861 | 95863 | 95864 | 95865 | 95866 | 95867 | 95868 |
| 95869               | 95870 | 95872 | 95875 |       |       |       |       |       |       |

| NCS Procedure Codes |       |       |       |       |       |       |       |       |       |
|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95885               | 95886 | 95887 | 95905 | 95907 | 95908 | 95909 | 95910 | 95911 | 95912 |
| 95913               | 95933 | 95937 |       |       |       |       |       |       |       |

Prior authorization is not required for EMGs.

EMG and NCS are restricted to the following diagnosis codes:

| Diagnosis Codes |      |      |      |      |      |      |      |
|-----------------|------|------|------|------|------|------|------|
| C701            | C720 | C721 | D510 | D511 | D513 | D518 | D519 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| D538            | E0842  | E0942  | E1041  | E1042  | E10610 | E1141  | E1142  |
| E1144           | E11610 | E1342  | E5111  | E5112  | E512   | E518   | E519   |
| E52             | E530   | E531   | E538   | E550   | E559   | E560   | E568   |
| E610            | E7281  | E7289  | E7841  | E7849  | E786   | E851   | E852   |
| E853            | E8581  | E8582  | E8589  | E859   | G120   | G121   | G1221  |
| G1222           | G1223  | G1224  | G1225  | G1229  | G128   | G129   | G130   |
| G243            | G2589  | G260   | G320   | G360   | G370   | G375   | G501   |
| G510            | G511   | G512   | G5131  | G5132  | G5133  | G5139  | G514   |
| G518            | G519   | G522   | G523   | G527   | G528   | G540   | G541   |
| G542            | G543   | G544   | G545   | G548   | G549   | G5601  | G5602  |
| G5603           | G5611  | G5612  | G5613  | G5621  | G5622  | G5623  | G5631  |
| G5632           | G5633  | G5641  | G5642  | G5643  | G5681  | G5682  | G5683  |
| G5691           | G5692  | G5693  | G5701  | G5702  | G5703  | G5711  | G5712  |
| G5713           | G5721  | G5722  | G5723  | G5731  | G5732  | G5733  | G5741  |
| G5742           | G5743  | G5751  | G5752  | G5753  | G5761  | G5762  | G5763  |
| G5771           | G5772  | G5773  | G5781  | G5782  | G5783  | G5791  | G5792  |
| G5793           | G587   | G588   | G589   | G590   | G600   | G601   | G602   |
| G603            | G608   | G609   | G610   | G6181  | G6182  | G6189  | G619   |
| G620            | G621   | G622   | G6281  | G6282  | G629   | G630   | G650   |
| G651            | G652   | G7000  | G7001  | G701   | G702   | G7081  | G7089  |
| G709            | G7100  | G7101  | G7102  | G7109  | G7111  | G7112  | G7113  |
| G7114           | G7119  | G7120  | G7121  | G71220 | G71228 | G7129  | G713   |
| G718            | G719   | G721   | G722   | G723   | G7241  | G7249  | G7281  |
| G7289           | G729   | G731   | G733   | G737   | G800   | G801   | G802   |
| G803            | G804   | G808   | G809   | G8311  | G8312  | G8313  | G8314  |
| G8321           | G8322  | G8323  | G8324  | G834   | G8381  | G8382  | G8383  |
| G8384           | G8389  | G839   | G9009  | G902   | G904   | G9050  | G90511 |
| G90512          | G90513 | G90519 | G90521 | G90522 | G90523 | G90529 | G9059  |
| G909            | G950   | G9511  | G9519  | G9520  | G9529  | G9581  | G9589  |
| G959            | G990   | G992   | I776   | I951   | J3800  | J3801  | J3802  |
| K5902           | K5903  | K5904  | K5909  | K592   | K594   | K624   | K6289  |
| M05411          | M05412 | M05421 | M05422 | M05431 | M05432 | M05441 | M05442 |
| M05451          | M05452 | M05461 | M05462 | M05471 | M05472 | M0549  | M05511 |
| M05512          | M05521 | M05522 | M05531 | M05532 | M05541 | M05542 | M05551 |
| M05552          | M05561 | M05562 | M05571 | M05572 | M0559  | M05711 | M05712 |
| M05721          | M05722 | M05731 | M05732 | M05741 | M05742 | M05751 | M05752 |
| M05761          | M05762 | M05769 | M05771 | M05772 | M05779 | M0579  | M057A  |
| M05811          | M05812 | M05821 | M05822 | M05831 | M05832 | M05841 | M05842 |
| M05851          | M05852 | M05861 | M05862 | M05871 | M05872 | M0589  | M058A  |
| M06011          | M06012 | M06021 | M06022 | M06031 | M06032 | M06041 | M06042 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| M06051          | M06052 | M06061 | M06062 | M06071 | M06072 | M0608  | M0609  |
| M060A           | M06811 | M06812 | M06821 | M06822 | M06831 | M06832 | M06841 |
| M06842          | M06852 | M06861 | M06862 | M06871 | M06872 | M0688  | M0689  |
| M068A           | M069   | M21271 | M21272 | M21331 | M21332 | M21511 | M21512 |
| M216X1          | M216X2 | M21831 | M21832 | M21931 | M21932 | M320   | M3210  |
| M3211           | M3212  | M3213  | M3214  | M3215  | M3219  | M328   | M329   |
| M3300           | M3301  | M3302  | M3309  | M3310  | M3311  | M3312  | M3319  |
| M3320           | M3321  | M3322  | M3329  | M3390  | M3391  | M3392  | M3399  |
| M340            | M341   | M342   | M3481  | M3482  | M3483  | M3489  | M3500  |
| M3501           | M3502  | M3503  | M3504  | M3505  | M3506  | M3507  | M3508  |
| M3509           | M350A  | M350B  | M350C  | M3581  | M3589  | M360   | M4321  |
| M4322           | M4323  | M4324  | M4325  | M4326  | M4327  | M4328  | M436   |
| M438X9          | M4644  | M4645  | M4646  | M4647  | M4711  | M4712  | M4713  |
| M4714           | M4715  | M4716  | M4721  | M4722  | M4723  | M4724  | M4725  |
| M4726           | M4727  | M4728  | M47811 | M47812 | M47813 | M47814 | M47815 |
| M47816          | M47817 | M47818 | M47891 | M47892 | M47893 | M47894 | M47895 |
| M47896          | M47897 | M47898 | M4801  | M4802  | M4803  | M4804  | M4805  |
| M48062          | M4807  | M4808  | M5000  | M5001  | M50020 | M50021 | M50022 |
| M50023          | M5003  | M5011  | M50120 | M50121 | M50122 | M50123 | M5013  |
| M5020           | M5021  | M50220 | M50221 | M50222 | M50223 | M5023  | M5030  |
| M5031           | M50320 | M50321 | M50322 | M50323 | M5033  | M5080  | M5081  |
| M50820          | M50821 | M50822 | M50823 | M5083  | M5091  | M50920 | M50921 |
| M50922          | M50923 | M5093  | M5104  | M5105  | M5106  | M5124  | M5125  |
| M5126           | M5127  | M5134  | M5135  | M5136  | M5137  | M5184  | M5185  |
| M5186           | M5187  | M5410  | M5411  | M5412  | M5413  | M5414  | M5415  |
| M5416           | M5417  | M5431  | M5432  | M5450  | M5451  | M5459  | M546   |
| M5489           | M60011 | M60012 | M60021 | M60022 | M60031 | M60032 | M60041 |
| M60042          | M60044 | M60045 | M60046 | M60051 | M60052 | M60061 | M60062 |
| M60070          | M60071 | M60073 | M60074 | M60076 | M60077 | M6008  | M6009  |
| M60111          | M60112 | M60121 | M60122 | M60131 | M60132 | M60141 | M60142 |
| M60151          | M60152 | M60161 | M60162 | M60171 | M60172 | M6018  | M6019  |
| M6090           | M6250  | M62511 | M62512 | M62519 | M62521 | M62522 | M62529 |
| M62531          | M62532 | M62539 | M62541 | M62542 | M62549 | M62551 | M62552 |
| M62559          | M62561 | M62562 | M62569 | M62571 | M62572 | M62579 | M6258  |
| M6259           | M625A0 | M625A1 | M625A2 | M625A9 | M6281  | M6284  | M629   |
| M7910           | M7911  | M7912  | M7918  | M792   | M79601 | M79602 | M79604 |
| M79605          | M79621 | M79622 | M79631 | M79632 | M79641 | M79642 | M79651 |
| M79652          | M79661 | M79662 | M79671 | M79672 | M797   | M961   | N393   |
| N3941           | N3942  | N3943  | N3944  | N3945  | N3946  | N39490 | N39491 |
| N39492          | N39498 | N94819 | R150   | R151   | R152   | R159   | R200   |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| R201            | R202    | R203    | R208    | R209    | R260    | R261    | R2681   |
| R2689           | R269    | R290    | R295    | R29701  | R29702  | R29703  | R29704  |
| R29705          | R29706  | R29707  | R29708  | R29709  | R29710  | R29711  | R29712  |
| R29713          | R29714  | R29715  | R29716  | R29717  | R29718  | R29719  | R29720  |
| R29721          | R29722  | R29723  | R29724  | R29725  | R29726  | R29727  | R29728  |
| R29729          | R29730  | R29731  | R29732  | R29733  | R29734  | R29735  | R29736  |
| R29737          | R29738  | R29739  | R29740  | R29741  | R29742  | R320    | R3914   |
| R39191          | R39192  | R39198  | R4702   | R471    | R4781   | R4789   | R498    |
| R6884           | S14101A | S14101D | S14101S | S14102A | S14102D | S14102S | S14103A |
| S14103D         | S14103S | S14104A | S14104D | S14104S | S14105A | S14105D | S14105S |
| S14106A         | S14106D | S14106S | S14107A | S14107D | S14107S | S14108A | S14108D |
| S14108S         | S14109A | S14109D | S14109S | S14111A | S14111D | S14111S | S14112A |
| S14112D         | S14112S | S14113A | S14113D | S14113S | S14114A | S14114D | S14114S |
| S14115A         | S14115D | S14115S | S14116A | S14116D | S14116S | S14117A | S14117D |
| S14117S         | S14118A | S14118D | S14118S | S14121A | S14121D | S14121S | S14122A |
| S14122D         | S14122S | S14123A | S14123D | S14123S | S14124A | S14124D | S14124S |
| S14125A         | S14125D | S14125S | S14126A | S14126D | S14126S | S14127A | S14127D |
| S14127S         | S14128A | S14128D | S14128S | S14131A | S14131D | S14131S | S14132A |
| S14132D         | S14132S | S14133A | S14133D | S14133S | S14134A | S14134D | S14134S |
| S14135A         | S14135D | S14135S | S14136A | S14136D | S14136S | S14137A | S14137D |
| S14137S         | S14138A | S14138D | S14138S | S14141A | S14141D | S14141S | S14142A |
| S14142D         | S14142S | S14143A | S14143D | S14143S | S14144A | S14144D | S14144S |
| S14145A         | S14145D | S14145S | S14146A | S14146D | S14146S | S14147A | S14147D |
| S14147S         | S14148A | S14148D | S14148S | S14151A | S14151D | S14151S | S14152A |
| S14152D         | S14152S | S14153A | S14153D | S14153S | S14154A | S14154D | S14154S |
| S14155A         | S14155D | S14155S | S14156A | S14156D | S14156S | S14157A | S14157D |
| S14157S         | S14158A | S14158D | S14158S | S142XXA | S142XXD | S142XXS | S143XXA |
| S143XXD         | S143XXS | S144XXA | S144XXD | S144XXS | S145XXA | S145XXD | S145XXS |
| S148XXA         | S148XXD | S148XXS | S149XXA | S149XXD | S149XXS | S24101A | S24101D |
| S24101S         | S24102A | S24102D | S24102S | S24103A | S24103D | S24103S | S24104A |
| S24104D         | S24104S | S24109A | S24109D | S24109S | S24111A | S24111D | S24111S |
| S24112A         | S24112D | S24112S | S24113A | S24113D | S24113S | S24114A | S24114D |
| S24114S         | S24131A | S24131D | S24131S | S24132A | S24132D | S24132S | S24133A |
| S24133D         | S24133S | S24134A | S24134D | S24134S | S24141A | S24141D | S24141S |
| S24142A         | S24142D | S24142S | S24143A | S24143D | S24143S | S24144A | S24144D |
| S24144S         | S24151A | S24151D | S24151S | S24152A | S24152D | S24152S | S24153A |
| S24153D         | S24153S | S24154A | S24154D | S24154S | S242XXA | S242XXD | S242XXS |
| S243XXA         | S243XXD | S243XXS | S244XXA | S244XXD | S244XXS | S248XXA | S248XXD |
| S248XXS         | S249XXA | S249XXD | S249XXS | S34109A | S34109D | S34109S | S34111A |
| S34111D         | S34111S | S34112A | S34112D | S34112S | S34113A | S34113D | S34113S |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| S34114A         | S34114D | S34114S | S34115A | S34115D | S34115S | S34121A | S34121D |
| S34121S         | S34122A | S34122D | S34122S | S34123A | S34123D | S34123S | S34124A |
| S34124D         | S34124S | S34125A | S34125D | S34125S | S34131A | S34131D | S34131S |
| S34132A         | S34132D | S34132S | S34139A | S34139D | S34139S | S3421XA | S3421XD |
| S3421XS         | S3422XA | S3422XD | S3422XS | S343XXA | S343XXD | S343XXS | S344XXA |
| S344XXD         | S344XXS | S345XXA | S345XXD | S345XXS | S4400XA | S4400XD | S4400XS |
| S4400XX         | S4401XA | S4401XD | S4401XS | S4402XA | S4402XD | S4402XS | S4410XA |
| S4410XD         | S4410XS | S4411XA | S4411XD | S4411XS | S4412XA | S4412XD | S4412XS |
| S4420XA         | S4420XD | S4420XS | S4421XA | S4421XD | S4421XS | S4422XA | S4422XD |
| S4422XS         | S4430XA | S4430XD | S4430XS | S4431XA | S4431XD | S4431XS | S4432XA |
| S4432XD         | S4432XS | S4440XA | S4440XD | S4440XS | S4441XA | S4441XD | S4441XS |
| S4442XA         | S4442XD | S4442XS | S4450XA | S4450XD | S4450XS | S4451XA | S4451XD |
| S4451XS         | S4452XA | S4452XD | S4452XS | S448X1A | S448X1D | S448X1S | S448X2A |
| S448X2D         | S448X2S | S448X9A | S448X9D | S448X9S | S4490XA | S4490XD | S4490XS |
| S4491XA         | S4491XD | S4491XS | S4492XA | S4492XD | S4492XS | S5400XA | S5400XD |
| S5400XS         | S5401XA | S5401XD | S5401XS | S5402XA | S5402XD | S5402XS | S5410XA |
| S5410XD         | S5410XS | S5411XA | S5411XD | S5411XS | S5412XA | S5412XD | S5412XS |
| S5420XA         | S5420XD | S5420XS | S5421XA | S5421XD | S5421XS | S5422XA | S5422XD |
| S5422XS         | S5430XA | S5430XD | S5430XS | S5431XA | S5431XD | S5431XS | S5432XA |
| S5432XD         | S5432XS | S5490XA | S5490XD | S5490XS | S5491XA | S5491XD | S5491XS |
| S5492XA         | S5492XD | S5492XS | S6400XA | S6400XD | S6400XS | S6401XA | S6401XD |
| S6401XS         | S6402XA | S6402XD | S6402XS | S6410XA | S6410XD | S6410XS | S6411XA |
| S6411XD         | S6411XS | S6412XA | S6412XD | S6412XS | S6420XA | S6420XD | S6420XS |
| S6421XA         | S6421XD | S6421XS | S6422XA | S6422XD | S6422XS | S6430XA | S6430XD |
| S6430XS         | S6431XA | S6431XD | S6431XS | S6432XA | S6432XD | S6432XS | S64490A |
| S64490D         | S64490S | S64491A | S64491D | S64491S | S64492A | S64492D | S64492S |
| S64493A         | S64493D | S64493S | S64494A | S64494D | S64494S | S64495A | S64495D |
| S64495S         | S64496A | S64496D | S64496S | S64497A | S64497D | S64497S | S64498A |
| S64498D         | S64498S | S648X1A | S648X1D | S648X1S | S648X2A | S648X2D | S648X2S |
| S648X9A         | S648X9D | S648X9S | S6490XA | S6490XD | S6490XS | S6491XA | S6491XD |
| S6491XS         | S6492XA | S6492XD | S6492XS | S7401XA | S7401XD | S7401XS | S7402XA |
| S7402XD         | S7402XS | S7411XA | S7411XD | S7411XS | S7412XA | S7412XD | S7412XS |
| S7421XA         | S7421XD | S7421XS | S7422XA | S7422XD | S7422XS | S748X1A | S748X1D |
| S748X1S         | S748X2A | S748X2D | S748X2S | S7491XA | S7491XD | S7491XS | S7492XA |
| S7492XD         | S7492XS | S8401XA | S8401XD | S8401XS | S8402XA | S8402XD | S8402XS |
| S8410XS         | S8411XA | S8411XD | S8411XS | S8412XA | S8412XD | S8412XS | S8421XA |
| S8421XD         | S8421XS | S8422XA | S8422XD | S8422XS | S84801A | S84801D | S84801S |
| S84802A         | S84802D | S84802S | S8491XA | S8491XD | S8491XS | S8492XA | S8492XD |
| S8492XS         | S9421XA | S9421XD | S9421XS | S9422XA | S9422XD | S9422XS | S9431XA |
| S9431XD         | S9431XS | S9432XA | S9432XD | S9432XS | S948X1A | S948X1D | S948X1S |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| S948X2A         | S948X2D | S948X2S | S948X9A | S948X9D | S948X9S | S9490XA | S9490XD |
| S9490XS         | S9491XA | S9491XD | S9491XS | S9492XA | S9492XD | S9492XS | T85840A |
| T85840D         | T85840S |         |         |         |         |         |         |

The electrodiagnostic testing must be guided by accepted practice parameters and physician guidelines. The number of studies performed is expected to be tailored to the clinical findings of the individual client.

Any electrodiagnostic testing procedures may be reimbursed up to four distinct dates of service per calendar year by the same provider.

Any evaluation and management service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

#### 31.2.19.2.1 EMG

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine.

The following procedure codes may be reimbursed for one service per day for each procedure by the same provider:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 51784           | 51785 | 95860 | 95861 | 95863 | 95864 | 95865 | 95867 | 95868 | 95869 |
| 95872           | 95875 |       |       |       |       |       |       |       |       |

Procedure code 95866 may be reimbursed up to one service per day, same provider.

Procedure code 95870 may be reimbursed in multiple quantities of up to four services per day, if specific muscles are documented.

Procedure codes 95872 and 95875 may be reimbursed up to two services per day, same provider.

#### 31.2.19.2.2 NCS

NCS must be performed by a physician or a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the electrodiagnostic laboratory while testing is underway, immediately available to provide the trained individual with assistance and direction, and responsible for selecting the appropriate NCS to be performed.

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier XE, XP, XS, XU, or 59. Modifier 59 should be used only when modifier XE, XP, XS, or XU is not appropriate.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.

Procedure codes 95885 and 95886 may be reimbursed once per extremity up to 2 units, any combination of procedure codes, per day, by any provider.

Procedure codes 95885, 95886, and 95887 must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913 on the same day, by the same provider.

Prior authorization is required for NCS for any diagnosis other than those listed above or when the anticipated number of studies planned for an evaluation exceeds the maximum number of studies, per date of service, by the same provider:

| NCS Procedure Code | Studies Allowed per Date of Service |
|--------------------|-------------------------------------|
| 95937              | 3                                   |

Claims for nerve conduction studies that are denied for exceeding the maximum number of studies allowed per day may be appealed with documentation of medical necessity.

Prior authorization is required for more than three studies per day. Documentation must be submitted to establish medical necessity for the additional studies, including one or more of the following:

- Additional diagnoses to be considered
- Clinical signs, symptoms, or electrodiagnostic findings that necessitate the consideration of the additional diagnosis

Requests must include documentation supporting medical necessity for the number of studies requested, and they must be received on or before the requested DOS.

Medical record documentation must establish medical necessity for any additional studies, including one or more of the following:

- Other diagnoses in the differential requires consideration. The provider must identify both of the additional diagnoses considered and the clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- Multiple diagnoses are established by NCS, and the limitations listed above for a single diagnostic category do not apply. Providers must document all diagnoses established as a result of electrodiagnostic testing.
- Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol usage) has been conducted.
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms. Some examples include underlying metabolic disease (e.g., thyroid condition or diabetes mellitus), nutritional deficiency (alcoholism), malignant disease, or inflammatory disorder (including, but not limited to, lupus, sarcoidosis, or Sjögren's syndrome).

NCS prior authorization requests must be submitted by the ordering provider on the [CSHCN Services Program Authorization and Prior Authorization Request Form](#). The form must be signed and dated by the ordering provider.

**Note:** *An APRN or a physician assistant (PA) may sign all documentation related to the provision of evoked response tests and neuromuscular procedures on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.*

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

### 31.2.19.3 Evoked Potential Procedures

Evoked potential (EP) procedures are a benefit of the CSHCN Services Program. The most common EP procedures are:

- Brainstem auditory evoked potentials (BAEPs)



- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Visual evoked potentials (VEPs)

Prior authorization is not required for EP procedures.

Each EP test (procedure codes 92650, 92651, 92652, 92653, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

**31.2.19.3.1 Vestibular Evoked Myogenic Potentials (VEMP)**

VEMP testing procedure codes 92517, 92518, and 92519 are benefits of the CSHCN Services Program.

Some conditions under which VEMP testing (procedure codes 92517, 92518, and 92519) may be appropriate include:

- Evaluation of chronic symptoms of pressure, tinnitus, disorientation, or chronic vertigo after all other recommended vestibular tests are completed and is lacking a definitive diagnosis.
- Evaluation after a positive CT scan for Superior Semicircular Canal Dehiscence Syndrome (SCDS).

Documentation must include the following:

- The other differential diagnoses under consideration
- The additional diagnoses considered
- The clinical signs, symptoms or electrodiagnostic findings that necessitated the inclusion

VEMP testing must be medically indicated, and reimbursement requires one of the diagnosis codes listed:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| H81311          | H81312 | H81313 | H81319 | H81391 | H81392 | H81393 | H81399 |
| H814            | H818X1 | H818X2 | H818X3 | H818X9 | H8190  | H8191  | H8192  |
| H8193           | H821   | H822   | H823   | H829   | H8301  | H8302  | H8303  |
| H8309           | H8311  | H8312  | H8313  | H8319  | H832X1 | H832X2 | H832X3 |
| H832X9          | H833X1 | H833X2 | H833X3 | H833X9 | H838X1 | H838X2 | H838X3 |
| H838X9          | H8390  | H8391  | H8392  | H8393  | H9311  | H9312  | H9313  |
| H9319           | R110   | R111   | R112   | R42    |        |        |        |

VEMP testing is not medically necessary for any other indications and will not be covered.

All of the following criteria are documentation requirements for VEMP testing:

- For each VEMP test performed, the referral reason must include a clear diagnostic impression documented in the client’s medical record.
- Medical necessity for the VEMP test must be clearly documented in the client’s medical record and reflect the actual results of specific tests (which could include latency and amplitude).
- Medical necessity for client reevaluation after the initial consultation and testing must be clearly documented in the client’s medical record. Supporting documentation must include the following:
  - New symptoms unrelated to previously evaluated symptoms that may result in a new diagnosis

- Rapidly changing client condition documentation supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
  - Clinical benefit of additional studies

The client’s medical records are subject to retrospective review.

**31.2.19.3.2 Intraoperative Neurophysiology Monitoring (IONM)**

Intraoperative neurophysiology monitoring (procedure codes 95940 and 95941) are a benefit when performed in addition to each evoked potential test on the same day. Prior authorization is not required for intraoperative neurophysiology monitoring.

The documentation for the intraoperative neurophysiology testing must include the time for which each test is performed.

Procedure code 95940 and 95941 are limited to a maximum of two hours per date of service, per client, per same procedure, by any provider.

Procedure code 95940 and 95941 must be billed in conjunction with one of the following procedure codes on the same day, by the same provider, or the service will be denied:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95822           | 95860 | 95861 | 95863 | 95864 | 95865 | 95866 | 95867 | 95868 | 95869 |
| 95870           | 95907 | 95908 | 95909 | 95910 | 95911 | 95912 | 95913 | 95925 | 95926 |
| 95927           | 95928 | 95929 | 95930 | 95933 | 95937 | 95938 | 95939 |       |       |

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

**31.2.19.4 Motion Analysis Studies (MAS)**

MA studies (procedure codes 96000, 96001, 96002, and 96003) will be considered for reimbursement through the CSHCN Services Program for clients who are 3 through 20 years of age and have a diagnosis of, but not limited to, cerebral palsy, traumatic brain injury, myelomeningocele, or stroke. Motion analysis is most often used as a diagnostic tool for clients with neuromuscular conditions, primarily as part of the surgical decision-making process when all conservative measures have been exhausted and surgical intervention is being considered.

Procedure codes 96000, 96001, 96002, and 96003 are limited to one per date of service by the same provider and two per year, any provider.

Procedure code 96000 will be denied if billed with 96001 by the same provider for the same date of service.

Procedure codes 95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, and 95872 will be denied if billed with 96002 or 96003 by the same provider for the same date of service.

Prior authorization requests for a diagnosis other than cerebral palsy, traumatic brain injury, myelomeningocele, or stroke, or for more than two services per year, will be considered with medical necessity on a case-by-case basis upon review by the CSHCN Services Program medical director or designee.

Prior authorization requests for MA studies must include documentation with the following information that indicates the client meets all the requirements for MA studies:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices

- Client is 3 through 20 years of age
- Physically able to tolerate up to three hours of testing
- Clear documentation that indicates the study is performed as part of a preoperative or postoperative assessment based on the surgical plan of the client

Providers must complete the [CSHCN Services Program Authorization and Prior Authorization Request Form](#) for MA studies prior authorization requests.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

**31.2.19.5 Prior Authorization for Unlisted Procedure Code 95999**

Prior authorization is required for unlisted neurological or neuromuscular diagnostic procedure code 95999; the following information is required to determine coverage:

- The client’s diagnosis
- A clear description of the neurological procedure that will be performed
- Documentation that indicates medical necessity of the neurological procedure
- Place of service where the neurological procedure is to be performed
- The physician’s intended fee for the neurological procedure being requested or a CPT or HCPCS procedure code that is comparable to the procedure.

Providers must complete the [CSHCN Services Program Authorization and Prior Authorization Request Form](#) for prior authorization requests.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

**31.2.20 Extracapsular Cataract Removal**

Extracapsular cataract removal (procedure codes 66989 and 66991) is a benefit of the CSHCN Services Program for clients who are 21 years of age or older.

Procedure codes 66989 and 66991 are limited to the following diagnosis codes:

| Diagnosis Codes |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|
| H401111         | H401112 | H401121 | H401122 | H401131 | H401132 |

Procedure codes 66989 and 66991 are limited to two services per lifetime, and must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure code 66989 is denied if billed on the same date of service by the same provider as procedure code 67015, 67025, 67027, 67030, or 67031.

**31.2.21 Extracorporeal Shock Wave Lithotripsy (ESWL)**

Procedure code 50590 is a benefit for the following diagnosis codes:

| Diagnosis Codes |      |      |       |       |      |      |      |
|-----------------|------|------|-------|-------|------|------|------|
| N130            | N131 | N132 | N1330 | N1339 | N200 | N201 | N202 |
| N209            | N219 | N22  |       |       |      |      |      |

All claims received for ESWL must include one of these diagnoses.

### 31.2.22 Gastrostomy Devices

Low-profile gastrostomy devices are a benefit of the CSHCN Services Program when prescribed by a physician. Authorization is required.

Physicians may be reimbursed for nonobtured and obtured gastrostomy devices.

**Referto:** Section 18.2.4.1, “Gastrostomy Devices” in Chapter 18, “Expendable Medical Supplies” for more information about documentation requirements, limitations, and additional devices.

Chapter 18, “Expendable Medical Supplies” for more information about related supplies and equipment.

Section 4.3, “Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

### 31.2.23 Genetics

Genetic services are a benefit of the CSHCN Services Program.

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response.

Genetic services may be provided by a physician and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client’s family members
- Genetic risk assessment
- Interpretation and evaluation of laboratory test results
- Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders
- Consultation with other medical professionals to provide treatment

The following procedure codes may be reimbursed for geneticists when provided in the office, inpatient hospital, or outpatient hospital setting:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 96040           | 99213 | 99214 | 99215 | 99244 | 99245 | 99254 | 99255 | 99402 | 99404 |

Office or other outpatient consultations (procedure codes 99244, 99245, or 99404) are limited to once every 3 years. One office or other outpatient consultation (procedure codes 99244 or 99245) may be reimbursed if an office/outpatient/inpatient consultation has not been reimbursed in the previous 3 years.

Inpatient or observation consultations (procedure code 99254 or 99255) may be reimbursed once every 3 years regardless of whether an office consultation was reimbursed in the previous 3 years.

A comprehensive follow up visit (procedure code 99215) is limited to once per year.

No authorization is required for genetic services that are a benefit of the CSHCN Services Program.

#### 31.2.23.1 Family History

It is important for primary care providers to recognize potential genetic risk factors in a client so that they can make appropriate referrals to a genetic specialist.

Obtaining an accurate family history is an important part of clinical evaluations, even when genetic abnormalities are not suspected. Knowing the family history may help health-care providers identify single-gene disorders or chromosomal abnormalities that occur in multiple family members or through multiple generations. Some genetic disorders that can be traced through an accurate family history include diabetes, hypertension, certain forms of cancer, and cystic fibrosis. Early identification of the client's risk for one of these diseases can lead to early intervention and preventive measures that can delay onset or improve health conditions.

Using a genetics-specific questionnaire helps to obtain the information needed to identify possible genetic patterns or disorders. The most commonly used questionnaires are provided by the American Medical Association and include the "Prenatal Screening Questionnaire," the "Pediatric Clinical Genetics Questionnaire," and the "Adult History Form."

### **31.2.23.2 Genetic Tests**

Diagnostic tests to check for genetic abnormalities must be performed only if the test results will affect treatment decisions or provide prognostic information. Tests for conditions that are treated symptomatically are not appropriate since the treatment would not change. Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client's needs.

Any genetic testing and screening procedure must be accompanied by appropriate nondirective counseling, both before and after the procedure. Information must be provided to the client and family (if appropriate) about the possible risks and purpose and nature of the tests being performed.

Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to confer about the client and his or her needs.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. The CSHCN Services Program supports national certification standards when available.

### **31.2.23.3 Laboratory Practices**

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race and ethnicity, family history, and other pertinent clinical and laboratory information. To facilitate test requests and ensure prompt initiation of appropriate testing procedures and accurate interpretation of test results, the requesting provider must be aware of the specific client information needed by the laboratory before tests are ordered.

To help providers make appropriate test selections and requests, handle and submit specimens, and provide clinical care, laboratories that perform molecular genetic testing for heritable diseases and conditions must educate providers that request services about the molecular genetic tests that the laboratory performs. For each molecular genetic test, the laboratory must provide the following information:

- Indications for testing
- Relevant clinical and laboratory information
- Client race and ethnicity
- Family history
- Pedigree

Testing performed on a client to provide genetic information for a family member, and testing performed on a non-CSHCN Services Program client to provide genetic information for a CSHCN Services Program client are not benefits of the CSHCN Services Program.

#### **31.2.23.4 Genetic Counselors**

Genetic counselor services may be billed by a physician when the genetic counselor is an employee of the physician. Services provided by independent genetic counselors are not a benefit of the CSHCN Services Program.

*Referto:* Section 25.2.5.2, “Cytogenetics Testing” in Chapter 25, “Laboratory Services” for more information on cytogenetic testing.

#### **31.2.24 Hyperbaric Oxygen Therapy (HBOT)**

Hyperbaric oxygen therapy is a type of treatment that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client’s body tissues. HBOT is a benefit when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmospheric absolute (atm.abs) or higher, that may hold one or several clients.

The CSHCN Services Program recognizes the following indications for HBOT, as approved by the Undersea & Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Necrotizing soft tissue infections
- Delayed radiation injury (soft tissue and bony necrosis)
- Refractory osteomyelitis
- Acute thermal burn injury
- Intracranial abscess

CSHCN Services Program considers HBOT experimental and investigational for any indications other than the ones approved by UHMS and outlined in this section. Non-covered indications, include, but are not limited to, autism and traumatic brain injury.

Oxygen administered outside of a hyperbaric chamber, by any means, is not considered hyperbaric treatment.

HBOT services must be provided in facilities that have experience in HBOT treatment of pediatric clients. The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber, and may not delegate this service.

Both the facility’s medical record and the client’s medical record must contain documentation to support that there was a physician in attendance who provided supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

Physicians who bill for the professional component of HBOT must use procedure code 99183.

Hospital providers who bill for the chamber time must use procedure code G0277 with revenue code 413.

**31.2.24.1 Prior Authorization Requirements**

HBOT procedure codes 99183 and G0277 require prior authorization. When requesting prior authorization, providers should use the [CSHCN Services Program Authorization and Prior Authorization Request Form](#).

*Referto:* Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

| Covered Indication  | Total Number of 30 Minute Intervals Allowed for Procedure Code G0277 | Total Number of Professional Sessions Allowed for Procedure Code 99183 | Medical Necessity Documentation of the Following is Required   |
|---|--|--|--|
| Air or gas embolism   | 6  | 2  | Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics   |
| Carbon monoxide poisoning - initial authorization   | 15   | 5  | Persistent neurological dysfunction secondary to carbon monoxide inhalation  |
| Carbon monoxide poisoning - one subsequent authorization  | 9  | 3  | Evidence of continuing improvement in cognitive functioning  |
| Central retinal artery occlusion  | 36   | 6  | Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion                                 |
| Compromised skin grafts and flaps - initial authorization   | 80   | 10   | Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia |
| Compromised skin grafts and flaps - one subsequent authorization  | 40   | 5  | Evidence of stabilization of graft or flap   |
| Crush injury, compartment syndrome and other acute traumatic ischemias  | 36   | 12   | Adjunct to standard medical and surgical interventions   |
| <p><b>*Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:</b></p> <ul style="list-style-type: none"> <li>• Grade 1: Superficial diabetic ulcer</li> <li>• Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)</li> <li>• Grade 3: Deep ulcer with abscess or osteomyelitis</li> <li>• Grade 4: Gangrene to portion of forefoot</li> <li>• Grade 5: Extensive gangrene of foot</li> </ul> |  |  |  |

| Covered Indication   | Total Number of 30 Minute Intervals Allowed for Procedure Code G0277 | Total Number of Professional Sessions Allowed for Procedure Code 99183 | Medical Necessity Documentation of the Following is Required  |
|--|--|--|---|
| Decompression sickness   | 28   | 1  | Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure  |
| Diabetic foot ulcer -initial authorization                                       | 60   | 30   | After at least 30 days of standard medical wound therapy, with a wound pO <sub>2</sub> less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *                  |
| Diabetic foot ulcer - two subsequent authorizations                              | 60   | 20   | Evidence of continuing healing and wound pO <sub>2</sub> less than 40 mmHg  |
| Severe anemia  | 50   | 10   | Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs |
| Clostridial myositis and myonecrosis (gas gangrene)                              | 39   | 13   | Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid   |
| Necrotizing soft tissue infections – initial authorization                       | 36   | 12   | Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue  |
| Necrotizing soft tissue infections - two subsequent authorizations               | 15   | 5  | Evidence that advancement of dying tissue has slowed  |
| Delayed radiation injury (soft tissue and bony necrosis) - initial authorization | 40   | 10   | Evidence of unsatisfactory response to conventional treatment   |
| Delayed radiation injury - one subsequent authorization                          | 40   | 10   | Evidence of improvement demonstrated by clinical response   |
| Refractory osteomyelitis - initial authorization                                 | 40   | 10   | Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment  |
| Refractory osteomyelitis - one subsequent authorization                          | 15   | 5  | Evidence of improvement demonstrated by clinical response   |

**\*Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:**

- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot



| Covered Indication  | Total Number of 30 Minute Intervals Allowed for Procedure Code G0277 | Total Number of Professional Sessions Allowed for Procedure Code 99183 | Medical Necessity Documentation of the Following is Required   |
|---|--|--|--|
| Acute thermal burn injury - initial authorization   | 45   | 15   | Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum  |
| Acute thermal burn injury – three subsequent authorizations   | 30   | 10   | Evidence of continuing improvement demonstrated by clinical response   |
| Intracranial abscess - initial authorization  | 15   | 5  | Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: <ul style="list-style-type: none"> <li>• Multiple abscesses</li> <li>• Abscesses in a deep or dominant location</li> <li>• Compromised host</li> <li>• Surgery contraindicated or client is a poor surgical risk</li> </ul> |
| Intracranial abscess - one subsequent authorization   | 15   | 5  | Evidence of improvement demonstrated by clinical response and radiological findings  |
| <p><b>*Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:</b></p> <ul style="list-style-type: none"> <li>• Grade 1: Superficial diabetic ulcer</li> <li>• Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)</li> <li>• Grade 3: Deep ulcer with abscess or osteomyelitis</li> <li>• Grade 4: Gangrene to portion of forefoot</li> <li>• Grade 5: Extensive gangrene of foot</li> </ul> |  |  |  |

Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code G0277 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and G0277 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization

**Example:** *In accordance with recommended protocols, a client with an air/gas embolus may receive up to 6 units (180 minutes) of HBOT over two treatments.*

- One prior authorization number may be issued for a quantity of 6 units for procedure code G0277 for the facility and 2 professional sessions for procedure code 99183.
- The 6 units of chamber time for procedure code G0277 may be divided in any manner across the two professional sessions. For procedure code 99183, the usual protocol is two 90-minute treatments.
- The facility bills 90 consecutive minutes (3 units) per HBOT treatment for procedure code G0277. The physician bills per treatment, which in this case would be 2 professional sessions for procedure code 99183.

Limitations beyond those listed in the table above are considered experimental and investigational.

### **31.2.25 Immunizations (Vaccines and Toxoids)**

Vaccines and vaccine administration, as recommended by the Advisory Committee on Immunization Practices (ACIP), is a benefit of the Children with Special Health Care Needs (CSHCN) Services Program.

A vaccine stimulates a person's immune system to produce immunity to a disease, thereby providing protection from that disease.

Vaccines may be administered orally, nasally, or by subcutaneous or intramuscular injection.

Providers must follow current ACIP recommendations; however, in the event of conflict, providers are required to more closely follow the Texas Vaccines for Children (TVFC) guidelines.

#### **31.2.25.1 Texas Vaccines for Children (TVFC) Program**

The CSHCN Services Program encourages providers administering vaccines to enroll in TVFC. Providers interested in enrollment information for TVFC may call the Department of State Health Services (DSHS), Immunizations Branch at 1-800-252-9152 or access the TVFC website at [www.dshs.texas.gov/immunize/tvfc/](http://www.dshs.texas.gov/immunize/tvfc/).

If the provider is enrolled in TVFC, the provider must screen the client and, if indicated, immunize the client using TVFC-obtained vaccine.

Providers must provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC) to each client. VISs explain the benefits and risks of the vaccine.

#### **31.2.25.2 Documentation Recommendations**

Providers must document the following information in the client's medical record for each vaccine administered:

- The vaccine given
- The date of the vaccine administration (day, month, year)
- The name of the vaccine manufacturer
- The vaccine lot number
- The signature and title of the person who administered the vaccine
- The location of where the vaccine was administered
- The publication date of the VIS issued to the client, parent, or guardian

If a vaccine was administered outside of ACIP's recommended routine immunization schedules, the reason must be included in the client's medical record. Reasons for administering a vaccine outside the routine schedule may include but are not limited to:

- An impaired immune system.
- Suspected exposure to a disease.

The client's medical records are subject to retrospective review to determine whether the utilization and reimbursement of this service was appropriate.

Procedure codes 90460 and 90461 include counseling by a qualified healthcare professional. Documentation of the counseling must be noted in the client's medical record.

### 31.2.25.3 Vaccine Reporting to the DSHS

All administered vaccines and toxoids must be reported to DSHS. DSHS submits all reported vaccinations with consent to a centralized repository of immunization histories. This repository is known in Texas as ImmTrac2.

*Note: Documentation of the injection site is recommended, but not required.*

#### 31.2.25.3.1 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after a vaccine has been administered. Even if the provider is unclear whether the adverse event was caused by the vaccine, it should still be reported. The National Childhood Vaccine Injury Act (NCVIA) requires health care providers to report:

- “Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- “Any reaction that is listed in the VAERS Reportable Events Table that occurs within the specified time period post vaccination.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from <https://vaers.hhs.gov/resources/materials.html>.

### 31.2.25.4 Authorization Requirements

Authorization is not required for any vaccine or its associated administration fee. Providers enrolled in TVFC are responsible for determining the eligibility of clients to receive TVFC reimbursement.

### 31.2.25.5 Vaccine Reimbursement

The diagnosis code Z23 should be reported regardless of the type of encounter when a vaccine was given. It must be reported and linked to both the vaccine product and the vaccine administration code.

When the client visit is only for vaccine administration, diagnosis code Z23 should be used as the appropriate vaccine diagnosis code.

When vaccines are given during a preventive health visit (e.g., well child exam), diagnosis code Z23 will follow the age appropriate diagnosis code for the preventive health visit.

When the client visit is only for vaccine administration, the office visit will not be reimbursed.

If a vaccine is administered as part of a preventive health visit (e.g., well child exam), or a visit due to a medical condition, the office visit will be reimbursed in addition to the vaccine given.

Reimbursement may be considered for any vaccine if it is not obtained through TVFC but has been recommended by ACIP and approved by the Health and Human Services Commission (HHSC).

Each vaccine and its administration must be submitted on the same claim in the following sequence: the vaccine procedure code immediately followed by the applicable vaccine administration procedure code(s). All of the vaccine administration procedure codes that correspond to a single vaccine procedure code must be submitted on the same claim as the vaccine procedure code.

Vaccines that are purchased by a provider may be reimbursed if the state-defined modifier U4 is billed with the vaccine and one of the following conditions is met:

- The provider is not enrolled in TVFC.
- The client does not meet the TVFC criteria.
- TVFC resolutions do not match the ACIP’s general usage recommendations.
- The provider purchases an ACIP-recommended vaccine that is not distributed by TVFC.

Providers purchasing the vaccine are reimbursed the lower of the billed amount for the vaccine or the amount allowed by Texas Medicaid or the maximum fee established by the CSHCN Services Program. The maximum fee will be determined from the least average wholesale price (AWP) per vaccine dose according to the current information reflected in the Texas Vendor Drug Program system.

Providers must submit claims for procedure codes 90460 (administration of first/only component of vaccine, with counseling) and 90461 (administration of each additional vaccine component, with counseling) based on the number of components per vaccine.

**31.2.25.6 Vaccine Administration**

Procedure code 90460 must be submitted for the administration of the first component.

Procedure code 90461 must be submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine.

Procedure codes 90471, 90472, 90473, and 90474 do not require counseling and can be reimbursed at any age.

The age ranges for vaccine administration are listed in the following table:

| Procedure Codes | Age Range                     |
|-----------------|-------------------------------|
| 90460           | Birth through 18 years of age |
| 90461           | Birth through 18 years of age |
| 90471           | All ages                      |
| 90472           | All ages                      |
| 90473           | All ages                      |
| 90474           | All ages                      |
| 96372           | All ages                      |
| 96372           | All ages                      |
| 96374           | All ages                      |

**31.2.25.6.1 Administration With Counseling**

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the 1st component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

| Procedure Code                                     | Quantity Billed |
|--|-----------------|
| Vaccine or toxoid procedure code with 1 component  | 1               |
| 90460 (1st component)                              | 1               |
| Vaccine or toxoid procedure code with 3 components | 1               |
| 90460 (1st component)                              | 1               |
| 90461 (2nd and 3rd components)                     | 2               |
| Vaccine or toxoid procedure code with 2 components | 1               |
| 90460 (1st component)                              | 1               |
| 90461 (2nd component)                              | 1               |
| Vaccine or toxoid procedure code with 4 components | 1               |
| 90460 (1st component)                              | 1               |
| 90461 (2nd, 3rd, and 4th components)               | 3               |
| Vaccine or toxoid procedure code with 5 components | 1               |
| 90460 (1st component)                              | 1               |
| 90461 (2nd, 3rd, 4th, and 5th components)          | 4               |

**Note:** The term “components” refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

#### 31.2.25.6.2 Administration Without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

| Procedure Code                   | Quantity Billed |
|----------------------------------|-----------------|
| Vaccine or toxoid procedure code | 1               |
| 90471 (Injection administration) | 1               |
| Vaccine or toxoid procedure code | 1               |
| 90472 (Injection administration) | 1               |
| Vaccine or toxoid procedure code | 1               |
| 90472 (Injection administration) | 1               |

The following is an example of how to submit claims for oral or nasal administration procedure codes when counseling is not provided:

| Procedure Code                    | Quantity Billed |
|-----------------------------------|-----------------|
| Vaccine or toxoid procedure code  | 1               |
| 90473 (Oral/nasal administration) | 1               |
| Vaccine or toxoid procedure code  | 1               |
| 90474 (Oral/nasal administration) | 1               |

**31.2.25.7 \* Vaccine and Toxoid Procedure Codes**

The vaccine procedure codes listed in the following table are benefits of the CSHCN Services Program.

**Note:** A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple components. All procedure codes with an asterisk (\*) can be distributed through TVFC.

| [Revised] Procedure Code | [Revised] Age Range                     | [Revised] Number of Recognized Components |
|--------------------------|---|---|
| 90287                    | All ages                                | 1   |
| 90585                    | All ages                                | 1   |
| 90619                    | 19 years of age and older               | 1   |
| 90620*                   | All ages                                | 1   |
| 90621*                   | All ages                                | 1   |
| 90623                    | 10 years of age through 23 years of age | 1   |
| 90632*                   | Birth through 20 years of age           | 1   |
| 90633*                   | Birth through 20 years of age           | 2   |
| 90636*                   | All ages                                | 2   |
| 90647*                   | All ages                                | 1   |
| 90648*                   | All ages                                | 1   |
| 90651*                   | All ages                                | 1   |
| 90670*                   | All ages                                | 1   |
| 90678                    | 10 years of age and older               | 1   |
| 90680*                   | Birth through 11 months of age          | 1   |
| 90681*                   | All ages                                | 1   |
| 90696*                   | 4 years of age through 6 years of age   | 4   |
| 90698*                   | All ages                                | 5   |
| 90700*                   | Birth through 6 years of age            | 3   |
| 90702*                   | Birth through 6 years of age            | 2   |
| 90707*                   | All ages                                | 3   |
| 90710*                   | All ages                                | 4   |
| 90713*                   | All ages                                | 1   |
| 90714*                   | 7 years of age and older                | 2   |
| 90715*                   | 7 years of age and older                | 3   |
| 90716*                   | All ages                                | 1   |
| 90723*                   | All ages                                | 5   |
| 90732*                   | 2 years of age and older                | 1   |
| 90733*                   | All ages                                | 1   |
| 90734*                   | All ages                                | 1   |
| 90736                    | 60 years of age and older               | 1   |
| 90739                    | 18 years of age and older               | 1   |
| 90740                    | All ages                                | 1   |
| 90743*                   | All ages                                | 1   |

|        |                           |   |
|--------|---------------------------|---|
| 90744* | All ages                  | 1 |
| 90746* | All ages                  | 1 |
| 90747  | All ages                  | 1 |
| 90748  | All ages                  | 2 |
| 90749  | All ages                  | 1 |
| 90750  | 50 years of age and older | 1 |

Procedure code 90670 is limited to one per day for clients who are birth through five years of age, same procedure, any provider, and to one per lifetime for clients who are age six and older.

The following immunizations are not a benefit of the CSHCN Services Program:

- Cholera vaccine, injectable
- Plague vaccine, intramuscular (IM)
- Typhoid vaccines
- Yellow fever vaccine, subcutaneous (SC)

### 31.2.25.8 Influenza Vaccines

The Advisory Committee on Immunization Practices (ACIP) reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations. Providers should refer to the Centers for Disease Control and Prevention (CDC) website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients and their age group for the current flu season.

Reimbursement for influenza vaccines is limited to three occurrences per one rolling year. Claims submitted for any influenza vaccine beyond three occurrences in a rolling year will be denied.

The age ranges for influenza vaccines are listed in the following table:

| Procedure Code | Age Range                                |
|----------------|--|
| 90630          | All ages                                 |
| 90654          | All ages                                 |
| 90655          | 6 months of age through 35 months of age |
| 90656          | 3 years of age and older                 |
| 90657          | 6 months of age through 35 months of age |
| 90658          | 3 years of age and older                 |
| 90660          | All ages                                 |
| 90661          | All ages                                 |
| 90662          | All ages                                 |
| 90672          | All ages                                 |
| 90673          | All ages                                 |
| 90674          | All ages                                 |
| 90682          | 18 years of age and older                |
| 90685          | 6 months of age through 35 months of age |
| 90686          | All ages                                 |
| 90687          | 6 months of age through 35 months of age |
| 90688          | All ages                                 |

|       |                          |
|-------|--------------------------|
| 90756 | 4 years of age and older |
|-------|--------------------------|

**31.2.25.9 Bacille Calmette-Guerin (BCG) Vaccine**

BCG vaccine (procedure code 90585) is a benefit of the CSHCN Services Program for diagnosis code Z23.

**31.2.25.10 Botulinum Antitoxin**

Procedure code 90287 is a benefit of the CSHCN Services Program for diagnosis code A051, A4851, A4852, or one of the following diagnosis codes for botulinum overdose or misinjection:

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T50901A         | T50901D | T50901S | T50902A | T50902D | T50902S | T50903A | T50903D |
| T50903S         | T50904A | T50904D | T50904S | T50991A | T50991D | T50991S | T50992A |
| T50992D         | T50992S | T50993A | T50993D | T50993S | T50994A | T50994D | T50994S |
| T50Z91A         | T50Z91D | T50Z91S | T50Z92A | T50Z92D | T50Z92S | T50Z93A | T50Z93D |
| T50Z93S         | T50Z94A | T50Z94D | T50Z94S |         |         |         |         |

**31.2.25.11 Hepatitis B Vaccine**

Procedure codes 90740 and 90747 are not considered routine vaccines and must be billed using administration procedure code 96372 or 96374.

**31.2.25.12 Rabies Postexposure Prophylaxis**

Postexposure prophylaxis for rabies (procedure codes 90375, 90376, 90377, and 90675) is a benefit of the CSHCN Services Program.

An exposed person who has never received a complete pre- or postexposure rabies vaccine series will first receive a dose of rabies immune globulin (HRIG). This is a blood product that contains antibodies against rabies and gives immediate, short-term protection. The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children. The injection should be given in or near the wound area.

The postexposure treatment will also include 5 doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person wh

21o has previously been vaccinated with a complete pre- or postexposure vaccine series, 2 doses of rabies vaccine should be given, one on day 0 and one on day 3.

HRIG that is not administered when vaccination begins can be administered up to 7 days after the administration of the first dose of vaccine. Beyond the seventh day, HRIG is not recommended since an antibody response to the vaccine is presumed to have occurred, and HRIG may inhibit the immune response to the vaccine.

Reimbursement for postexposure rabies vaccine is limited to 1 per client, per day, by any provider, not to exceed a total of 5 per 90 rolling days.

Animal bites to people must be reported as soon as possible to the local rabies control authority. Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus. Health-care providers who determine that their client requires the preventive rabies vaccination series after valid rabies exposure may obtain the biologicals directly from the manufacturer or through one of the DSHS depots around the state. The physician must maintain documentation of the exposure in the client’s medical record.

Postexposure rabies treatment is limited to clients with diagnosis code Z203.



Injection administration is a benefit for administration of postexposure rabies vaccine.

### **31.2.25.13 Respiratory Syncytial Virus (RSV) Prophylaxis**

The RSV prophylaxis drug palivizumab (Synagis) must be obtained through the Texas Vendor Drug Program (VDP). Providers must obtain prior authorization through the CSHCN Services Program using the CSHCN Services Program Synagis Prior Authorization form.

Providers may refer to the Texas Vendor Drug Program website at [www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment](http://www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment) for more information about obtaining palivizumab for CSHCN Services Program clients.

Prior authorization request forms are reviewed annually. Providers must use the most current version of the CSHCN Synagis Prior Authorization Request (HHS Form 1055) to submit prior authorization requests. Forms received outside the RSV season schedule will not be processed.

### **31.2.26 Injections and Oral Medications**

Oral medication must be used in preference to injectable medication in the office and outpatient hospital unless one of the following circumstances applies:

- No acceptable oral equivalent is available.
- Injectable medication is the standard treatment of choice.
- The oral route is contraindicated.
- The client has a temperature over 102°F (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.
- The client has demonstrated noncompliance with orally prescribed medication (documented on the claim and in the medical record).
- Previously attempted oral medication regimens have proven ineffective and are supported by the medical record.
- An emergency situation occurs.

Claims submitted for antibiotic or steroid injections billed in a physician's office or in the outpatient hospital setting must include modifiers AT, ET, or KX.

Providers dispensing physician-administered drugs in an outpatient setting may utilize an optional delivery method referred to as "white bagging," in which the treating provider submits prescriptions to pharmacies and the prescription is shipped or mailed to the provider's office. Providers must use the following steps for this delivery method:

- 1) The treating provider identifies a CSHCN Services Program-enrolled client.
- 2) The treating provider or treating provider's agent sends a single prescription with no additional refills to a CSHCN Services Program-enrolled pharmacy and obtains any necessary prior authorizations. (The provider must write a new prescription for any additional refills.)
- 3) Once approved, the dispensing pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the CSHCN Services Program client, directly to the treating provider. These medications must not be used on any other patient and cannot be returned to the pharmacy for credit.

4) The treating provider administers the medication to the CSHCN Services Program client in the office setting. The treating provider bills for an administration fee and any medically necessary service provided at time of administration. The treating provider must not bill the CSHCN Services Program for the drug.

*Note: Providers may perform other services in addition to any evaluation and management during the client’s white bagging medication administration visit, such as: administering other medications or immunizations maintained in the office, administering treatments, X-rays, or labs.*

**31.2.26.1 Reimbursement for the Unused Portion of the Single-Dose Vial**

Providers may bill and receive reimbursement for the unused portion of weight-based or variable dosing clinician-administered drugs (CADs) manufactured only in single-dose vials.

Providers must also include modifier JW on their claims for consideration of reimbursement. The JW modifier on the claim will identify the unused portion and discarded portion of the vial contents.

This only applies to medical claims for weight-based or variable dosing CADs billed with HCPCS procedure codes, manufactured only in single-dose vials, and provided in a professional or outpatient setting.

**31.2.26.2 Injection Administration Billed by a Physician**

Injection administration billed by a physician may be reimbursed separately from the medication. Injection administration must be billed using procedure code 96372. Procedure code 96372 may be reimbursed in addition to an E/M or consultation visit. This ensures that each injection receives one administration fee regardless of the dosage.

Most injectable medications may be reimbursed the average wholesale price (AWP) minus 10.5 percent. However, the CSHCN Services Program reserves the option to use other data services when the AWP results have been determined as unreasonable or inefficient.

**31.2.26.3 Unit Calculations for Billing Drugs**

Providers must calculate the number of units to be billed on the claim based on the number of units indicated in the procedure code description and the amount of the drug actually administered. Providers should refer to the procedure code description for the unit amount to calculate the number of units to be billed.

The formula to calculate the appropriate quantity of units to bill is the amount administered divided by the units indicated in the procedure code description. For example:

| Units Indicated in the Description | Amount Administered by the Provider | Calculation     | Quantity to Bill on the Claim |
|------------------------------------|-------------------------------------|-----------------|-------------------------------|
| 50 mg                              | 100 mg                              | $100/50 = 2$    | 2 units                       |
| per unit                           | 20 units                            | $20/1 = 20$     | 20 units                      |
| per 100 units                      | 2500 units                          | $2500/100 = 25$ | 25 units                      |
| per 50 mg                          | 250 mg                              | $250/50 = 5$    | 5 units                       |

Claims submitted with incorrect unit calculations may cause delayed or incorrect payment.

The specific National Drug Code (NDC) of the drug actually dispensed should be entered on the claim form.

**Refer to:** Section 5.6.2.4, “National Drug Codes (NDC)” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for more information.

Section 5.6.2.5, “Drug Rebate Program” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for information about the reimbursement of clinician-administered drugs and biologicals

Additional information about NDC code requirements is also available on the NDC page of the TMHP website at [www.tmhp.com](http://www.tmhp.com).

### **31.2.26.4 JW Modifier Claims Filing Instructions**

Providers must not use the JW modifier for medications manufactured in a multi-dose vial format.

Providers must choose the most appropriate vial size(s) required to prepare a dose to minimize the discarded portion of the vial payable.

Claims considered for reimbursement must not exceed the package size of the vial used for preparation of the dose. Providers must not bill for vial contents overfill.

Providers must not use the JW modifier when the actual dose of the drug or biological administered is less than the billing unit.

Example: One billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a client while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would process for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

Reimbursement for JW modifier claims is only available for drugs covered in an outpatient setting.

Inpatient and diagnostic radiopharmaceuticals claims are not eligible for reimbursement, and may not include the JW modifier.

Coverage is for “buy and bill” providers only. Specialty pharmacies billing through the medical benefit must not submit claims with a JW modifier because they are unaware of how much the provider administered or discarded.

Federally Qualified Health Center (FQHC) and Rural Healthcare Clinic (RHC) are not eligible to bill with the JW modifier because these providers do not bill for the coverage of drugs or biologicals separately.

Critical Access Hospitals (CAH) are eligible to bill with the JW modifier because these providers bill for the coverage of drugs or biologicals separately.

The JW modifier is not allowed for medications prepared in an institutional setting via “batch processing or bulk productions” methods. An example of a batch processing method is when a hospital or repackaging facility produces multiple non-patient specific doses of medications in advance of anticipated use. These preparations are labeled and distributed with client specific information only when orders are received. Because these doses may be recycled for other client use, they are not eligible.

Providers may utilize automatic systems to calculate dose and discard amounts. However, providers must continue to document the exact usage/discard accurately.

Providers must enter the dose administered (used portion) line item detail of the CAD and also enter the dose discarded (unused portion) line item detail of the CAD on the same claim. The dose discarded (unused portion) line item detail must include the JW modifier to be considered for reimbursement. When billing for reimbursement of wastage on an outpatient claim, the HCPCS and Current Procedural Terminology (CPT) code should always be provided along with the revenue code.

**31.2.26.5 \* Injection Procedure Codes**

The following injections are benefits of the CSHCN Services Program and are subject to the indicated limitations:

| Name of Injection  | [Revised] Procedure Code(s) | Limitation(s)   |
|--|-----------------------------|---|
| Alglucosidase alfa   | J0220                       | Diagnosis limitation: E7400, E7401, E7402, E7403, E7404, E7409  |
| Andexxa  | J7169                       | Restricted to clients who are 18 years of age or older  |
| Anifrolumab-fnia   | J0491                       | Restricted to clients who are 18 years of age or older  |
| Antithrombin   | J7197                       | Diagnosis limitation: D6800, D6801, D68020, D68021, D68022, D68023, D68029, D6803, D6804, D6809, D6851, D6852, D6859, D6861, D6862, D6869, D75821, D75822, D75828, D75829, D75838, D7584  |
| Avalglucosidase Alfa-ngpt  | J0219                       | Restricted to clients who are 1 year of age or older  |
| Azacitidine (Vidaza)   | J9025                       | Benefit for clients 13 years of age or older<br>Diagnosis limitations: C9202, C9210, C9212, C9220, C9222, C9232, C9242, C9252, C9262, C9290, C9292, C92A2, C92Z0, C92Z2, C9310, C9312, C9330, C9332, C9502, C9510, C9512, C9592, D460, D461, D4621, D4622, D469, D46A, D46B, D46C, D640, D641, D642, D643<br>Must be submitted with an 11-digit NDC   |
| Bevacizumab-maly (Alymsys)   | Q5126                       | Restricted to clients who are 18 years of age or older  |
| Blood Factor Product VIII (Jivi)   | J7208                       | N/A   |
| Bupivacaine  | J0665                       | Restricted to clients who are 18 years of age or older  |
| Cabotegravir (Apretude)  | J0739                       | Restricted to clients who are 10 years of age or older  |
| Cidofovir  | J0740                       | N/A   |
| Ciltacabtagene autoleucel  | Q2056                       | Restricted to clients who are 18 years of age or older  |
| Clofarabine (Clorar)   | J9027                       | Prior authorization is required. Requests for prior authorization must be submitted by the ordering provider using the <a href="#">CSHCN Services Program Authorization and Prior Authorization Request Form</a> .<br>Documentation of the following must be submitted with the prior authorization request form: <ul style="list-style-type: none"> <li>• Diagnosis code C9100 or C9102</li> <li>• At least 2 prior failed regimens</li> </ul> |
| <b>(Diagnosis limitations) The procedure code must be billed with one of the codes listed.</b> |                             |   |

| Name of Injection                              | [Revised] Procedure Code(s) | Limitation(s)   |
|--|-----------------------------|---|
| Coagulation Factor IX (Ixinity)                | J7213                       | Restricted to clients who are 12 years of age or older  |
| C1 Esterase Inhibitor (Human) (Cinryze)        | J0598                       | Restricted to clients who are 6 years of age or older   |
| C1 Esterase Inhibitor (Human) (Haegarda)       | J0599                       | Restricted to clients who are 6 years of age or older<br>Diagnosis limitation: D841                         |
| C1 Esterase Inhibitor (Recombinant) (Ruconest) | J0596                       | Restricted to clients who are 13 years of age or older<br>Diagnosis limitation: D841                        |
| Dalteparin sodium                              | J1645                       | N/A   |
| Eculizumab                                     | J1300                       | Diagnosis limitations: D588, D5910, D5911, D5912, D5913, D5919, D5930, D5932, D5939, D594, D595, D596, D598 |
| Efgartigimod Alfa-fcab (Vyvgart)               | J9332                       | Restricted to clients who are 18 years of age or older<br>Diagnosis limitations: G700, G7001                |
| Eflapegrastim-xnst                             | J1449                       | Restricted to clients who are 18 years of age or older  |
| Emapalumab-lzsg (Gamifant)                     | J9210                       | N/A   |
| Enoxaparin sodium                              | J1650                       | N/A   |
| Epcoritamab-bysp (Epkinly)                     | C9155                       | Restricted to clients who are 18 years of age or older  |
| Epoprostenol                                   | J1325                       | Diagnosis limitation: I270, I2720, I2721, I2722, I2723, I2724, I2729, I2783, P2930                          |
| Esmolol hydrochloride                          | J1805                       | Restricted to clients who are 18 years of age or older  |
| Faricimab-svoa                                 | J2777                       | Restricted to clients who are 18 years of age or older  |
| Fecal microbiota                               | J1440                       | Restricted to clients who are 18 years of age or older<br>Diagnosis limitations: A0471, A0472               |
| Fondaparinux sodium                            | J1652                       | N/A   |
| Furosemide (Furoscix)                          | J1941                       | Restricted to clients who are 18 years of age or older  |
| Galsulfase                                     | J1458                       | Diagnosis limitations: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, E769    |
| Granisetron hydrochloride                      | J1626                       | Diagnosis limitations: Z510, Z5111, Z5112<br>The quantity used must appear on the claim.                    |
| Idursulfase                                    | J1743                       | Diagnosis limitations: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, E769    |
| Inclisiran                                     | J1306                       | Restricted to clients who are 18 years of age or older  |

(Diagnosis limitations) The procedure code must be billed with one of the codes listed.

| Name of Injection  | [Revised] Procedure Code(s) | Limitation(s)   |
|--|-----------------------------|---|
| Invega hafyera   | J2427                       | Restricted to clients who are 18 years of age or older  |
| Ixabepilone  | J9207                       | Diagnosis limitations: C50011, C50012, C50019, C50111, C50112, C50119, C50211, C50212, C50219, C50311, C50312, C50319, C50411, C50412, C50419, C50511, C50512, C50519, C50611, C50612, C50619, C50811, C50812, C50819, C50911, C50912, C50919, C563, C7963, C847A, D0500, D0501, D0502, D0510, D0511, D0512, D0580, D0581, D0582, D0590, D0591, D0592 |
| Lanoxin (Digoxin)  | J1920                       | Restricted to clients who are 1 year of age or older  |
| Lanreotide (Cipla)   | J1932                       | Restricted to clients who are 18 years of age or older  |
| Lefamulin  | J0691                       | Restricted to clients who are 18 years of age and older   |
| Linezolid  | J2020                       | N/A   |
| Lioresal   | J0475<br>J0476              | Separate payment for the device is not a benefit for the physician or the hospital.   |
| Loncastuximab Tesirine-lpyl  | J9359                       | Restricted to clients who are 18 years of age or older<br><br>Diagnosis limitations: C8330, C8331, C8332, C8333, C8334, C8335, C8336, C8337, C8338, C8339   |
| Melphalan  | J9245                       | Diagnosis limitations: C9000, C9001, C9002  |
| Melphalan (Evomela)  | J9246                       | Diagnosis limitations: C9000, C9001, C9002  |
| Midazolam hydrochloride  | J2250                       | N/A   |
| Moxetumomab Pasudotox-tdfk (Lumoxiti)  | J9313                       | Restricted to clients who are 18 years of age and older   |
| Natalizumab injection  | J2323                       | Diagnosis limitations: G35, K5000, K50011, K50012, K50013, K50014, K50018, K5010, K50111, K50112, K50113, K50114, K50118, K5080, K50811, K50812, K50813, K50814, K50818, K5090, K50911, K50912, K50913, K50914, K50918, K50919, K5650, K5651, K5652, K56600, K56601, K56609, K56690, K56691, K56699, K9130, K9131, K9132                              |
| Naxitamab-ggqk (Danyelza)  | J9348                       | Restricted to clients who are 1 year of age or older.   |
| Nivolumab and Relatlimab-rmbw  | J9298                       | Restricted to clients who are 12 years of age or older  |
| Nitroglycerin  | J2305                       | Restricted to clients who are 18 years of age or older  |
| Oliceridine  | C9101                       | Restricted to clients who are 18 years of age or older  |
| <b>(Diagnosis limitations) The procedure code must be billed with one of the codes listed.</b> |                             |   |

| Name of Injection  | [Revised] Procedure Code(s) | Limitation(s)   |
|--|-----------------------------|---|
| Omadacycline   | J0121                       | Restricted to clients who are 8 years of age and older  |
| Pegcetacoplan  | J2781                       | Restricted to clients who are 18 years of age or older  |
| Plazomicin   | J0291                       | Restricted to clients who are 18 years of age and older   |
| Porfimer sodium  | J9600                       | Diagnosis limitations: C153, C154, C155, C158, C159, C787, C7880, C7889   |
| Ranibizumab-eqrn (Cimerli)   | Q5128                       | Restricted to clients who are 18 years of age or older  |
| Ravulizumab-cwvz (Ultomiris)   | J1303                       | Diagnosis limitations: D5930, D5931, D5932, D5939   |
| Releuko  | Q5125                       | N/A   |
| Remimazolam  | J2249                       | Restricted to clients who are 18 years of age or older  |
| Retifanlimab-dlwr (Zynyz)  | J9345                       | Restricted to clients who are 18 years of age or older  |
| Rituximab  | J9310                       | N/A   |
| Sirolimus Protein-bound Particles (Fyarro)   | J9331                       | Restricted to clients who are 18 years of age or older  |
| Sumatriptan succinate  | J3030                       | Limited to treatment of classical migraines<br>Diagnosis limitation: G43001, G43011, G43101, G43109, G43111, G43119, G43401, G43409, G43411, G43419, G43501, G43509, G43511, G43519, G43601, G43609, G43611, G43619, G43701, G43709, G43711, G43719, G43801, G43809, G43811, G43819, G43821, G43829, G43831, G43839, G43901, G43909, G43911, G43919, G43A0, G43A1, G43B0, G43B1, G43C0, G43C1, G43D0, G43D1 |
| Sutimlimab-jome (Enjaymo)  | J1302                       | Restricted to clients who are 18 years of age or older  |
| Tebentafusp-tebn   | J9274                       | Restricted to clients who are 18 years of age or older  |
| Tezepelumab-ekko (Tezspire)  | J2356                       | Restricted to clients who are 12 years of age or older  |
| Tildrakizumab (Ilumya)   | J3245                       | Restricted to clients who are 18 years of age and older   |
| Tisotumab Vedotin-tftv   | J9273                       | Restricted to female clients who are 18 years of age or older   |
| Triamcinolone Acetonide (Xipere)   | J3299                       | Restricted to clients who are 18 years of age or older  |
| Ublituximab-xiiv (Briumvi)   | J2329                       | Restricted to clients who are 18 years of age or older  |
| Valrubicin   | J9357                       | Diagnosis limitation: D090  |
| <b>(Diagnosis limitations) The procedure code must be billed with one of the codes listed.</b> |                             |   |

| Name of Injection  | [Revised] Procedure Code(s) | Limitation(s)   |
|--|-----------------------------|---|
| Vasopressin  | J2598<br>J2599              | Restricted to clients who are 18 years of age or older  |
| Verteporfin  | J3396                       | Diagnosis limitations: H35021, H35022, H35023, H353110, H353111, H353112, H353113, H353114, H353120, H353121, H353122, H353123, H353124, H353130, H353131, H353132, H353133, H353134, H353190, H353191, H353192, H353193, H353194, H353210, H353211, H353212, H353213, H353220, H353221, H353222, H353223, H353230, H353231, H353232, H353233, H353290, H353291, H353292, H353293 |
| <b>(Diagnosis limitations) The procedure code must be billed with one of the codes listed.</b> |                             |   |

In addition to the injections listed in the above table, the following sections indicate additional injections that may be reimbursed by the CSHCN Services Program and the applicable limitations.

### 31.2.26.6 Adalimumab

Adalimumab (procedure code J0135) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| K5000           | K50011 | K50012 | K50013 | K50014 | K50018 | K5010  | K50111 |
| K50112          | K50113 | K50114 | K50118 | K5080  | K50811 | K50812 | K50813 |
| K50814          | K50818 | K5090  | K50911 | K50912 | K50913 | K50914 | K50918 |
| K50919          | K5100  | K51011 | K51012 | K51013 | K51014 | K51018 | K51019 |
| K5120           | K51211 | K51212 | K51213 | K51214 | K51218 | K5130  | K51311 |
| K51312          | K51313 | K51314 | K51318 | K5140  | K51411 | K51412 | K51413 |
| K51414          | K51418 | K51419 | K5150  | K51511 | K51512 | K51513 | K51514 |
| K51518          | K51519 | K5180  | K51811 | K51812 | K51813 | K51814 | K51818 |
| K51819          | K5190  | K51911 | K51912 | K51913 | K51914 | K51918 | L400   |
| L401            | L402   | L403   | L404   | L4050  | L4051  | L4052  | L4053  |
| L4054           | L4059  | L408   | M00039 | M00071 | M00072 | M00079 | M00171 |
| M00172          | M00179 | M00271 | M00272 | M00279 | M00871 | M00872 | M00879 |
| M0500           | M05011 | M05012 | M05019 | M05021 | M05022 | M05029 | M05031 |
| M05032          | M05039 | M05041 | M05042 | M05049 | M05051 | M05052 | M05059 |
| M05061          | M05062 | M05069 | M05071 | M05072 | M05079 | M0509  | M05271 |
| M0530           | M0540  | M05411 | M05412 | M05419 | M05421 | M05422 | M05429 |
| M05431          | M05432 | M05439 | M05441 | M05442 | M05449 | M05451 | M05452 |
| M05459          | M05461 | M05462 | M05469 | M05471 | M05472 | M05479 | M0549  |
| M0550           | M05511 | M05512 | M05519 | M05521 | M05522 | M05529 | M05531 |
| M05532          | M05539 | M05541 | M05542 | M05549 | M05551 | M05552 | M05559 |
| M05561          | M05562 | M05569 | M05571 | M05572 | M05579 | M0559  | M0560  |
| M05611          | M05612 | M05619 | M05621 | M05622 | M05629 | M05631 | M05632 |



| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| M05639          | M05641 | M05642 | M05649 | M05651 | M05652 | M05659 | M05661 |
| M05662          | M05669 | M05671 | M05672 | M05679 | M0569  | M0570  | M05711 |
| M05712          | M05719 | M05721 | M05722 | M05729 | M05731 | M05732 | M05739 |
| M05741          | M05742 | M05749 | M05751 | M05752 | M05759 | M05761 | M05762 |
| M05769          | M05771 | M05772 | M05779 | M0579  | M0580  | M05811 | M05812 |
| M05819          | M05821 | M05822 | M05829 | M05831 | M05832 | M05839 | M05841 |
| M05842          | M05849 | M05851 | M05852 | M05859 | M05861 | M05862 | M05869 |
| M05871          | M05872 | M05879 | M0589  | M059   | M0600  | M06011 | M06012 |
| M06019          | M06021 | M06022 | M06029 | M06031 | M06032 | M06039 | M06041 |
| M06042          | M06049 | M06051 | M06052 | M06059 | M06061 | M06062 | M06069 |
| M06071          | M06072 | M06079 | M0608  | M0609  | M061   | M0620  | M06211 |
| M06212          | M06219 | M06221 | M06222 | M06229 | M06231 | M06232 | M06239 |
| M06241          | M06242 | M06249 | M06251 | M06252 | M06259 | M06261 | M06262 |
| M06269          | M06271 | M06272 | M06279 | M0628  | M0629  | M0630  | M06311 |
| M06312          | M06319 | M06321 | M06322 | M06329 | M06331 | M06332 | M06339 |
| M06341          | M06342 | M06349 | M06351 | M06352 | M06359 | M06361 | M06362 |
| M06369          | M06371 | M06372 | M06379 | M0638  | M0639  | M0680  | M06811 |
| M06812          | M06819 | M06821 | M06822 | M06829 | M06831 | M06832 | M06839 |
| M06841          | M06842 | M06849 | M06851 | M06852 | M06859 | M06861 | M06862 |
| M06869          | M06871 | M06872 | M06879 | M0688  | M0689  | M069   | M0800  |
| M08011          | M08012 | M08019 | M08021 | M08022 | M08029 | M08031 | M08032 |
| M08039          | M08041 | M08042 | M08049 | M08051 | M08052 | M08059 | M08061 |
| M08062          | M08069 | M08071 | M08072 | M08079 | M0808  | M0809  | M081   |
| M08811          | M08812 | M08821 | M08822 | M08831 | M08832 | M08839 | M08841 |
| M08842          | M08849 | M08851 | M08852 | M08859 | M08861 | M08862 | M08871 |
| M08872          | M0888  | M0889  | M08911 | M08912 | M08919 | M08921 | M08922 |
| M08929          | M08931 | M08932 | M08939 | M08941 | M08942 | M08949 | M08951 |
| M08952          | M08959 | M08961 | M08962 | M08969 | M08971 | M08972 | M0898  |
| M13871          | M13872 | M13879 | M450   | M451   | M452   | M453   | M454   |
| M455            | M456   | M457   | M458   | M459   | M488X1 | M488X2 | M488X3 |
| M488X4          | M488X5 | M488X6 | M488X7 | M488X8 | M488X9 |        |        |

**31.2.26.7 Ado-Trastuzumab Emtansine**

Ado-trastuzumab emtansine (procedure code J9354) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50011          | C50012 | C50019 | C50021 | C50022 | C50029 | C50111 | C50112 |
| C50119          | C50121 | C50122 | C50129 | C50211 | C50212 | C50219 | C50221 |
| C50222          | C50229 | C50311 | C50312 | C50319 | C50321 | C50322 | C50329 |
| C50411          | C50412 | C50419 | C50421 | C50422 | C50429 | C50511 | C50512 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50519          | C50521 | C50522 | C50529 | C50611 | C50612 | C50619 | C50621 |
| C50622          | C50629 | C50811 | C50812 | C50819 | C50821 | C50822 | C50829 |
| C50911          | C50912 | C50919 | C50921 | C50922 | C50929 |        |        |

Documentation must support the administration of Ado-trastuzumab emtansine and include all of the following:

- Evidence of HER2 positive breast cancer as evidenced by an immunochemistry (IHC) test or fluorescent in situ hybridization (FISH) test
- Evidence of metastatic breast cancer
- Evidence of prior treatment for HER2 positive metastatic breast cancer with trastuzumab and a taxane oncology agent given separately or in combination
- Evidence demonstrating receipt of prior therapy for HER2 positive metastatic breast cancer or recurrent disease, including previous treatment protocol, within six months of completing adjuvant therapy.

All documentation must be maintained in the client's medical record and is subject to retrospective review.

### 31.2.26.8 Bevacizumab

Bevacizumab (procedure code J9035) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

| Diagnosis Codes |       |       |        |        |        |       |       |
|-----------------|-------|-------|--------|--------|--------|-------|-------|
| C180            | C181  | C182  | C183   | C184   | C185   | C186  | C187  |
| C188            | C189  | C19   | C20    | C210   | C211   | C218  | C3400 |
| C3401           | C3402 | C3410 | C3411  | C3412  | C342   | C3430 | C3431 |
| C3432           | C3480 | C3481 | C3482  | C3490  | C3491  | C3492 | C538  |
| C539            | C563  | C641  | C642   | C649   | C711   | C712  | C713  |
| C714            | C715  | C716  | C717   | C718   | C719   | C7800 | C7801 |
| C7802           | C7931 | C7963 | Z85038 | Z85048 | Z85118 | Z853  |       |

### 31.2.26.9 Botulinum Toxin (Type A and Type B)

The CSHCN Services Program may reimburse botulinum toxin, types A and B, for clients with specific diagnoses. Botulinum toxin, type A procedure code J0585 is payable when billed with the following diagnosis codes:

| Diagnosis Codes |        |        |       |       |       |       |        |
|-----------------|--------|--------|-------|-------|-------|-------|--------|
| G114            | G2401  | G2402  | G241  | G243  | G244  | G245  | G248   |
| G250            | G251   | G252   | G253  | G35   | G360  | G370  | G371   |
| G372            | G373   | G374   | G375  | G3781 | G3789 | G379  | G43701 |
| G43709          | G43711 | G43719 | G5131 | G5132 | G5133 | G5139 | G800   |
| G801            | G802   | G803   | G804  | G808  | G809  | G8110 | G8111  |
| G8112           | G8113  | G8114  | G8191 | G8192 | G8193 | G8194 | G8220  |
| G8221           | G8222  | G8250  | G8251 | G8252 | G8253 | G8254 | G830   |
| G8310           | G8311  | G8312  | G8313 | G8314 | G8320 | G8321 | G8322  |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| G8323           | G8324  | G8330  | G8331  | G8332  | G8333  | G8334  | G834   |
| G8921           | H4901  | H4902  | H4903  | H4911  | H4912  | H4913  | H4921  |
| H4922           | H4923  | H4931  | H4932  | H4933  | H4941  | H4942  | H4943  |
| H499            | H5000  | H50011 | H50012 | H50021 | H50022 | H50031 | H50032 |
| H50041          | H50042 | H5005  | H5006  | H5007  | H5008  | H5010  | H50111 |
| H50112          | H50121 | H50122 | H50131 | H50132 | H50141 | H50142 | H5015  |
| H5016           | H5017  | H5018  | H5021  | H5022  | H5030  | H50311 | H50312 |
| H5032           | H50331 | H50332 | H5034  | H5040  | H50411 | H50412 | H5042  |
| H5043           | H5050  | H5051  | H5052  | H5053  | H5054  | H5055  | H5060  |
| H50611          | H50612 | H50621 | H50622 | H50629 | H50631 | H50632 | H50639 |
| H50641          | H50642 | H50649 | H50651 | H50652 | H50659 | H50661 | H50662 |
| H50669          | H50671 | H50672 | H50679 | H50681 | H50682 | H50689 | H5069  |
| H50811          | H50812 | H5089  | H510   | H5111  | H5112  | H5121  | H5122  |
| H5123           | H518   | H519   | I69031 | I69032 | I69033 | I69034 | I69041 |
| I69042          | I69043 | I69044 | I69051 | I69052 | I69053 | I69054 | I69061 |
| I69062          | I69063 | I69064 | I69065 | I69098 | I69131 | I69132 | I69133 |
| I69134          | I69141 | I69142 | I69143 | I69144 | I69151 | I69152 | I69153 |
| I69154          | I69161 | I69162 | I69163 | I69164 | I69165 | I69198 | I69231 |
| I69232          | I69233 | I69234 | I69241 | I69242 | I69243 | I69244 | I69251 |
| I69252          | I69253 | I69254 | I69261 | I69262 | I69263 | I69264 | I69265 |
| I69298          | I69331 | I69332 | I69333 | I69334 | I69341 | I69342 | I69343 |
| I69344          | I69351 | I69352 | I69353 | I69354 | I69361 | I69362 | I69363 |
| I69364          | I69365 | I69398 | I69831 | I69832 | I69833 | I69834 | I69841 |
| I69842          | I69843 | I69844 | I69851 | I69852 | I69853 | I69854 | I69861 |
| I69862          | I69863 | I69864 | I69865 | I69898 | J385   | K117   | K220   |
| K594            | K600   | K601   | K602   | M436   | M62838 | M722   | N310   |
| N311            | N312   | N318   | N319   | N3281  | N3644  | R490   | R498   |
| R532            |        |        |        |        |        |        |        |

Procedure code J0586 is payable when billed with the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| G114            | G2401  | G2402  | G241   | G243   | G244   | G245   | G248   |
| G35             | G360   | G370   | G371   | G372   | G373   | G374   | G375   |
| G3781           | G3789  | G379   | G800   | G801   | G802   | G803   | G804   |
| G808            | G809   | G8110  | G8111  | G8112  | G8113  | G8114  | G8191  |
| G8192           | G8193  | G8194  | G8253  | G8254  | G830   | G8320  | G8321  |
| G8322           | G8323  | G8324  | I69031 | I69032 | I69033 | I69034 | I69039 |
| I69051          | I69052 | I69053 | I69054 | I69059 | I69131 | I69132 | I69133 |
| I69134          | I69139 | I69151 | I69152 | I69153 | I69154 | I69231 | I69232 |
| I69233          | I69234 | I69239 | I69251 | I69252 | I69253 | I69254 | I69259 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| I69331          | I69332 | I69333 | I69334 | I69339 | I69351 | I69352 | I69353 |
| I69354          | I69359 | I69831 | I69832 | I69833 | I69834 | I69839 | I69851 |
| I69852          | I69853 | I69854 | I69859 | I69931 | I69932 | I69933 | I69934 |
| I69939          | I69951 | I69952 | I69953 | I69954 | I69959 | J385   | M436   |
| M62838          | M722   | R532   |        |        |        |        |        |

The chemodenervation procedure codes in the following table are a benefit in addition to botulinum toxin type A:

| Procedure Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 64600           | 64605 | 64610 | 64611 | 64612 | 64615 | 64616 | 64617 |
| 64620           | 64624 | 64625 | 64630 | 64632 | 64633 | 64634 | 64635 |
| 64636           | 64640 | 64642 | 64643 | 64644 | 64645 | 64646 | 64647 |
| 64680           | 64681 | 67345 |       |       |       |       |       |

Procedure code 64612 requires prior authorization. All other chemodenervation and nerve destruction by neurolytic agent procedure codes do not require prior authorization. Add-on procedure codes 95873 and 95874 will be reimbursed only when billed with the appropriate primary procedure code on the same day, by the same provider.

Procedure code J0588 is a benefit and is limited to the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| G243            | G245   | G800   | G801   | G802   | G8110  | G8111  | G8112  |
| G8113           | G8114  | G8253  | G8254  | G830   | G8320  | G8321  | G8322  |
| G8323           | G8324  | I69031 | I69032 | I69033 | I69034 | I69039 | I69051 |
| I69052          | I69053 | I69054 | I69059 | I69131 | I69132 | I69133 | I69134 |
| I69139          | I69151 | I69152 | I69153 | I69154 | I69231 | I69232 | I69233 |
| I69234          | I69239 | I69251 | I69252 | I69253 | I69254 | I69259 | I69331 |
| I69332          | I69333 | I69334 | I69339 | I69351 | I69352 | I69353 | I69354 |
| I69359          | I69831 | I69832 | I69833 | I69834 | I69839 | I69851 | I69852 |
| I69853          | I69854 | I69859 | I69931 | I69932 | I69933 | I69934 | I69939 |
| I69951          | I69952 | I69953 | I69954 | I69959 |        |        |        |

Procedure code J0587 must be submitted for reimbursement of the type B botulinum toxin (per 100 units) and is limited to the following diagnosis codes:

| Diagnosis Codes |       |      |
|-----------------|-------|------|
| G243            | G8921 | K117 |

Procedure code J0587 is limited to a billed quantity of 100 units. Any claim billed in excess of 100 billing units will be denied.

The CSHCN Services Program requires a trial of type A botulinum toxin prior to the use of type B botulinum toxin.

Injections of either toxin are limited to no more than once every three months. Supplies used to administer the toxins will not be reimbursed separately.

Medications other than botulinum toxins may be used for chemodenervation procedures.

Claims for Botulinum Toxin Type A and B must indicate the number of units used. Providers should bill the amount of injections per units used for Botulinum Toxin. If the units are not specified, the claim may be reimbursed as a quantity of one.

| Procedure Codes | Quantity Limitations of Medication | Billing Units   |
|-----------------|------------------------------------|---|
| J0585           | 400 units                          | One billing unit is equal to 1 unit of medication.<br><i>Example:</i> A provider that administers 400 units of medication would submit a claim for a quantity of 400.       |
| J0586           | 1,500 units                        | One billing unit is equal to 5 units of medication.<br><i>Example:</i> A provider that administers 1,500 units of medication would submit a claim for a quantity of 300.    |
| J0587           | 10,000 units                       | One billing unit is equal to 100 units of medication.<br><i>Example:</i> A provider that administers 10,000 units of medication would submit a claim for a quantity of 100. |
| J0588           | 400 units                          | One billing unit is equal to 1 unit of medication.<br><i>Example:</i> A provider that administers 400 units of medication would submit a claim for a quantity of 400.       |

Procedure codes J0586, J0587, and J0588 will be denied when billed on the same date of service, by any provider with procedure code J0585.

Procedure codes J0587 and J0588 will be denied when billed on the same date of service, by any provider with procedure code J0586.

Procedure code J0587 will be denied when billed on the same date of service, by any provider with procedure code J0588.

Providers may not bill for an office visit if botulinum injections are the only reason for the visit.

### 31.2.26.9.1 Prior Authorization Requirements

Prior authorization is required for quantities of medication greater than the defined limitations for botulinum toxins. Documentation of medical need for exceeding the limit must be submitted with the request for prior authorization.

Prior authorization and medical review is required for diagnoses other than those listed above. Documentation for consideration of other diagnoses must include the diagnosis, clinical course, clinical history, and other treatments with an explanation of ineffective results. This documentation to support medical necessity must be submitted to the TMHP-CSHCN Services Program Authorization Department with the [CSHCN Services Program Authorization and Prior Authorization Request Form](#). Prior authorization requests may be approved for a 12-month period. All extension requests must include diagnosis, clinical course, and result of previous botulinum toxin therapy and expected length of treatment.

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for more information about authorization and prior authorization requirements.

Procedures incidental to the administration of botulinum toxin, such as EMGs, do not require authorization and may be reimbursed in the quantity billed.

APRNs and physician assistants administering botulinum toxin therapy must be supervised by a physician who is board eligible or board certified in the physician's specialty. Documentation of the APRN's and physician assistant's training must be kept in the supervising physician's records and be available for review on request by the CSHCN Services Program or its designee.

#### 31.2.26.9.2 Reimbursement

Botulinum toxin may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

#### 31.2.26.10 Epirubicin Hydrochloride

Epirubicin hydrochloride (procedure code J9178) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50011          | C50012 | C50019 | C50021 | C50022 | C50029 | C50111 | C50112 |
| C50119          | C50121 | C50122 | C50129 | C50211 | C50212 | C50219 | C50221 |
| C50222          | C50229 | C50311 | C50312 | C50319 | C50321 | C50322 | C50329 |
| C50411          | C50412 | C50419 | C50421 | C50422 | C50429 | C50511 | C50512 |
| C50519          | C50521 | C50522 | C50529 | C50611 | C50612 | C50619 | C50621 |
| C50622          | C50629 | C50811 | C50812 | C50819 | C50821 | C50822 | C50829 |
| C50911          | C50912 | C50919 | C50921 | C50922 | C50929 | C847A  |        |

#### 31.2.26.11 Erythropoietin Alfa (EPO) and Darbepoetin

EPO and darbepoetin (procedure codes J0881 and J0885) are benefits of the CSHCN Services Program for the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| B20             | C880   | C9000  | C9001  | C9002  | D500   | D501   | D508   |
| D509            | D510   | D511   | D512   | D513   | D518   | D519   | D520   |
| D521            | D528   | D529   | D530   | D531   | D532   | D538   | D539   |
| D550            | D551   | D553   | D558   | D560   | D561   | D562   | D563   |
| D564            | D565   | D568   | D569   | D5701  | D5702  | D571   | D5720  |
| D57211          | D57212 | D573   | D5740  | D57411 | D57412 | D5780  | D57811 |
| D57812          | D580   | D581   | D582   | D588   | D590   | D592   | D594   |
| D595            | D596   | D598   | D600   | D601   | D608   | D6101  | D6109  |
| D611            | D612   | D613   | D61810 | D61811 | D61818 | D6182  | D6189  |
| D619            | D62    | D630   | D631   | D638   | D640   | D641   | D642   |
| D643            | D644   | D6481  | D6489  | D649   | D7801  | D7802  | D7821  |
| D7822           | E3601  | E3602  | G9731  | G9732  | G9751  | G9752  | H59111 |
| H59112          | H59113 | H59119 | H59121 | H59122 | H59123 | H59129 | H59311 |
| H59312          | H59313 | H59319 | H59321 | H59322 | H59323 | H59329 | H9521  |
| H9522           | H9541  | H9542  | I120   | I129   | I130   | I1310  | I1311  |
| I132            | I97410 | I97411 | I97418 | I9742  | I97610 | I97611 | I97618 |
| I9762           | J9561  | J9562  | J95830 | J95831 | K9161  | K9162  | K91840 |
| K91841          | L7601  | L7602  | L7621  | L7622  | M0540  | M05411 | M05412 |
| M05419          | M05421 | M05422 | M05429 | M05431 | M05432 | M05439 | M05441 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| M05442          | M05449 | M05451 | M05452 | M05459 | M05461 | M05462 | M05469 |
| M05471          | M05472 | M05479 | M0549  | M0550  | M05511 | M05512 | M05519 |
| M05521          | M05522 | M05529 | M05531 | M05532 | M05539 | M05541 | M05542 |
| M05549          | M05551 | M05552 | M05559 | M05561 | M05562 | M05569 | M05571 |
| M05572          | M05579 | M0559  | M0570  | M05711 | M05712 | M05719 | M05721 |
| M05722          | M05729 | M05731 | M05732 | M05739 | M05741 | M05742 | M05749 |
| M05751          | M05752 | M05759 | M05761 | M05762 | M05769 | M05771 | M05772 |
| M05779          | M0579  | M0580  | M05811 | M05812 | M05819 | M05821 | M05822 |
| M05829          | M05831 | M05832 | M05839 | M05841 | M05842 | M05849 | M05851 |
| M05852          | M05859 | M05861 | M05862 | M05869 | M05871 | M05872 | M05879 |
| M0589           | M059   | M0600  | M06011 | M06012 | M06019 | M06021 | M06022 |
| M06029          | M06031 | M06032 | M06039 | M06041 | M06042 | M06049 | M06051 |
| M06052          | M06059 | M06061 | M06062 | M06069 | M06071 | M06072 | M06079 |
| M0608           | M0609  | M0620  | M06211 | M06212 | M06219 | M06221 | M06222 |
| M06229          | M06231 | M06232 | M06239 | M06241 | M06242 | M06249 | M06251 |
| M06252          | M06259 | M06261 | M06262 | M06269 | M06271 | M06272 | M06279 |
| M0628           | M0629  | M0630  | M06311 | M06312 | M06319 | M06321 | M06322 |
| M06329          | M06331 | M06332 | M06339 | M06341 | M06342 | M06349 | M06351 |
| M06352          | M06359 | M06361 | M06362 | M06369 | M06371 | M06372 | M06379 |
| M0638           | M0639  | M0680  | M06811 | M06812 | M06819 | M06821 | M06822 |
| M06829          | M06831 | M06832 | M06839 | M06841 | M06842 | M06849 | M06851 |
| M06852          | M06859 | M06861 | M06862 | M06869 | M06871 | M06872 | M06879 |
| M0688           | M0689  | M069   | M96810 | M96811 | M96830 | M96831 | N19    |
| N2589           | N9961  | N9962  | N99820 | N99821 | Z48298 | Z5111  | Z5112  |
| Z7682           |        |        |        |        |        |        |        |

In addition to the diagnosis codes listed above, procedure code J0885 may also be considered for reimbursement with the following diagnosis codes:

| Diagnosis Codes |      |      |      |      |      |
|-----------------|------|------|------|------|------|
| N181            | N182 | N184 | N185 | N186 | N189 |

Procedure code J0882 is a benefit of the CSHCN Services Program for the following diagnosis codes:

| Diagnosis Codes |        |       |       |        |        |       |        |
|-----------------|--------|-------|-------|--------|--------|-------|--------|
| B20             | C880   | C9000 | C9001 | C9002  | D500   | D501  | D508   |
| D509            | D510   | D511  | D512  | D513   | D518   | D519  | D520   |
| D521            | D528   | D529  | D530  | D531   | D532   | D538  | D539   |
| D550            | D551   | D553  | D558  | D560   | D561   | D562  | D563   |
| D564            | D565   | D568  | D569  | D5701  | D5702  | D571  | D5720  |
| D57211          | D57212 | D573  | D5740 | D57411 | D57412 | D5780 | D57811 |
| D57812          | D580   | D581  | D582  | D588   | D590   | D592  | D594   |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| D595            | D596   | D598   | D600   | D601   | D608   | D6101  | D6109  |
| D611            | D612   | D613   | D61810 | D61811 | D61818 | D6182  | D6189  |
| D619            | D62    | D630   | D631   | D638   | D640   | D641   | D642   |
| D643            | D644   | D6481  | D6489  | D649   | D7801  | D7802  | D7821  |
| D7822           | E3601  | E3602  | G9731  | G9732  | G9751  | G9752  | H59111 |
| H59112          | H59113 | H59119 | H59121 | H59122 | H59123 | H59129 | H59311 |
| H59312          | H59313 | H59319 | H59321 | H59322 | H59323 | H59329 | H9521  |
| H9522           | H9541  | H9542  | I120   | I129   | I130   | I1310  | I1311  |
| I132            | I97410 | I97411 | I97418 | I9742  | I97610 | I97611 | I97618 |
| I9762           | J9561  | J9562  | J95830 | J95831 | K9161  | K9162  | K91840 |
| K91841          | L7601  | L7602  | L7621  | L7622  | M0540  | M05411 | M05412 |
| M05419          | M05421 | M05422 | M05429 | M05431 | M05432 | M05439 | M05441 |
| M05442          | M05449 | M05451 | M05452 | M05459 | M05461 | M05462 | M05469 |
| M05471          | M05472 | M05479 | M0549  | M0550  | M05511 | M05512 | M05519 |
| M05521          | M05522 | M05529 | M05531 | M05532 | M05539 | M05541 | M05542 |
| M05549          | M05551 | M05552 | M05559 | M05561 | M05562 | M05569 | M05571 |
| M05572          | M05579 | M0559  | M0570  | M05711 | M05712 | M05719 | M05721 |
| M05722          | M05729 | M05731 | M05732 | M05739 | M05741 | M05742 | M05749 |
| M05751          | M05752 | M05759 | M05761 | M05762 | M05769 | M05771 | M05772 |
| M05779          | M0579  | M0580  | M05811 | M05812 | M05819 | M05821 | M05822 |
| M05829          | M05831 | M05832 | M05839 | M05841 | M05842 | M05849 | M05851 |
| M05852          | M05859 | M05861 | M05862 | M05869 | M05871 | M05872 | M05879 |
| M0589           | M059   | M0600  | M06011 | M06012 | M06019 | M06021 | M06022 |
| M06029          | M06031 | M06032 | M06039 | M06041 | M06042 | M06049 | M06051 |
| M06052          | M06059 | M06061 | M06062 | M06069 | M06071 | M06072 | M06079 |
| M0608           | M0609  | M0620  | M06211 | M06212 | M06219 | M06221 | M06222 |
| M06229          | M06231 | M06232 | M06239 | M06241 | M06242 | M06249 | M06251 |
| M06252          | M06259 | M06261 | M06262 | M06269 | M06271 | M06272 | M06279 |
| M0628           | M0629  | M0630  | M06311 | M06312 | M06319 | M06321 | M06322 |
| M06329          | M06331 | M06332 | M06339 | M06341 | M06342 | M06349 | M06351 |
| M06352          | M06359 | M06361 | M06362 | M06369 | M06371 | M06372 | M06379 |
| M0638           | M0639  | M0680  | M06811 | M06812 | M06819 | M06821 | M06822 |
| M06829          | M06831 | M06832 | M06839 | M06841 | M06842 | M06849 | M06851 |
| M06852          | M06859 | M06861 | M06862 | M06869 | M06871 | M06872 | M06879 |
| M0688           | M0689  | M069   | M96810 | M96811 | M96830 | M96831 | N19    |
| N2589           | N9961  | N9962  | N99820 | N99821 | Z48298 | Z5111  | Z5112  |
| Z7682           |        |        |        |        |        |        |        |

EPO is limited to three injections per calendar week (Sunday through Saturday). Procedure code J0885 must be submitted with an 11-digit NDC.



### 31.2.26.12 Growth Hormone

The Vendor Drug Program (VDP) reimburses growth hormone (hGH) injections for CSHCN Services Program clients for any of the following conditions:

- Chronic kidney disease
- Pituitary gland insufficiency
- Prader-Willi syndrome
- Turner syndrome
- Noonan syndrome
- SHOX deficiency
- Other specified disorders resulting from impaired renal function

Pharmacies must submit claims to the VDP. Pharmacies are reimbursed the same drug costs and dispensing fees allowed by the Texas Medicaid VDP.

Providers may refer to the [Texas Vendor Drug Program website for the CSHCN Growth Hormone Products Authorization Request \(HHS Form 1312\)](#).

#### 31.2.26.12.1 Prior Authorization Requirements

Requests for prior approval of the medical criteria for growth hormone therapy must be submitted on the CSHCN Growth Hormone Products Authorization Request (HHS Form 1312) by a program-approved endocrinologist. In addition to the conditions listed in the section above, the following criteria must also be met for an initial request:

- Normal thyroid function or may be corrected with medication
- Normal pituitary function studies or may be corrected with medication
- Documentation of open epiphyses (done in last 12 months)
- Evidence of deficient growth hormone (GH) production on two pharmacological provocative tests (GH peak less than 10 ng/ml)
- Physical stature less than the 3rd percentile
- Growth velocity 4cm or less per year
- Below normal somatomedin C level or insulin-like growth factor binding protein 3 (IGF/BP3)

Nutropin® is the only product approved for the treatment of chronic renal failure, and Genotropin® is the only product approved for the treatment of Prader-Willi syndrome.

Clients with Turner's syndrome or Prader-Willi syndrome, Noonan Syndrome, or SHOX deficiency may be approved without evidence of deficient growth hormone production on provocative testing if other criteria are met.

Clients with a diagnosis of panhypopituitarism whose epiphyses have closed will be considered for approval with documentation of deficient growth hormone levels.

Initial approval is for a 6-month period. Requests for extensions may be granted for an additional 12 months at a time. Approval for continued growth hormone therapy may be granted if the following criteria are met:

- Growth chart documents growth equal to a minimum of 4cm per year and documents a significant increase from pretreatment levels
- Epiphyses must be open

- Bone age must be documented annually after a boy has reached a chronological age of 16 years and a girl has reached a chronological age of 14 years.

If an initial or extension request cannot be approved based on the above criteria, the approval request may be sent for medical review and reconsideration to the CSHCN Services Program.

**Referto:** Section 3.1.1, “Prescription Drug Benefits” in Chapter 3, “Client Benefits and Eligibility” for more information about the VDP.

**31.2.26.13 Immune Globulins**

Immune globulins may be indicated for treatment of certain immune disorders and states of immunodeficiency.

Immune and gamma globulins and the administration of immune and gamma globulins are benefits of the CSHCN Services Program.

Providers are responsible for administering immune globulins based on the Food and Drug Administration (FDA)-approved guidelines. In the absence of FDA indications, a drug must meet the following criteria for consideration of coverage:

- The drug is recognized by the American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Vol. I., or two articles from major peer-reviewed journals that have validated data supporting the proposed use for the specific medical condition is safe and effective.
- It is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic debilitating conditions.
- The drug is not experimental or investigational.

The following procedure codes may be used to submit claims for immune and gamma globulin injections:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90281           | 90283 | 90284 | 90291 | 90371 | 90389 | 90396 | 90399 | J0850 | J1459 |
| J1460           | J1551 | J1555 | J1556 | J1557 | J1559 | J1561 | J1566 | J1568 | J1569 |
| J1571           | J1572 | J1573 | J1575 | J1576 | J1670 | J2788 | J2791 | J2792 |       |

The following conditions apply when billing immune globulin procedure codes:

- If procedure codes 90389 and J1670 are billed with the same date of service by any provider, only one is considered for reimbursement.
- If procedure codes J1571 and 90371 are billed with the same date of service by any provider, only one may be reimbursed.

Administration procedure codes 96369, 96370, 96372, and 96374 may be billed with the immune globulins listed in this section.

Procedure code 96370 is an add-on code and must be billed with the appropriate primary procedure code on the same date of service, by the same provider, or the service will be denied.

Reimbursement for the following procedure codes will be based on the lowest AWP, minus 10.5 percent, according to the prices in the current edition of the *Red Book*, published by Thomson Healthcare, on file with the CSHCN Services Program.

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| 90281           | 90283 | 90291 | 90371 | 90389 | 90396 |

All other procedure codes for immune and gamma globulins may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service submitted on the claim.

**31.2.26.13.1 Authorization Requirements**

Unlisted procedure code 90399 may be considered for reimbursement with prior authorization. Requests for prior authorization must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request Form. The requesting provider must submit the following documentation with the authorization request:

- The client’s diagnosis
- Medical records that indicate any prior treatments for this diagnosis
- A clear, concise description of the medical necessity of the immune globulin and the rationale for the recommendation of this particular immune globulin
- A procedure code that is comparable to the immune globulin being requested
- Documentation that this immune globulin is not investigational or experimental
- The place of service at which the immune globulin is to be administered
- The provider’s intended fee for this immune globulin

**31.2.26.14 Infliximab, Inflectra, and Renflexis**

Infliximab (procedure code J1745), inflectra (procedure code Q5103), and renflexis (procedure code Q5104) are benefits of the CSHCN Services Program with the following diagnosis limitations:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| H2013           | K5000  | K50011 | K50012 | K50013 | K50014 | K50018 | K50019 |
| K5010           | K50111 | K50112 | K50113 | K50114 | K50118 | K50119 | K5080  |
| K50811          | K50812 | K50813 | K50814 | K50818 | K50819 | K5090  | K50911 |
| K50912          | K50913 | K50914 | K50918 | K50919 | K5100  | K51011 | K51012 |
| K51013          | K51014 | K51018 | K51019 | K5120  | K51211 | K51212 | K51213 |
| K51214          | K51218 | K51219 | K5130  | K51311 | K51312 | K51313 | K51314 |
| K51318          | K51319 | K5140  | K51411 | K51412 | K51413 | K51414 | K51418 |
| K51419          | K5150  | K51511 | K51512 | K51513 | K51514 | K51518 | K51519 |
| K5180           | K51811 | K51812 | K51813 | K51814 | K51818 | K51819 | K5190  |
| K51911          | K51912 | K51913 | K51914 | K51918 | K51919 | K603   | K632   |
| L400            | L401   | L402   | L403   | L4050  | L4051  | L4052  | L4053  |
| L4054           | L4059  | L408   | L409   | M0500  | M05011 | M05012 | M05019 |
| M05021          | M05022 | M05029 | M05031 | M05032 | M05039 | M05041 | M05042 |
| M05049          | M05051 | M05052 | M05059 | M05061 | M05062 | M05069 | M05071 |
| M05072          | M05079 | M0509  | M0510  | M05111 | M05112 | M05119 | M05121 |
| M05122          | M05129 | M05131 | M05132 | M05139 | M05141 | M05142 | M05149 |
| M05151          | M05152 | M05159 | M05161 | M05162 | M05169 | M05171 | M05172 |
| M05179          | M0519  | M0520  | M05211 | M05212 | M05219 | M05221 | M05222 |
| M05229          | M05231 | M05232 | M05239 | M05241 | M05242 | M05249 | M05251 |
| M05252          | M05259 | M05261 | M05262 | M05269 | M05271 | M05272 | M05279 |

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| M0529           | M0530  | M05311 | M05312 | M05319 | M05321 | M05322 | M05329 |
| M05331          | M05332 | M05339 | M05341 | M05342 | M05349 | M05351 | M05352 |
| M05359          | M05361 | M05362 | M05369 | M05371 | M05372 | M05379 | M0539  |
| M0540           | M05411 | M05412 | M05419 | M05421 | M05422 | M05429 | M05431 |
| M05432          | M05439 | M05441 | M05442 | M05449 | M05451 | M05452 | M05459 |
| M05461          | M05462 | M05469 | M05471 | M05472 | M05479 | M0549  | M0550  |
| M05511          | M05512 | M05519 | M05521 | M05522 | M05529 | M05531 | M05532 |
| M05539          | M05541 | M05542 | M05549 | M05551 | M05552 | M05559 | M05561 |
| M05562          | M05569 | M05571 | M05572 | M05579 | M0559  | M0560  | M05611 |
| M05612          | M05619 | M05621 | M05622 | M05629 | M05631 | M05632 | M05639 |
| M05641          | M05642 | M05649 | M05651 | M05652 | M05659 | M05661 | M05662 |
| M05669          | M05671 | M05672 | M05679 | M0569  | M0570  | M05711 | M05712 |
| M05719          | M05721 | M05722 | M05729 | M05731 | M05732 | M05739 | M05741 |
| M05742          | M05749 | M05751 | M05752 | M05759 | M05761 | M05762 | M05769 |
| M05771          | M05772 | M05779 | M0579  | M0580  | M05811 | M05812 | M05819 |
| M05821          | M05822 | M05829 | M05831 | M05832 | M05839 | M05841 | M05842 |
| M05849          | M05851 | M05852 | M05859 | M05861 | M05862 | M05869 | M05871 |
| M05872          | M05879 | M0589  | M059   | M060A  | M068A  | M069   | M08011 |
| M08012          | M08021 | M08022 | M08031 | M08032 | M08041 | M08042 | M08051 |
| M08052          | M08061 | M08062 | M08071 | M08072 | M0809  | M08832 | M08841 |
| M08842          | M08851 | M08852 | M08861 | M08931 | M08932 | M08941 | M08942 |
| M08951          | M08952 | M08961 | M08962 | M1389  | M450   | M451   | M452   |
| M453            | M454   | M455   | M456   | M457   | M458   | M459   | M45A0  |
| M45A1           | M45A2  | M45A3  | M45A4  | M45A5  | M45A6  | M45A7  | M45A8  |
| M45AB           |        |        |        |        |        |        |        |

Procedure codes J1745, Q5103, and Q5104 will not be reimbursed for the same date of service by any provider.

### 31.2.26.15 Inotuzumab ozogamicin (Besponsa)

Inotuzumab ozogamicin (Besponsa) (procedure code J9229) is a benefit of the CSHCN Services Program.

Inotuzumab ozogamicin is indicated for the treatment of relapsed or refractory precursor B-cell acute lymphoblastic leukemia (ALL) and must be prescribed by an oncologist or in consultation with an oncologist.

Procedure code J9229 requires prior authorization and may be approved when all of the following criteria is met:

- The client has a confirmed diagnosis of precursor B-cell ALL.
- The client must have relapsed or refractory disease.
- The client is 18 years of age or older.

The provider must agree to monitor the client for signs and symptoms of hepatic veno-occlusive disease (VOD) during the duration of Besponsa therapy.

Requests for prior authorization of procedure code J9229 must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request form.

### 31.2.26.16 Leuprolide Acetate Injection

Procedure code J9217 is allowed for use in monthly, 3-month, 4-month, and 6-month doses. Providers must bill the following dosage increments:

| Dose Period | Dose Quantity | Quantity Billed | Limitation          |
|-------------|---------------|-----------------|---------------------|
| Monthly     | 7.5 mg        | 1               | Once per month      |
| 3-month     | 22.5 mg       | 3               | Once every 3 months |
| 4-month     | 30 mg         | 4               | Once every 4 months |
| 6-month     | 45 mg         | 6               | Once every 6 months |

### 31.2.26.17 Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria

#### 31.2.26.17.1 Omalizumab

Omalizumab (procedure code J2357) is a benefit of the CSHCN Services Program when medically necessary and must be prior authorized.

Omalizumab is FDA approved for the treatment of clients who are 6 years of age and older with moderate to severe asthma. Omalizumab is also approved for the treatment of clients who are 12 years of age and older with chronic idiopathic urticaria, who remain symptomatic despite H1 antihistamine treatment. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program Medical Director or designee.

#### 31.2.26.17.2 Benralizumab

Benralizumab (procedure code J0517) is a benefit of the CSHCN Services Program with prior authorization.

Benralizumab is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 12 years of age and older that have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

#### 31.2.26.17.3 Mepolizumab

Mepolizumab (procedure code J2182) is a benefit of the CSHCN Services Program when prior authorized.

Mepolizumab is an injectable drug that is approved by the U.S. Food and Drug Administration (FDA) for the treatment of clients who are 12 years of age and older and have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

Providers may not bill for an office visit if the only reason for the visit is an omalizumab, benralizumab, mepolizumab, or reslizumab injection.

#### 31.2.26.17.4 Reslizumab

Reslizumab (procedure code J2786) is a benefit of the CSHCN Services Program when prior authorized.

Reslizumab is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 18 years of age and older and have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

Procedure codes J0517, J2182, J2786, and J2357 may not be billed in any combination for the same date of services by any provider.

#### 31.2.26.17.5 Prior Authorization Requirements

Omalizumab (procedure code J2357), benralizumab (procedure code J0517), mepolizumab (procedure code J2182), or reslizumab (procedure code J2786) must be used to request prior authorization and the exact dosage must be indicated on the [CSHCN Services Program Authorization and Prior Authorization Request Form](#).

Prior authorization of omalizumab may be approved for clients who are 6 years of age or older with moderate to severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorization of benralizumab and mepolizumab may be approved for clients who are 12 years of age or older that have severe asthma with an eosinophilic phenotype (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorization of reslizumab may be approved for clients who are 18 years of age or older with severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorizations for omalizumab, benralizumab, mepolizumab, or reslizumab are for intervals of six months at a time. Clients must be compliant with their omalizumab, benralizumab, mepolizumab, or reslizumab regimen in order to qualify for additional authorizations. The provider must submit a statement documenting compliance with the requests for each renewal.

Benralizumab, mepolizumab or reslizumab may only be initiated after a six-month trial of omalizumab therapy that has resulted in inadequate response. Criteria is detailed below in the benralizumab, mepolizumab, and reslizumab sections.

Treatment of benralizumab, mepolizumab or reslizumab may not be used concurrently with omalizumab or any other interleukin-5 antagonist.

#### 31.2.26.17.6 Chronic Idiopathic Urticaria

Prior authorization for omalizumab will be considered for clients who are 12 years of age or older with chronic idiopathic urticaria (CIU).

Documentation supporting medical necessity for treatment of CIU with omalizumab must be submitted with the request and include all of the following:

- Documented failure of, or contraindication to, antihistamine and leukotriene inhibitor therapies.
- Evidence of an evaluation that excludes other medical diagnoses associated with chronic urticaria.

#### 31.2.26.17.7 Asthma Moderate to Severe (Omalizumab) and Severe (Benralizumab, Mepolizumab, and Reslizumab)

Documentation supporting medical necessity for treatment of asthma with omalizumab, benralizumab, mepolizumab, or reslizumab must be submitted with the request and must indicate the following:

- Symptoms are inadequately controlled with use of one of the following combination therapies:
  - 12 months of high-dose inhaled corticosteroid (ICS) given in combination with a minimum of 3 months of controller medication (either a long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], or theophylline), unless the individual is intolerant of, or has a medical contraindication to these agents

- 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (a LABA, LTRA, or theophylline), unless the individual is intolerant of, or has a medical contraindication to these agents

**Note:** *Exceptions to the criteria above will be considered on a case-by-case basis, which will require a letter from the prescribing provider stating the medical necessity for omalizumab, benralizumab, mepolizumab, or reslizumab, the client's asthma severity level, and the duration of current and past therapies and lack of asthma control. Consideration for these exceptions will be reviewed by the CSHCN Services Program Medical Director or designee.*

- Pulmonary function tests must have been performed within a three-month period and be documented for all clients.

**Note:** *Exceptions may be considered with documentation of medical reasons explaining why pulmonary function tests cannot be performed.*

- Client is not currently smoking.
- When requesting prior authorization, the exact dosage must be included with the request.

#### 31.2.26.17.8 Omalizumab

Additional documentation of the following must also be submitted for treatment with omalizumab:

- A positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months
- Total IgE level greater than 30 IU/ml but less than 1300 IU/ml within the past 12 months

#### 31.2.26.17.9 Benralizumab

The following additional documentation for treatment with benralizumab must be submitted with the initial prior authorization request:

- Documented diagnosis of severe eosinophilic asthma
- Blood eosinophil count greater than or equal to 150 cells/microliter before the initiation of therapy, in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection

**Note:** *1 microliter (ul) is equal to 1 cubic millimeter (mm<sup>3</sup>).*

- Prior authorization for an initial request for benralizumab will be considered when the client meets the criteria for benralizumab and has had an inadequate response after being compliant with 6 months of omalizumab treatment. Failure to respond to omalizumab must be documented in a letter that is signed and dated by the prescribing provider and submitted with the prior authorization request.

**Note:** *Exceptions may be considered for clients who meet the requirements for treatment with benralizumab but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range, negative skin test, or RAST to a perennial aeroallergen) must be submitted along with the other required documentation for treatment with benralizumab.*

#### 31.2.26.17.10 Mepolizumab

Additional documentation of the following must also be submitted for treatment with mepolizumab:

- One of the following blood eosinophil counts in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection:
  - Greater than or equal to 150 cells/microliter at initiation of therapy

- Greater than or equal to 300 cells/microliter within 12 months prior to initiation of therapy

**Note:** 1 microliter (ul) is equal to 1 cubic millimeter (mm<sup>3</sup>)

Prior authorization for an initial request for mepolizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

**Note:** Exceptions may be considered for clients who meet the criteria for treatment with mepolizumab but do not meet the criteria for omalizumab. Supporting documentation, such as an IgE level fall outside of the required range or a negative skin test/RAST to a perennial aeroallergen, must be submitted along with the documentation for treatment with mepolizumab, as described above.

#### 31.2.26.17.11 Reslizumab

Additional documentation of the following must also be submitted for treatment with reslizumab:

- Has an eosinophilic phenotype as determined by blood eosinophils of 400 cells/microliter or higher to initiation of therapy (within 3-4 weeks of dosing).

**Note:** 1 microliter (9ul) is equal to 1 cubic millimeter (mm<sup>3</sup>).

- Prior authorization for an initial request for reslizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab and meets the criteria for reslizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

**Note:** Exceptions may be considered for clients who meet the requirements for treatment with reslizumab, but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range and/or negative skin test/RAST to a perennial aeroallergen) must be submitted along with the documentation for treatment with reslizumab as described above.

When requesting prior authorization, the exact dosage must be included with the request.

#### 31.2.26.17.12 Requirements for Continuation of Therapy

For continuation of therapy with omalizumab, benralizumab, mepolizumab, or reslizumab after 6 continuous months, the requesting provider must submit the following documentation of the client's compliance and satisfactory clinical response to omalizumab, benralizumab, mepolizumab, or reslizumab:

- Documentation of clinical improvement must include one or more of the following:
  - Decreased utilization of rescue medications
  - Increase in predicted FEV1 (forced expiratory volume) from pretreatment baseline
  - Reduction in reported asthma-related symptoms, as evidenced by decreases in frequency or magnitude of one or more of the following symptoms:
    - Asthma attacks
    - Chest tightness or heaviness
    - Coughing or clearing throat
    - Difficulty taking deep breath or difficulty breathing out
    - Shortness of breath
    - Sleep disturbance, night waking, or symptoms upon awakening



- Tiredness
- Wheezing/heavy breathing/fighting for air
- Client has not exhibited symptoms of hypersensitivity or anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of omalizumab, benralizumab, mepolizumab, or reslizumab.

After lapses in treatment of 3 months or greater, prior authorization requests submitted with documentation will be reviewed by the CSHCN Services Program Medical Director or designee.

Requests for clients who do not meet the above criteria will be reviewed for medical necessity by the CSHCN Services Program Medical Director or designee.

### 31.2.26.18 Trastuzumab

Trastuzumab (procedure code J9355) is a benefit of the CSHCN Services Program as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients with HER2 overexpressing, node positive breast cancer. Procedure code J9355 is payable when billed with the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50011          | C50012 | C50019 | C50021 | C50022 | C50029 | C50111 | C50112 |
| C50119          | C50121 | C50122 | C50129 | C50211 | C50212 | C50219 | C50221 |
| C50222          | C50229 | C50311 | C50312 | C50319 | C50321 | C50322 | C50329 |
| C50411          | C50412 | C50419 | C50421 | C50422 | C50429 | C50511 | C50512 |
| C50519          | C50521 | C50522 | C50529 | C50611 | C50612 | C50619 | C50621 |
| C50622          | C50629 | C50811 | C50812 | C50819 | C50821 | C50822 | C50829 |
| C50911          | C50912 | C50919 | C50921 | C50922 | C50929 | C563   | C7963  |
| C847A           |        |        |        |        |        |        |        |

### 31.2.26.19 Triamcinolone Acetonide

Triamcinolone acetonide (procedure code J3304) is a benefit of the CSHCN Services Program and is restricted to the following diagnosis codes:

| Diagnosis Codes |       |       |      |       |       |      |      |
|-----------------|-------|-------|------|-------|-------|------|------|
| M170            | M1711 | M1712 | M172 | M1731 | M1732 | M174 | M175 |
| M1909           | M1919 | M1929 |      |       |       |      |      |

Procedure code J3304 is limited to one per 12 weeks, any provider.

### 31.2.27 Intracranial Pressure Monitoring

Intracranial pressure monitoring is a benefit of the CSHCN Services Program.

Authorization is not required for intracranial pressure monitoring and is not limited to specific diagnoses. Physicians should use procedure code 61210 to submit a claim for intracranial pressure monitoring. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

## 31.2.28 Laboratory Services

### 31.2.28.1 Clinical Pathology Services and Pathology Consultations

Clinical pathology consultations (procedure codes 80503, 80504, 80505, or 80506) are a benefit when they are performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80503, 80504, 80505, or 80506 using their physician provider identifier.

Routine conversations between a consultant and an attending physician about test orders or results are not considered consultations.

The service does not qualify as a consultation if the information could ordinarily be furnished by a non-physician laboratory specialist.

Claims for clinical pathology consultations must be submitted with the following documentation:

- The name and address, or the CSHCN Services Program provider identifier for the physician requesting the consultation, must be included on the claim. The national provider identifier (NPI) of the physician requesting the consultation should also be included, if known.
- A copy of the written narrative report describing the consultation findings.
- Documented interaction that clearly outlines that the consultant interpreted the test results and made specific recommendations to the ordering physician.

If the claim does not include all of this information, the clinical pathology consultation will be denied.

### 31.2.28.2 Claims Filing for Laboratory Tests

Physicians may only be reimbursed for the total component of laboratory tests that are actually performed in their office laboratories.

Interpretation of laboratory tests is considered part of a physician's professional services (hospital, office, or emergency room visits) and must not be billed separately.

The claim must indicate the specific type of laboratory procedure performed. Providers who perform only the technical service must bill for the technical component.

### 31.2.28.3 Reimbursement

Clinical laboratory services performed in a physician's office may be reimbursed 60 percent of the prevailing charge levels.

*Referto:* Chapter 25, "Enrollment" for additional information concerning coding and reimbursement for laboratory procedures.

### 31.2.28.4 Cytopathology Studies (Gynecological, Pap Smears)

Pap smears for early detection of cancer are a benefit of the CSHCN Services Program.

Procurement and handling of the Pap smears are considered part of the E/M of the client and will not be reimbursed separately. Physicians interpreting a cytopathology specimen (Pap smears) must report the place of service according to where the cytopathology specimen is interpreted (office, inpatient hospital, outpatient hospital, or independent lab).

Because of the technical nature of processing and interpreting Pap smears or specimens for cytopathology, pathologists are the only physician specialty that may be reimbursed for these services.

*Referto:* Section 25.2.5.3, "Genetic Testing for Colorectal Cancer" in Chapter 25, "Laboratory Services" for additional information concerning coding and reimbursement for gynecological cytopathology studies.

### 31.2.28.5 Cytogenetics Testing

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias, lymphomas, and other tumors, especially in children. The detection of the well-defined, recurring, genetic abnormalities often enables a correct diagnosis along with important prognostic information affecting the treatment protocol. Cytogenetics testing may be a part of an evaluation for unusual physical features or learning difficulties.

**Referto:** Section 25.2.5.2, “Cytogenetics Testing” in Chapter 25, “Laboratory Services” for additional information about reimbursement for cytogenetics testing.

### 31.2.28.6 Helicobacter pylori (H. pylori)

The following procedure codes are benefits for physicians in the office setting.

| Procedure Codes        |       |       |       |       |       |        |
|------------------------|-------|-------|-------|-------|-------|--------|
| 78267                  | 78268 | 83009 | 83013 | 83014 | 86677 | 87338^ |
| ^ QW modifier required |       |       |       |       |       |        |

**Referto:** Section 25.2.9, “Helicobacter pylori (H. pylori)” in Chapter 25, “Laboratory Services” for additional information about reimbursement for H. pylori testing.

### 31.2.28.7 CLIA Requirement

**Referto:** Section 2.1.5.6, “Clinical Laboratory Improvement Amendments (CLIA) of 1988” in Chapter 2, “Provider Enrollment and Responsibilities.”

Section 25.1.1, “Clinical Laboratory Improvement Amendments (CLIA) of 1988” in Chapter 25, “Laboratory Services” for additional information regarding CLIA regulations.

### 31.2.29 Magnetoencephalography (MEG)

MEG is a benefit of the CSHCN Services Program when used in pre-surgical planning for clients with intractable focal epilepsy, brain tumors, or vascular malformations.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services that are provided in the office, inpatient hospital, and outpatient hospital settings. Procedure code 95967 must be submitted along with primary procedure code 95966 on the same day, by the same provider.

Physicians may be reimbursed for the professional component of MEG services and the lower of the billed amount or the amount allowed by Texas Medicaid.

#### 31.2.29.1 Authorization Requirements

Prior authorization is required for MEG procedures and must be obtained prior to the date of service. Requests for MEG must be submitted on the [CSHCN Services Program Authorization and Prior Authorization Request Form](#) to the TMHP CSHCN Services Program Authorization Department.

The provider must complete and submit a prior authorization request, which should include all required documentation through any CSHCN approved method. A copy of the prior authorization request and all submitted documentation must be maintained in the client’s medical record.

**Note:** All prior authorization requests must be submitted with the ordering practitioner’s signature.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the service(s) requested.

Documentation must support the medical need of pre-surgical planning for clients with intractable focal epilepsy, brain tumors, or vascular malformations, and must include the following, as applicable:

- Evidence of intractable focal epilepsy, neoplasm, or arterial venous malformations (AVMs), and

- Evidence of prior treatment failures with antiepileptic drugs, if applicable, and
- Evidence demonstrating failure of previous brain surgery or failure of more traditional testing to locate the epileptic foci, and
- Evidence of current and past diagnostic studies indicating the need for MEG.

**Note:** Requests for repeat MEG scans must include the date of the previous MEG and documentation supporting the medical necessity for the repeat scan.

If the service is medically necessary, provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Authorization and Prior Authorization Request Form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete PA requests.

Prior authorization and medical review is required for all other indications. Documentation for consideration must include diagnosis, clinical course, clinical history, and other treatments with an explanation of ineffective results. This documentation to support medical necessity must be submitted to the CSHCN Services Program Medical Director or designee.

### **31.2.29.2 Documentation Requirements**

All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided. Services not supported by documentation are subject to recoupment.

Providers may be asked to provide additional documentation to clarify a prior authorization request or to clarify medical necessity of the client.

### **31.2.29.3 Exclusions**

MEG is not a stand-alone test, and is not the first order test after clinical and routine EEG diagnosis of epilepsy, and cannot replace, but may guide, the placement of intracranial EEG.

Services and procedures that are investigational or experimental are not benefits of the CSHCN Services Program.

### **31.2.30 Neurostimulator Devices and Supplies**

Neurostimulator devices and supplies are benefits of the CSHCN Services Program.

**Referto:** Chapter 27, "Neurostimulators and Neuromuscular Stimulators" for information about benefits for neurostimulator devices and supplies.

### **31.2.31 Ophthalmological Services**

Ophthalmological services are benefits of the CSHCN Services Program.

**Referto:** Chapter 40, "Vision Services" for additional information about reimbursement for ophthalmology.

#### **31.2.31.1 Intraocular Lenses (IOL)**

An ophthalmologist who performs cataract extractions and IOL implants in the office may be reimbursed for the lens. The provider must submit a copy of the manufacturer's invoice for the IOL with the claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (minus any discount) plus a handling fee not to exceed 5 percent of the actual acquisition cost.

**Note:** The CSHCN Services Program does not reimburse physicians who supply IOLs to ASCs or HASCs. Payment for the IOL is included in the facility fee.

### 31.2.31.2 Vitrasert Ganciclovir Implant

Procedure code 67027 is a benefit with diagnosis code B251, B258, B259, H3090, H3091, H3092, or H3093. If a provider bills vitrectomy and implantation of intravitreal drug delivery system with the same date of service, the insertion code may be reimbursed and the vitrectomy code payment is denied as part of the other service.

### 31.2.32 Osteopathic Manipulative Treatment (OMT)

OMT, performed by a physician, is a benefit for acute musculoskeletal conditions, acute exacerbations of a chronic condition, and acute pre or postsurgery treatments when they are directly related to surgery.

**Referto:** Chapter 30, “Physical Medicine and Rehabilitation” for more information about OMT services.

### 31.2.33 Physical Medicine and Physical Therapy (PT) Services

PT performed by a physician or physical therapist is a benefit of the CSHCN Services Program.

**Referto:** Chapter 30, “Physical Medicine and Rehabilitation” for more information about PT services.

The CSHCN Services Program may reimburse physicians for therapy services performed in their offices.

The following procedure codes may be used for physical medicine and rehabilitation services:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 97012           | 97016 | 97018 | 97022 | 97024 | 97026 | 97028 | 97032 | 97033 | 97034 |
| 97035           | 97036 | 97110 | 97112 | 97113 | 97116 | 97124 | 97140 | 97150 | 97161 |
| 97162           | 97163 | 97164 | 97165 | 97166 | 97167 | 97168 | 97530 | 97535 | 97537 |
| 97542           | 97750 | 97755 | 97760 | 97761 | 97762 | 97799 |       |       |       |

Physical therapy services must be billed with the GP modifier.

### 31.2.34 Podiatry

Services provided by a licensed podiatrist (DPM) are a benefit of the CSHCN Services Program. Podiatry services may be reimbursed when provided by a physician (MD or DO).

Surgery procedure codes 11055, 11056, 11057, 11719, and G0127 are limited to one service every 6 months per client.

Supportive devices such as molds, inlays, shoes, or supports and all services connected with the fitting or application of these devices must meet the CSHCN Services Program requirements for foot orthotics.

**Referto:** Section 28.2.2, “Orthoses and Prostheses (Not All-Inclusive)” in Chapter 28, “Orthotic and Prosthetic Devices” and Section 28.3.7.2, “Prescription Shoes” in Chapter 28, “Orthotic and Prosthetic Devices” for additional information about foot orthotics.

Podiatrists may be reimbursed for medically necessary laboratory services and radiological procedures that include the foot, ankle, toes, or heel.

Podiatrists may prescribe medications, supplies, braces, and prosthetic devices for conditions of the foot and ankle.

Authorization and prior authorization requirements applied to services provided by physicians also apply to services provided by a podiatrist. All CSHCN Services Program requirements concerning reimbursement for surgical procedures, such as the global fee concept, apply to podiatrists.

Podiatrists may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization and prior authorization requirements.

### 31.2.35 Psychological Testing

Psychological testing (procedure codes 96130, 96131, 96136 and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are benefits of the CSHCN Services Program and may be reimbursed up to 4 hours per day and 8 hours per calendar year, per client, for any provider. Providers must bill the units of each half hour of testing and indicate that number of units on the claim form. Claim submissions for over 4 hours per day and 8 hours per calendar year must include documentation of medical necessity. Add-on procedure codes 96121, 96131, 96133, and 96137 must be billed with their corresponding primary procedure code 96116, 96130, 96132, or 96136 on the same day, by the same provider.

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Reimbursement of psychological testing, neuropsychological testing, and neurobehavioral status exams include testing scoring and interpretation of results. The number of units on the claim must reflect the time spent face-to-face testing with the client, as well as the time spent scoring and interpreting the results in one hour increments.

If the performance, interpretation, and reporting of the testing are performed on different dates of service, then the date of service on the claim must reflect the date and time spent for each service performed. Even if scoring and interpretation are completed on a different date from the testing, providers must submit only one claim for each psychological or neuropsychological test or neurobehavioral status exam performed. If necessary, providers can submit the claim with multiple details for each date of service. A claim must not be submitted until performance, interpretation, and reporting of the testing is complete.

Behavioral health testing and neurobehavioral status exams may be performed during an assessment by an APRN or physician assistant but will not be reimbursed separately.

Psychological testing (procedure codes 96130, 96131, 96136 and 96137) and neurobehavioral testing (procedure codes 96132, 96133, 96136, and 96137) may be reimbursed on the same date of service as procedure code 90791 or procedure code 90792.

Testing procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 count towards the 30 per calendar year limitation.

Psychological testing (procedure codes 96130, 96131, 96136 and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) will not be reimbursed on the same date of service by the same provider.

**Referto:** Section 24.3.1.3, “Inpatient Behavioral Health” in Chapter 24, “Hospital” for additional information about behavioral health services.

Chapter 29, “Outpatient Behavioral Health” for additional information about behavioral health services.

### 31.2.36 Sign Language Interpreting Services

Sign language interpreting services are available to CSHCN Services Program clients who are deaf or hard of hearing or to a parent or guardian of a person receiving CSHCN Services Program benefits, who is deaf or hard of hearing.

The sign language interpreting services must be requested by a physician and provided by a qualified interpreter. A physician’s determination of the need for sign language interpreting services must give primary consideration to the needs of the individual who is deaf or hard of hearing.

Sign language interpreting services are benefits of the CSHCN Services Program. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, per provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from the CSHCN Services Program for providing this service.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels a through h) issued by either HHSC, the Office for Deaf and Hard of Hearing Services, the Board for Evaluation of Interpreters (BEI), or the National Registry of Interpreters for the Deaf (RID):

- a) BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic).
- b) BEI Basic and RID NIC (National Interpreter Certificate) Certified.
- c) BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate).
- d) BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter).
- e) BEI Advanced and RID NIC Advanced.
- f) BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal).
- g) EI V/VI.
- h) BEI Master; and RID NIC Master.

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by the CSHCN Services Program or its designee.

### 31.2.37 Skin Therapy

Procedure codes 96900, 96910, 96912, and 96913 are benefits of the CSHCN Services Program for the following diagnosis codes:

| Diagnosis Codes |        |        |        |       |       |       |       |
|-----------------|--------|--------|--------|-------|-------|-------|-------|
| A672            | B070   | B081   | B550   | B551  | B552  | B559  | C8401 |
| C8402           | C8403  | C8404  | C8405  | C8406 | C8407 | C8408 | C8409 |
| H02731          | H02732 | H02734 | H02735 | L100  | L101  | L102  | L103  |
| L104            | L105   | L1081  | L1089  | L120  | L121  | L122  | L128  |
| L130            | L131   | L138   | L139   | L14   | L200  | L2081 | L2082 |
| L2084           | L2089  | L209   | L210   | L211  | L218  | L219  | L22   |
| L230            | L231   | L232   | L233   | L234  | L235  | L236  | L237  |

| Diagnosis Codes |       |      |       |       |      |      |      |
|-----------------|-------|------|-------|-------|------|------|------|
| L2381           | L2389 | L239 | L240  | L241  | L242 | L243 | L244 |
| L245            | L246  | L247 | L2481 | L2489 | L249 | L250 | L252 |
| L258            | L259  | L270 | L271  | L272  | L278 | L279 | L300 |
| L302            | L308  | L309 | L401  | L560  | L561 | L562 | L563 |
| L564            | L565  | L570 | L571  | L572  | L573 | L574 | L575 |
| L580            | L581  | L589 | L598  | L599  | L700 | L701 | L702 |
| L703            | L704  | L705 | L708  | L730  | L80  | L811 | L812 |
| L813            | L815  | L816 | L818  |       |      |      |      |

### 31.2.38 Sleep Studies

Polysomnography, multiple sleep latency tests, and pediatric pneumograms are benefits of the CSHCN Services Program.

Sleep facilities that perform services for CSHCN Services Program clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Documentation of accreditation must be maintained in the facility and be available for review. Sleep facilities must also follow current AASM practice parameters and clinical guidelines. Providers may refer to the AASM website at [www.aasm.org](http://www.aasm.org) for AASM facility certification requirements or to the JCAHO website at [www.jointcommission.org](http://www.jointcommission.org) for JCAHO facility accreditation information.

Sleep facility technicians and technologists must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

The sleep facility must have one or more supervision physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of the non-physician staff who use the equipment.

#### 31.2.38.1 Polysomnography

Polysomnography is the recording, analysis, and interpretation of the multiple simultaneous physiological measurements of sleep for 6 or more hours. The studies are performed to diagnose a variety of sleep disorders, such as sleep apnea, and are considered part of the clinical workup performed before the surgical procedure uvulopalatopharyngoplasty.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which includes a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG).

Additional parameters of sleep include, but are not limited to:

- Airflow.
- Body positions.
- Continuous blood pressure monitoring.
- Electrocardiogram (ECG).
- Extended EEG monitoring.
- Extremity/motor activity movement.
- Gas exchange by oximetry.



- Gastroesophageal reflux.
- Penile tumescence.
- Snoring.
- Ventilation and respiratory effort.

For a study to be reported as polysomnography, sleep must be recorded and staged.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist or physician.

***Note:** Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is being provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (M.D. or D.O.).
- A polysomnographic technician provides comprehensive polysomnographic testing and analysis, and associated interventions under the general supervision of a polysomnographic technologist or clinical director (M.D. or D.O.).

***Note:** The supervising physician must be readily available to the performing technologist throughout the duration of the study but is not required to be in the building.*

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is restricted to the following diagnosis codes:

| Diagnosis Codes |       |       |       |       |        |        |        |
|-----------------|-------|-------|-------|-------|--------|--------|--------|
| E662            | F5101 | F5102 | F5103 | F5104 | F5109  | F5111  | F5112  |
| F5113           | F5119 | F513  | F514  | F515  | F518   | F519   | F984   |
| G253            | G2589 | G259  | G26   | G4700 | G4701  | G4710  | G4711  |
| G4712           | G4713 | G4714 | G4719 | G4720 | G4721  | G4722  | G4723  |
| G4724           | G4725 | G4726 | G4727 | G4729 | G4730  | G4731  | G4733  |
| G4734           | G4735 | G4736 | G4737 | G4739 | G47411 | G47419 | G47421 |
| G47429          | G4750 | G4751 | G4752 | G4753 | G4754  | G4759  | G4761  |
| G4769           | G478  | G479  | J9610 | J9611 | J9612  | R0600  | R0609  |
| R063            | R0683 | R0689 | R069  | R0901 |        |        |        |

Polysomnography is payable to physicians in outpatient hospital and office settings. Procedure codes 95782, 95783, 95808, 95810, and 95811 are limited to one per day by any provider. When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied.

### 31.2.38.2 Multiple Sleep Latency Test

Multiple sleep latency tests involve the client being given a chance to sleep every 2 hours during normal wake time. Observations are made of the time taken to reach stages of sleep. This test measures the degree of daytime sleepiness and how soon rapid eye movement (REM) sleep begins. This test is a benefit for diagnosing narcolepsy.

Multiple sleep latency tests (procedure code 95805) are restricted to the following diagnosis codes:

| Diagnosis Codes |        |        |       |       |       |       |        |
|-----------------|--------|--------|-------|-------|-------|-------|--------|
| E662            | G4700  | G4710  | G4711 | G4712 | G4720 | G4733 | G47411 |
| G47419          | G47421 | G47429 | G478  | G479  |       |       |        |

Multiple sleep latency tests are payable to physicians in outpatient hospital and office settings. Procedure code 95805 is limited to one per day by any provider. Sleep study procedure codes 95806 and 95807 are not a benefit of the CSHCN Services Program.

### 31.2.38.3 Pediatric Pneumogram

A pneumogram is a 12- to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

Procedure code 94772 is a benefit for CSHCN Services Program clients from birth through 12 months of age with one of the following diagnosis codes:

| Diagnosis Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| K2080           | K2081 | K2090 | K2091 | K2100 | K2101 | K219  | K220  |
| P220            | P228  | P229  | P270  | P271  | P278  | P279  | P282  |
| P2830           | P2831 | P2832 | P2833 | P2839 | P2840 | P2841 | P2842 |
| P2843           | P2849 | P285  | P2881 | P2889 | P84   | R0600 | R0609 |
| R062            | R063  | R0681 | R0682 | R0683 | R0689 | R069  | R6813 |

Pediatric pneumograms are payable to physicians in office, inpatient hospital, and outpatient hospital settings. A pediatric pneumogram is limited to two services per lifetime without authorization based on the diagnoses listed above. Authorization is required for more than two pneumograms. Requests for prior authorization must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request form.

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms may be reimbursed on the same date of service as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component of the reimbursement and are denied if billed separately.

### 31.2.38.4 Home Sleep Study Test

Home sleep study tests are unattended studies that are performed in the client's home using a portable monitoring device. The portable monitoring device must meet AASM practice parameters and clinical guidelines.

Home sleep study testing is a benefit of the CSHCN Services Program only when performed in conjunction with a comprehensive sleep evaluation that has been performed by a physician who is board-certified or board-eligible, as outlined in the AASM guidelines. Documentation of the compre-

hensive sleep evaluation must be kept in the client's medical record. The evaluation must indicate probability of moderate to severe obstructive sleep apnea to support medical necessity for home sleep study testing.

Procedure codes G0398, G0399, and G0400 are a benefit for CSHCN Services Program clients who are 18 years of age and older with suspected or proven simple, uncomplicated obstructive sleep apnea. Procedure codes G0398, G0399, and G0400 are restricted to diagnosis code G4733.

Home sleep study tests are payable to physicians in the office setting. Procedure codes G0398, G0399, and G0400 are limited to one per day and a combined total of two tests per rolling year, with any provider. If a client needs more than two tests in a rolling year, subsequent tests must be performed in a sleep facility.

### **31.2.39 Surgery**

Surgical services, including surgical procedures involving an assistant surgeon or cosurgeon, are a benefit of the CSHCN Services Program.

Authorization of cosurgeon and assistant surgeon services is not required; however, all other authorization requirements associated with the surgical procedure must be met.

***Reminder:** An authorization request can be submitted up to 95 days after the date of service. The completed authorization form can be attached to the paper claim.*

Specific surgical procedures, as specified throughout this section, require prior authorization. If a prior authorization is not obtained for the procedure, the facility's services, the surgeon's services, and the assistant surgeon's services are denied; however, anesthesia services may be paid.

Prior authorization must be obtained for procedures that are completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in the appropriate sections below.

Unless otherwise stated, no additional reimbursement is provided to physicians who elect to use special instruments or advanced technology to accomplish a surgical procedure.

Surgical procedures may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

#### **31.2.39.1 Anesthesia Administered by Surgeon**

If the physician submits a surgical procedure and anesthesia for the same surgery for reimbursement, the anesthesia procedure code is denied as part of the surgical procedure.

#### **31.2.39.2 Primary Surgeons**

The primary surgeon is the lead surgeon who participates and directs the technical aspects of a surgical case.

Physicians cannot provide services as a surgeon and assistant surgeon, or as a surgeon and anesthesiologist during the same surgical procedure. A physician may bill as a surgeon and assistant surgeon on the same client, if two separate procedures are performed. Full payment is allowed for surgery, and the assistant surgical procedure may be reimbursed half of the reimbursement amount for an assistant surgery.

If the physician is an anesthesiologist who is billing for general anesthesia and a surgical procedure which is considered part of the anesthesia, the surgical procedure is not reimbursed.

#### **31.2.39.3 Assistant Surgeons**

An assistant surgeon assists the primary surgeon during a complex surgical procedure that warrants an assistant to safely and effectively accomplish the procedure.

Assistant surgeons may be reimbursed 16 percent of the prevailing fee for the surgical procedure performed.

The CSHCN Services Program follows the *Tax Equity and Fiscal Responsibility Act (TEFRA)* of 1982 regulation for assistant surgeons in teaching hospitals.

An assistant surgeon is not paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. These claims are paid only if modifiers 82 or 80 (assistant surgeon) and KX (documentation on file) are present on the claim. These modifiers should be used in the following situations:

- There are exceptional medical circumstances, such as emergency or life-threatening situations that require immediate attention.
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of their clients.
- The surgical procedure is complex and qualifies for more than one physician.
- Use modifier 82 when no qualified resident was available to assist with the surgery.

If the physician seeks an exception to the TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or be attached to the claim form:

“I understand that Section 1842(b)(6)(D) of the *Social Security Act* generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP-CSHCN.”

Payment to an assistant surgeon for multiple surgical procedures follows the same guidelines as payment to the primary surgeon.

If an assistant surgeon bills separate charges for local or regional anesthesia and assistant surgery on the same day, the anesthesia is included as part of the surgical procedure and not reimbursed separately.

#### **31.2.39.4 Cosurgery**

Cosurgery is a benefit of the CSHCN Services Program if the CMS fee schedule indicates that the procedure allows for cosurgeons.

When billing for cosurgery, each surgeon must bill the same procedure codes and modifier 62 (cosurgeon).

Cosurgery occurs when two surgeons, usually with different specialties or skills, work together as primary surgeons performing distinct parts of a single reportable procedure. Neither surgeon is acting as an assistant surgeon; both have comparable roles in the procedure. When two surgeons work together as primary surgeons performing distinct parts of the procedure, each surgeon should report their distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes for that procedure, as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure codes. If additional procedures (including add-on procedures) are performed during the same surgical session, separate codes may be reported without modifier 62 added.

Authorization is not specifically required for procedures using cosurgeons, although all other authorization requirements must be met. Prior authorization must be obtained for those procedures completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in Section 31.2.39.11, “Cleft/Craniofacial Procedures” in this chapter and Section 31.2.42.2, “Transplants - Nonsolid Organ” in this chapter.

If a cosurgeon acts as an assistant in the performance of additional procedures during the same surgical session, those services can be reported using separate procedure codes with the modifier 80 or 81 (minimum assistant surgeon) added, as appropriate.

Each surgeon receives 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee. Additional payment is not made for an assistant surgeon on the same procedure being reimbursed as cosurgery.

Claims submitted without the cosurgery modifier 62 are not considered cosurgery. Reimbursement for these claims is determined by other surgery reimbursement methodology.

**Note:** *Each surgeon that performs cosurgery must bill only the appropriate procedure code for the specific surgery performed.*

The CSHCN Services Program does not reimburse for team surgery. Surgeons and assistant surgeons participating in a team surgery should bill for procedures they personally completed, and may be reimbursed based on the multiple surgery guidelines.

### **31.2.39.5 Bilateral Procedures**

When a bilateral procedure is performed and an appropriate bilateral procedure code is not available, a unilateral procedure code must be used. The unilateral procedure code must be billed twice with a quantity of one for each procedure code. For all procedures, modifiers LT (left side), and RT (right side) must be used as appropriate.

Bilateral procedures performed on separate limbs are paid the full allowance for the major procedure and half the allowance for subsequent procedures performed on the same day, when medically justified.

### **31.2.39.6 Global Fees**

The CSHCN Services Program uses global surgical periods to determine reimbursement for surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

The CSHCN Services Program will adhere to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period—Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period—Reimbursement includes the surgical procedure and all associated services provided on the day of the surgery through 10 days after the surgical procedure.
- 90-day Global Period—Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, and all associated services that are provided on the day of the surgery through 90 days after the surgical procedure.

Procedure codes that are designated as “Carrier Discretion” will have their global periods determined by the CSHCN Services Program.

**Note:** *Note: All unlisted surgical procedure codes have a 42-day global period assigned by the CSHCN Services Program.*

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Radiology and laboratory services related to the surgical procedure are not subject to the global period and are reimbursed separately.

#### 31.2.39.6.1 Modifiers

To align with CMS, the CSHCN Services Program will add certain modifiers that are related to surgical services. For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

| Modifiers Related to Surgical Fees |    |    |    |    |    |    |    |    |    |
|------------------------------------|----|----|----|----|----|----|----|----|----|
| 24                                 | 25 | 54 | 55 | 56 | 57 | 58 | 62 | 76 | 77 |
| 78                                 | 79 |    |    |    |    |    |    |    |    |

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the provider performing preoperative or postoperative care. Reimbursement for claims associated with modifiers 54, 55, and 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

#### 31.2.39.6.2 Documentation Requirements

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client's medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to:

- Progress notes.
- Operative reports.
- Laboratory reports.
- Hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

**Note:** *Retrospective review may be performed to ensure documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.*

#### 31.2.39.6.3 Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a separately identifiable service and are above and beyond the usual preoperative and postoperative care, may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services

Program upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when they are billed with modifier 57. The client's medical record should clearly indicate when the initial decision to perform the procedure was made.

#### 31.2.39.6.4 Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

#### 31.2.39.6.5 Postoperative Services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Follow-up visits (any place of service)
- Pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care
  - Platelet gel
  - Removal of operative packs
  - Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
  - Replacement of vascular access lines
  - Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
  - Changes or removal of tracheostomy tubes

**Note:** *Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of surgery, and modifier 54, which indicates that he or she was the surgeon
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care

**Note:** *Providers must not submit a claim for a procedure until after the client has been seen during a face-to-face follow-up visit.*

When transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider who assumes in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- The surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
- Documentation in the medical record must include all of the following:
  - A copy of the written transfer agreement
  - The dates the care was assumed and relinquished
- The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

When a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until at least one service has been provided.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and was one of the following:

- It was planned at the time of the initial surgical procedure
- It is more extensive than the initial surgical procedure
- It is for therapy following an invasive diagnostic surgical procedure

**Note:** *Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).*

Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:

- Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.
- Critical care is provided by the surgeon for a burn or trauma patient.
- The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. Documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.



### 31.2.39.6.6 Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifiers 76 and 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure should be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period, only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis
- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier
- When a different procedure is performed with the same diagnosis
- When a different procedure is performed with a different diagnosis

Billing with modifier 79 initiates a new global surgical period.

### 31.2.39.7 Multiple Surgeries

The CSHCN Services Program payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the major procedure (e.g., the highest paying procedure) is paid at the full amount allowed by Texas Medicaid. Secondary procedures performed on the same day are paid at half of the amount allowed by Texas Medicaid when medically justified.
- When a surgical procedure and a biopsy on the same organ or structure are performed on the same day, the procedures are reviewed and only the service with the higher of the allowed amounts may be reimbursed.

### 31.2.39.8 Second Opinions

CSHCN Services Program benefits include payment to physicians when a CSHCN Services Program client requests a second opinion regarding surgery. The claim must be coded with the appropriate office or hospital visit procedure code, and the notation “Client Initiated Second Opinion” must be noted in Block 24D of the CMS-1500 paper claim form.

### 31.2.39.9 Unlisted Surgical Procedure Code Considerations

Unlisted surgical procedure codes are commonly used when a matching description of a procedure performed *cannot* be found within HCPCS.

**Note:** *All unlisted surgical procedure codes have a 42-day global period assigned by the CSHCN Services Program.*

Providers may use the procedure code that best matches the surgery performed. If an unlisted procedure code is used, the following must be included with the claim:

- A complete description of all procedures performed
- An operative report of procedures

Providers must verify whether a procedure requires authorization. Filing a claim correctly the first time helps ensure that the claim is processed in a timely manner.

**Referto:** Section 31.2.1, “Authorization and Prior Authorization Requirements” in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

Section 31.2.39.11, “Cleft/Craniofacial Procedures” in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

Section 31.2.42.2, “Transplants - Nonsolid Organ” in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

### 31.2.39.10 Circumcision

Circumcision (procedure codes 54150, 54160, and 54161) is a benefit of the CSHCN Services Program when medically necessary.

Conditions that may require circumcision include, but are not limited to, the following:

- Congenital obstructive urinary tract anomalies
- Neurogenic bladder
- Spina bifida
- History of recurrent urinary tract infections
- Vesicoureteral reflux of at least a Grade III
- Paraphimosis
- Phimosis causing urinary obstruction

Elective circumcision of a newborn male for cosmetic, routine, or ritual purposes is not a benefit of the CSHCN Services Program. The newborn period is defined as the first 28 days of life. Circumcision of a female of any age is not a benefit of the CSHCN Services Program.

Authorization is required for a circumcision. Documentation should include the diagnosis and the specific medical necessity for the circumcision.

**Referto:** Section 4.3, “Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

Procedure codes 54162 and 54163 are also a benefit of the CSHCN Services Program when medically necessary and do not require authorization.

When anesthesia or analgesia stronger than topical analgesia is used during the procedure, providers must follow applicable modifier guidelines and bill their usual and customary charges.

If a circumcision is billed in addition to a hypospadias or epispadias repair, the circumcision is denied as part of another procedure. A circumcision billed in addition to other surgical procedures on the male genital or urinary system is paid according to multiple surgery reimbursement guidelines. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Claims submitted by an assistant surgeon for a circumcision are denied.

### **31.2.39.11 Cleft/Craniofacial Procedures**

Cleft and craniofacial services provided by a cleft and craniofacial (C/C) team or through a coordinated multidisciplinary team, including surgical interventions required to treat cleft lip, cleft palate, and craniofacial anomalies, are benefits of the CSHCN Services Program.

The CSHCN Services Program recognizes the standard of care needed to appropriately address the repair of C/C anomalies, as outlined in the guidelines prepared by the American Cleft Palate-Craniofacial Association ([www.acpa-cpf.org](http://www.acpa-cpf.org)).

A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients who have complex medical conditions that require treatment by a broad range of medical specialists. The standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach by either a C/C team or an equivalent coordinated multidisciplinary team. The following exceptions to this requirement may be considered:

- A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. Medical record documentation must explain the reasons for which the client is unable to travel.
- A C/C or equivalent multidisciplinary team is not available in the area and the team approach cannot be coordinated over multiple locations. Medical record documentation must describe the attempts that were made to coordinate a team approach.
- A C/C or equivalent multidisciplinary team is available but the client or the client's parent or guardian refuses care from the team. Medical record documentation must document the reason that the client or the client's parent or guardian gave for refusing care from the team.

The C/C or equivalent coordinated multidisciplinary team must have surgical and medical specialists, including, but not limited to the following:

- Operating surgeon
- Orthodontist
- Speech-language pathologist
- At least one of the following specialists:
  - Otolaryngologist
  - Audiologist
  - Pediatrician
  - Geneticist
  - Social worker
  - Psychologist
  - General pediatric or prosthetic dentist

Each C/C or equivalent coordinated multidisciplinary team must identify the following:

- An administrator who is responsible for coordinating and maintaining C/C team records and ensuring that the C/C team adheres to CSHCN Services Program rules and regulations

- A team care coordinator to ensure that the focus of the service is client and family oriented, and that the client, family, and C/C team jointly develop a comprehensive treatment plan for the client

The comprehensive treatment plan must be maintained in the client’s medical record and must be provided to the client and family, the referring physician, other collaborating providers, and the Department of State Health Services (DSHS) regional social worker upon request.

The plan will include the specific services that will be provided by the members of the C/C team, action steps, persons responsible, and time-frame objectives for meeting treatment outcomes.

Documentation of medical necessity must be kept in the client’s medical record if the requested surgical procedure is being performed because of injury or other trauma that is not associated with the repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies.

The following procedure codes must be prior authorized:

| Surgery and Assistant Surgery Procedure Codes |       |       |       |       |       |       |       |       |       |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 20902   | 21120 | 21121 | 21122 | 21123 | 21125 | 21127 | 21137 | 21138 | 21139 |
| 21141   | 21142 | 21143 | 21145 | 21146 | 21147 | 21150 | 21151 | 21154 | 21155 |
| 21159   | 21160 | 21172 | 21175 | 21179 | 21180 | 21181 | 21182 | 21183 | 21184 |
| 21188   | 21193 | 21194 | 21195 | 21196 | 21198 | 21199 | 21206 | 21209 | 21210 |
| 21230   | 21244 | 21247 | 21255 | 21256 | 21260 | 21261 | 21263 | 21267 | 21268 |
| 21275   | 21299 | 40799 | 42210 | 61550 | 61552 | 61556 | 61557 | 61558 | 61559 |
| 62115   | 62117 |       |       |       |       |       |       |       |       |

| Surgery Only Procedure Codes |       |       |       |       |       |       |       |       |       |
|------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 14040                        | 14041 | 14060 | 14061 | 15120 | 15121 | 15135 | 15136 | 15155 | 15156 |
| 15157                        | 15240 | 15241 | 15260 | 15261 | 15576 | 21076 | 21077 | 21079 | 21080 |
| 21081                        | 21082 | 21083 | 21084 | 21085 | 21086 | 21087 | 21088 | 21089 | 21100 |
| 21110                        | 21208 | 21215 | 21235 | 21245 | 21246 | 21248 | 21249 | 21270 | 21280 |
| 21282                        | 21295 | 21296 | 21497 | 30400 | 30410 | 30420 | 30435 | 30450 | 30460 |
| 30462                        | 30465 | 30520 | 30540 | 30545 | 30560 | 30580 | 30600 | 30620 | 30630 |
| 40527                        | 40650 | 40652 | 40654 | 40700 | 40701 | 40702 | 40720 | 40761 | 42145 |
| 42200                        | 42205 | 42215 | 42220 | 42225 | 42226 | 42227 | 42235 | 42260 | 42280 |
| 42281                        | 67950 | 67961 | 67966 | 67971 | 67973 | 67974 | 67975 |       |       |

Documentation of medical necessity must be submitted with the prior authorization request form if the surgical procedure is to be performed for reasons unrelated to the repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies.

Prior authorization is also required for orthodontic services that are performed in conjunction with C/ C services.

**Referto:** [CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only](#)

[CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons](#)

**31.2.40 Diagnostic and Surgical/Reconstructive Breast Therapies**

The following services are benefits of the CSHCN Services Program:

- Breast therapies

- Diagnostic
- Surgical
- Reconstructive
- Treatment of complications of breast reconstruction
- External breast prostheses
- Corrective procedures

Surgical, reconstructive, and corrective procedures must be medically necessary.

Only new, unused durable medical equipment will be purchased for CSHCN clients.

Diagnostic and surgical/reconstructive breast therapies and corrective procedures include:

- Diagnostic procedures for the breast
- Mastectomy for the treatment of breast cancer
- Prophylactic mastectomy
- Mastectomy for gynecomastia
- Reconstructive procedures
- Treatment of complications of breast reconstruction
- External breast prostheses
- Corrective procedures

The following provider types, services and settings apply:

- Diagnostic and surgical/reconstructive breast therapies may be provided by physicians, physician assistants, and advanced practice registered nurses, in the office, outpatient and inpatient hospital settings.
- Corrective procedures may be provided by physicians, dentists, podiatrists, physician assistants, and advanced practice registered nurses, in office, inpatient and outpatient hospital settings.
- Breast prostheses which are considered DME and may be provided by DME providers in the home setting.

To be considered for reimbursement, a LT or RT modifier must be appropriately appended to the procedure codes submitted for diagnostic and surgical/reconstructive breast therapies, external breast prostheses, or corrective procedures.

### **31.2.40.1 Breast Therapies**

#### **31.2.40.1.1 Diagnostic Breast Procedures**

Diagnostic breast procedures are a benefit of the CSHCN Services Program for a diagnosis of a condition or malignancy of the breast.

Diagnostic procedures may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy

- Nipple exploration

Excision of the following:

- Lactiferous duct fistula
- Benign or malignant breast lesion
- Chest wall tumor

The following procedure codes may be reimbursed for diagnostic procedures:

| Procedure Codes  |       |       |       |       |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 19000  | 19001 | 19020 | 19030 | 19081 | 19082 | 19083 | 19084 | 19085 | 19086 |
| 19100  | 19101 | 19110 | 19112 | 19120 | 19125 | 19126 | 19281 | 19282 | 19283 |
| 19284  | 19285 | 19286 | 19287 | 19288 | 21601 | 21602 | 21603 |       |       |
| <b>*Procedure code 21603 is limited to one procedure per lifetime.</b> |       |       |       |       |       |       |       |       |       |

The following procedure codes are add-on codes and must be billed with the appropriate primary procedure code, on the same day, by the same provider:

| Add-on Procedure Codes |       |       |       |       |       |       |       |       |
|------------------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 19001                  | 19082 | 19084 | 19086 | 19126 | 19282 | 19284 | 19286 | 19288 |

### 31.2.40.2 Surgical Breast Procedures

#### 31.2.40.2.1 Mastectomy

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, or segmentectomy) is a benefit of the CSHCN Services Program when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

The following mastectomy procedure codes are benefits of the CSHCN Services Program for male and female clients of all ages:

| Procedure Codes  | Limitations   |
|--|---|
| Partial Mastectomy   |   |
| 19301, 19302   | One left breast per lifetime<br>One right breast per lifetime |
| Simple, Subcutaneous, Radical, and Modified Radical Mastectomy |   |
| 19303 19305, 19306, 19307                                      | One left breast per lifetime<br>One right breast per lifetime |

### 31.2.40.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit of the CSHCN Services Program and is limited to clients who are at moderate or high-risk for the development of breast cancer and have one or more of the following conditions:

- Personal history
  - Current or previous history of breast cancer
  - Lobular carcinoma in situ (LCIS)
  - Radiation therapy to the chest before the age of 30
- Family history of breast or ovarian cancer in mother, sister, or daughter
- Presence of any of the following genetic mutations:
  - Breast cancer gene 1 (BRCA1)
  - Breast cancer gene 2 (BRCA2)
  - Tumor protein 53 ( TP 53)
  - Phosphatase and tensin homolog (PTEN)

***Note:** The above risk factors are identified by the National Cancer Institute and the National Comprehensive Cancer Network.*

Documentation that supports medical necessity for the procedure must be maintained in the client's medical record and must indicate the following:

- The client is moderate-to-high risk, as previously defined
- As a candidate for prophylactic mastectomy, the client has undergone counseling from a health professional other than the operating surgeon. The counseling must include assessment of the following:
  - The client's ability to understand the risks and long-term implications of the surgical procedure
  - The client's informed choice to proceed with the surgical procedure

### 31.2.40.2.3 Mastectomy for Gynecomastia

Surgery to correct gynecomastia is a benefit of the CSHCN Services Program for males who are 20 years of age or younger, when the criteria is met.

Procedure code 19300 may be reimbursed when billing for a mastectomy for pubertal gynecomastia.

### 31.2.40.2.4 Breast Reconstruction

Breast reconstruction is a benefit of the CSHCN Services Program when performed to correct or repair abnormal structures of the breast caused by one or more of the following:

- Mastectomy or a history of complications of mastectomy
- Tumor or disease (e.g., following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma or injury to the chest wall

Breast reconstruction may be performed using one of the following:

- Implants (saline or silicone)
- Tissue transfers, including, but not limited to:
  - Latissimus dorsi flap
  - Transverse rectus abdominis myocutaneous (TRAM) flap
  - Deep inferior epigastric perforator (DIEP) flap
  - Superficial inferior epigastric artery (SIEA) flap
- Nipple or areola reconstruction
- Reduction mammoplasty
- Mastopexy
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Breast reconstruction may be performed as single or multiple, staged procedures (e.g., tissue expansion followed by implants, nipple or areola reconstruction). Nipple-areola pigmentation, commonly known as medical tattooing, is the final stage of breast reconstruction surgery. All of the following criteria must be met for breast reconstruction following a medically necessary mastectomy.

- The client is eligible for CSHCN Services Program at the time of the breast reconstruction.
- The client has a documented history of a mastectomy.
- The client meets age and gender criteria for the requested procedure.

The following procedure codes may be reimbursed for breast reconstruction:

| Procedure Code | Client Gender and Ages  | Limitation                  |
|----------------|-------------------------|-----------------------------|
| 11920          | Male and female clients | Two procedures per lifetime |
| 11921          | Male and female clients | Two procedures per lifetime |
| 11922          | Male and female clients | Two procedures per lifetime |
| 11970          | Male and female clients |                             |
| 11971          | Male and female clients |                             |
| 19316          | Female clients          |                             |
| 19318          | Female clients          |                             |
| 19325          | Female clients          |                             |
| 19340          | Female clients          |                             |
| 19342          | Female clients          |                             |
| 19350          | Male and female clients |                             |
| 19355          | Male and female clients |                             |
| 19357          | Female clients          |                             |
| 19361          | Male and female clients |                             |
| 19364          | Male and female clients |                             |
| 19367          | Male and female clients |                             |
| 19368          | Male and female clients |                             |
| 19369          | Female clients          |                             |



| Procedure Code | Client Gender and Ages  | Limitation |
|----------------|-------------------------|------------|
| 19396          | Female clients          |            |
| S2068          | Male and female clients |            |

Tattooing (procedure codes 11920, 11921, and 11922) is limited to clients with a documented history of a breast reconstruction performed while the client was eligible for the CSHCN Services Program.

Denied claims for tattooing may be appealed with supporting documentation stating the date of breast reconstruction.

Denied claims for breast reconstruction may be appealed with supporting documentation which includes the date of mastectomy.

#### 31.2.40.2.5 Excision or Destruction of Benign Lesions

The client must have a documented history of mastectomy or a history of complications of mastectomy performed while eligible for the CSHCN Services Program.

Documentation supporting medical necessity for treatment of a benign lesion, cyst, or lipoma must be maintained in the client's medical record and identify that the lesion requiring treatment is one or more of the following:

- Inflamed
- Infected
- Irritated
- Bleeding
- Increasing in size
- Obstructing vision
- Interfering with oral function
- Located in an area that could affect motion or function

When a lesion is suspicious for malignancy, documentation supporting medical necessity for excision or destruction of the lesion must be maintained in the client's medical record.

For blepharoplasty procedures (procedure codes 15820, 15821, 15822, and 15823) additional documentation of medical necessity must be submitted with both of the following:

- Photographs of the eyelid problem
- Visual field measurements

Excision or destruction of multiple lesions, cysts, or lipomas are reimbursed according to the multiple surgery payment guidelines. Initial or follow-up visits billed in addition to a lesion excision and/or destruction for the same diagnosis are subject to global surgery payment criteria.

**Referto:** Section 31.2.39.6, "Global Fees" in this chapter and Section 31.2.39.7, "Multiple Surgeries" in this chapter for additional information about global surgery and multiple surgery fees.

### 31.2.40.2.6 Treatment for Complications of Breast Reconstruction

The following procedure codes are benefits of the CSHCN Services Program for the treatment of complications of breast reconstruction:

| Procedure Codes                     |        |        |        |       |
|-------------------------------------|--------|--------|--------|-------|
| 19328*                              | 19330* | 19370* | 19371* | 19380 |
| * A benefit for female clients only |        |        |        |       |

Regardless of the client's eligibility at the time of the original breast reconstruction, the treatment of complications is considered for reimbursement when medical criteria are met.

### 31.2.40.2.7 Reduction Mammoplasty

Procedure code 19318 may be reimbursed with prior authorization for reduction mammoplasty. This procedure is limited to two per lifetime.

### 31.2.40.2.8 External Breast Prostheses

External breast prostheses must be provided by a durable medical equipment (DME) provider to a female client with a history of a medically necessary mastectomy procedure.

External breast prostheses may be reimbursed if the client has a documented history of breast surgery in the past.

*Referto:* Chapter 17, "Durable Medical Equipment (DME)" for breast prosthesis benefits and limitations.

## 31.2.40.3 Prior Authorization and Authorization Requirements

All prior authorization and authorization requests must be submitted with documentation of medical necessity.

Prior authorization requests must be submitted using a [CSHCN Services Program Authorization and Prior Authorization Request form](#). Prior authorization requests that do not contain required information are considered incomplete and will be denied. The requesting provider may be asked for additional information to clarify or support the authorization request.

Prior authorization requests for external breast prostheses must be submitted using the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form and Instructions](#).

Requests must include the physician's original signature and the date signed. Stamped signatures and dates will not be accepted. Requests will be considered incomplete without this information.

Requests for DME quantities exceeding limitations must be prior authorized by the CSHCN medical director and must be submitted with documentation of medical necessity.

Procedure code 15828 requires prior authorization. All requests must be reviewed by the CSHCN Services Program Medical Director or designee.

## 31.2.40.4 Prior Authorization and Authorization Requirements for Mastectomy, Breast Reconstruction, and External Prostheses

Prior authorization is not required when:

- The client is 18 years of age or older, meets gender criteria and the procedure is a mastectomy or breast reconstruction, or
- The client is 18 years of age or older, meets gender criteria, and the request is for one of the following external breast prosthesis procedure codes:

| Procedure Codes |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|
| L8000           | L8001 | L8002 | L8010 | L8015 | L8020 | L8030 |

- Partial mastectomy, procedure codes 19301 and 19302 are exceptions. Procedure codes 19301 and 19302 are eligible for reimbursement regardless of the client's age, and therefore they do not require prior authorization.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client does not meet criteria
- Mastectomy for pubertal gynecomastia
- Unlisted breast procedure code 19499
- Tattooing for clients without an established history of breast reconstruction during eligibility for the CSHCN Services Program
- External breast prosthesis procedure codes L8035 and L8039

#### 31.2.40.4.1 Mastectomy and Breast Reconstruction

Prior authorization for mastectomy, prophylactic mastectomy, or breast reconstruction is required for one or more of the following:

- The client is 17 years of age or younger, or
- The client does not meet the gender criteria for the requested procedure, as required by the CSHCN Services Program, or
- The client does not have an established history of related services while eligible for the CSHCN Services Program.

Documentation for a mastectomy must be submitted for conditions, including but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

#### 31.2.40.4.2 Breast Reconstruction

Documentation must be submitted which identifies one or more of the following:

- Mastectomy or a history of complications of mastectomy
- Tumor or disease (e.g., following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma or injury to the chest wall

#### 31.2.40.4.3 Mastectomy for Gynecomastia

Prior authorization is required for procedure code 19300, which indicates mastectomy for pubertal gynecomastia. The following documentation must be submitted with all prior authorization requests:

- Gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification.
- Puberty is at or near completion, as evidenced by documentation of the following:
  - 95 percent of adult height based on bone age, and
  - Tanner stage V
- Glandular breast tissue confirming true gynecomastia is documented on physical examination or mammography.
- Hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas and hypogonadism, have been excluded by appropriate laboratory testing. If present, hormonal causes must have been treated for at least one year and are resolved, as supported by appropriate laboratory test results.
- Medical documentation must be submitted with a prior authorization request for a client that has used gynecomastia inducing drugs or other substances, when identified as the cause of gynecomastia. The documentation must indicate that the client has been off the drugs or other substances for a minimum of one year and must include the dates that the client has been off such substances.
- Psychological and psycho-social effects which were identified in the pre-surgical history and physical.
- Identification of left breast, right breast or both breasts, which require mastectomy.

#### 31.2.40.4.4 Reduction Mammoplasty

Prior authorization is required for procedure code 19318, which indicates reduction mammoplasty.

When requesting prior authorization for procedure code 19318, the following documentation must be submitted with all prior authorization requests:

- Surgeons are required to include the following information documenting medical necessity when requesting prior authorization:
  - Client's name and CSHCN Services Program client number,
  - Complete history and physical, including height, weight, and breast size
  - Description of functional debility caused by the condition
  - Preoperative photographs (both front and side views)
  - Description of past treatments and outcomes
  - Number of grams of tissue to be removed from each side
  - Requesting surgeon's National Provider Identifier (NPI) number, and
  - Name and address of facility where services are to be performed and the provider's NPI.

#### 31.2.40.4.5 Unlisted Procedure

Prior authorization is required for procedure code 19499, which indicates an unlisted breast procedure.

When requesting a prior authorization for procedure code 19499, the following documentation must be submitted to determine coverage:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure

- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation this procedure is not investigational or experimental
- Place of service the procedure is to be performed, and
- The provider's intended fee for this procedure.

Prior authorization requests must be submitted using a [CSHCN Services Program Authorization and Prior Authorization Request form](#).

Prior authorization requests that do not contain the required information are considered incomplete and will be denied.

#### 31.2.40.4.6 Breast Prostheses

Prior authorization requests for external breast prostheses must be submitted using the [CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form and Instructions](#).

External breast prostheses of the same type will be considered for coverage at any time, through the prior authorization process, if it is lost, stolen, or irreparably damaged.

An external breast prosthesis that is a replacement or a different type will be considered for coverage at any time, through the prior authorization process, if the prosthesis is needed due to a change in the client's medical condition.

Prior authorization is required for procedure codes L8035 and L8039 when the request is for new or replacement external breast prosthesis. The following documentation of medical necessity must be submitted with the prior authorization request:

- The client's diagnosis
- Prior treatment for this diagnosis, and
- Medical necessity of the requested prosthesis.

When requesting a prior authorization for procedure code L8039, the following additional information must also be submitted in order to determine coverage:

- A clear, concise description of the prosthesis which is requested
- Reason for recommending this particular prosthesis
- A CPT or HCPCS procedure code, which is comparable to the prosthesis requested
- Documentation that this prosthesis is not investigational or experimental
- Provider's place of service, and
- The provider's intended fee for this prosthesis.

#### 31.2.40.5 Documentation Requirements

In addition to documentation requirements outlined in the Prior Authorization and Authorization Requirements section, the following requirements apply:

- All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided, and
- Services not supported by documentation are subject to recoupment.

**31.2.40.6 Reconstructive and Corrective Procedures (Not Related to Breast Therapies)**

Reconstructive and corrective procedures are performed on structures of the body for any of the following purposes:

- Improving or restoring bodily functions
- Correcting significant deformity resulting from:
  - Disease
  - Trauma
  - Previous surgical procedure
  - Congenital or developmental anomalies

Excision or destruction of a benign lesion, cyst, or lipoma is a benefit only when the lesion is:

- Inflamed
- Infected
- Irritated
- Bleeding
- Increasing in size
- Obstructing vision
- Interfering with oral function
- Located in an area that could affect motion or function

Excision or destruction of a lesion may be a benefit when there is suspicion of malignancy.

The following procedure codes may be reimbursed for corrective procedures:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 10040           | 11200 | 11201 | 11300 | 11301 | 11302 | 11303 | 11305 | 11306 | 11307 |
| 11308           | 11310 | 13111 | 11312 | 11313 | 11400 | 11401 | 11402 | 11403 | 11404 |
| 11406           | 11420 | 11421 | 11422 | 11423 | 11424 | 11426 | 11440 | 11441 | 11442 |
| 11443           | 11444 | 11446 | 11760 | 11762 | 11960 | 15781 | 15782 | 15783 | 15786 |
| 15787           | 15788 | 15789 | 15792 | 15793 | 15820 | 15821 | 15822 | 15823 | 15830 |
| 15847           | 17000 | 17003 | 17004 | 17106 | 17107 | 17108 | 17110 | 17111 | 17311 |
| 17312           | 17313 | 17314 | 17315 | 21555 | 21740 | 21742 | 21743 | 21930 | 21931 |
| 22900           | 22901 | 22902 | 22903 | 23071 | 23073 | 23075 | 23076 | 23077 | 23078 |
| 24071           | 24073 | 24075 | 24076 | 24077 | 24079 | 25075 | 26115 | 27043 | 27045 |
| 27047           | 27048 | 27049 | 27327 | 27328 | 27337 | 27339 | 27618 | 27619 | 27634 |
| 28039           | 28041 | 28043 | 28045 | 28313 | 40818 | 54660 |       |       |       |

The following procedure codes are add-on codes and must be billed with the appropriate primary procedure code, on the same day, by the same provider:

| Add-on Procedure Codes |       |       |       |       |       |       |       |
|------------------------|-------|-------|-------|-------|-------|-------|-------|
| 11201                  | 15777 | 15787 | 15847 | 17003 | 17312 | 17314 | 17315 |

### 31.2.40.7 Prior Authorization and Authorization for Corrective Procedures

#### 31.2.40.7.1 Oral Procedures

Procedures that are performed as part of cleft-craniofacial surgery require prior authorization.

**Referto:** Section 31.2.39.11, “Cleft/Craniofacial Procedures” in this chapter for information about CSHCN Services Program cleft-craniofacial benefits and limitations.

#### 31.2.40.7.2 Dermatological and Blepharoplasty Procedures

Acne surgeries, dermabrasion, and chemical peel, and blepharoplasty procedures (procedure codes 10040, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 15820, 15821, 15822, and 15823) require prior authorization, and must meet one of the following criteria:

- Correction or repair of severe disfigurement due to disease or accidental injury (photographic documentation is required), or
- Restoration of physical function resulting from disease or accidental injury (specific function must be detailed in prior authorization request).

#### 31.2.40.7.3 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits for panniculectomy and abdominoplasty procedures.

Panniculectomy and abdominoplasty procedures are limited to once per lifetime, by the same provider.

Panniculectomy and abdominoplasty procedure codes 15830 and 15847 require prior authorization. The following documentation supporting medical necessity must be submitted with all prior authorization requests:

- Photographic documentation that the panniculus hangs below the level of the pubis,
- The panniculus is the result of weight loss of at least 75 pounds that has been sustained for over one year, and
- Documentation of one or more of the following conditions which directly impairs physical function:
  - Interference with ambulation, urination or other activities of daily living, or
  - Recurring persistent fungal and bacterial panniculitis that is refractory to good personal hygiene and documented optimal medical management including topical anti-infectives, and at least three systemic medication treatments.

#### 31.2.40.7.4 Noncovered Services

The following services are not a benefit of the CSHCN Services Program:

- Alteration of a natural, undamaged, or unimpaired body part, except as specifically outlined in this chapter.

The following cosmetic procedures are not a benefit of the CSHCN Services Program:

- Rhytidectomies (procedure codes 15824, 15825, 15826, and 15829)
- Excisions of excessive skin and subcutaneous tissue (includes lipectomy) (procedure codes 15832, 15833, 15834, 15835, 15836, 15837, and 15839)
- Suction assisted lipectomies (procedure codes 15877, 15878, and 15879)
- Cryotherapy for acne (procedure code 17340)
- Chemical exfoliation (procedure code 17360)
- Electrolysis epilation (procedure code 17380)

### 31.2.40.8 Rhizotomy

Rhizotomy for clients with spastic cerebral palsy is a benefit of the CSHCN Services Program.

Rhizotomies (procedure codes 63185 and 63190) must be prior authorized.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

[CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only Form.](#)

Rhizotomies are a benefit when submitted for reimbursement with one of the following diagnosis codes:

| Diagnosis Codes |      |      |      |      |      |       |
|-----------------|------|------|------|------|------|-------|
| G800            | G801 | G802 | G808 | G809 | G835 | G8389 |

Documentation of whether or not the client has spastic cerebral palsy with no athetosis or fluctuations in muscle tone, but does have underlying muscle strength, must be included with the prior authorization request form.

Either electromyography or intraoperative neurophysiology testing is paid, but not both during the same procedure, when performed on the same day.

PT and occupational therapy (OT) are benefits up to three times a week (each) for a period of 1 year postoperatively.

### 31.2.40.9 Septoplasty

Septoplasty (procedure code 30520) that is not related to the repair or reconstruction of a cleft lip, cleft palate, or craniofacial anomaly may be prior authorized with documentation to support medical necessity.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

[CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only](#)

[CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons](#)

### 31.2.41 Therapeutic Apheresis

Therapeutic apheresis does not require authorization.

Reimbursement for procedure codes 36511, 36512, 36513, 36514, and 36516 is limited to the following diagnosis codes:

| Diagnosis Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| C880            | C882  | C883  | C888  | C9000 | C9002 | C9010 | C9012 |
| C9020           | C9022 | C9030 | C9032 | C9100 | C9102 | C9110 | C9112 |
| C9130           | C9132 | C9140 | C9142 | C9150 | C9152 | C9160 | C9162 |
| C9190           | C9192 | C91A0 | C91A2 | C91Z0 | C91Z2 | C9200 | C9202 |
| C9210           | C9220 | C9230 | C9232 | C9240 | C9242 | C9250 | C9252 |
| C9260           | C9262 | C9290 | C9292 | C92A0 | C92A2 | C92Z0 | C92Z2 |
| C9300           | C9302 | C9310 | C9312 | C9330 | C9332 | C9390 | C9392 |
| C93Z0           | C93Z2 | C9400 | C9402 | C9420 | C9422 | C9430 | C9432 |
| C9440           | C9442 | C9480 | C9482 | C9500 | C9502 | C9510 | C9512 |



| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C9590           | C9592  | D45    | D472   | D473   | D474   | D5700  | D5701  |
| D5702           | D5703  | D5704  | D5709  | D571   | D5720  | D57211 | D57212 |
| D57213          | D57214 | D57218 | D57219 | D5780  | D57811 | D57812 | D57813 |
| D57818          | D57819 | D588   | D589   | D590   | D5910  | D5911  | D5912  |
| D5913           | D5919  | D592   | D5930  | D5931  | D5932  | D5939  | D594   |
| D599            | D6182  | D65    | D682   | D68311 | D688   | D690   | D691   |
| D692            | D693   | D6941  | D6942  | D6949  | D696   | D698   | D699   |
| D72828          | D740   | D748   | D749   | D750   | D751   | D7589  | D759   |
| D761            | D762   | D763   | D77    | D890   | D8940  | D8941  | D8942  |
| D8943           | D8949  | D892   | E0842  | E0942  | E1042  | E1142  | E7800  |
| E7801           | E7841  | E7849  | G603   | G610   | G6181  | G6182  | G6189  |
| G620            | G621   | G622   | G6281  | G6282  | G63    | G64    | G650   |
| G7000           | G7001  | G731   | I00    | I010   | I012   | I018   | I019   |
| I773            | I776   | I7789  | K716   | K7200  | K7201  | K7581  | K759   |
| K760            | K762   | K7689  | K77    | L100   | L101   | L102   | L103   |
| L104            | L105   | L1081  | L1089  | L109   | L900   | L940   | L941   |
| L943            | M05011 | M05012 | M05021 | M05022 | M05031 | M05032 | M05041 |
| M05042          | M05051 | M05052 | M05061 | M05062 | M05071 | M05072 | M0509  |
| M05411          | M05412 | M05421 | M05422 | M05431 | M05432 | M05441 | M05442 |
| M05451          | M05452 | M05461 | M05462 | M05471 | M05472 | M0549  | M05611 |
| M05612          | M05621 | M05622 | M05631 | M05632 | M05641 | M05642 | M05651 |
| M05652          | M05661 | M05662 | M05671 | M05672 | M0569  | M069   | M08011 |
| M08012          | M08021 | M08022 | M08031 | M08032 | M08041 | M08042 | M08051 |
| M08052          | M08061 | M08062 | M08071 | M08072 | M0809  | M080A  | M083   |
| M08411          | M08412 | M08421 | M08422 | M08431 | M08432 | M08441 | M08442 |
| M08451          | M08452 | M08461 | M08462 | M08471 | M08472 | M0848  | M084A  |
| M08832          | M08841 | M08842 | M08851 | M08852 | M08861 | M08931 | M08932 |
| M08941          | M08942 | M08951 | M08952 | M08961 | M08962 | M089A  | M310   |
| M3110           | M3111  | M3119  | M320   | M3210  | M3219  | M328   | M3300  |
| M3301           | M3302  | M3309  | M3310  | M3311  | M3312  | M3319  | M3320  |
| M3321           | M3322  | M3329  | M3390  | M3391  | M3392  | M3399  | M340   |
| M341            | M342   | M3481  | M3482  | M3483  | M3489  | N000   | N001   |
| N002            | N003   | N004   | N005   | N006   | N007   | N008   | N00A   |
| N010            | N011   | N012   | N013   | N014   | N015   | N016   | N017   |
| N018            | N01A   | N02B1  | N02B2  | N02B3  | N02B4  | N02B5  | N02B6  |
| N02B9           | N032   | N034   | N035   | N037   | N03A   | N040   | N0420  |
| N0421           | N0422  | N0429  | N044   | N045   | N046   | N047   | N048   |
| N049            | N04A   | N052   | N053   | N054   | N055   | N056   | N058   |
| N059            | N05A   | N08    | N171   | N172   | T8690  | T8691  | T8692  |
| T8699           |        |        |        |        |        |        |        |

Other diagnoses may be considered upon appeal with documentation of medical necessity.

Therapeutic apheresis with extracorporeal affinity column adsorption and plasma reinfusion may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber® LA 15) or the protein A immunoabsorption columns (such as Prosorba®).

Claims for apheresis services must be submitted with procedure codes 36511, 36512, 36513, 36514, and 36516, as appropriate.

Therapeutic apheresis requires direct supervision by a physician.

Procedure codes for therapeutic apheresis may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

## **31.2.42 Transplants**

### **31.2.42.1 Renal (Kidney) Transplant**

Renal transplants are a benefit for CSHCN Services Program clients when the projected costs of the transplant and follow-up care are less than the cost of continuing dialysis treatments. The estimated cost of the renal transplant over a 1-year period versus the cost of renal dialysis for 1 year at the requesting facility must be both documented and reviewed.

Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

Renal transplants may only be considered for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant center facility, certified by the United Network of Organ Sharing (UNOS).

**Referto:** Section 2.1.7, “Transplant Specialty Centers” in Chapter 2, “Provider Enrollment and Responsibilities.”

For any client who is 18 years of age or older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for services through the CSHCN Services Program.

Renal transplants must be prior authorized, and approval is subject to the availability of funds. Only an initial and one subsequent renal transplant may be reimbursed for a client as a lifetime benefit.

Documentation supporting the prior authorization request must include the following:

- [The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant form](#)
- A recent and complete history and physical
- A statement of the client’s status including why a transplant is being recommended at this time
- Documentation of the cost effectiveness of the transplant versus continued dialysis

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

Nationally, hospital stays for renal transplants are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program may be authorized without an appeal documenting medical necessity.

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6 weeks postoperative period are denied for the surgeon, assistant surgeon, or facility. The anesthesiologist may be reimbursed.

The following procedure codes must be used to bill for physician services related to the renal transplant:

| Surgery and Assistant Surgery Procedure Codes |       |       |       |       |       |       |       |       |       |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 50300   | 50320 | 50323 | 50325 | 50327 | 50328 | 50329 | 50340 | 50360 | 50365 |
| 50370   | 50380 | 50547 |       |       |       |       |       |       |       |

| Anesthesia Procedure Code |
|---------------------------|
| 00868                     |

| Radiology Procedure Code |
|--------------------------|
| 76776                    |

Procedure codes 50323, 50325, 50327, 50328, and 50329 are payable under the organ recipient, and may only be reimbursed when procedure code 50360 or 50365 has been paid for the same date of service.

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Reimbursement for renal transplants includes the cost of the transplant services and one of the following:

- The cost of procuring a cadaveric organ and services associated with procurement from an organ procurement organization (OPO) designated by the Secretary of Health and Human Services. Documentation validating the organ’s source must accompany the claim.
- Donor costs for living donors. Donor costs must be included on the client’s inpatient hospital claim and may only be reimbursed if another source of payment is not available. Donor costs for CSHCN Services Program clients who also have Medicaid will not be reimbursed.

A maximum amount of \$200,000 per client may be reimbursed for a transplant hospitalization. All hospital charges for patient care (inpatient hospital only) during the time of the hospital stay are applied to the \$200,000 limit. Donor costs are included in this \$200,000 limit.

Renal transplant recipients are eligible for follow-up care (outside the \$200,000 limit) immediately following hospital discharge.

**31.2.42.2 Transplants - Nonsolid Organ**

Stem cell transplants and post-transplantation cellular infusions must be performed in a Texas facility that is a designated children’s hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), UNOS, or the National Marrow Donor Program (NMDP). TMHP maintains a current list of approved centers.

*Referto:* Section 2.1.7, “Transplant Specialty Centers” in Chapter 2, “Provider Enrollment and Responsibilities.”

The following surgery procedure codes should be used to submit claims for reimbursement of transplantation and post-transplantation cellular infusion procedures:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 38206           | 38230 | 38232 | 38240 | 38241 | 38242 | 38243 | 38999 | S2142 |

Stem cell transplants and post-transplantation cellular infusions must be prior authorized. Prior authorization must be obtained by both the facility and the physician.

Providers may fax prior authorization requests to 1-512-514-4222.

**Referto:** Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements.

[CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant Form and Instructions.](#)

The CSHCN Services Program does not authorize the following:

- Experimental or investigational services, supplies, or procedures
- Human leukocyte antigen (HLA)-typing of possible donors

The CSHCN Services Program may cover post-transplantation cellular infusions and only autologous and matched related and matched nonrelated allogenic transplants.

The CSHCN Services Program will recognize the following covered indications for allogenic stem cell transplants:

- Bone marrow disorders
- Hemoglobinopathies
- Immunodeficiency disorders
- Inherited metabolic disorders
- Leukemias
- Lymphomas
- Multiple myeloma/plasma cell disorders
- Platelet function disorder

The CSHCN Services Program will recognize the following covered indications for autologous stem cell transplants:

- Brain tumors
- Germ cell tumors
- Leukemias
- Lymphomas
- Multiple myeloma/plasma cell disorders
- Small round blue cell tumors of childhood

Indications for post-transplantation cellular infusions include the following:

- Stem cell infusion for failure to graft (autologous)
- Donor leukocyte infusion for persistent or relapsed malignant disease (allogenic)
- Donor hematopoietic progenitor cell (HPC) boost infusion for relapse and post-transplantation cytopenias (allogenic)

Post-transplantation cellular infusions must be prior authorized separately with evidence of previous stem cell transplantation.

Stem cell transplants and post-transplantation cellular infusions may be considered for other conditions if documentation provides clinical evidence of the efficacy for the condition.

Coverage is limited to an initial transplant and one subsequent transplant, for a total of two transplants per lifetime regardless of payer. Indications for re-transplantation include the following:

- Relapse of disease

- Failure to engraft or poor graft function
- Graft rejection

The subsequent transplant must be prior authorized separately from the initial transplant.

#### 31.2.42.2.1 Physician Reimbursement

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

If approved, a letter with the authorization number is sent to the physician (when applicable) and to the hospital where the procedure is to be performed. This authorization number must be placed in Block 23 of the CMS-1500 paper claim form.

**Note:** *A benefit of up to 60 inpatient days may be granted to a client, to begin the date of an approved stem cell transplant. Any days remaining from the standard 60 inpatient day limit may be added to the 60 days for the transplant if the \$200,000 limit for the transplant maximum amount has not been exceeded. Donor costs must be included on the client's inpatient hospital claim for the transplant and are included in the \$200,000 limit for the transplant maximum amount. If prior authorization is received for a second stem cell transplant after a client has already received an initial transplant, an additional benefit of up to 60 inpatient days may be reimbursed for an additional maximum amount of \$200,000, beginning with the actual first day of the second transplant.*

### 31.2.43 Wound Care Management

Wound care management includes first- and second-line therapies.

The following services are not a benefit of the CSHCN Services Program:

- Infrared therapy
- Ultraviolet therapy
- Topical hyperbaric oxygen therapy
- Low-energy ultrasound wound cleanser (MIST therapy)
- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy
- More than 10 applications of skin substitute grafts per episode of wound care in a 12- week period of care per rolling year, which will begin on the first day of the first skin substitute application
- Separately billed repeated use of the skin substitute product after 12 weeks for a single wound or episode
- Skin substitute grafting for partial thickness loss with the retention of epithelial appendages as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting
- Skin substitute products not billed concurrently with procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 are not separately reimbursed.

#### 31.2.43.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleaning, antibiotics, and pressure off-loading
- Compression
- Debridement

- Dressings may include wet and dry dressings (Dressings applied to the wound are considered part of the service for wound debridement)
- Whirlpool for burns

**31.2.43.1.1 Compression**

Compression therapy is an important component in the standard of care for treatment of venous ulcers. An Unna boot may be used as part of compression therapy to promote healing, control edema, increase blood return to the heart, and reduce infection. Compression or off-loading performed as part of wound care management may be reimbursed when billed with procedure codes 29445, 29580, or 29581.

**31.2.43.1.2 Debridement**

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion
- Mechanical debridement

The following procedure codes are a benefit for wound debridement:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 11000           | 11001 | 11042 | 11043 | 11044 | 11045 | 11046 | 11047 | 16020 | 16025 |
| 16030           | 97597 | 97598 | 97602 |       |       |       |       |       |       |

The procedure code submitted on the claim must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

Wound debridement procedure codes 11042, 11043, 11044, 11045, 11046, and 11047 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

**31.2.43.2 Second-Line Wound Care Therapy**

Second-line wound care therapy is limited to chronic Stage 3 or 4 wounds and is a benefit only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second-line wound care measures as indicated by the client’s medical condition. Second-line wound care therapy includes the following:

- Application of metabolically active skin equivalents/skin substitutes
- Pulsatile jet irrigation
- Whirlpool

#### 31.2.43.2.1 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage 3 or 4 wounds when other forms of treatment have failed. To cleanse a wound bed, pulsatile-jet irrigation uses lavage, which increases impaired circulation and removal of waste from the lymphatic system. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may also be reimbursed to a licensed physical therapist or physical therapy group when the service is determined to be within the provider's scope of practice and the service is prescribed by a supervising physician or qualified non-physician provider who is enrolled in the CSHCN Services Program.

#### 31.2.43.2.2 Application of Metabolically Active Skin Equivalents and Wound Preparation

Metabolically active skin equivalents/skin substitutes may be a benefit when provided in accordance with the material's Food and Drug Administration (FDA) approved package label and applied according to the manufacturer's instructions for use. Skin substitutes are used for partial- or full- thickness wounds, which do not involve tendon, muscle, joint capsule, or exposed bone or sinus tracts, and are applied to wounds that have demonstrated failed or insufficient response to conservative wound care measures.

The application of skin substitutes may be a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth, or has not changed in baseline size or depth, and shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with the Food and Drug Administration (FDA) assessments and submitted guidelines for the specific skin substitute product(s) used is expected.

Wound care services that include the use of skin substitutes must be provided in accordance with the FDA-approved package label and applied according to the manufacturer's instructions for use. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and or investigational.

Procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 are a benefit for the application of skin substitute grafts.

Procedure codes 15002, 15003, 15004, 15005, 15040, and 15050 are a benefit for surgical wound preparation.

### 31.2.43.3 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, including the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
- Wound location
  - Wound measurements, which includes length, width, and depth, any tunneling and/or undermining

- Wound color, drainage (type and amount), and odor, if present
- The prescribed wound care regimen, which includes frequency, duration, and supplies needed
- Treatment for infection, if present
- All previous wound care therapy regimens, if appropriate
- The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

All wound care management services are subject to retrospective review.

All wound treatments involving the application of skin substitutes must include, but are not limited to, documentation of the following:

- Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.
- All wounds must be free of infection, necrotic tissue, or exudate and any underlying conditions that compromise wound healing. The documentation in the client's record must reflect the conditions have been treated and resolved.
- Clients who use tobacco will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.
- Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg]).
- The wound has a skin deficit at least 1.0 square centimeter in size.
- For diabetic foot ulcers, the client's medical record reflects a diagnosis of Type 1 or Type 2 diabetes. Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure, or sinus tracts.
- Documentation of the wound's response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

Documentation maintained in the client's medical record must support the need for skin substitute applications and the product used.

### **31.3 Claims Information**

To avoid claim denials, providers billing as a group *must* use the performing provider identifier number on their claims.

Physician services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.



When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Physicians who submit a claim using the physician's own provider identifier for services provided by an APRN or physician assistant must submit one of the following modifiers on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit:

- SA - Services were provided by an APRN
- U7 - Services were provided by a physician assistant

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

### 31.3.1 General Medical Record Documentation Requirements

The CSHCN Services Program routinely performs a retrospective review of all providers. This review may include comparing services billed to the client's medical record. The provider must document the following information in the client's medical record:

- Service
- Date the service was rendered
- Any pertinent information about the client's condition that supports the need for the service
- Care provided

**Note:** *If a provider bills for an office visit, the client's medical record must contain documentation for that date of service about the client's complaint, physician's findings, and any physician orders. If the visit is a follow-up office visit, the client's progress relating to the previous condition must be documented for the date of service billed. If billing for a hospital visit, whether it is a routine hospital visit or other type of hospital visit, documentation of that visit must be part of the client's medical record and must be written in the physician's orders or the client's progress notes.*

The following are general requirements for all providers. Mandatory requirements not present in the client's medical record subject the associated services to recoupment.

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

| Requirement  | Mandatory/Desirable |
|--|---------------------|
| All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider. | Mandatory           |

| Requirement  | Mandatory/Desirable |
|--|---------------------|
| Each page of the medical record documents the client's name and CSHCN Services Program identification number.  | Mandatory           |
| Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.  | Mandatory           |
| The selection of E/M codes (levels of service) is supported by the client's clinical record documentation. The AMA's CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.                                  | Mandatory           |
| Necessary follow-up visits specify the time of return by at least the week or month.   | Mandatory           |
| The history and physical documents the presenting complaint with appropriate subjective and objective information, e.g., medical and surgical history, current medications and supplements, family history, social history, diet, pertinent physical examination measurements and findings, etc. | Mandatory           |
| The services provided are clearly documented in the medical record with all pertinent information about the client's condition to substantiate the need 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           |
| Unresolved problems are noted in the record.   | Mandatory           |
| Immunizations are noted in the record as complete or up-to-date.   | Mandatory           |
| Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.  | Desirable           |

### 31.4 Reimbursement

Physicians may be reimbursed for most physician services according to the Texas Medicaid Reimbursement Methodology (TMRM).

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an APRN or physician assistant if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. The 92 percent reimbursement rate will not apply to laboratory services, radiology services, and injections provided by an APRN or physician assistant.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

**Referto:** Section 31.2.5, "Anesthesia Services" in this chapter for more information about anesthesia services that may be reimbursed according to relative value units (RVUs).

### **31.4.1 Physician Services in Outpatient Hospital Setting**

#### **31.4.1.1 Reimbursement Reduction**

Nonemergent and nonurgent services provided by physician providers in an outpatient setting (POS 5) may be reimbursed at 60 percent of the allowed amount. The 40 percent reduction in reimbursement will be based upon the emergency department service that is submitted on the claim.

*Note: Rural hospital outpatient imaging services may be reimbursed at 65 percent of the allowed amount for nonemergent services provided by physician providers in an outpatient setting (POS 5).*

### **31.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **PHYSICIAN ASSISTANT (PA)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# PHYSICIAN ASSISTANT (PA)

## Table of Contents

- 32.1 Enrollment .....3**
- 32.2 Benefits, Limitations, and Authorization Requirements .....3**
  - 32.2.1 Authorization Requirements ..... 4
- 32.3 Claims Information.....4**
- 32.4 Reimbursement.....4**
- 32.5 TMHP-CSHCN Services Program Contact Center .....5**

## 32.1 Enrollment

To enroll in the CSHCN Services Program, a physician assistant (PA) must be actively enrolled in Texas Medicaid, licensed as a physician assistant, and recognized as a PA by the Texas Physician Assistant Board. PAs may enroll as a CSHCN Services Program provider by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). Out-of-state PAs must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program enrollment procedures.

## 32.2 Benefits, Limitations, and Authorization Requirements

Services provided by PAs are benefits if the services are:

- Within the scope of practice for PAs, as defined by Texas state law.
- Consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority.
- Benefits of the CSHCN Services Program when provided by a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]).
- Reasonable and medically necessary as determined by DSHS or its designee.

PAs who are employed or paid by a physician, hospital, facility, or other provider must not bill the CSHCN Services Program for their services, if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician’s own provider identifier for services provided by a PA must submit modifier U7 on each claim detail if the physician does not make a decision regarding the client’s care or treatment on the same date of service as the billable medical visit.

All limitations applicable to physicians for the same service will also be applied to the PA.

### 32.2.1 Authorization Requirements

Authorization and prior authorization requirements are listed in individual sections of this manual. Authorization requirements applied to services provided by physicians (MD or DO) also apply to services provided by PAs.

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization and prior authorization requirements.

Section 31.2.12, “Clinician-Directed Care Coordination Services” in Chapter 31, “Physician” for information and prior authorization requirements for clinician-directed care coordination services.

## 32.3 Claims Information

PA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 32.4 Reimbursement

PAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a PA if the physician does not make a decision regarding the client’s care or treatment on the same date of service as the billable medical visit.

Exceptions to the 92 percent reimbursement methodology for PAs and physicians include injections, laboratory services, radiology services, and immunizations.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

### **32.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.



# **PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

## Table of Contents

|             |   |           |
|-------------|---|-----------|
| <b>33.1</b> | <b>Enrollment .....</b>   | <b>3</b>  |
| <b>33.2</b> | <b>Benefits, Limitations, and Authorization Requirements.....</b> | <b>3</b>  |
| 33.2.1      | Prior Authorization and Authorization Requirements .....          | 5         |
| 33.2.1.1    | Initial Prior Authorization Requests.....                         | 5         |
| 33.2.1.2    | Revisions to the POC.....   | 8         |
| 33.2.1.3    | Extension of PPECC Services .....                                 | 9         |
| <b>33.3</b> | <b>Documentation Requirements .....</b>                           | <b>9</b>  |
| <b>33.4</b> | <b>Coordination of Services .....</b>                             | <b>10</b> |
| <b>33.5</b> | <b>Exclusions .....</b>   | <b>10</b> |
| <b>33.6</b> | <b>Reimbursement.....</b>   | <b>11</b> |
| <b>33.7</b> | <b>TMHP-CSHCN Services Program Contact Center.....</b>            | <b>11</b> |

### 33.1 Enrollment

To enroll in the Children with Special Health Care Needs (CSHCN) Services Program, Prescribed Pediatric Extended Care Centers (PPECC) providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. The provider must be licensed as a PPECC facility by the Texas Health and Human Services Commission (HHSC). Providers cannot be enrolled if their license is due to expire within 30 days.

Out-of-state PPECC providers must meet all applicable enrollment requirements, and be located in the United States, within 50 miles of the Texas state border.

PPECCs may enroll or reenroll as CSHCN Services Program providers by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Option 2.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are responsible not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), Part 1, Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

### 33.2 Benefits, Limitations, and Authorization Requirements

PPECC services are a benefit of the CSHCN Services Program for medically fragile clients who are 20 years of age and younger who have a chronic medically complex or fragile condition or disability that requires extended and complex skilled nursing interventions and monitoring beyond the level of Home Health skilled nursing and Home Health aide services and require the routine use of a medical device or assistive technology to compensate for the loss of a body function needed to participate in activities of daily living.

Chronic medically fragile conditions include, but are not limited to:

- Cerebral palsy
- Cystic fibrosis
- Muscular dystrophy, or

- Other diagnoses which may be considered on a case by case basis

Medically dependent and medically fragile clients live with an ongoing risk of deterioration of their clinical condition, loss of function, risk to health status due to medical fragility and/or death.

PPECCs provide nonresidential facility based care as an alternative to extended skilled nursing services for individuals who require ongoing technology based skilled nursing care to avert death or further disability and who require the routine use of a medical device to compensate for a deficit in a life sustaining body function.

Stable, controlled, or occasional medical conditions that do not require ongoing skilled nursing services do not meet the medical necessity requirements for PPECC services.

**Note:** *PPECC clients require ongoing skilled nursing services for treatment of chronic conditions which are not expected to resolve in 60 calendar days or less and who require the routine use of a medical device or assistive technology.*

A PPECC offers physician prescribed services that meet the client's medical, nursing, psychosocial, therapeutic, and developmental needs.

PPECC services include the following:

- Skilled nursing services
- Personal care services to assist with activities of daily living
- Functional developmental services
- Nutritional and dietary services including nutritional counseling
- Psychosocial services
- Transportation services needed by a client to access PPECC services (as applicable)
- Caregiver training
- Therapies, i.e., speech, physical, occupational, and certified respiratory care practitioner services

**Note:** *Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Certified Respiratory Care Practitioner services (CRCP), and hospice services that are provided at the PPECC must be billed separately by CSHCN enrolled service providers.*

**Note:** *Nonemergency ambulance transports are not reimbursed when the physician prescribes transportation services to and from the PPECC. The client must be able to utilize transportation services provided by the PPECC. A Registered Nurse (RN) or Licensed Vocational Nurse (LVN) employed by the PPECC will be on board the transport vehicle.*

**Note:** *A client may decline PPECC transportation and choose to be transported by other means including transportation by the client's responsible adult to and from the PPECC.*

PPECC services are limited to 12 hours in a 24 hour period and are limited to 400 hours per calendar year.

CSHCN clients who meet PPECC medical necessity criteria must be stable for outpatient medical services and not present significant risk to other clients or personnel at the center.

PPECC services must be furnished in a manner not primarily intended for the convenience of the client, the client's responsible adult, or the provider.

The CSHCN Services Program will not authorize services that duplicate services that are the legal responsibility of the school districts.

**Referto:** Chapter 21, “Home Health Services” for additional information about home health services.

Chapter 22, “Home Health (Skilled Nursing) Care” for additional information about home health skilled nursing care services.

Chapter 13, “Certified Respiratory Care Practitioner (CRCP)” for additional information about CRCP services.

Chapter 37, “Speech-Language Pathology (SLP) Services” for additional information about SLP services.

Chapter 30, “Physical Medicine and Rehabilitation” for additional information about physical and occupational therapy services.

Chapter 23, “Hospice” for additional information about hospice services.

### **33.2.1 Prior Authorization and Authorization Requirements**

Prior authorization is required for PPECC. Prior authorization requests must be submitted on the CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form to the TMHP CSHCN Services Program Prior Authorization Department.

Medical necessity documentation must be submitted with the request. To avoid unnecessary denials, the PPECC and the ordering/prescribing physician must submit correct and complete information. Providers may be asked to provide additional documentation to clarify a prior authorization request or to clarify medical necessity of the client as outlined in the Documentation Requirements section of this chapter. All prior authorization requests will be reviewed by the CSHCN Services Program.

**Note:** *A separate prior authorization is required for therapy, respiratory care, and hospice services.*

Verbal orders are not accepted. The prior authorization form must be signed and dated by the ordering/prescribing physician and the PPECC provider. All signatures must be current, unaltered, original, and handwritten.

To complete the prior authorization process electronically, the ordering/prescribing physician and the PPECC provider must complete and submit the prior authorization requirements documentation through any approved electronic method.

To complete the prior authorization process by paper, the ordering/prescribing physician and the PPECC provider must complete and submit the prior authorization requirements documentation through fax or mail.

#### **33.2.1.1 Initial Prior Authorization Requests**

Initial prior authorization requests may be authorized for a maximum of 90 calendar days.

Prior authorization must be obtained before the delivery date or start of care (SOC) of the service.

If the service is medically necessary, provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form, a PPECC Plan of Care, and a PPECC nursing assessment must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program to correct incomplete prior authorization requests.

**Note:** *PPECC providers may submit a form developed by the PPECC for the POC and the nursing assessment. The forms must contain all criteria specified in this chapter.*

Home health aide (procedure codes G0156, G0299, and G0300) services will not be authorized when the client is receiving PPECC services.

Medical nutritional therapy procedure codes 97802 and 97803 and nutritional counseling procedure code S9470 will not be reimbursed when the client is receiving PPECC services.

**Note:** *The request for services (as noted above) with language to deny authorization or reimbursement must be reviewed by the CSHCN Services Program before a denial is issued.*

Services must be provided according to an individualized written Plan of Care (POC) which is reviewed, signed, and dated by the ordering/prescribing physician who will provide ongoing supervision of the client and the POC.

The ordering/prescribing physician must be familiar with the client and the client's medical condition(s) and must have examined the client within 30 days prior to initiation of PPECC services.

Physician orders must be submitted on the CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request form and include the following:

- Client name, date of birth, gender, and CSHCN Services Program identification number
- Ordering/prescribing physician name, address, contact information, National Provider Identifier (NPI) number
- Date client last seen by the ordering/prescribing physician
- Diagnoses and description of current medical condition(s) and documentation of medical necessity that the client requires ongoing extended skilled nursing services beyond the level of Home Health skilled nursing and Home Health aide services, and the client has a chronic medically complex or fragile condition, which requires the routine use of medical device or assistive technology.
- Attestation that the client's medical condition is stable and will allow for safe delivery of PPECC services in accordance with the PPECC POC.
- Nursing Services required
- Medication administration, if applicable
- Dietary and nutritional needs
- Permitted activities
- Therapies, if applicable
- Transportation authorization, if applicable
- Other services as needed

The POC must be developed in conjunction with the client and/or the client's responsible adult. A signed and dated copy of the POC must be submitted with the Prior Authorization request. The POC must be signed before the SOC date by the ordering/prescribing physician who ordered PPECC services. The SOC date must be documented in the POC. Providers are required to deliver the requested services from the SOC date agreed to by the ordering/prescribing physician, the PPECC, the client, and/or the client's responsible adult.

An initial nursing assessment that is signed and dated by a PPECC RN must be completed no earlier than three business days before the client's SOC at the PPECC and must be submitted with the PA request. The initial nursing assessment is used to establish the POC and must support medical necessity for the client to receive ongoing skilled nursing care.

The assessment must include but is not limited to the following:

- Complexity and intensity of the client's condition.
- Frequency of the client's need for skilled nursing care.
- Stability and predictability of the client's condition.

- Description of the client's wounds if present.
- Comprehension level of the client and the client's responsible adult.
- Receptivity to training and ability level of the client and the client's responsible adult.
- The client's equipment needs and if the PPECC is adequate to accommodate use of the equipment.
- Identified medical, nursing, psychosocial, therapeutic, nutritional/dietary, functional/developmental, and educational needs and goals and any training needs for the client's caregiver or the client's responsible adult.

The POC must be initiated and signed and dated by a qualified individual, e.g., RN, APRN, PA, or physician employed by the PPECC in coordination with the interdisciplinary team, the client, and/or the client's responsible adult prior to the SOC and include all of the following:

- The client's name, date of birth, gender, CSHCN number, the ordering/prescribing physician's license number, and the PPECC provider's NPI
- Date the PPECC nursing assessment was completed
- The name, title, credentials, and signature of the team member preparing the POC
- Date the client was last seen by the ordering/prescribing physician
- The SOC date for PPECC services, including scheduled days, and hours of attendance
- All diagnoses and known allergies
- Prognosis
- Nursing Services to be provided including amount, duration, and frequency
- The client's mental status
- The types of therapies requested including amount, duration, and frequency including how the therapies are accessed and who will provide the service.
- Equipment and supplies needed
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements including type, method of administration, and frequency
- Medications including dose, route, and frequency
- Treatments including amount and frequency
- Wound care orders and measurements
- Individualized client goals and objectives
- Safety measures to protect against injury
- Method of transportation to the PPECC
- Discharge Plan
- Responsible adult training needs

The PPECC must ensure the requested services are supported by the client assessment, the POC, and the ordering/prescribing physician orders, and the PPECC must maintain the following in the client's medical record:

- A signed consent by the client or the client's responsible adult for PPECC services.

- Emergency contact information.
- A contingency plan for client emergencies and a plan when PPECC services are not available which has been signed by the client or the client's responsible adult.
- List of services the client receives in the home and in the school setting.
- Documentation of interdisciplinary team meetings at least every 90 calendar days or more frequently if there is a change in the client's condition or needs.

**Note:** *The PPECC must convene an interdisciplinary conference for the initial development of the POC as well as for any reauthorizations and when the POC is changed.*

- Documentation of the client's and/or the client's responsible adult's participation in the interdisciplinary team meetings.
- Documentation that the client and/or the client's responsible adult has reviewed and agrees with the PPECC POC.
- Transportation needs of the client.

**Note:** *If a client or PPECC provider discontinues services during an existing PPECC prior authorization period and the client requests services through a new PPECC provider, the ordering/prescribing physician and the new PPECC provider must submit a new prior authorization form, POC, nursing assessment, and all required documentation as specified under the Initial Prior Authorization section of this chapter before the client's SOC. A change of provider letter is required documenting the date the client ended PPECC services with the previous provider, the name of the new provider, and an explanation why providers were changed. The letter must be signed and dated by the client or the client's responsible adult. A change of provider is treated as a request for initial prior authorization.*

### 33.2.1.2 Revisions to the POC

The PPECC provider may request a revision to the POC at any time during the prior authorization period due to a change in the client's condition or due to a change in the schedule of the client or the client's responsible adult that affects the amount and duration of PPECC services.

**Note:** *A prior authorization request for a revision to the POC must fall within the current authorization period. All revision requests will be reviewed by the CSHCN Services Program.*

A nursing reassessment (completed by a PPECC RN) is required when changes in the client's condition occur during the course of the prior authorization period that impact the amount and duration of PPECC services.

Revision requests must be submitted on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC Services along with a revised POC and a revised nursing assessment.

The revised POC, nursing reassessment, and new prior authorization request form must be submitted to the TMHP CSHCN Prior Authorization Department as soon as the need is identified but no later than three business days from the date of the revision.

The ordering physician must sign and date the revised POC and prior authorization request form prior to submission to TMHP.

A nursing reassessment, revised POC, and a new prior authorization request form is also required when there is an unexpected change in the client or the responsible adult's schedule even if there is no change in the client's condition. A reason for the revision request must be provided, and medical necessity to



support continued PPECC services must be documented on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC services as soon as the need is identified but no later than three business days from the date of the revision request.

*Note: Requests received after the three business days allowed will be denied for dates of service that occurred before the revision is approved.*

The ordering physician must sign and date the new prior authorization request form prior to submission to TMHP.

*Note: Schedule changes that affect previously ordered medical services to the client and a disruption of clinical services provided to the client such as nursing services or therapy services require updated medical orders addressing the client's needs which must be submitted along with the revision request.*

### **33.2.1.3 Extension of PPECC Services**

Requests to extend PPECC services must be submitted on a new CSHCN Services Program Prescribed Pediatric Extended Care (PPECC) Services Prior Authorization Request Form for PPECC Services. Extension requests will be reviewed by the CSHCN Services Program.

A current signed and dated copy of the POC and a current nursing assessment must be submitted with the extension request.

Extensions may be granted for up to a maximum of 180 days.

PPECC services must not exceed 400 hours per calendar year.

Extension requests must be received before the end of the current prior authorization period but no sooner than 30 days before and no less than 7 days before the current prior authorization expires.

*Note: Extension requests that are received after the current prior authorization expires will be denied for dates of service that occur before the extension request is approved.*

The ordering/prescribing physician must sign and date the extension request and the POC.

If there is no change in the client's condition the POC must document medical necessity as defined in the Statement of Benefits to support continuing PPECC services.

## **33.3 Documentation Requirements**

In addition to the documentation requirements outlined in the Prior Authorization and Authorization Requirements section the following requirements apply:

- All services outlined in this chapter are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.
- Services not supported by documentation are subject to recoupment.
- The ordering/prescribing physician must retain a copy of all signed orders, the POC, and the nursing assessment in the client's medical record.
- The PPECC must retain a copy of all signed orders, the POC, and the nursing assessment in the client's medical record.
- If the client utilizes PPECC transportation the responsible adult must sign, date, and indicate the time that the client was put on the vehicle and must also sign, date, and indicate the time when the client was returned to the responsible adult's care.
- The PPECC must sign, date, and indicate the arrival time of the client at the PPECC and must also sign, date, and indicate the time when the client is put on the vehicle to return the client to their place of residence.

- If a responsible adult provides the transportation, the responsible adult must sign and indicate the date and time that the client is dropped off and picked up from a PPECC. The PPECC provider must document and retain arrival and departure times from the PPECC.

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

- The PPECC must maintain documentation in the client's medical record of the notification provided to the client and/or the client's responsible adult of an intent to transfer or discharge the client as follows:
  - A copy of the written notification provided.
  - Documentation of the personal contact with the client and/or the client's responsible adult.
  - Documentation that the client's prescribing physician was notified of the date of transfer or discharge.

Documentation must be maintained in the client's medical record that a written one page summary of services provided to the client has been provided to the client's responsible adult for each day the client is at the PPECC.

Documentation must be maintained in the client's medical record of all discrepancies between approved weekly service hours scheduled and the service hours provided, (e.g., the PPECC was closed for a day, the client is hospitalized, or the responsible adult's schedule changed).

### **33.4 Coordination of Services**

A PPECC must ensure appropriate coordination of services between the client and providers rendering services to the client (if known by the PPECC) including, but not limited to, Home Health extended skilled nursing, PT, OT, ST, CRCP, and Hospice providers not employed or contracted by the PPECC.

Documentation must be maintained in the client's medical record that reflects coordination of services that includes the effective exchange of information, reporting, and coordination of the client's services.

The PPECC may not duplicate or provide services that conflict with a client's plan of care, or service plan with another provider.

The PPECC and the provider must have a written agreement for the provision of services that will be provided by a Home Health Agency therapist or independent therapist at the PPECC. The written agreement must address how the providers will coordinate care related to the client's POC, (e.g., participation in the client's interdisciplinary team meetings and inclusion in planning activities for the client).

The PPECC, client, and or the client's responsible adult must agree that the provision of services by the provider is appropriate.

The written agreement must include the provider's compliance with PPECC policies and procedures.

### **33.5 Exclusions**

Examples of services not covered under PPECC reimbursement include, but are not limited to, the following:

- Services that have not been prior authorized
- Services that have been requested for the sole purpose of the responsible adult's training needs
- Routine baby food or formula
- PPECC services for clients related to the PPECC owner by blood, marriage, or adoption

- Skilled home health nursing and home health aide services for medical conditions expected to resolve within 60 days or less will not be authorized at the same time PPECC services are authorized.
- Dietary and nutritional counseling services will not be authorized at the same time PPECC services are authorized.
- Services intended to provide respite care or childcare
- Services covered separately by the CSHCN Services Program such as:
  - Occupational, speech, physical and certified respiratory care practitioner services
  - Behavioral health services
  - Durable medical equipment (DME), medical supplies, nutritional products provided to the client by a CSHCN DME and/or medical supply providers

### 33.6 Reimbursement

PPECC services may be reimbursed when billed with procedure codes T1026 and T2002.

Procedure code T1026 is limited to 12 hours per day and to 400 hours per calendar year.

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

Procedure Code T2002 is reimbursed once per day when the PPECC transports the client. Procedure code T2002 is not allowed without a PPECC service procedure code billed on the same day by the same provider.

PT, OT, ST, CRCP services and hospice services require separate prior authorization subject to the prior authorization requirements of CSHCN therapy, certified respiratory care practitioner services and hospice policies. These services may be rendered at a PPECC but are not included in the reimbursement rate for T1026.

**Note:** *Therapy and respiratory care services and hospice services may be provided by CSHCN-enrolled providers contracted with or employed by a PPECC or by CSHCN enrolled providers not employed or contracted with a PPECC.*

All therapy, respiratory care services and hospice services must meet prior authorization and policy requirements as specified by the CSHCN Services Program.

Transportation and the time the client spends in transit to and from the PPECC are billed with procedure code T2002 when the client utilizes PPECC transportation.

Transportation time does not count towards the 400 hour per year limitation.

**Note:** *A nonemergency ambulance may not be billed and will not be reimbursed to transport a client to and from home to a PPECC.*

Services begin when the client is boarded onto PPECC transportation or when the client is brought to the PPECC by the client's responsible adult.

Extended skilled nursing procedure codes S9123 and S9124 may not be billed on the same date of service as PPECC services procedure code T1026, any provider.

### 33.7 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **RADIATION THERAPY SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# RADIATION THERAPY SERVICES

## Table of Contents

|             |   |          |
|-------------|---|----------|
| <b>34.1</b> | <b>Enrollment</b> .....   | <b>3</b> |
| <b>34.2</b> | <b>Benefits, Limitations, and Authorization Requirements</b> .....                  | <b>3</b> |
| 34.2.1      | Prior Authorization Requirements .....  | 4        |
| 34.2.2      | Clinical Brachytherapy .....  | 4        |
| 34.2.3      | Clinical Treatment Planning .....   | 5        |
| 34.2.4      | Intensity Modulated Radiation Therapy (IMRT) .....                                  | 5        |
| 34.2.5      | Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services ..... | 5        |
| 34.2.6      | Proton-Beam and Neutron-Beam Delivery .....   | 6        |
| 34.2.6.1    | Prior Authorization Requirements .....  | 6        |
| 34.2.6.1.1  | <i>Proton-Beam Treatment Delivery</i> .....   | 6        |
| 34.2.6.1.2  | <i>Neutron-Beam Treatment Delivery</i> .....  | 6        |
| 34.2.7      | Radiation Treatment Management and Delivery .....                                   | 6        |
| 34.2.7.1    | Radioisotope Therapy .....  | 7        |
| 34.2.8      | Stereotactic Radiosurgery .....   | 7        |
| 34.2.8.1    | Prior Authorization Requirements .....  | 7        |
| 34.2.9      | Strontium-89 .....  | 8        |
| 34.2.10     | Technetium TC 99M Tetrofosmin .....   | 8        |
| <b>34.3</b> | <b>Claims Information</b> .....   | <b>8</b> |
| <b>34.4</b> | <b>Reimbursement</b> .....  | <b>9</b> |
| <b>34.5</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....                             | <b>9</b> |

## 34.1 Enrollment

To enroll and be reimbursed for services in the CSHCN Services Program, radiation therapy services providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state and federal laws and requirements. Out-of-state radiation therapy services providers must meet all the above conditions and be located in the United States within 50 miles of the Texas state border.

Physicians, hospitals, and free-standing radiation treatment centers are eligible to enroll in Texas Medicaid and to receive reimbursement for CSHCN Services Program radiation therapy services.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 34.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may reimburse radiation therapy services performed by physicians, radiation treatment centers, and inpatient and outpatient hospitals.

Radiation therapy services include, but are not limited to, the following:

- Clinical brachytherapy
- Clinical treatment planning
- Intensity modulated radiation therapy (IMRT) (prior authorization required)
- Medical radiation physics, dosimetry, and treatment devices
- Proton- or neutron-beam therapy (prior authorization required)
- Radiation treatment management and delivery
- Stereotactic radiation therapies

All drugs given during the course of radiation therapy should be billed separately for appropriate reimbursement.

All inpatient radiation therapy services must be billed with the appropriate procedure code(s) in addition to the revenue code (333).

**Note:** *Outpatient hospital services include those services performed in the emergency room or clinic setting of a hospital. In instances of sudden illness or injury, the client may receive treatment in the emergency room and be discharged, admitted for observation, or admitted for further care as an inpatient. If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be submitted as ancillary charges.*

**Referto:** Chapter 24, “Hospital” for more information about inpatient, outpatient, ER, and observation services.

Normal follow-up care by the same physician on the same day as any therapeutic radiology service will be denied. Any other E/M office visit will not be reimbursed when billed with the same date of service by the same provider as the radiation treatment or a radiation treatment complication. If complications occur on the same day as a therapeutic radiology service, or if medical visits are necessary for services unrelated to the radiation treatment, additional care may be reimbursed on appeal with documentation of medical necessity.

Providers may use modifier 25 to indicate the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client’s medical record and made available to the CSHCN Services Program upon request.

**Note:** *Each provider is responsible for verifying client eligibility. Any services that are provided outside of the client’s eligibility period or beyond the limitations of the CSHCN Services Program are not considered for reimbursement.*

**34.2.1 Prior Authorization Requirements**

Prior authorization is required for stereotactic radiation therapies, proton- or neutron-beam treatment delivery, and IMRT. Prior authorization is not required for all other radiation therapy services. Prior authorization must be obtained before submitting claims for the services rendered. Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization is given only if the client is eligible for CSHCN Services Program benefits when TMHP receives the request.

**Referto:** Chapter 4, “Prior Authorizations and Authorizations” for more information about authorizations and prior authorizations.

**34.2.2 Clinical Brachytherapy**

The following surgical procedure codes for brachytherapy may be reimbursed:

| Surgery Procedure Codes  |       |        |        |       |       |       |        |        |       |
|--|-------|--------|--------|-------|-------|-------|--------|--------|-------|
| 10035  | 10036 | 19296  | 19297  | 19298 | 31626 | 31643 | 32553* | 49327* | 49411 |
| 49412  | 55860 | 55862* | 55865* | 55874 | 55875 | 55876 | 57156  | 58346  | 61770 |
| 92974  |       |        |        |       |       |       |        |        |       |
| *Assistant surgeons also may be reimbursed for procedure codes 32553, 49327, 55862, and 55865. |       |        |        |       |       |       |        |        |       |

Add-on procedure codes 10036, 19297, 49327, 49412 and 92974 must be billed with the appropriate primary procedure code, on the same day, by the same provider.

The following radiation therapy procedure codes may be reimbursed:

| Radiation Therapy Procedure Codes |        |        |        |        |        |       |       |       |       |
|-----------------------------------|--------|--------|--------|--------|--------|-------|-------|-------|-------|
| 77321                             | 77470  | 77750* | 77761* | 77762* | 77763* | 77767 | 77768 | 77770 | 77771 |
| 77772                             | 77778* | 77789  | 77799  |        |        |       |       |       |       |
| *Total component only.            |        |        |        |        |        |       |       |       |       |

Clinical brachytherapy services include admission to the hospital, daily care, and same-day office visits. Initial and subsequent hospital care and same-day office visits will be denied when billed with the same date of service as clinical brachytherapy services.

### 34.2.3 Clinical Treatment Planning

The following radiation therapy procedure codes must be used to bill clinical treatment planning services:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 77261           | 77262 | 77263 | 77280 | 77285 | 77290 | 77293 | 77295 | 77299 |

Therapeutic radiology field setting procedure code 77295 is limited to once per day.

Procedure code 77293 will be denied if not billed on the same date of service by the same provider as either procedure code 77295 or 77301.

An office visit performed on the same day by the same provider as clinical treatment planning is included in the therapeutic radiology procedure.

Clinical treatment planning includes interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, determination of number and size of treatment ports, selection of appropriate treatment devices, and other procedures.

The following procedure codes will not be reimbursed by the CSHCN Services Program:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 77331           | 77336 | 77370 | 77600 | 77605 | 77610 | 77615 | 77620 | 77790 |

### 34.2.4 Intensity Modulated Radiation Therapy (IMRT)

IMRT (procedure codes 77385 and 77386) must be prior-authorized and may be considered after review of documentation of medical necessity along with a review of current literature supporting the requested use.

### 34.2.5 Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

The following procedure codes may be reimbursed for medical radiation physics, dosimetry, treatment devices, and special services:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 77300           | 77301 | 77306 | 77307 | 77316 | 77317 | 77318 | 77332 | 77333 | 77334 |
| 77338           | 77399 |       |       |       |       |       |       |       |       |



### 34.2.6 Proton-Beam and Neutron-Beam Delivery

The following procedure codes may be used to bill proton-beam and neutron-beam treatment delivery services:

| Procedure Codes     |       |       |       |       |
|---------------------|-------|-------|-------|-------|
| <b>Proton-Beam</b>  |       |       |       |       |
| 77520               | 77522 | 77523 | 77525 | S8030 |
| <b>Neutron-Beam</b> |       |       |       |       |
| 77423               |       |       |       |       |

#### 34.2.6.1 Prior Authorization Requirements

Prior authorization requirements for proton-beam and neutron-beam treatment delivery may include, but are not limited to, diagnoses indicating one of the following medical conditions:

##### 34.2.6.1.1 Proton-Beam Treatment Delivery

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures

##### 34.2.6.1.2 Neutron-Beam Treatment Delivery

- Malignant neoplasms of the salivary glands

Other diagnoses may be considered for proton-beam and neutron-beam treatment delivery after a review of medical necessity documentation along with a review of current literature supporting the use of the requested therapy.

Providers must use the [CSHCN Services Program Authorization and Prior Authorization Request form](#) to submit requests for prior authorization.

*Referto:* Chapter 4, “Prior Authorizations and Authorizations” for more information about authorizations and prior authorizations.

### 34.2.7 Radiation Treatment Management and Delivery

The total radiation therapy component for the following procedure codes may be reimbursed for radiation treatment management services:

| Radiation Treatment Management Procedure Codes |       |       |       |       |
|--|-------|-------|-------|-------|
| 77427  | 77431 | 77432 | 77435 | 77499 |

The following procedure codes may be reimbursed for radiation treatment delivery services:

| Radiation Treatment Delivery/Port Films |        |        |         |         |        |        |        |        |        |
|---|--------|--------|---------|---------|--------|--------|--------|--------|--------|
| 77385*                                  | 77386* | 77387  | 77401** | 77417** | 77423* | G6002* | G6003* | G6004* | G6005* |
| G6006*                                  | G6007* | G6008* | G6009*  | G6010*  | G6011* | G6012* | G6013* | G6014* | G6015* |
| G6016*                                  | G6017* |        |         |         |        |        |        |        |        |
| *Total component only.                  |        |        |         |         |        |        |        |        |        |
| **Technical component only.             |        |        |         |         |        |        |        |        |        |

Radiation treatment delivery/port films procedure codes may be billed in addition to procedure codes 77427 and 77431 when provided in the office setting.

**34.2.7.1 Radioisotope Therapy**

The CSHCN Services Program may reimburse therapeutic radioisotopes separately.

Diagnostic radioisotopes are considered part of the diagnostic service and will not be reimbursed separately.

**34.2.8 Stereotactic Radiosurgery**

The surgical component of the following procedure codes may be reimbursed for stereotactic radiosurgery services (SRS) and stereotactic body radiation therapy (SBRT):

| Surgery Procedure Codes |       |       |       |       |       |       |       |       |       |
|-------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 32701                   | 61781 | 61782 | 61783 | 61796 | 61797 | 61798 | 61799 | 61800 | 63620 |
| 63621                   |       |       |       |       |       |       |       |       |       |

Add-on procedure codes 61781, 61782, 61783, 61797, 61799, 61800, and 63621 must be billed with the appropriate primary procedure code, on the same day, by the same provider.

The total radiation therapy component of the following procedure codes may be reimbursed for SRS and SBRT:

| Radiation Therapy Procedure Codes |       |       |       |       |       |
|-----------------------------------|-------|-------|-------|-------|-------|
| 77371                             | 77372 | 77373 | G0339 | G0340 | G6002 |

The benefit and limitation information listed in the following table applies to the procedure codes indicated:

| Procedure Code | Benefits and Limitations   |
|----------------|--|
| 61796          | Services will not be reimbursed more than once per course of treatment. Procedure codes 61796 and 61798  |
| 61797          | Procedure code 61797 will not be reimbursed more than once per lesion. Procedure code 61797 may be reimbursed up to four times for the entire course of treatment regardless of the number of lesions treated.   |
| 61798          | Procedure code 69718 will be denied if it is billed with procedure code 61796.   |
| 61799          | Procedure code 61799 will not be reimbursed more than once per lesion. Procedure code 61799 may be reimbursed up to four times for the entire course of treatment regardless of the number of lesions treated.   |
| 63620          | Procedure code 63620 may be reimbursed once per course of treatment. Procedure code 63620 will not be reimbursed for services rendered on the same date of service by the same provider as radiation treatment management procedure code 77435.  |
| 63621          | Procedure code 63621 may be reimbursed two times for the entire course of treatment, regardless of the number of lesions treated. Procedure code 63621 will not be reimbursed for services rendered on the same date of service by the same provider as radiation treatment management procedure code 77435. |

**34.2.8.1 Prior Authorization Requirements**

Prior authorization will be considered for SRS and SBRT procedure codes with a diagnosis indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system

- Vascular malformations
- Soft tissue tumors in the chest, abdomen, and pelvis
- Trigeminal neuralgia refractory to medical management

**Note:** SRS and SBRT are considered investigational and not a benefit of the CSHCN Services Program for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.

Providers must use the [CSHCN Services Program Authorization and Prior Authorization Request form](#) to submit requests for prior authorization.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

**Referto:** Chapter 4, "Prior Authorizations and Authorizations" for more information about authorizations and prior authorizations.

### 34.2.9 Strontium-89

Strontium-89 is a benefit of the CSHCN Services Program. Procedure code A9600 may be reimbursed once every 90 days by any provider.

Procedure code A9600 must be submitted with one of the following diagnosis codes to be considered for reimbursement:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50011          | C50012 | C50019 | C50021 | C50022 | C50029 | C50111 | C50112 |
| C50119          | C50121 | C50122 | C50129 | C50211 | C50212 | C50219 | C50221 |
| C50222          | C50229 | C50311 | C50312 | C50319 | C50321 | C50322 | C50329 |
| C50411          | C50412 | C50419 | C50421 | C50422 | C50429 | C50511 | C50512 |
| C50519          | C50521 | C50522 | C50529 | C50611 | C50612 | C50619 | C50621 |
| C50622          | C50629 | C50811 | C50812 | C50819 | C50821 | C50822 | C50829 |
| C50911          | C50912 | C50919 | C50921 | C50922 | C50929 | C61    | C7951  |
| C7952           |        |        |        |        |        |        |        |

### 34.2.10 Technetium TC 99M Tetrofosmin

Procedure codes A9500 and A9502 are limited to a quantity of three each per day when billed by the same provider.

## 34.3 Claims Information

Claims for radiation therapy services must include the following:

- *The referring provider.* Radiologists are required to identify the referring provider by full name and address or CSHCN Services Program provider identifier in Block 17 of the CMS-1500 paper claim form. Baseline screening or comparison studies are not benefits.
- *Authorization and prior authorization number (as appropriate).* All claims must meet all authorization and prior authorization requirements and claim filing and authorization deadlines. Details are given in the description of the services and in more detail in association with services described in this chapter and in Chapter 4, "Prior Authorizations and Authorizations."

Radiation therapy services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Chapter 5, “CMS-1500 Paper Claim Form Instructions” and Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Inpatient and outpatient hospitals must use the UB-04 CMS-1450 paper claim form to submit charges for covered services. If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be submitted on the UB-04 CMS-1450 paper claim form as an ancillary charge.

## 34.4 Reimbursement

Physicians and radiation treatment centers may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Inpatient hospitals may be reimbursed at 80 percent of the All Patient Refund Diagnosis Groups (APR-DRG) payment for CSHCN Services. Outpatient hospital may be reimbursed at 72 percent of the billed amount multiplied by the hospital’s Medicaid interim rate.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 34.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **RENAL DIALYSIS**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# RENAL DIALYSIS

## Table of Contents

- 35.1 Enrollment ..... 3**
- 35.2 Client Eligibility..... 3**
- 35.3 Benefits, Limitations, and Authorization Requirements..... 3**
  - 35.3.1 Renal Dialysis Facilities - Consolidated Billing ..... 5
    - 35.3.1.1 Maintenance Hemodialysis ..... 5
    - 35.3.1.2 Maintenance IPD ..... 6
    - 35.3.1.3 Maintenance CAPD and CCPD..... 6
  - 35.3.2 Maintenance Hemodialysis ..... 7
    - 35.3.2.1 Training for Hemodialysis, IPD, CCPD, and CAPD..... 7
  - 35.3.3 Ultrafiltration..... 8
  - 35.3.4 Home Dialysis Items and Services ..... 8
  - 35.3.5 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility ..... 9
  - 35.3.6 Ultrafiltration..... 12
  - 35.3.7 Evaluation and Management ..... 12
  - 35.3.8 Renal Transplants..... 14
  - 35.3.9 Prior Authorization Requirements..... 14
- 35.4 Claims Information.....14**
- 35.5 Reimbursement.....15**
- 35.6 TMHP-CSHCN Services Program Contact Center .....15**

## 35.1 Enrollment

To enroll in the CSHCN Services Program, renal dialysis facilities must be licensed by the state of Texas as an end-stage renal disease (ESRD) facility, and be certified by Medicare. Home health agencies must be licensed by the state of Texas as home and community support services agencies designated to provide home dialysis services. The facilities must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state renal dialysis facility providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in Title 1 of the TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 35.2 Client Eligibility

Clients needing renal dialysis must also apply for Medicare coverage, unless the referring provider attests that the client is not eligible for Medicare. If the client is not eligible for Medicare coverage, the CSHCN Services Program may reimburse dialysis services as long as the services are needed. CSHCN Services Program coverage of renal dialysis begins with the client’s initial date of eligibility or the first dialysis treatment, whichever is later.

## 35.3 Benefits, Limitations, and Authorization Requirements

The following services are a benefit of renal dialysis centers billing under Reimbursement Methodology Consolidated Billing:

Revenue Codes - Hemodialysis

| Revenue Code | Description  |
|--------------|--|
| 821          | Hemodialysis (outpatient/home) - composite or other rate. Use for maintenance. |
| 829          | Hemodialysis (outpatient/home) - other. Use for training.                      |

Revenue Codes - Intermittent Peritoneal Dialysis (IPD)

| Revenue Code | Description   |
|--------------|---|
| 831          | Peritoneal Dialysis (outpatient/home) - composite or other rate. Use for maintenance. |
| 839          | Peritoneal Dialysis (outpatient/home) - other. Use for training.                      |

Revenue Codes - Continuous Cycling Peritoneal Dialysis (CCPD)

| Revenue Code | Description  |
|--------------|--|
| 851          | CCPD (outpatient/home) - composite or other rate. Use for maintenance. |
| 859          | CCPD (outpatient/home) - other. Use for training.                      |

Revenue Codes - Ultrafiltration

| Revenue Code | Description                              |
|--------------|--|
| 881          | Miscellaneous dialysis - ultrafiltration |

The following physician services are a benefit for physician supervision of end-stage renal disease (ESRD) dialysis services and are restricted to chronic kidney disease stage 5 (diagnosis code N185) and ESRD (diagnosis code N186).

Procedure Codes - Physician Services for End-Stage Renal Dialysis

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 | 90963 | 90964 | 90965 | 90966 | 90967 | 90968 | 90969 | 90970 |

Physician Services for Hemodialysis or Other Dialysis Procedures

| Procedure Codes |       |       |       |  |  |  |  |  |  |
|-----------------|-------|-------|-------|--|--|--|--|--|--|
| 90935           | 90937 | 90945 | 90947 |  |  |  |  |  |  |

Physician supervision of outpatient ESRD dialysis includes services rendered by the attending physician during office visits where any of the following occur:

- Routine monitoring of dialysis
- Treatment or follow-up of complications of dialysis, including:
  - Evaluation of related diagnostic tests and procedures
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-contact contracts

All physician, renal dialysis center, and medical supplier supporting documentation is subject to retrospective review.



Renal dialysis services must be submitted with the most appropriate diagnosis code from the following table:

| Diagnosis Codes |         |      |      |      |      |      |         |
|-----------------|---------|------|------|------|------|------|---------|
| N170            | N171    | N172 | N178 | N179 | N181 | N182 | N1830   |
| N1831           | N1832   | N184 | N185 | N186 | N189 | N990 | T795XXA |
| T795XXD         | T795XXS |      |      |      |      |      |         |

**Note:** All services, except ultrafiltration (revenue code 881), are diagnosis restricted as listed in the above table.

Procedure code G0257 may be reimbursed for services rendered to clients with stage V chronic kidney disease (diagnosis code N185) and end-stage renal disease (ESRD) (diagnosis code N186).

The following additional services related to renal dialysis are benefits of the CSHCN Services Program:

- Ultrafiltration
- Dialysis training not to exceed 18 days of hemodialysis or peritoneal (IPD, CAPD, or CCPD) training

**Note:** The facility charge for dialysis services is denied as part of the dialysis training when billed with the same date of service as the dialysis training.

- Related physician services
- Dialysis support services

The installation and repair of home hemodialysis machines is not a benefit. Home modifications for use of medical equipment are not a benefit.

### 35.3.1 Renal Dialysis Facilities - Consolidated Billing

Outpatient dialysis is furnished on an outpatient basis at a renal dialysis center or facility.

Allowable outpatient dialysis services include:

- Staff-assisted dialysis performed by the center's or facility's staff.
- Self-dialysis performed by a client with little or no professional assistance, provided that the client has completed an appropriate course of training.
- In-home dialysis performed by an appropriately trained client or an appropriately trained caregiver.
- Dialysis services provided in an approved renal dialysis facility on an outpatient basis.

Renal dialysis facilities are reimbursed according to composite rates, which are based on CMS-specified calculations and the Texas Medicaid Reimbursement Methodology (TMRM).

The facility bills an amount that represents the charge for the facility's service to the dialysis client. The facility's charge must not include the charge for the physician's routine supervision.

A revenue code (821, 831, 841, or 851) must be billed for the dialysis facility to receive the composite rate payment.

#### 35.3.1.1 Maintenance Hemodialysis

ESRD facilities furnishing dialysis treatments in-facility are paid for up to three treatments per week. ESRD facilities treating patients at home, regardless of modality, receive payment for three hemodialysis equivalent treatments per week.

### 35.3.1.2 Maintenance IPD

Maintenance intermittent peritoneal dialysis (IPD) is usually performed in sessions of 10 to 12 hours duration, three times per week. However, it is sometimes performed in fewer sessions of longer duration.

### 35.3.1.3 Maintenance CAPD and CCPD

For clients undergoing CAPD or CCPD in the home, the number of days of peritoneal dialysis regardless of dialysate exchanges performed each day will be 14 per 31 days.

A combination of HD, IPD, CAPD, CCPD dialysis treatments are limited to 14 sessions within 31 days for any provider. If more than 14 sessions are needed, the provider must supply documentation of medical necessity with the claim. Documentation can include but is not limited to medical records, physicians' notes, and lab results. Records must clearly show why extra sessions are medically required.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

The composite rate includes all necessary equipment, supplies, and services for the client receiving dialysis whether in the home or in a facility. The following procedure codes are for ESRD DME supplies:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 36000           | 36430 | 36591 | 36593 | 49421 | 71045 | 71046 | 71047 | 71048 | 93005 |
| 93040           | 93041 | A4215 | A4216 | A4217 | A4218 | A4244 | A4245 | A4246 | A4247 |
| A4248           | A4450 | A4452 | A4651 | A4652 | A4653 | A4657 | A4660 | A4663 | A4670 |
| A4671           | A4672 | A4673 | A4674 | A4680 | A4690 | A4706 | A4707 | A4708 | A4709 |
| A4714           | A4719 | A4720 | A4721 | A4722 | A4723 | A4724 | A4725 | A4726 | A4728 |
| A4730           | A4736 | A4737 | A4740 | A4750 | A4755 | A4760 | A4765 | A4766 | A4770 |
| A4771           | A4772 | A4773 | A4774 | A4802 | A4860 | A4870 | A4890 | A4911 | A4913 |
| A4918           | A4927 | A4928 | A4929 | A4930 | A4931 | A4932 | A6204 | A6215 | A6216 |
| A6250           | A6260 | A6402 | E0210 | E0424 | E0431 | E0434 | E0439 | E0440 | E0441 |
| E0442           | E0443 | E0444 | E0447 | E1500 | E1510 | E1520 | E1530 | E1540 | E1550 |
| E1560           | E1570 | E1575 | E1580 | E1590 | E1592 | E1594 | E1600 | E1610 | E1615 |
| E1620           | E1625 | E1630 | E1632 | E1634 | E1635 | E1636 | E1637 | E1639 | E1699 |

Procedure codes for equipment and supplies listed in the above DME ESRD Supply HCPCS table are included in the composite rate and are not reimbursed separately.

The Tablo hemodialysis system procedure code (E1629) is excluded from the composite rate and will be paid separately for clients receiving services within the home.

Providers must use procedure code E1629 with revenue code 821.

Laboratory testing may be obtained and processed in the renal dialysis facility or by an outside laboratory. Charges for the following routine laboratory tests are included in the facility's composite rate billed to Medicaid regardless of where tests were processed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by the renal dialysis facility unless they are inclusive tests.

The following procedure codes are for labs subjected to ESRD consolidated billing:

| Procedure Codes |        |        |        |        |       |       |        |       |       |
|-----------------|--------|--------|--------|--------|-------|-------|--------|-------|-------|
| 80047^          | 80048^ | 80051^ | 80053^ | 80069^ | 80076 | 81050 | 82040^ | 82108 | 82306 |
| ^ QW Modifier   |        |        |        |        |       |       |        |       |       |

| Procedure Codes |        |        |        |        |        |        |       |       |        |
|-----------------|--------|--------|--------|--------|--------|--------|-------|-------|--------|
| 82310^          | 82330^ | 82374^ | 82379  | 82435^ | 82565^ | 82570^ | 82575 | 82607 | 82610  |
| 82652           | 82668  | 82728  | 82746  | 82947  | 83540  | 83550  | 83615 | 83735 | 83970  |
| 84075^          | 84100  | 84132^ | 84134  | 84155^ | 84157  | 84295^ | 84450 | 84466 | 84520^ |
| 84540           | 84545  | 85004  | 85014^ | 85018^ | 85025^ | 85027  | 85041 | 85044 | 85045  |
| 85046           | 85048  | 85345  | 85347  | 85610  | 86704  | 86705  | 86706 | 87040 | 87070  |
| 87071           | 87073  | 87075  | 87076  | 87077  | 87081  | 87340  | 87341 | 87467 | G0306  |
| G0307           | G0499  |        |        |        |        |        |       |       |        |
| ^ QW Modifier   |        |        |        |        |        |        |       |       |        |

Routine laboratory services listed in the procedure codes table for labs subject to ESRD consolidated billing are included in the composite rate and are not reimbursed separately.

All drugs and biologicals used for the treatment of ESRD or acute kidney injury (AKI) (unless specified otherwise) are included in the composite rate payment and are not paid separately. This includes the following drugs, which are subjected to ESRD consolidated billing:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| J0360           | J0604 | J0606 | J0620 | J0630 | J0636 | J0670 | J0878 | J0884 | J0887 |
| J0892           | J0895 | J0899 | J0945 | J1160 | J1200 | J1205 | J1240 | J1265 | J1270 |
| J1443           | J1444 | J1445 | J1642 | J1643 | J1644 | J1720 | J1740 | J1750 | J1800 |
| J1940           | J1945 | J1955 | J2001 | J2150 | J2360 | J2430 | J2501 | J2720 | J2795 |
| J2993           | J2997 | J3265 | J3364 | J3365 | J3370 | J3410 | J3420 | J3480 | J3489 |
| J7030           | J7040 | J7042 | J7050 | J7060 | J7070 | J7120 | J7131 | Q0163 | Q5105 |

Procedure codes for labs or drugs subjected to ESRD consolidated billing will deny if submitted with procedure code G0257 or the following revenue codes:

| Revenue Codes |     |     |     |     |     |     |     |     |
|---------------|-----|-----|-----|-----|-----|-----|-----|-----|
| 821           | 829 | 831 | 839 | 841 | 849 | 851 | 859 | 880 |

The following drugs used for the treatment of ESRD are excluded from the composite rate and will be paid separately:

| Procedure Codes |       |       |       |       |
|-----------------|-------|-------|-------|-------|
| J0882           | J1439 | J1756 | J2916 | Q4081 |

Other drugs and biologicals furnished by an ESRD facility that are not used for the treatment of ESRD may be billed separately.

The ordering physician must maintain documentation supporting medical necessity in the client's medical record.

### 35.3.2 Maintenance Hemodialysis

#### 35.3.2.1 Training for Hemodialysis, IPD, CCPD, and CAPD

Most self-dialysis training for hemodialysis, IPD, CCPD, and CAPD is provided in an outpatient setting. Dialysis training provided in an inpatient setting will be reimbursed at the same rate as the facility's outpatient training rate.

Reimbursement for hemodialysis, IPD, CCPD, and CAPD training services and supplies provided by the dialysis facility include personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine dialysis laboratory tests. It may be necessary to supplement the patient's dialysis CAPD training with intermittent peritoneal dialysis or hemodialysis because the client has not mastered the CAPD technique.

Training is limited to once per day. The composite rate will be denied as part of dialysis training when billed for the same date of service.

The following revenue codes may be reimbursed for dialysis training:

| Revenue Code | Procedure Description  | Limitations              |
|--------------|--|--------------------------|
| 829          | Hemodialysis (outpatient/home) - other. Use for training.        | 18 sessions per lifetime |
| 839          | Peritoneal Dialysis (outpatient/home) - other. Use for training. | 18 sessions per lifetime |
| 849          | CAPD (outpatient/home) - other. Use for training.                | 18 sessions per lifetime |
| 859          | CCPD (outpatient/home) - other. Use for training.                | 18 sessions per lifetime |

### 35.3.3 Ultrafiltration

A separate ultrafiltration treatment to remove the excess fluid may be covered.

Ultrafiltration is performed on a day other than the day of a dialysis treatment. The dialysis facility must document in the medical record why the ultrafiltration could not have been performed at the time of dialysis treatment. Ultrafiltration performed on the same day as the dialysis treatment is not separately reimbursed.

Ultrafiltration may be reimbursed using revenue code 881 up to a maximum of 3 times per week:

| Revenue Code | Procedure Description                    | Limitations |
|--------------|--|-------------|
| 881          | Miscellaneous dialysis - ultrafiltration | 3 per week  |

Providers can request extra ultrafiltration procedures if they provide attachments that state any of the following:

- Fluid overload (E8771) or diagnosis codes (E8770, E8779, E878) are provided on claim.
- Clotted IV access.
- CRD treatment performed on another day due to holiday.
- Or other reasons why extra ultrafiltration is necessary.

### 35.3.4 Home Dialysis Items and Services

Texas Medicaid utilizes Medicare's composite rate reimbursement system, Consolidated Billing. Under this reimbursement system, the dialysis facility must assume responsibility for providing all home dialysis equipment, supplies, and home support services.

One of the following revenue codes must be billed for the dialysis facility to receive the composite rate payment for clients being treated in the home:

| Revenue Code | Procedure Description   | Limitations              |
|--------------|---|--------------------------|
| 821          | Hemodialysis (HD) (outpatient/home) - composite or other rate. Use for maintenance.   | 3 per week               |
| 831          | Peritoneal Dialysis (outpatient/home) - composite or other rate. Use for maintenance. | 3 per week               |
| 841          | CAPD (outpatient/home) - composite or other rate. Use for maintenance.                | HD - equivalent sessions |
| 851          | CCPD (outpatient/home) - composite or other rate. Use for maintenance.                | HD - equivalent sessions |

Support services are included in the composite rate. Support services that are specifically applicable to home clients include, but are not limited to:

- Periodic monitoring of a client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Visits by trained personnel for the client with a qualified social worker and a qualified dietitian, made in accordance with a plan prepared and periodically reviewed by a professional team, which includes the physician.
- Client's unscheduled visits to a facility made on an as-needed basis (e.g., assistance with difficult access situations).
- ESRD related laboratory tests covered under the composite rate.
- Providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment.
- Ordering of supplies on an ongoing basis.
- A record keeping system that assures continuity of care.
- Support services specifically applicable to CAPD also include but are not limited to the following:
  - Changing connecting tube/administration set.
  - Watching the client perform CAPD and assuring that it is done correctly and reviewing for the client any aspects of the technique they may have forgotten or informing the client of modifications in apparatus or technique.
  - Documenting whether the client has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary).
  - Inspection of the catheter site.

### 35.3.5 Unscheduled or Emergency Dialysis in a Non-Certified ESRD Facility

The CSHCN Services Program will reimburse an unscheduled or emergency dialysis treatment furnished to ESRD clients in the outpatient department of a hospital that does not have a certified ESRD facility.

Reimbursement for procedure code G0257 is limited to the same services included in the composite. Providers will not be reimbursed for individual services related to dialysis. (Refer to Appendix for list of bundled services).

Reimbursement of other outpatient hospital services are only reimbursed when medically necessary and when they are not related to an unscheduled or emergency dialysis services. Providers must submit documentation of unrelated services.

Repeated billing of this service by the same provider for the same clients may indicate routine dialysis treatments are being performed and providers will be subject to recoupment upon medical record review.

Procedure code G0257 is limited to one service a day, any provider.

Procedure code G0257 must be billed with revenue code 880 on the same claim. If procedure code G0257 is not on the same claim as revenue code 880, it will be denied.

Erythropoietin (procedure code Q4081) may be billed separately and must be billed with revenue code 634 or 635 on the same claim.

Procedure code Q4081 is limited to three injections per calendar week (Sunday through Saturday).

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 | 90963 | 90964 | 90965 | 90966 | 90967 | 90968 | 90969 | 90970 |

In the circumstances where the client not on home dialysis has had a complete assessment visit during the calendar month and a full month of ESRD-related services are provided, the following procedure codes must be used:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 |       |       |       |       |       |       |       |       |

**Note:** The procedure code will be determined by the number of face-to-face visits the physician has had with the client during the month, and the client's age.

When a full calendar month of ESRD-related services are reported for clients on home dialysis, the appropriate procedure code (90963, 90964, 90965, or 90966) must be used.

Report procedure codes 90967, 90968, 90969, and 90970 when ESRD-related services are provided for less than a full month, per day, under the following conditions:

- Partial month during which the client, not on home dialysis, received one or more face-to-face visits but did not receive a complete assessment.
- Client on home dialysis received less than a full month of services.
- Transient client.
- Client was hospitalized during a month of services before a complete assessment could be performed.
- Dialysis was stopped due to recovery or death of client.
- Client received a kidney transplant.

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the dates of service must indicate each day that supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed during the same calendar month by any provider as one of the following procedure codes, which are limited to once per month, any provider:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 | 90963 | 90964 | 90965 | 90966 |       |       |       |       |

The following services may be provided in conjunction with physician supervision of outpatient ESRD dialysis but are considered nonroutine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Dialysis at an outpatient facility other than the usual dialysis setting for a client of a physician who bills the Monthly Capitated Payment (MCP). The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for the days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the client's renal condition that causes the number of physician-client contacts to increase. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.
- Physician services to inpatients.

If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician should bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days.

If a client has a complete assessment during a month in which the client is hospitalized, one of the following procedure codes must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month and the client's age:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 |       |       |       |       |       |       |       |       |

**Note:** *The appropriate inpatient evaluation and management codes should be reported for procedures provided during the hospitalization.*

Procedure codes 90935, 90937, 90945, and 90947 may be reimbursed as follows:

- Inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis procedure. These codes are not payable for a cursory visit by the physician; hospital visit procedure codes must be used for a cursory visit.
- The procedure codes are per day procedure codes and include complete care of the client; hospital visits cannot be billed on the same day as these codes.

- If the physician only sees the client when they are not dialyzing, the physician should bill the appropriate hospital visit procedure code. The inpatient dialysis procedure code should not be submitted for payment.
- Outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis procedure.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the clients is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the MCP for physician supervision rendered to maintenance facility clients.

### **35.3.6 Ultrafiltration**

Ultrafiltration of the client's blood is part of a hemodialysis treatment and is included in the reimbursement for the hemodialysis treatment. Ultrafiltration is not a substitute for dialysis.

Medical complications may occur if the client retains excess fluid following a regular dialysis treatment. When an additional treatment is required to remove the excess fluid, the facility must provide documentation indicating the medical necessity of this additional treatment and must submit the claim for the ultrafiltration procedure using revenue code 881.

### **35.3.7 Evaluation and Management**

Physician evaluation procedure codes 90935, 90937, 90945, and 90947 are a benefit in an inpatient setting for ESRD or non-ESRD services only when provided by a physician. The physician must be physically present and involved during the course of the dialysis.

Procedure codes 90935, 90937, 90945, and 90947 are also a benefit in an office or outpatient setting for non-ESRD services that are provided by a physician, physician assistant, or advanced practice registered nurse (APRN).

Only one evaluation procedure code may be reimbursed per day for any provider, regardless of setting. Hospital visits cannot be billed for the same date of service as an evaluation code.

If the physician only sees the patient when they are not dialyzing, the physician should bill the appropriate hospital visit procedure code. The inpatient dialysis procedure code should not be submitted for payment.

Outpatient dialysis services for non-ESRD clients may be reimbursed with procedure codes 90935, 90937, 90945, and 90947.



Reimbursement for physician supervision of outpatient ESRD dialysis includes services provided by the attending physician in the course of office visits where any of the following occur:

- The routine monitoring of dialysis
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts

The following procedure codes may be reimbursed for physician supervision of ESRD dialysis services:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 | 90963 | 90964 | 90965 | 90966 | 90967 | 90969 | 90970 |       |

In circumstances where the client is not on home dialysis, has had a complete assessment visit during the calendar month, and a full month of ESRD-related services are provided, one of the following procedure codes must be used:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961           | 90962 |       |       |       |       |       |       |       |       |

The procedure code will be determined by the number of face-to-face visits the physician has had with the client during the month and by the client’s age.

When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure code 90963, 90964, 90965, or 90966 must be used. The appropriate procedure code will be determined by the client’s age.

Procedure codes 90967, 90968, 90969, or 90970 should be billed per day when ESRD-related services are provided for less than a full month under the following conditions:

- Partial month during which the client, not on home dialysis, received one or more face-to-face visits but did not receive a complete assessment
- Client on home dialysis received less than a full month of services
- Transient client
- Client was hospitalized during a month of services before a complete assessment could be performed
- Dialysis was stopped due to recovery or death of client
- Client received a kidney transplant

Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing these procedure codes, the dates of service must indicate each day that supervision was provided.

Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed during the same calendar month by any provider as the procedure codes in the following table. Only one of the procedure codes in the following table will be reimbursed per calendar month to any provider:

| Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951           | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |

| Procedure Codes |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|
| 90961           | 90962 | 90963 | 90964 | 90965 | 90966 |

Physician services beyond those that are related to the treatment of the client’s renal condition that cause the number of physician-client contacts to increase are considered nonroutine, and may be separately reimbursed. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

### 35.3.8 Renal Transplants

Renal transplants are a benefit of the CSHCN Services Program with documentation of end-stage renal disease (ESRD).

**Referto:** Section 24.3.1.5, “Renal (Kidney) Transplants” in Chapter 24, “Hospital” and Section 31.2.42.1, “Renal (Kidney) Transplant” in Chapter 31, “Physician” for detailed information about renal transplants.

### 35.3.9 Prior Authorization Requirements

Authorization is not required for renal dialysis services.

## 35.4 Claims Information

Renal dialysis facilities must submit claims to TMHP in an approved electronic format or on the UB-04 CMS-1450 paper claim form. Claims for separately billable drugs and laboratory fees must be submitted to TMHP in an approved electronic format or on the appropriate paper claim form. Hospitals and renal dialysis facilities must use the UB-04 CMS-1450 paper claim form and may include these separately billable items on the same UB-04 CMS-1450 form as the dialysis services. Physicians must use the CMS-1500 paper claim form. Providers may purchase both claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing claim forms, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The HCPCS/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” and Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 35.5 Reimbursement

The CSHCN Services Program may reimburse dialysis services using one of the following methods as defined by CMS:

- **Method I: Composite Rate.** The composite rate is paid to the dialysis facility as a comprehensive payment for all in-facility and Method I home dialysis. The cost of an item or service is included in this rate unless specifically excluded as separately billable. Separately billable services would include the physician's professional services, lab work that is designated as separately billable, and drugs that are designated as separately billable. The reimbursement rates associated with revenue codes (composite rates) are available in the Static Fee Schedules, Renal Dialysis Facility Insert, on the TMHP website at [www.tmhp.com](http://www.tmhp.com). CSHCN providers are reimbursed at the same rate as Medicaid providers.

**Referto:** Section 35.3.1, "Renal Dialysis Facilities - Consolidated Billing" in this chapter for benefits and limitations concerning Method I billing.

- **Method II: Direct Dealing.** With direct dealing, the client works with a single supplier such as a durable medical equipment (DME) or other medical supplier (not a dialysis facility) to obtain supplies and equipment to dialyze at home. The supplier will bill the CSHCN Services Program for the services provided. Reimbursement for supplies and services is limited to a maximum amount of \$1,974.45 per client, per calendar year.

**Referto:** Section , "" in this chapter for benefits and limitations concerning Method II billing.

Physicians, laboratories, and medical suppliers may be reimbursed for renal dialysis services the lower of the billed amount or the amount allowed by Texas Medicaid.

Outpatient hospitals may be reimbursed for renal dialysis services at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

Advanced practice registered nurses (APRNs) and physician assistants may be reimbursed for renal dialysis services the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for the same service provided by a physician.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 35.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **RESPIRATORY EQUIPMENT AND SUPPLIES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# RESPIRATORY EQUIPMENT AND SUPPLIES

## Table of Contents

- 36.1 Enrollment .....4**
- 36.2 Benefits, Limitations, and Authorization Requirements .....4**
- 36.2.1 General Authorization Requirements ..... 8
- 36.2.2 Noninvasive Positive Pressure Ventilation (NPPV) ..... 8
  - 36.2.2.1 Continuous Positive Airway Pressure (CPAP) System ..... 9
  - 36.2.2.2 Respiratory Assist Devices (RADs), including BiPAP ..... 10
    - 36.2.2.2.1 *RAD for Treatment of Obstructive Sleep Apnea (OSA)* ..... 10
    - 36.2.2.2.2 *RAD for Treatment of Restrictive Thoracic Medical Conditions* ..... 10
    - 36.2.2.2.3 *RAD for Treatment of Severe COPD* ..... 11
    - 36.2.2.2.4 *RAD for Treatment of Central sleep Apnea (CSA) or Complex Sleep apnea (CompSA)* ..... 11
    - 36.2.2.2.5 *RAD for Treatment of Hypoventilation Syndrome* ..... 12
    - 36.2.2.2.6 *Extension Request for RAD With or Without a Set Backup Rate* ..... 12
- 36.2.3 Controlled Dose Inhalation Drug Delivery System ..... 13
- 36.2.4 Secretion and Mucus Clearance Devices ..... 13
  - 36.2.4.1 Cough Augmentation Device (Insufflation Devices or Cough Assist Machine) ..... 14
  - 36.2.4.2 Electrical Percussors ..... 14
  - 36.2.4.3 High Frequency Chest Wall Oscillation (HFCWO) System ..... 14
  - 36.2.4.4 Percussion Cup ..... 16
  - 36.2.4.5 Intermittent Positive Pressure Breathing (IPPB) Devices ..... 16
- 36.2.5 Nebulizers ..... 16
  - 36.2.5.1 Medications Small Volume Nebulizer ..... 17
  - 36.2.5.2 Large Volume Nebulizer ..... 18
  - 36.2.5.3 Compressors and other DME used with Large Volume Nebulizers ..... 18
  - 36.2.5.4 Filtered Nebulizer ..... 18
  - 36.2.5.5 Ultrasonic Nebulizers ..... 19
- 36.2.6 Oxygen Therapy ..... 19
  - 36.2.6.1 Stationary Oxygen Systems ..... 22
  - 36.2.6.2 Portable Oxygen Systems ..... 22
- 36.2.7 Pulse Oximeters ..... 22
- 36.2.8 Tracheostomy Tubes and Related Supplies ..... 23
  - 36.2.8.1 Tracheostomy Tube Inner Cannula ..... 24
- 36.2.9 Cardiorespiratory Monitor (CRM) ..... 25
- 36.2.10 Mechanical Ventilation ..... 26
- 36.2.11 Negative Pressure Ventilators ..... 26
- 36.2.12 Home Ventilators (any type) with or without Invasive Interface ..... 27
- 36.2.13 Repair to Client -Owned Equipment ..... 27
- 36.2.14 Aerosol Treatments ..... 28
- 36.2.15 Diagnostic Testing ..... 28
- 36.2.16 Other Equipment ..... 29

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**36.3 Claims Information.....29**  
**36.4 Reimbursement.....29**  
**36.5 TMHP-CSHCN Services Program Contact Center.....30**

## 36.1 Enrollment

Durable medical equipment (DME) providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state respiratory equipment providers must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 36.2 Benefits, Limitations, and Authorization Requirements

*The CSHCN Services Program may reimburse the rental or purchase of medically necessary and appropriate respiratory equipment. The item must be prescribed by a licensed physician and be a benefit of the CSHCN Services Program.*

Equipment may be rented or purchased depending on the cost-effectiveness of the action requested. In general, equipment is purchased if it is needed for more than 6 months. Only new, unused equipment will be rented or purchased for clients. The reimbursement of rented equipment includes all supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period. Supplies needed for use with client owned equipment may be considered for purchase.

Respiratory supplies are a benefit when medically necessary and are available without prior authorization up to the stated quantity limitation unless otherwise stated. Prior authorization is required for quantities exceeding the limitation.

Sterile respiratory supplies are a benefit with prior authorization when medically necessary and documentation shows that the client’s medical needs cannot be met with non-sterile (clean) supplies.

**Exception:** *Ventilators, oxygen concentrators, and cough stimulating devices are rented, not purchased, because of high maintenance costs and the frequency of required repairs.*

Repairs are considered if the item was purchased by the CSHCN Services Program or is an item on the CSHCN Services Program-approved list that was obtained from another source. The repair must be more cost-effective than the cost of replacement. Repairs may be reimbursed at the list price of parts plus labor time.

The CSHCN Services Program considers requests for coverage of the following types of respiratory equipment:

- Rental or purchase of:
  - Suction equipment
  - Electric percussors for chest physiotherapy
  - High frequency chest wall oscillation systems (HFCWO)
  - Medical grade or “heavy duty” air compressors
  - Continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) machines (BiPAP machines will only be provided to clients who have documented treatment failure of CPAP)
  - Immersion heaters
  - Nebulizers
  - Pulse oximeters
  - Ventilators and supplies (ventilators may be a benefit for lease only)
  - Controlled dose inhalation drug delivery system
  - Cardiorespiratory (apnea) monitors (only nonrecording apnea monitors will be authorized for ventilator dependent clients)
- Rental of:
  - Stationary gaseous oxygen cylinders or liquid oxygen systems
  - Portable gaseous oxygen system

***Note:** Stands, carts, regulators, oxygen conservers, and carrying cases are included in the rental reimbursement for stationary gaseous oxygen cylinders, liquid oxygen systems, and portable gaseous oxygen systems.*

  - Oxygen concentrators (a back up cylinder of gaseous oxygen is included in the rental reimbursement)
  - Cough stimulating devices (Cofflator)
- Purchase of:
  - Liquid or gaseous oxygen contents or refills for client-owned equipment
  - Oxygen humidification devices (e.g., Cascade device)
  - Ambu bag
  - Tracheostomy tubes and supplies
  - Incentive spirometer
  - Mucus clearance valve

***Note:** Rental of substitute equipment is not covered when a purchased item that is under warranty is being repaired.*



The CSHCN Services Program will cover only one of the following per client:

- A cough stimulating device
- An HFCWO

The CSHCN Services Program will consider the following two situations with documentation of medical necessity:

- Requests for the rental or purchase of duplicate items that will be used in two different locations. The CSHCN Services Program will not pay for the rental or purchase of items when the provision of the items are the legal responsibility of a school district or the Texas Workforce Commission (TWC).
- Requests to replace items purchased within the last 2 years.

The CSHCN Services Program may cover items under the Family Support Services (FSS) benefit within annual coverage limits. Type of items include, but are not limited to:

- Room air vaporizers or humidifiers
- Air filtering systems
- Specialized vacuum cleaners
- Heaters
- Air conditioners
- Dehumidifiers

Contact the CSHCN Services Program at 1-800-252-8023 for additional information about the FSS benefit.

The following equipment is not a benefit of the CSHCN Services Program:

- Intrapulmonary percussive ventilation (IPV) system
- Vaporizers
- Room air humidifiers

Providers must have the client or the client's representative complete the [CSHCN Services Program Documentation of Receipt form](#) when DME is delivered to the client. The date of delivery on the documentation of receipt form is the date of service that should appear on the claim. The provider should retain this form; do not submit it with the claim.

The documentation of receipt form is available in both [English](#) and [Spanish](#).

The following table is a list of respiratory equipment and supplies and their limitations.

| Procedure Code | Maximum Limitation | Procedure Code         | Maximum Limitation | Procedure Code | Maximum Limitation |
|----------------|--------------------|------------------------|--------------------|----------------|--------------------|
| A4216          | As needed          | A4481                  | 31 per month       | A4483          | 15 per month       |
| A4556          | 15 per month       | A4557                  | 2 per month        | A4605          | 10 per month       |
| A4606          | 4 per month        | A4606 with modifier U5 | 1 per 6 months     | A4611          | 1 per 5 years      |
| A4612          | 1 per 5 years      | A4613                  | 1 per 5 years      | A4614          | 1 per 6 months     |
| A4615          | 2 per month        | A4616                  | 4 per year         | A4617          | 2 per month        |
| A4618          | 4 per month        | A4619                  | 2 per month        | A4620          | 2 per month        |
| A4623          | 1 per month        | A4623 with modifier U3 | 31 per month       | A4624          | 85 per month       |

| Procedure Code         | Maximum Limitation                         | Procedure Code | Maximum Limitation                          | Procedure Code         | Maximum Limitation                          |
|------------------------|--|----------------|---|------------------------|---|
| A4627                  | 1 per 6 months                             | A4628          | 2 per month                                 | A4629                  | 30 per month                                |
| A7000                  | 5 per month                                | A7002          | 8 per month                                 | A7003                  | 2 per month                                 |
| A7004                  | 2 per month                                | A7005          | 1 per 6 months                              | A7006                  | 1 per month                                 |
| A7007                  | 2 per month                                | A7009          | 1 per year                                  | A7010                  | 1 per 2 months                              |
| A7012                  | 2 per month                                | A7013          | 2 per month                                 | A7014                  | 1 per 3 months                              |
| A7015                  | 1 per month                                | A7016          | 2 per month                                 | A7017                  | 1 per 3 years                               |
| A7018                  | 4 per month                                | A7025          | 1 per lifetime                              | A7026                  | 1 per 6 months                              |
| A7027                  | 1 per 3 months                             | A7028          | 1 per month                                 | A7029                  | 2 per month                                 |
| A7030                  | 1 per 3 months                             | A7031          | 1 per month                                 | A7032                  | 2 per month                                 |
| A7033                  | 2 per month                                | A7034          | 1 per 3 months                              | A7035                  | 1 per 6 months                              |
| A7036                  | 1 per 6 months                             | A7037          | 1 per month                                 | A7038                  | 2 per month                                 |
| A7039                  | 1 per 6 months                             | A7520          | 1 per month                                 | A7520 with U1 modifier | 1 per month                                 |
| A7520 with U2 modifier | 1 per month                                | A7521          | 1 per month                                 | A7522                  | 4 per year                                  |
| A7523                  | 1 per 2 years                              | A7525          | 4 per month                                 | A7526                  | 20 per month                                |
| A9284                  | 1 per 6 months                             | A9900          | As needed                                   | E0424                  | 1 rental per month                          |
| E0431                  | 1 rental per month                         | E0433          | 1 rental per month                          | E0434                  | 1 rental per month                          |
| E0439                  | 1 rental per month                         | E0441          | 1 per month                                 | E0442                  | 1 per month                                 |
| E0443                  | 1 per month                                | E0444          | 1 per month                                 | E0445                  | 1 rental per month                          |
| E0445 with modifier U4 | 1 purchase per 5 years; 1 rental per month | E0457          | 1 purchase per 5 years; 1 rental per month  | E0459                  | 1 purchase per lifetime; 1 rental per month |
| E0465                  | 1 rental per month                         | E0466          | 1 rental per month                          | E0470                  | 1 purchase per 5 years; 1 rental per month  |
| E0471                  | 1 rental per month                         | E0472          | 1 rental per month                          | E0480                  | 1 purchase per 5 years; 1 rental per month  |
| E0482                  | 1 rental per month                         | E0483          | 1 purchase per lifetime; 1 rental per month | E0500                  | 1 purchase per 5 years; 1 rental per month  |
| E0550                  | 1 purchase per 3 years; 1 rental per month | E0561          | 1 purchase per 5 years; 1 rental per month  | E0562                  | 1 purchase per 5 years; 1 rental per month  |
| E0565                  | 1 purchase per 5 years; 1 rental per month | E0570          | 1 per 5 years                               | E0574                  | 1 per 5 years                               |

| Procedure Code | Maximum Limitation                         | Procedure Code | Maximum Limitation                         | Procedure Code | Maximum Limitation                         |
|----------------|--|----------------|--|----------------|--|
| E0575          | 1 per 5 years                              | E0580          | 1 purchase per 3 years; 1 rental per month | E0600          | 1 per 5 years                              |
| E0601          | 1 purchase per 5 years; 1 rental per month | E0618          | 1 purchase per 5 years; 1 rental per month | E0619          | 1 purchase per 5 years; 1 rental per month |
| E1353          | 1 per year                                 | E1355          | 1 per 3 years                              | E1372          | 1 per 3 years                              |
| E1390          | 1 per calendar month                       | E1399          | As needed                                  | K0462          | 1 per month                                |
| K0730          | 1 per 5 years                              | K0738          | 1 per month                                | K0739          | 2 hours per day                            |
| L8501          | 1 per 6 months                             | S8101          | 1 per 6 months                             | S8185          | 1 per 5 years                              |
| S8189          | As needed                                  | S8999          | 1 per year                                 |                |  |

### 36.2.1 General Authorization Requirements

Requirements for authorization and prior authorization vary with the type of equipment requested. Refer to the types of equipment listed below for authorization and prior authorization requirements. Authorization and prior authorization request forms must be submitted in writing and must include documentation of medical necessity.

**Referto:** Chapter 4, “Prior Authorizations and Authorizations.”

[CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment \(DME\) Form.](#)

**Note:** Fax transmittal confirmations are not accepted as proof of timely authorization submission.

### 36.2.2 Noninvasive Positive Pressure Ventilation (NPPV)

Prior authorization is required for rental or purchase of NPPV devices, including CPAP and respiratory assist devices (RADS) which include Bi-Level PAP with or without a set backup respiratory rate when medically necessary primarily for clients requiring treatment of obstructive sleep apnea, restrictive thoracic disorders, severe chronic obstructive pulmonary disease, central sleep apnea, complex sleep apnea, and hypoventilation syndrome. Prior authorization must be submitted on a completed CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form that has been signed and dated by the prescribing physician.

**Note:** Other conditions may be considered with prior authorization of medical necessity.

RADS with a set backup rate are available for rental only when medically necessary.

For client owned devices, proof of ownership of the NPPV device is required when requesting prior authorization for purchase of the associated supplies. A claims history of the purchase of an NPPV device or the associated supplies will meet this requirement. A statement from the ordering physician providing the make and model of the client-owned device will meet this requirement if claims history is not available.

Humidification devices used with continuous positive airway pressure (CPAP), or respiratory assist devices (RAD) such as a bi-level PAP with or without a set backup respiratory rate require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization. Prior authorization for heated humidification must include documentation of a medical reason requiring heated humidification.

Tubing and filters are considered part of the rental and will not be reimbursed separately.

Headgear, masks, and other client interfaces may be prior authorized separately when requested for the rental of NPPV with documentation of medical necessity.

### 36.2.2.1 Continuous Positive Airway Pressure (CPAP) System

A CPAP device (procedure code E0601) is used primarily for the treatment of obstructive sleep apnea. Other conditions may be considered based on medical necessity.

The CPAP device may be prior authorized for rental or purchase based on the physician's predicted length of treatment.

The CPAP device may be approved for an initial 3-month rental period based on documentation that supports the medical necessity and appropriateness of the device along with documentation of a sleep study lasting a minimum of 2 hours and when at least one of the following conditions are met for clients who are 18 years of age and older:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than or equal to 15 events per hour
- The Sleep Study RDI or AHI is greater than 5 events per hour and at least one of the following is true:
  - Excessive daytime sleepiness (documented by either an Epworth Sleepiness Scale 10 or greater or a Multiple Sleep Latency Test less than six)
  - Documented symptoms of impaired cognition, mood disorders, or insomnia
  - Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg)
  - Documented ischemic heart disease or previous myocardial infarction
  - Documented history of stroke
  - Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
  - Any one episode of oxygen desaturation less than 70 percent
  - Documented pulmonary hypertension

Polysomnography documentation of AHI greater than one event per hour may be used to establish medical necessity for clients who are 17 years of age and younger.

CPAP may be medically necessary for the treatment of obstructive sleep apnea (OSA) in clients who are younger than 18 years of age when one of the following criteria are met:

- Adenoidectomy or tonsillectomy is contraindicated
- Adenoidectomy or tonsillectomy is delayed
- Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA

**Note:** *American Academy of Sleep Medicine guidelines indicate that it is clinically appropriate to treat clients who are 18 through 20 years of age using the adult criteria.*

Prior authorization for purchase after a maximum three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours in a 24 hour period and symptoms are improved as documented by a physician. This documentation of compliance and effectiveness must be provided with a new completed CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form signed and dated by a physician.

### 36.2.2.2 Respiratory Assist Devices (RADs), including BiPAP

A RAD with or without a set backup rate may be considered for prior authorization when the client has one of the following conditions as documented by a sleep study and meets criteria for medical necessity for the specific medical condition:

- OSA
- Restrictive thoracic disorders i.e., neuromuscular diseases or severe thoracic cage abnormalities
- Severe chronic obstructive pulmonary disease (COPD)
- Central sleep apnea (CSA)
- Complex sleep apnea (CompSA)
- Hypoventilation syndrome
- Meets criteria for the specific medical condition noted below

#### 36.2.2.2.1 RAD for Treatment of Obstructive Sleep Apnea (OSA)

A RAD without backup may be considered for an initial three month trial period with prior authorization for treatment of OSA when all of the following criteria are met:

- All of the required documentation listed in the CPAP section is submitted with the prior authorization request
- The client meets the criteria for the initial CPAP three month trial
- Documentation supports that CPAP has been tried with documentation of one of the following:
  - The treating practitioner verifies that a CPAP trial failed to be effective in treating the client's OSA
  - CPAP was found to be ineffective during the initial facility based or sleep laboratory titration trial

If a CPAP device is tried and is not effective during an initial facility based titration or home trial; substitution of a RAD does not require a new face to face clinical evaluation or a new sleep test.

#### 36.2.2.2.2 RAD for Treatment of Restrictive Thoracic Medical Conditions

A RAD without a set backup rate may be considered for treatment of thoracic medical conditions with prior authorization when all of the following are met:

- The client is diagnosed with a neuromuscular disorder, (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) or has a diagnosis of a severe thoracic cage abnormality, (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort.
- Medical necessity documentation indicates significant respiratory insufficiency documented by one of the following:
  - An arterial blood gas (ABG) PaCO<sub>2</sub> > 45mm Hg, obtained while awake and breathing the client's routinely prescribed FI<sub>O2</sub>
  - Sleep oximetry demonstrates oxygen saturation < 88% for > 5 minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO<sub>2</sub>

For clients who have been diagnosed with a neuromuscular disorder only, documentation must support one of the following:

- Maximal inspiratory pressure is < 60 cm H<sub>2</sub>
- Forced vital capacity is < 50% of predicted

A RAD with a set back-up rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client meets the criteria for use of the RAD without a back-up rate for treatment of a thoracic medical condition
- The ordering physician verifies the following:
  - Client has tried a RAD without a backup rate for at least 60 Days
  - Client was compliant in use of the device using on average 4 or more hrs in a 24 hr day
  - The desired therapeutic respiratory response was not achieved with the RAD without a set back up rate

#### 36.2.2.2.3 RAD for Treatment of Severe COPD

A RAD without a set backup rate may be considered for the treatment of severe COPD with prior authorization when all of the following criteria are met:

- The client's arterial blood gas PaCO<sub>2</sub> is less than 52 mm Hg, obtained while awake and when the client is using their routinely prescribed FIO<sub>2</sub> or 2LPM of oxygen. The blood gas should be obtained while the client is using whichever concentration of oxygen is the higher of the two.
- Sleep oximetry demonstrates oxygen saturation < 88% for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2LPM or the client's prescribed FIO<sub>2</sub> (whichever is higher).
- Prior to initiating therapy, documentation of sleep apnea and that treatment with a CPAP has been considered with an explanation of why it has been ruled out.

To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the client's medical record submitted with the request that demonstrates the client does not have some form of OSA, CSA, or CompSA as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation.

A RAD with a backup feature will be considered with prior authorization for severe COPD when all of the following criteria are met:

- The client meets the criteria for use of the RAD without a backup rate for COPD
- The ordering practitioner verifies that:
  - The client has tried the RAD without a backup rate for at least 60 days.
  - The client was compliant in the use of the device using on average 4 or more hours in a 24 hour day.
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate.

#### 36.2.2.2.4 RAD for Treatment of Central sleep Apnea (CSA) or Complex Sleep apnea (CompSA)

A RAD without a set backup rate will be considered with prior authorization for the treatment of CSA or CompSA when a facility based polysomnogram indicates all of the following:

- The client has a diagnosis of CSA or CompSA
- The sleep study documents one of the following:
  - The sum total of central hypopneas plus central apneas is greater than 50% of the total apneas and hypopneas rate

- A central hypopnea/apnea rate index greater than 5 events per hour and significant improvement of the sleep associated hypoventilation while breathing the client's prescribed FiO<sub>2</sub>
- Documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated hypoventilation

A RAD with a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of CSA or CompSA
- The ordering practitioner verifies that all of the following are met:
  - Client has tried a RAD without a backup rate for at least 60 days
  - Client was compliant in the use of the device using on average 4 or more hours in a 24 hour day
  - The desired therapeutic response was not achieved with the RAD without a set backup rate

#### 36.2.2.2.5 RAD for Treatment of Hypoventilation Syndrome

A RAD without a set backup rate may be considered for treatment of hypoventilation syndrome with prior authorization when all of the following criteria are met:

- An initial arterial blood gas PaCO<sub>2</sub> is > 45 mm Hg while awake breathing routinely prescribed FIO<sub>2</sub>
- A spirometry shows a forced expired volume in 1 sec (FEV<sub>1</sub>) or the forced vital capacity (FVC) is > 70%.
- A facility based polysomnogram demonstrates an oxygen saturation < 88% for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hrs) not caused by obstructive upper airway events

A RAD with a set backup respiratory rate may be considered with prior authorization for the treatment of hypoventilation syndrome when one of the following are met:

- The client has hypoventilation syndrome as determined by a facility based polysomnogram that demonstrates the desired respiratory therapeutic effects were not achieved with a RAD without a backup rate
- The client meets the criteria for RAD without a backup rate for hypoventilation syndrome and the physician documents the desired respiratory therapeutic effects were not achieved with the RAD without a backup rate

#### 36.2.2.2.6 Extension Request for RAD With or Without a Set Backup Rate

Prior authorization is required for an extension of a RAD with or without a set backup rate.

Purchase of a RAD without a set backup rate or continued rental of a RAD with or without a set backup rate (after the initial rental) may be considered with prior authorization and all of the following:

- The client has completed an initial three month rental period
- Submission of a new CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form that has been signed and dated by the ordering practitioner
- Submission of medical necessity documentation that the client is continuing to use the equipment a minimum of four hours in a 24 hour period
- Medical necessity documentation indicates that client symptoms are improved

When requesting an extension for a RAD with or without a set backup rate documentation of a capillary blood gas (CBG) demonstrating a PaCO<sub>2</sub> greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed FI<sub>02</sub> may be submitted in lieu of an ABG.

### 36.2.3 Controlled Dose Inhalation Drug Delivery System

Prior authorization is required for purchase of a controlled dose inhalation drug delivery system (procedure code K0730) and requires documentation of medical necessity for the following conditions:

| Conditions                             |
|--|
| Pulmonary artery hypertension          |
| Chronic pulmonary heart disease        |
| Other chronic pulmonary heart diseases |

Other conditions may be considered with prior authorization and documentation of medical necessity.

*Note: The pulmonary hypertension may not be secondary to pulmonary venous hypertension or disorders of the respiratory system.*

### 36.2.4 Secretion and Mucus Clearance Devices

Secretion and mucus clearing devices are a benefit when medically necessary and are typically needed by clients diagnosed with cystic fibrosis (CF), chronic bronchitis, bronchiectasis, ciliary dyskinesia syndromes, some forms of asthma, neuromuscular degenerative disorders, post-operative atelectasis, or thoracic wall defects.

Secretion and mucus clearing devices may be considered when documentation clearly shows the client has one of the following indications for this form of therapy as described by the American Association for Respiratory Care (AARC) in the Clinical Practices Guidelines for Postural Drainage Therapy (I) (199-1):

- Evidence retained secretions
- Evidence that the client is having difficulty with the secretion clearance
- Presence of atelectasis caused by mucus plugging

The following therapies and devices do not require prior authorization when requested within the benefit limitations:

- Incentive spirometers
- Manual percussion
- Mucus clearance valved chamber (Oscillating Positive Expiratory Pressure (PEP) - Flutter Valve)
- Moisture exchangers (procedure code A4483) for use only when used for mechanically ventilated clients who own their own equipment

These following therapies and devices require prior authorization:

- Insufflation-exsufflation devices, (e.g., Cough Assist, Cofflator)
- Electrical percussors
- High frequency chest wall oscillation (HFCWO) system
- Percussion cup
- Intermittent positive pressure breathing (IPPB) devices



Prior authorization requests for rental or purchase of secretion and mucus clearance devices must be submitted on the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form signed and dated by a physician.

*Note: Clients requiring more than one secretion and mucus clearance device must have a pulmonologist as the prescribing physician who submits a signed and dated letter of medical necessity for the need of two devices.*

#### **36.2.4.1 Cough Augmentation Device (Insufflation Devices or Cough Assist Machine)**

A cough augmentation device may be considered for prior authorization for rental only for those clients who have chronic pulmonary disease or neuromuscular disorders (including spinal cord injury) that affect the respiratory musculature, causing a weak, ineffectual or absent cough.

Prior authorization for a cough augmentation device may be considered for an initial three-month rental period with all of the following documentation completed, signed, and dated by the client's treating physician:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies (if applicable); due to diagnosis-related complications.
- History of school, work, or extracurricular activity or absences or other clinical evidence supporting deterioration to the level of requiring the use of a cough augmentation device to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs).
- Medical reasons why the client, parent, guardian, or caregiver cannot do chest physiotherapy, or why such therapies were previously ineffective.

Requests for prior authorization recertification must include documentation by the client's treating physician that the client is compliant with the use of the equipment and that the treatment is effective.

#### **36.2.4.2 Electrical Percussors**

An electrical percussor may be considered for rental or purchase with documentation of medical necessity on the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form including a description of all previous courses of therapy (such as manual percussion and postural drainage (P&PD) and valved devices) and why they did not adequately assist the client in airway mucus clearance.

*Note: Rental period may be considered for a maximum of nine months.*

#### **36.2.4.3 High Frequency Chest Wall Oscillation (HFCWO) System**

Prior authorization of a HFCWO system may be considered for clients with one of the following conditions:

- Bronchiectasis when it is confirmed by CT scan and characterized by either a continuous daily productive cough for 6 months or frequent exacerbations of pulmonary infections (i.e., more than 2 times per year) requiring antibiotic therapy
- Cystic Fibrosis or other documented chronic suppurative endobronchitis
- Chronic neuromuscular disorder affecting the ability to cough or clear respiratory secretions

A HFCWO system may be considered for prior authorization with documentation of all the following:

- Medical necessity including submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form
- Other mechanical devices or chest physiotherapy modalities used by a client, parent, guardian, or caregiver
- Reason why other modalities have not been effective

- If previously used, the device use has not resulted in aspiration, exacerbation of any gastrointestinal or pulmonary issues, nor caused an exacerbations of seizure activity

An initial three-month rental may be prior authorized for the HFCWO system. If the HFCWO system is documented to be effective, at the end of the initial three-month rental, purchase of the system may be prior authorized. If at the end of the initial three-month rental, a determination of purchase cannot be made, an additional three-month rental may be given.

Prior authorization for the initial three-month rental of an HFCWO system generator and vest may be considered with all of the following information:

- Documentation that the client has one of the medical conditions listed above and has used a cough augmentation device for a minimum of three months prior to the request and that this therapy has been ineffective
- Client has a chronic respiratory illness or with exacerbation or change in baseline respiratory condition in the past 6 months (provide additional information in narrative section)
- Client or family unable to do chest physiotherapy or chest physiotherapy is contraindicated (provide medical reasons in narrative section)
- Client has tried other appropriate (age, ability, skill) modes of chest physiotherapy, such as the use of electrical percussor therapy or oscillating positive expiratory pressure valve for a minimum of four months prior to the request and why the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section)

Prior authorization for an additional three-month rental may be considered with the above documentation and documentation of compliance with the ordered therapy.

Prior authorization for the purchase of an HFCWO system may be considered based on the outcome of the rental period(s) and the following required documentation:

- Documentation of vest tolerance and positive outcomes or results of therapy, including physician's statement of a trial of the HFCWO in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system
- Physician's description and assessment of the effectiveness including:
  - Decreased medication use
  - Shorter hospital length of stay
  - Decreased hospitalizations
  - Fewer school, work, or extracurricular activity absences due to diagnosis- related complications
  - The frequency and compliance graphs from the device for the 6-month period showing use of the system at least 50 percent or 3 months of the maximum time prescribed by the physician for each day
- Diagnosis and background history including:
  - Complications
  - Medications used
  - IV antibiotic therapy with dosage, frequency and duration
  - Recent hospitalizations
  - School, work, and extracurricular activity absences due to diagnosis-related complications
- Evidence of clinical improvement other than pulmonary function tests, including improved work or school attendance or ability to participate in extracurricular activities

- Documentation that the previous use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity

A HFCWO system purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer.

*Note: Requests for a vest replacement due to growth or is no longer functional will be considered for prior authorization with appropriate documentation and submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form.*

#### **36.2.4.4 Percussion Cup**

Requests for purchase of a percussion cup for chest physiotherapy requires submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form and documentation of medical necessity. Requests for percussion cups should be requested with the miscellaneous DME procedure code E1399.

#### **36.2.4.5 Intermittent Positive Pressure Breathing (IPPB) Devices**

Prior authorization is required for rental or purchase of an IPPB (procedure code E0500) with documentation of ineffective response with use of other modalities (e.g. treatment with a cough assist device) and there is a need to improve lung expansion due to:

- The presence of clinically significant pulmonary atelectasis when other forms of therapy have been unsuccessful or the client is unable to cooperate with the treatment
- Inability to clear secretions due to pathology that severely limits the client's ability to ventilate or cough effectively and failure to respond to other modes of treatment including but not limited to:
  - Neuromuscular disorders or kyphoscoliosis with decreases in lung volume
  - Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy
  - The need to deliver aerosol medication
- The need to deliver aerosol medications when other methods of delivery have been unsuccessful including but not limited to:
  - Clients with fatigue as a result of ventilary muscle weakness such as neuromuscular disease, kyphoscoliosis or spinal cord injury
  - Clients with severe hyperinflation where IPPB may decrease dyspnea and discomfort during nebulized therapy

Rental of the IPPB device includes all supplies (e.g. humidification and tubing).

#### **36.2.5 Nebulizers**

A nebulizer may be rented or purchased for clients when:

- The equipment is prescribed by a physician for an approved diagnosis.
- The documentation submitted with the claim, the authorization, or prior authorization request supports medical necessity and appropriateness.

The purchase of nebulizers may be reimbursed with the anticipation that the equipment will last a minimum of 2 years with continuous use and up to 5 years with intermittent use.

The following procedure codes may be reimbursed for nebulizers and supplies:

| Procedure Codes                                 |       |       |       |       |
|---|-------|-------|-------|-------|
| <b>Small Volume Nebulizer and Supplies</b>      |       |       |       |       |
| A7003   | A7004 | A7005 | A7006 | E0565 |
| <b>Large Volume Nebulizer and Supplies</b>      |       |       |       |       |
| A7007   | A7008 | E0585 |       |       |
| <b>Filtered Volume Nebulizer and Supplies</b>   |       |       |       |       |
| A7006   | E0565 |       |       |       |
| <b>Ultrasonic Volume Nebulizer and Supplies</b> |       |       |       |       |
| E0574   | E0575 |       |       |       |

**Note:** Prescribed medications for use with aerosol delivery by SVN may be considered under the Vendor Drug Program.

### 36.2.5.1 Medications Small Volume Nebulizer

Prior authorization is not required for purchase of a medication small volume nebulizer (SVN) and related supplies for the conditions listed below.

| Conditions   |
|--|
| Bronchiectasis - any type  |
| Cystic Fibrosis with pulmonary manifestations  |
| Pneumonia - any type   |
| Influenza  |
| Bronchitis - any type  |
| Emphysema - any type   |
| Asthma - any type  |
| COPD - any type  |
| Pneumoconiosis - any type  |
| Acute, Sub-acute or Chronic respiratory conditions   |
| Respiratory conditions due to radiation, smoke, unspecified and specified external agents  |
| Abnormal sputum  |
| Other diseases of the trachea and bronchus   |
| Tracheostomy Status  |
| Attention to tracheostomy  |
| HIV with pulmonary manifestations  |
| Pneumocystis   |
| Complications of a specified or unspecified transplanted organ, bone marrow, or stem cells |
| Primary Pulmonary Hypertension   |
| Other Chronic Pulmonary Heart Disease  |

**Note:** Prescribed medications for use with aerosol delivery by SVN may be considered under the Vendor Drug Program.

SVNs for conditions not listed above require prior authorization with documentation of medical necessity.

Sterile water, saline, and dextrose, diluent/flush 10 ml does not require prior authorization when requested within the limitations within this chapter.

Documentation for prior authorization must include frequency and duration of need for the nebulizer treatments ordered.

### **36.2.5.2 Large Volume Nebulizer**

Prior authorization is not required for large volume nebulizers (procedure codes A7007 and A7017) used with compressors in humidification systems and may be considered for purchase when medically necessary. Prior authorization with documentation of medical necessity is required for large volume nebulizers that exceed the limitations in this chapter.

If heat is required, a heating element, such as an immersion element, may be added.

The autoclave nebulizer (procedure code E0580) for use with a regulator or flow meter may be considered with prior authorization and documentation of medical necessity.

### **36.2.5.3 Compressors and other DME used with Large Volume Nebulizers**

Prior authorization is required for rental or purchase of compressors (procedure code E0565), nebulizer compressors and heaters (procedure code E0585), or large volume ultrasonic nebulizers (procedure code E0575) when the following criteria is met:

- The client has thick, tenacious secretions
- The client has one of the following medical conditions:
  - Cystic fibrosis
  - Bronchitis
  - A tracheostomy
  - A tracheobronchial stent

Equipment used with a large volume nebulizer to create a humidification system may be considered with prior authorization and documentation of medical necessity.

Procedure code E0565 may be considered when all of the following criteria are met:

- The compressor is needed for the administration of pentamide using a filtered nebulizer
- The client has one of the following medical conditions:
  - HIV with pulmonary complications
  - Pneumocystosis
  - Complications of organ transplants

### **36.2.5.4 Filtered Nebulizer**

Prior authorization is required for the administration set with small volume filtered pneumatic nebulizers (procedure code A7006) and must include documentation of medical necessity of one of the following conditions:

- HIV
- Complications of organ transplants, unspecified site

The administration set may be considered for other immunodeficiency conditions with prior authorization and documentation of medical necessity.

### 36.2.5.5 Ultrasonic Nebulizers

Prior authorization with documentation of medical necessity is required for purchase of ultrasonic nebulizers (procedure code E0574) used for the administration of bronchodilators and other select medication for clients who meet the criteria for a standard nebulizer.

*Note: Speed, convenience, or ease of use is not considered medically necessary.*

The prior authorization request must provide documentation that:

- The client did not have clinical improvement with treatment using a medication small volume nebulizer
- The client was compliant with other nebulizer treatment and medication therapy
- Use of a standard nebulizer has failed to control the client's disease process resulting in emergency room use or hospitalizations

### 36.2.6 Oxygen Therapy

All oxygen therapy supplies and related equipment requires prior authorization.

Devices used for in-home oxygen therapy including stationary oxygen concentrators, portable compressed gas cylinders, or liquid oxygen reservoir oxygen systems are a benefit when medically necessary and require prior authorization.

Prior authorization may be considered for monthly rental only and must be requested on a completed CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form signed and dated by the client's ordering practitioner. Medical necessity documentation must be submitted with the request.

Oxygen system rental includes, but is not be limited to:

- Oxygen concentrator or oxygen tanks
- Regulator
- Flow meter
- Humidifier
- Cannula or mask
- Tubing

Devices used for in-home oxygen therapy may be considered for the treatment of chronic hypoxemia which may be the result of, but not limited to:

- Bronchopulmonary dysplasia or other respiratory diagnoses due to prematurity.
- Respiratory failure or insufficiency; musculoskeletal weakness, such as that caused by Duchenne's muscular dystrophy or spinal muscle atrophy.
- Diagnosis of cluster headaches.
- Severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuses interstitial lung disease, cystic fibrosis, bronchiectasis, or widespread pulmonary neoplasm.

Stationary oxygen concentrators are the preferred oxygen therapy home delivery system. If other types of oxygen therapy home delivery systems are required, documentation of medical necessity to support an exception must be provided. The other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks).
- Liquid oxygen reservoir systems.

Multiple oxygen types (e.g., liquid and gas) will not be prior authorized concurrently.

Extensive supplemental humidification systems (procedure code E0550) may be prior authorized separately for monthly rental of oxygen equipment with documentation of medical necessity. The documentation must include all of the following:

- The client has a tracheostomy or tracheobronchial stent
- The client has thick tenacious secretions not responsive to normal levels of humidification provided with routine humidifiers used with regulators or flow meters.
- The client is not currently renting a ventilator
- The client is not currently renting a compressor for the delivery of humidification

All other humidification systems are included in the oxygen monthly rental and will not be prior authorized separately.

Supplies and refills (procedure codes E0441, E0442, E0443, E0444, and E0447) may be prior authorized for those clients who own their own oxygen systems.

Prior authorization of home oxygen therapy for an initial three-month rental period may be considered when a CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form is submitted along with medical necessity documentation that meets one of the oxygen coverage categories below:

- Evidence from the client's treating physician of a determination that the client has severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen therapy.
  - The client's medical diagnosis requiring oxygen therapy
  - The oxygen flow rate
  - An estimate of the frequency, duration of use (e.g., 2 liters per minute, 15 minutes per hour, 12 hours per day) and duration of need (e.g., 3 months)
- A qualifying blood gas assessment may be supported by the results of either pulse oximetry or an arterial blood gas and includes all of the following:
  - Date of testing
  - Results of testing
  - If the blood gas assessment occurred during the client's inpatient hospital stay, a blood gas performed no more than two days before discharge is acceptable
  - If a blood gas is obtained while the client is at home, the assessment must be performed while the client is in a stable chronic state (i.e., not during a period of acute illness or an exacerbation of their underlying disease) within the 30-day period prior to the request for service

Oxygen therapy is available for clients with an eligible condition as outlined below.

Prior authorization may be considered for clients of any age with significant hypoxemia with documentation of any of the following:

- An arterial pO<sub>2</sub> (partial pressure of oxygen) equal to or less than 55 mm Hg or an arterial oxygen saturation equal to or less than 88 percent, taken at rest, breathing room air
- An arterial pO<sub>2</sub> equal to or less than 55 mm Hg or arterial oxygen saturation at or below 88 percent, taken during sleep and lasting for at least 5 continuous minutes for clients who have a pO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake
- A decrease in arterial pO<sub>2</sub> more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5 percent, for at least 5 continuous minutes taken during sleep with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia)

- An arterial pO<sub>2</sub> equal to or less than 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates a pO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, supplemental oxygen may be provided for use during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air

Prior authorization may be considered for clients who are 20 years of age and younger when evidenced by any of the above or the following documentation:

- A neonate, and premature infant of any age who have not reached their 40th week of gestational maturity with an arterial pO<sub>2</sub> of less than 60 mmHg or an arterial oxygen saturation level is less than 92 percent
- An infant with chronic neonatal lung disease with an arterial oxygen saturation equal to or less than 92 percent
- Other medical conditions that may be considered on a case by case basis with supporting documentation from the treating physician supporting the need for oxygen therapy. These requests will be reviewed by the CSHCN Services Program Medical Director or designee. Examples include, but are not limited to:
  - Infants with bronchopulmonary dysplasia
  - Infants with apnea of prematurity or recurrent cyanotic apneic episodes
  - Children with severe pulmonary hypotension
  - Children who have sickle cell anemia with respiratory conditions
  - Infants or children who have idiopathic pulmonary hypertension with sleep associated desaturations or a documented need for an emergent use of oxygen

Coverage for clients of any age whose arterial pO<sub>2</sub> is 56-59 Hg or whose arterial blood oxygen saturation is 89 percent with documentation of any of the following:

- Dependent edema suggesting congestive heart failure (CHF)
- Cor Pulmonale (pulmonary hypertension)
- Erythrocythemia with a hematocrit greater than 56 percent

Coverage for clients with a diagnosis of cluster headaches with documentation of all of the following:

- Neurological evaluation with diagnosis of cluster headache
- Documentation of failed medical therapy

For clients whose only diagnosis is Obstructive Sleep Apnea (OSA), documentation must support that the client's oxygen sleep desaturation was not corrected by CPAP or RADs.

For clients not meeting the above blood gas assessment criteria, a request for oxygen therapy may be submitted with the required documentation along with evidenced based documentation supporting the benefits of oxygen therapy for the client's condition, and a letter of medical necessity from the treating practitioner. Submission of the request and the required documentation does not guarantee approval. These requests will be reviewed by the CSHCN Services Program Medical Director or designee.

Prior authorization of oxygen therapy after an initial three-month rental period may be considered for periods of six months a time with the submission of all of the following documentation:

- A new CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form
- Documentation of a continued need for oxygen therapy



- Documentation of the client's compliance with the oxygen therapy by the ordering practitioner

Documentation (date of test and results) of a new blood gas assessment using pulse oximetry or arterial blood gas documentation that the client meets the criteria of any of the above defined oxygen category requirements.

For clients not meeting the above criteria, a request for oxygen therapy renewal may be submitted with all of the required medical necessity documentation along with evidenced based documentation demonstrating the benefit of oxygen therapy for the client's condition. These requests will be reviewed on a case by case basis by the CSHCN Services Program Medical Director or designee.

**Note:** *The initial CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form cannot be used to request oxygen therapy renewal or extension. A new prior authorization form must be submitted for each request.*

### **36.2.6.1 Stationary Oxygen Systems**

Rental of a stationary oxygen system includes, but is not limited to, the nasal cannula or mask, tubing, and a basic bubble humidification system. These supplies will not be prior authorized separately.

The types of covered stationary oxygen delivery systems include:

- Oxygen concentrators
- Compressed oxygen gas cylinder systems
- Liquid oxygen cylinder systems

### **36.2.6.2 Portable Oxygen Systems**

Portable oxygen therapy may be considered for prior authorization when medical necessity documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside of the home environment.

Portable oxygen systems will not be considered for prior authorization for travel outside of the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

The types of covered portable oxygen and portable oxygen related delivery systems include:

- Portable tanks for compressed oxygen gas cylinder systems
- Portable tanks for liquid oxygen cylinder systems
- Home compressor attachment used on an oxygen compressor to fill oxygen tanks
- Portable gaseous oxygen system home compressor
- Portable concentrator systems

### **36.2.7 Pulse Oximeters**

Pulse oximeters may be considered for short or long term rental or purchase with prior authorization when medically necessary for continuous overnight monitoring. A completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form must be submitted with documentation of medical necessity.

A pulse oximeter (procedure code E0445 without modifier U4) required for short-term use, defined as equipment rented up to one per six calendar months, may be a benefit when medically necessary and does not require prior authorization for clients with one of the following conditions:

- When the client is stable and is able to wean from home oxygen or ventilator
- When a change in the client's condition requires an adjustment in the liter flow of their home oxygen treatment

- To determine the client's appropriate home oxygen liter flow for ambulation, exercise, or sleep
- To determine the client's appropriate home oxygen liter flow for those who have neuromuscular disease involving the respiratory muscles, with chronic lung disease, or with severe cardiopulmonary disease

Pulse oximetry for use as a continuous client vital signs monitor or for routine spot checks is not a benefit.

Short-term pulse oximetry that is medically necessary more frequently than once every six months requires prior authorization and documentation of all medical necessity will be considered on a case by case basis. Requests must be submitted on the CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form and include documentation why earlier weaning attempts were unsuccessful and changes in the client's condition since the failed weaning attempt.

A pulse oximeter required for long-term use (procedure code E0445 with modifier U4), defined as periods longer than one calendar month in a six month period, may be a benefit for rental or purchase with documentation of medical necessity. The request must be submitted on a completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form.

A long-term pulse oximeter may be prior authorized for monthly rental up to a maximum of six months. Recertification for an additional three-month period may be considered for a maximum of nine months.

Documentation of medical of necessity must include a caregiver or health care provider present who has been trained in use of the oximeter and how to respond to readings in a medically safe and appropriate manner, and the client meets one of the following criteria:

- Client is oxygen or ventilator dependent, is not stable, and therefore has frequent need for changes in oxygen or ventilator settings
- Client frequently experiences respiratory complications and requires equipment that has oxygen saturation monitoring capabilities

Pulse oximeter related supplies are included in the pulse oximeter rental, do not require prior authorization within the defined limits for client-owned equipment, and are limited as follows:

- Disposable pulse oximeter probes (procedure code A4606) are limited to four per month
- Reusable pulse oximeter sensor probes (procedure code A4606 with modifier U5) are limited to one every six months

Pulse oximeter probes (procedure codes A4606 and A4606 with modifier U5) are included in the pulse oximeter equipment rental. Pulse oximeter probes will be denied if billed with pulse oximeter equipment (procedure codes E0445 and E0445 with modifier U4) in the same month of service by any provider.

Prior authorization for purchase of the pulse oximeter at the end of the nine months of rental may be considered, if the continuation of pulse oximeter use is documented to be medically necessary by a physician.

A pulse oximeter may be prior authorized for purchase when a purchase is determined to be more cost effective than leasing the device with supplies.

Pulse oximetry equipment that has been purchased is anticipated to last a minimum of five years. Replacement of equipment may also be considered for prior authorization when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

### **36.2.8 Tracheostomy Tubes and Related Supplies**

Tracheostomy tubes and related supplies may be a benefit when medically necessary for clients with a tracheostomy.

Tracheostomy supplies, including inner cannulas, are available for purchase when medically necessary without prior authorization within the benefit limits.

A tracheostomy speaking valve (procedure code L8501) is considered a medically necessary accessory that enhances the function of the tracheostomy and is available for purchase without prior authorization when requested within the benefit limits.

Tracheostomy tubes (procedure codes A7520, A7521, and A7522) are medically necessary for clients with a tracheostomy and are available for purchase with prior authorization.

For the initial tracheostomy tube request, two tubes may be considered for prior authorization in the first month of service (two the same size and one smaller for emergencies).

For the remainder of the initial prior authorization period and for subsequent requests, one tracheostomy tube will be prior authorized per month.

More than one tracheostomy tube per month may be considered on a case-by-case basis with medical documentation supporting why the tracheostomy tube must be changed more frequently in order to meet the client's medical needs.

When requesting prior authorization for non-customized or non-specialized tracheostomy tubes without specialized functions, providers must submit the most appropriate procedure code, no modifier is required.

When requesting prior authorization for specialized, but non-customized tracheostomy tubes with specialized functions, providers submit the request with modifier U1.

When requesting prior authorization for customized tracheostomy tubes, providers must submit the request with modifier U2.

With the use of either modifier U1 or U2, the following documentation is required:

- The manufacturer's retail or invoice pricing information
- A physician statement of the reason the client cannot use a standard tracheostomy tube
- The manufacturer's information on the specialized functions of the tracheostomy tube or the order form describing the customization of the tracheostomy tube

A non-in-line humidification system is acceptable for clients using a tracheostomy collar.

Suction machines, suction canisters, suction tubing, tracheal suction tubes, and oropharyngeal suction catheters are a benefit with documentation of medical necessity to have oral, nasopharyngeal, or tracheal suctioning performed.

### **36.2.8.1 Tracheostomy Tube Inner Cannula**

Clients with a tracheostomy tube with a reusable inner cannula (procedure code A4623) are allowed one reusable inner cannula per month without prior authorization.

Reusable inner cannulas are included in the prior authorization for any custom tracheostomy tube that is approved.

Requests for more than one reusable inner cannula per month require prior authorization and medical documentation from the client's physician to support the need for more than one reusable inner cannula per month.

Clients with a tracheostomy tube with a disposable inner cannula (procedure code A4623 with modifier U3) are allowed 31 disposable inner cannulas per month without prior authorization.

If more than 31 disposable inner cannulas per month are needed, prior authorization is required and documentation from the client's ordering practitioner must support the medical need.

A tracheostomy speaking valve (procedure code L8501) is considered a medically necessary accessory that enhances the function of the tracheostomy and is limited to one per six months without prior authorization.

### **36.2.9 Cardiorespiratory Monitor (CRM)**

A cardiorespiratory monitor (CRM) is a benefit when medically necessary and may be considered for clients who require moment to moment cardiac and respiratory monitoring due to the potential for sudden unexpected deterioration. Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

A CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for clients who are four months of age and younger for a maximum of two months with documentation of one of the following conditions:

- Central apnea (respiratory control disorders)
- Cardiac rhythm issues

If a two-month rental has expired for clients who are four months of age and younger, continuation may be considered with prior authorization which must include all of the following:

- The client has on-going, documented cardiorespiratory episodes (e.g., apnea or dysrhythmia)
- A physician interpretation, signed and dated by the physician, of the most recent two month's
- CRM data recorded downloads
- A completed CSHCN Services Program Authorization and Prior Authorization Request for Cardiorespiratory Monitor (CRM) Form must be submitted with documentation of medical necessity

A CRM with or without recording feature (procedure codes E0618 or E0619) may be considered for prior authorization for rental or purchase for clients who are five months of age and older with one of the following conditions:

- An episode of apparent life-threatening event (ALTE) in an infant birth through 12 months of age
- Symptomatic central apnea
- Technology dependence such as:
  - Mechanical ventilation
  - Tracheostomy with a critical airway obstruction
  - Assisted ventilation dependence
  - Cardiac dysrhythmia with significant risk of morbidity or mortality

A CRM may be prior authorized initially for monthly rental up to a maximum of six months. Extension for an additional three month rental may be considered for a maximum total of nine months.

Prior authorization for purchase of the CRM at the end of the nine month rental may be considered if the continued use of the pulse oximeter is documented to be medically necessary by a physician.

Procedure codes A4556 and A4557 for the CRM may be reimbursed for clients with a purchased monitor, procedure code E0618 or E0619, within the last 5 years.

Leads and electrodes for use with a CRM owned by the client must be prior authorized. A physician statement must be submitted with the claim confirming that the client owns the monitor.

### 36.2.10 Mechanical Ventilation

Positive and negative pressure ventilators and related equipment may be considered for rental only with prior authorization and documentation of medical necessity. All requests must include the ventilator settings. Requests for prior authorization must be completed by the ordering practitioner and submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form with documentation of medical necessity.

All ventilators (pressure support with or without invasive interface), related equipment and supplies require prior authorization.

Documentation must support why heated or non-heated humidification (when requested) is medically necessary for use with the mechanical ventilation including the expected outcome.

Mechanical ventilation may be considered for treatment of, but not limited to the following:

- Neuromuscular and/or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive disease
- Chronic respiratory failure

For rented or client owned ventilators, when heated or non-heated humidification is requested, documentation submitted must support why it is medically necessary for the use with the ventilation.

### 36.2.11 Negative Pressure Ventilators

Mechanical ventilation may be considered for the treatment of, but not limited to:

- Neuromuscular or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive diseases
- Chronic respiratory failure

The following table lists covered mechanical ventilation services and benefit limitations for clients who require assisted mechanical ventilation. All items must be requested by the client's treating physician and require prior authorization for rental only:

| Service   | Rental Limitation |
|---|-------------------|
| Chest Shell (cuirass or "clam shell" (procedure code E0457)   | 1 per month       |
| Chest wrap (procedure code E0459)   | 1 per month       |
| Invasive home ventilator for clients with a tracheostomy (procedure code E0465)                                       | 1 per month       |
| Noninvasive positive pressure or volume control ventilator- for clients without a tracheostomy (procedure code E0466) | 1 per month       |

Rental of a chest shell and chest wrap is limited to once per month for a total of up to six months. Consideration for each additional six months requires prior authorization with documentation of continued medical necessity, client compliance, and maintenance of the client's respiratory status.

A chest shell may be prior authorized for purchase following the initial three-month rental period of the non-invasive negative pressure ventilator depending on the physician's predicted length of treatment and the client's compliance.

A ventilator may be considered for an initial three-month rental period. Following the initial three-month rental period, if the ventilator was effective, it may be considered for ongoing six-month rental periods. A new prior authorization form must be submitted with each request.

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. The contingency plan should include input from the client's physician that takes into account the severity of the client's condition and time restraints in providing emergency support. Back-up ventilators are not paid separately from the primary ventilator in use and are considered to be a part of the primary ventilator DME rental agreement.

### **36.2.12 Home Ventilators (any type) with or without Invasive Interface**

A home ventilator using an invasive interface (procedure code E0465), a non-invasive interface (procedure code E0466), or a multi-function respiratory device (procedure code E0467) may be prior authorized for a rental of an initial period of three months for clients who require assisted mechanical ventilation.

Requests must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and must be completed by the ordering practitioner and submitted with documentation of medical necessity.

Following the initial rental period of three months, additional requests may be considered for six month intervals at a time with prior authorization, documentation of medical necessity, and documentation of client compliance and effectiveness. A new prior authorization form must be submitted for each request.

The monthly ventilator rental includes all ventilator equipment and related supplies regardless of the client's duration of use, whether 24 hours per day or less including but not limited to:

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- Humidification systems including supplies and solutions, (e.g., sterile or distilled water)
- Compressors and supplies
- Tracheostomy tube filters and humidification devices, such as heat moisture exchangers (HME)
- Humidification device
- Resuscitation bag
- Back up ventilator

***Note:** Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.*

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. The contingency plan should include input from the client's physician that takes into account the severity of the client's condition and time restraints in providing emergency support. Back-up ventilators are not paid separately from the primary ventilator in use and are considered to be a part of the primary ventilator DME rental agreement.

### **36.2.13 Repair to Client -Owned Equipment**

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity.

***Note:** Technician fees are considered part of the cost of the repair.*

The CSHCN Services Program or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. When there is documented proof of abuse or neglect, requests for repairs will not be authorized.

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

Documentation must include all the following:

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

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

Labor for repair of client owned equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of 8 units).

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

### 36.2.14 Aerosol Treatments

Outpatient nebulized aerosol treatments may be a benefit when medically necessary for worsening of an acute or chronic respiratory condition and evidence that the client's breathing is compromised when billed with revenue code B-412 with one following procedure codes in addition to the code for the primary procedure:

| Procedure Codes |       |       |
|-----------------|-------|-------|
| 94640           | 94644 | 94645 |

Documentation must be maintained in the client's medical record that supports the need for outpatient aerosol treatment for worsening of the client's respiratory condition and is subject to retrospective review and recoupment.

### 36.2.15 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) may be a benefit when medically necessary to diagnose or assess asthma and/or to evaluate the client's response to anti-inflammatory therapy. Procedure code 95012 is limited to once per day and must be billed with procedure codes 94010 or 94060.

Revenue code B-419 is a benefit for the hospital when billed with procedure code 95012.

Exhaled NO measurement may be reimbursed when it is utilized to determine responsiveness to anti-inflammatory steroid treatment for clients with chronic respiratory symptoms possibly due to eosinophilic airway inflammation as follows:

- To assist in assessing the etiology of respiratory symptoms
- To help identify the eosinophilic asthma phenotype
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS)

- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma
- To guide changes in dosing of anti-inflammatory medications: step down dosing, step-up dosing, or discontinuation of anti-inflammatory medications
- To assist in evaluation of compliance with use of anti-inflammatory medications
- To assess whether airway inflammation is contributing to respiratory symptoms

If expired NO determination is measure during an office visit and additional evaluation and management (E&M) components are billed, a separate E&M procedure code may be reimbursed using modifier 25.

**Note:** *Procedure code 95012 is reimbursed as a global service and cannot be separated into technical and professional components because the instrument produces an exhaled NO value requiring little interpretation.*

### 36.2.16 Other Equipment

All other respiratory equipment must be authorized. Documentation of medical necessity for the item must accompany the claim.

## 36.3 Claims Information

DME services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment.

Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank.

## 36.4 Reimbursement

Respiratory equipment may be reimbursed the lower of either the billed amount or the amount allowed by Texas Medicaid.



Reimbursement of rented equipment includes all of the supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period.

Respiratory equipment that has been purchased is anticipated to last a minimum of five years and may be considered for replacement when five years have passed or the equipment is no longer repairable.

Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the request.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

*Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

### **36.5 TMHP-CSHCN Services Program Contact Center**

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

## Table of Contents

|             |   |          |
|-------------|---|----------|
| <b>37.1</b> | <b>Enrollment</b>   | <b>3</b> |
| <b>37.2</b> | <b>Benefits, Limitations, and Authorization Requirements</b>  | <b>3</b> |
| 37.2.1      | Speech Therapy Limitations                                    | 4        |
| 37.2.2      | Authorization Requirements                                    | 5        |
| 37.2.2.1    | Paper and Electronic Prior Authorization Documentation        | 6        |
| 37.2.2.2    | Initial Prior Authorization Request for Therapy Services      | 6        |
| 37.2.2.2.1  | <i>Supporting Documentation</i>                               | 6        |
| 37.2.2.3    | Prior Authorization Request for Extension of Therapy Services | 7        |
| 37.2.2.3.1  | <i>Supporting Documentation</i>                               | 7        |
| 37.2.2.3.2  | <i>Discontinuation of Therapy or Change of Provider</i>       | 8        |
| 37.2.3      | Services That Are Not a Benefit                               | 8        |
| <b>37.3</b> | <b>Coordination with the Public School System</b>             | <b>8</b> |
| <b>37.4</b> | <b>Claims Information</b>                                     | <b>9</b> |
| <b>37.5</b> | <b>Reimbursement</b>  | <b>9</b> |
| <b>37.6</b> | <b>TMHP-CSHCN Services Program Contact Center</b>             | <b>9</b> |

## 37.1 Enrollment

To enroll in the Children with Special Health Care Needs (CSHCN) Services Program, speech-language pathology (SLP) providers must be actively enrolled in Texas Medicaid, have completed the CSHCN Services Program enrollment process, have a valid Provider Agreement with the CSHCN Services Program, and comply with all applicable state laws and requirements. Out-of-state SLP providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 37.2 Benefits, Limitations, and Authorization Requirements

SLP services are benefits of the CSHCN Services Program for clients with acute or chronic medical conditions when documentation from the prescribing physician and the treating therapist shows there is or will be progress made towards goals.

**Note:** *An advanced practice registered nurse (APRN) or physician assistant (PA) may sign and date all documentation related to the provision of SLP services on behalf of the client’s physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider’s signature and license number must appear on the forms where the physician signature and license number are required.*

Speech therapy services must be rendered in accordance with the State Board of Examiners for Speech-Language Pathology and Audiology or performed by a physician within their scope of practice.

The CSHCN Services Program may reimburse licensed speech-language pathologists, physicians, home health agencies, hospitals, and outpatient facilities based on the procedure codes listed in this chapter.

**Note:** *Therapy services provided by a licensed intern or assistant must be billed by the licensed supervising provider.*

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

- Improving function

- Maintaining function
- Slowing the deterioration of function

Speech therapy evaluations and treatments must be ordered or prescribed by the client’s physician, APRN, or PA and based on medical necessity.

A client may receive any combination of physical, occupational, or speech therapy in the office, home, or outpatient setting, up to the limits outlined in this chapter for each type of therapy.

Therapy evaluations and re-evaluations are a benefit once per 180 days, any provider. Speech therapy re-evaluations are a benefit when documentation supports one of the following:

- A change in the client’s status
- A request for extension of services
- A change of provider

Additional therapy evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client’s medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
  - The date that the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation of why providers were changed

All documentation, including the medical necessity and comprehensive treatment plan related to the therapy services prior authorized and provided, must be maintained in the client’s medical record and made available upon request.

Each therapy discipline provided must be of the level of complexity that requires the judgment, knowledge, and skill of a licensed speech-language pathologist, or physician within their scope of practice, to perform or directly supervise.

The documentation maintained in the client’s medical record must identify the therapy provider’s name and credentials, and must include all of the following:

- Date of service
- Start time of the therapy
- Stop time of the therapy
- Total minutes of the therapy
- Specific therapy performed
- Client’s response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

### 37.2.1 Speech Therapy Limitations

Providers should use the following procedure codes for speech therapy services:

| Procedure Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 92507           | 92521 | 92522 | 92523 | 92524 | 92526 | 92610 | S9152 |

Only one of the following encounter-based speech therapy treatment codes is payable per date of service any provider:

| Procedure Codes |       |
|-----------------|-------|
| 92507           | 92526 |

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

Speech therapy treatment procedure codes should be billed with the GN modifier.

The following modifiers must be used to indicate when treatment services have been rendered by a licensed therapist or physician, or by a licensed therapy assistant under supervision of a licensed therapist:

| Modifier | Modifier Description   |
|----------|--|
| U5       | Services delivered by a licensed therapist or physician                                      |
| UB       | Services delivered by a licensed therapy assistant under supervision of a licensed therapist |

**Note:** *These modifiers are not required for evaluation and re-evaluation procedure codes because those services may not be rendered by licensed therapy assistants.*

SLP evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, and S9152) are untimed and do not require a modifier.

Re-evaluations of oral and pharyngeal swallowing functions (procedure code 92610) require the U2 modifier.

If an initial evaluation and a re-evaluation from the same therapy discipline are billed for the same date of service by any provider, the re-evaluation will be denied.

If a therapy evaluation or re-evaluation procedure code and therapy treatment procedure code(s) from the same discipline are billed for the same date of service by any provider, the evaluation or re-evaluation will be denied.

An evaluation or re-evaluation performed on the same day as therapy treatment from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Outpatient speech therapy treatments will deny if billed on the same date of service by any provider as procedure code G0153.

### 37.2.2 Authorization Requirements

Speech therapy evaluations and re-evaluations do not require prior authorization.

All other speech therapy services require prior authorization. Only one encounter-based speech therapy treatment procedure code is payable per day per provider. Additional services may be considered with documentation of medical necessity supporting the rationale for exceeding the daily limitation.

**Note:** *If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day.*

Prior authorization for therapy services will be considered when all of the following are met:

- The client has acute or chronic medical conditions resulting in a significant decrease in functional ability that will benefit from therapy services in an office, home, or outpatient setting.
- Documentation must support treatment goals and outcomes for the specific therapy disciplines requested.

- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

### **37.2.2.1 Paper and Electronic Prior Authorization Documentation**

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization request and required documentation through fax or mail.

A copy of the prior authorization request and all submitted documentation must be maintained in the client's medical record at the therapy provider's place of business.

*Note: All prior authorization requests must be submitted with the ordering practitioner's signature.*

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization request and required documentation through any approved method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician, APRN or PA must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The ordering practitioner must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

### **37.2.2.2 Initial Prior Authorization Request for Therapy Services**

The initial request for prior authorization must be approved before the initiation of therapy treatment services. Requests received after therapy treatments start will be denied for dates of service that occurred before the date the request was approved.

Initial prior authorization may be given for a service period not to exceed 180 days. Requests for extensions of ongoing treatment services may be granted up to an additional 180 days for chronic conditions with documentation of medical necessity. Prior authorizations may be approved for a time period less than the established maximum.

#### **37.2.2.2.1 Supporting Documentation**

Documentation supporting the medical need for SLP services include all of the following:

- A completed [CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy \(TP1\) Form](#). The request form must be signed and dated by the ordering physician, APRN, or PA and therapy providers.

*Note: A request form that is missing required information is considered incomplete.*

- A current evaluation for each therapy service requested and comprehensive treatment plan with the following:
  - Date of the evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals for the therapy discipline, and associated disciplines, requested related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services

- Prognosis for improvement
- Requested dates of service
- Date and signature of the licensed therapist

**Note:** A therapy evaluation is current when performed within 60 rolling days before the initiation of therapy treatment services. The ordering practitioner must sign and date the treatment plan and request form on or after the date the evaluation was performed.

### 37.2.2.3 Prior Authorization Request for Extension of Therapy Services

A prior authorization request for extension of ongoing treatment services must be received and approved no earlier than 30 days before the current authorization expires. Prior authorization requests received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was approved.

Prior authorization requests for extensions of services may be considered in increments up to 180 days for chronic conditions with documentation supporting medical necessity.

#### 37.2.2.3.1 Supporting Documentation

Documentation supporting medical necessity of the extension of services must include all of the following:

- A new [CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy \(TP2\) Form](#). The request form must be signed and dated by the ordering physician, APRN, or PA and therapy provider(s).

**Note:** A request form that is missing required information is considered incomplete.

- A current therapy evaluation or re-evaluation for each therapy discipline requested and an updated treatment plan containing the following:
  - Date of the evaluation or re-evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Prior and new short- and long-term treatment goals documenting the client's progress towards prior treatment goals
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested dates of service
  - Date and signature of the licensed therapist

**Note:** A therapy evaluation or re-evaluation is current when performed within 60 days before the request for extension of ongoing services. The ordering practitioner must sign and date the updated treatment plan and request form on or after the date that the evaluation or re-evaluation was performed.



### 37.2.2.3.2 Discontinuation of Therapy or Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider the new provider must submit evidence of the following, including all documentation required for an initial request for therapy services:

- A change of provider letter signed and dated by the client, parent, or guardian documenting:
  - The date the client ended therapy with the previous provider (effective date of change)
  - The names of the previous and new providers
  - An explanation why providers were changed

A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond limitations.

**Referto:** Section 4.3, “Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about authorization requirements.

Chapter 10, “Augmentative Communication Devices (ACDs).”

[CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy \(TP1\) Form](#)

[CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy \(TP2\) Form](#)

**Note:** Fax transmittal confirmations are not accepted as proof of timely authorization submission.

### 37.2.3 Services That Are Not a Benefit

The following speech therapy services are not a benefit of the CSHCN Services Program:

- Group therapy for SLP services (procedure code 92508)
- Services provided by unlicensed SLP aides, orderlies, students, or technicians
- Separate reimbursement for VitalStim therapy for dysphagia
- Unattended electrical stimulation
- Treatment solely for the instruction of other agency or professional personnel in the client’s physical, occupational, or speech therapy program
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- Emotional support, adjustment to extended hospitalization or disability and behavioral readjustment
- Services and procedures that are investigational or experimental

## 37.3 Coordination with the Public School System

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses different client needs. If the client is of school age, therapy provided through the CSHCN Services Program is not intended to duplicate, replace, or supplement services that are the legal responsibility of other entities or institutions.

The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client’s ability to progress.

## 37.4 Claims Information

Claims for SLP treatment services must include modifier GN. Outpatient therapy services provided by outpatient facilities and SLP providers must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Note:** *NCCI guidelines do not apply to therapy procedure codes if a valid prior authorization number is submitted on the claim.*

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 37.5 Reimbursement

The CSHCN Services Program may reimburse therapy providers at the lesser of the billed amount or the amount allowed by Texas Medicaid. Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital’s Medicaid interim rate.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 37.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **TELECOMMUNICATION SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# TELECOMMUNICATION SERVICES

## Table of Contents

- 38.1 Enrollment ..... 3**
- 38.2 Benefits, Limitations, and Authorization Requirements..... 3**
  - 38.2.1 Patient Health Information Security ..... 4
  - 38.2.2 Telemedicine Services ..... 4
    - 38.2.2.1 Distant Site ..... 5
    - 38.2.2.2 Other Patient Site..... 5
    - 38.2.2.3 Patient Site ..... 6
  - 38.2.3 Telehealth Services ..... 7
    - 38.2.3.1 Distant Site ..... 8
    - 38.2.3.2 Patient Site ..... 8
  - 38.2.4 Telemonitoring Services ..... 9
    - 38.2.4.1 Collection and Interpretation of Client Data ..... 10
    - 38.2.4.2 Facility Services..... 10
    - 38.2.4.3 Prior Authorization Guidelines ..... 11
- 38.3 Claims Information.....12**
- 38.4 Reimbursement.....13**
- 38.5 TMHP-CSHCN Services Program Contact Center .....13**

## 38.1 Enrollment

To enroll in the CSHCN Services Program, telecommunication providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Home health agency and hospital providers who wish to provide telemonitoring services must notify TMHP as follows:

- Current providers must use the Provider Enrollment and Management System (PEMS) to indicate that they provide telemonitoring services.
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers will indicate whether they provide telemonitoring services during the enrollment process.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 38.2 Benefits, Limitations, and Authorization Requirements

Authorization is not required for telemedicine or telehealth services, however prior authorization may be required for the individual procedure codes billed.

Telemedicine and telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

Only those services that involve direct face-to-face interactive video communication between the client and the distant-site provider constitute a telemedicine or telehealth service. No separate reimbursement will be made for the cost of telemedicine and telehealth hardware or equipment, electronic documentation, and transmissions. Telephone conversations, chart reviews, electronic mail messages, and fax transmissions alone do not constitute a telemedicine or telehealth interactive video service and will not be reimbursed as telemedicine or telehealth services.

Emergency room care, critical care, home care, preventive care, newborn care, and care provided in a nursing home, skilled nursing facility, or client's home, are not approved telemedicine or telehealth services. Consultative, but not routine, inpatient care, is included as a telemedicine or telehealth service.

Documentation for a service provided via telemedicine or telehealth must be the same as for a comparable in-person service.

The audio and visual fidelity and clarity, and field of view of the telemedicine or telehealth service must be functionally equivalent to an evaluation performed on a client when the provider and client are both at the same physical location or the client is at an established medical site.

More than one medically necessary telemedicine or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

### **38.2.1 Patient Health Information Security**

All video and data transmissions between the patient site provider and the distant site provider must comply with the Health Insurance Portability and Accountability Act (HIPAA) and the United States Health and Human Services (HHS) rules implementing HIPAA.

Distant and patient site providers should refer to the National Institute of Standards and Technology (NIST) for additional information about HIPAA-compliant health data storage and encryption technologies.

The software system used by both the distant and patient site providers must allow secure authentication of the distant site provider and the client.

The physical environments of the client and the distant site provider must ensure that the client's protected health information remains confidential. A parent or responsible adult may be physically located in the patient site or distant site environment during a telemedicine or telehealth visit with a child.

A parent or responsible adult must provide written or verbal consent to the distant site provider to allow any other individual, other than the distant site provider, the patient site presenter, or a representative of the distant site provider or patient site presenter, to be physically present in the distant or patient site environment during the visit with a child.

An adult client must also provide written or verbal consent to the distant site provider to allow any other individual, other than the distant site provider, the patient site presenter, or a representative of the distant site provider or patient site presenter, to be physically present in the distant or patient site environment during the visit.

Documentation of the written or verbal consent must be maintained in the client's medical record.

### **38.2.2 Telemedicine Services**

Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:

- Client assessment by a health professional
- Diagnosis, consultation, or treatment by a physician
- Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health-care services or medical specialty expertise.

### 38.2.2.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site benefits include services that are performed by the following providers, who must be enrolled as a CSHCN Services Program provider:

- Physician
- Advanced Practice Registered Nurse (APRN)
- Physician assistant (PA)

Distant site providers that communicate with clients through email or other electronic methods must provide clients with written notification of their privacy practices prior to evaluation and treatment. A good faith effort must be made to obtain the client's written acknowledgment of the notice, which must be maintained in the client's medical record.

Before providing services, distant site providers who use telemedicine medical services must give their clients notice regarding telemedicine medical services, including the risks and benefits of being treated via telemedicine, how to receive follow-up care or assistance in the event of an emergency or adverse event, or in the event of a technology or equipment failure.

Procedure codes that indicate remote (telemedicine or telehealth) delivery in their description do not need to be billed with the 95 modifier. The following procedure codes, when billed with the 95 modifier, are a benefit for distant-site providers:

| Procedure Codes   |       |       |       |       |        |        |        |       |       |
|---|-------|-------|-------|-------|--------|--------|--------|-------|-------|
| 90791   | 90792 | 90832 | 90833 | 90834 | 90836  | 90837  | 90838  | 90951 | 90952 |
| 90954   | 90955 | 90957 | 90958 | 90960 | 90961  | 99202  | 99203  | 99204 | 99205 |
| 99211   | 99212 | 99213 | 99214 | 99215 | 99242  | 99243  | 99244  | 99245 | 99252 |
| 99253   | 99254 | 99255 | 99417 | 99418 | G0406* | G0407* | G0408* | G0425 | G0426 |
| G0427   | G0459 |       |       |       |        |        |        |       |       |
| *Procedure codes are limited to one service per day.<br>Note: Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health." Procedure codes 90833, 90836, 90838, 99417, and 99418 are add-on codes and must be billed with a primary procedure code on the same day, by the same provider in order to be reimbursed. |       |       |       |       |        |        |        |       |       |

Electronic documentation of the telemedicine consultation must be kept on file at the distant site location and must be available for review upon request by DSHS or its designee.

**Referto:** Section 19.2.3, "Telecommunication Services" in Chapter 19, "Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)" for information about billing telemedicine services by FQHC providers.

### 38.2.2.2 Other Patient Site

For telemedicine medical services provided at a site other than an established medical site for a client's previously diagnosed condition, the following will apply:

- Patient-site presenters are not required for pre-existing conditions previously diagnosed by a physician through a face-to-face visit
- All clients must be seen by a physician for an in-person evaluation at least once a year
- Telemedicine medical services may not be used to treat chronic pain with scheduled drugs at a site other than a medical practice site

- A distant site provider may treat an established client's new symptoms that are unrelated to the client's pre-existing condition. The client must be advised to see a physician in a face-to-face visit within 72 hours. A distant site provider may not provide continuing telemedicine medical services for these new symptoms if the client has not seen a physician within 72 hours. If the client's symptoms are resolved within 72 hours, and continuing treatment for the acute symptoms is no longer necessary, then a follow-up face-to-face visit is not required.

A distant site provider who provides telemedicine services at a site other than an established medical site for a previously diagnosed condition must do one of the following:

- See the client one time in a face-to-face visit before providing telemedicine medical care
- See the client without a face-to-face visit, as long as the client has received an in-person evaluation by another physician who has referred the client for additional care and the referral is documented in the medical record

### **38.2.2.3 Patient Site**

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site* - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.
- *Established health site* - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client's presenting complaint. A defined health provider-client relationship is required. A client's private home is not considered an established health site.

Telemedicine services provided at an established medical site require a defined physician-client relationship. The following communications do not meet the defined physician-client relationship requirement:

- An online questionnaire
- Questions and answers exchanged through email, electronic text, or chat
- Telephonic evaluation or consultation with a client

Patient-site providers enrolled in the CSHCN Services Program may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to advanced practice registered nurses, physician assistants, and physicians in the office and outpatient hospital settings and to hospitals in the outpatient hospital setting. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.



A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 *Texas Administrative Code* (TAC) 412.303

For new conditions, the patient site presenter must be readily available onsite at the established medical site to assist with care.

*Note: Readily available means the patient site presenter is in the same room as the client or at the discretion of the licensed or certified professional providing the service, is not in the same room as the client but within the proximity determined by the licensed or certified professional providing the telemedicine service.*

A distant site provider delegating tasks to a patient site presenter must ensure that the patient site presenter is properly supervised when the tasks or activities are delegated.

For follow-up evaluations or treatment of a previously diagnosed condition, the distant site physician will determine if a patient site presenter is necessary.

A client's home may be considered an established medical site when the services provided in the home are limited to mental health services.

If the only services provided are related to mental health services, a patient site presenter is not required, except in cases of behavioral emergencies.

For medical services other than mental health services to be provided in the client's home, the following requirements must be met:

- A patient site presenter is present
- There is a defined physician-client relationship
- The patient site presenter has sufficient communication and remote medical diagnostic technology to allow the physician to carry out an adequate physical examination for the client's presenting condition, while seeing and hearing the client in real time. The physical examination will be held to the same standard of acceptable medical practices as those in traditional clinical settings.

Procedure code Q3014 is not a benefit if the patient site is the client's home.

The patient-site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an electronic-health-record format.

### **38.2.3 Telehealth Services**

Telehealth is defined as health services, other than telemedicine, that:

- Are delivered by licensed or certified health professionals who are acting within the scope of their license or certification.
- Require the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health care services or medical specialty expertise.

Before receiving a telehealth service, the client must receive an in-person evaluation for the same diagnosis or condition. An in-person evaluation is a client evaluation that is conducted by a provider who is at the same physical location as the client.

**Exception:** *Clients who have a mental health diagnosis or condition may receive a telehealth service without an in-person evaluation if the purpose of the initial telehealth appointment is to screen and refer the client for additional services. The referral must be documented in the medical record.*

To continue receiving telehealth services, the client must have had an in-person evaluation by a person who is qualified to determine a continued need for services at least once in the 12 months before the telehealth service.

Written policies and procedures must be maintained and evaluated at least annually by both the distant-site provider and the patient-site presenter and must address all of the following:

- Client privacy, to assure confidentiality and integrity of client telehealth services
- Archival and retrieval of client service records
- Quality oversight mechanisms

### 38.2.3.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site benefits include services that are performed by the following providers, who must be enrolled as a CSHCN Services Program provider:

- Licensed professional counselor
- Licensed marriage and family therapist
- Licensed clinical social worker
- Psychologist
- Licensed dietician

The following procedure codes, when billed with the 95 modifier, are a benefit for distant-site providers:

| Procedure Codes                                      |       |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|-------|
| 90791  | 90832 | 90834 | 90837 | 97802 | 97803 | S9470 |
| *Procedure codes are limited to one service per day. |       |       |       |       |       |       |

**Note:** *Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health."*

Procedure codes 90833, 90836, 90838, 99417, and 99418 are add-on codes and must be billed with a primary procedure code on the same day, by the same provider in order to be reimbursed.

Electronic documentation of the telehealth consultation must be kept on file at the distant site location and must be available for review upon request by DSHS or its designee.

### 38.2.3.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site* - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.

- *Established health site* - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client's presenting complaint. A defined health provider-client relationship is required. A client's private home is not considered an established health site.

Telehealth services provided at an established medical site require a defined physician-client relationship. The following communications do not meet the defined physician-client relationship requirement:

- An online questionnaire
- Questions and answers exchanged through email, electronic text, or chat
- Telephonic evaluation or consultation with a client

The facility fee (procedure code Q3014) is not a benefit for telehealth services. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.

A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 *Texas Administrative Code* (TAC) 412.303

For telehealth services, the patient-site presenter must be readily available.

**Note:** *Readily available means in the same room or (at the discretion of the licensed or certified professional that is providing the service) not in the same room as the client but within a proximity determined by the licensed or certified professional who is providing the telehealth service.*

If the telehealth services relate only to mental health, a patient-site presenter does not have to be readily available unless the client is a danger to the client or to others (e.g., behavioral health emergency).

The patient-site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an electronic-health-record format.

### **38.2.4 Telemonitoring Services**

Home telemonitoring services are a benefit of the CSHCN Services Program.

Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency or a hospital. The data transmission must comply with standards set by the *Health Insurance Portability and Accountability Act* (HIPAA).

Data parameters are established as ordered by a physician's plan of care. Data must be reviewed by a registered nurse (RN), APRN, or PA, who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters.

Telemonitoring providers must be available 24 hours a day, 7 days a week. Although transmissions are generally at scheduled times, they can occur any time of the day or day of the week, according to the client's plan of care.

The physician who orders home telemonitoring services has a responsibility to ensure that the client has the right to discontinue home telemonitoring services at any time.

Although the CSHCN Services Program supports the use of home telemonitoring, clients are not required to use this service.

#### **38.2.4.1 Collection and Interpretation of Client Data**

The collection and interpretation of a client's data (procedure code 99091) for home telemonitoring services is a benefit and limited to reimbursement once per 30 days. Prior authorization is not required for procedure code 99091.

#### **38.2.4.2 Facility Services**

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency or the hospital. The initial setup and installation (procedure code S9110 with modifier U1) of the equipment in the client's home is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 with procedure code S9110 and one of the appropriate modifiers listed in the table within this section.

Procedure code S9110 (with modifier U1) is limited to once per episode of care even if monitoring parameters are added after initial setup and installation. A claim for a subsequent set up and installation will not be reimbursed unless there is a documented new episode of care or documentation of the occurrence of extenuating circumstances.

Home monitoring (procedure code S9110 with the appropriate modifier) is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 with procedure code S9110 and the appropriate modifier for monthly home monitoring. Refer to table below for the appropriate modifier.

Use one of the following modifiers with monthly home monitoring services procedure code S9110 to indicate the number of transmission days per month:

| <b>Modifier</b> | <b>Number of Days Per Month</b> |
|-----------------|---------------------------------|
| U2              | 1 through 5 days per month      |
| U3              | 6 through 10 days per month     |
| U4              | 11 through 15 days per month    |
| U7              | 16 through 20 days per month    |
| U8              | 21 through 25 days per month    |
| U9              | 26 through 30 days per month    |

The unit of reimbursement for procedure code S9110 and the appropriate modifier is a rolling month.

Providers must bill the appropriate modifier to indicate the number of days that transmissions of data were received and reviewed for the client within a rolling month.

Monthly home monitoring for transmission of client data will not be prior authorized more than once per rolling month for the length of the prior authorization period.

Providers are not required to submit modifiers U2, U3, U4, U7, U8, or U9 for telemonitoring on the prior authorization request, but are required to submit the appropriate modifier on the claim for reimbursement based on the number of days as outlined in the table.

Claims for procedure code S9110 with any modifier should not be submitted to Medicare. Procedure code S9110 is not reimbursed by Medicare.

### **38.2.4.3 Prior Authorization Guidelines**

Procedure code S9110 with or without modifier U1 requires prior authorization. Telemonitoring services may be requested and approved for up to 90 days per prior authorization request. The initial setup and installation (procedure code S9110 with modifier U1) may be prior authorized once per episode of care, unless the provider submits documentation of extenuating circumstances that require another installation of telemonitoring equipment. If additional home telemonitoring services are needed, the home health agency or hospital must request prior authorization before the current prior authorization period ends.

Home telemonitoring services are available to clients only after the home health agency or hospital has received prior authorization. Dates of service requested before the prior authorization request is received will be denied.

The Home Telemonitoring Services Prior Authorization Request form must be signed and dated by the prescribing provider within 30 days before the start of care. If the form is signed after the start of care, all dates of services before the prescribing provider's signature date will be denied.

An RN, APRN, or PA may sign the prior authorization request form on behalf of the client's physician when the physician delegates this authority to the RN, APRN, or PA. The RN, APRN, or PA must complete Section D, then sign and date the form.

To avoid unnecessary denials, the prescribing physician must provide correct and complete information, including documentation of medical necessity for the equipment and supplies requested.

Home telemonitoring services are a benefit only for clients who are diagnosed with one or more of the following conditions:

- Diabetes
- Hypertension
- Congestive heart failure
- End-stage solid organ disease
- Organ transplant recipient
- Requiring mechanical ventilation

Clients with diabetes or hypertension must exhibit two or more of the following risk factors for approval of telemonitoring services:

- Two or more hospitalizations in the previous 12-month period
- Frequent or recurrent emergency department visits
- A documented history of poor adherence to ordered medication regimens
- Documented history of falls in the previous six-month period
- Limited or absent informal support systems
- Living alone or being home alone for extended periods of time
- A documented history of care access challenges

Documentation that supports the prior authorization request must be maintained in the client's medical record.

The home health agency or hospital must maintain documentation of all the following information:

- The telemonitoring equipment meets all the following requirements:
  - The equipment is capable of monitoring any data parameters included in the plan of care
  - The equipment is classified as a Food and Drug Administration Class II hospital-grade medical device
  - The equipment is capable of measuring and transmitting client weight, oxygen levels in blood, glucose levels in blood, or blood pressure data
- The client's medical record, which must include data transmission information that demonstrates the use of monitoring equipment, such as the following:
  - Date of transmission
  - Frequency of transmission
  - Clinical data provided to the client's primary care physician, or his or her designee
- The provider's staff is qualified to install the telemonitoring equipment and to monitor the client data transmitted according to the client's care plan.
- Monitoring of the client's clinical data is not duplicated by any other provider.
- The client's ability to operate the equipment or has a willing and able person to assist in completing electronic transmission of data, unless the equipment does not require active participation from the recipient.
- Written protocols, policies and procedures on the provision of home telemonitoring services are available to the Department of State Health Services (DSHS) or its designee upon request. Written protocols must address all of the following:
  - Authentication and authorization of users
  - Authentication of the origin of client data transmitted
  - Prevention of unauthorized access to the system or information
  - System security, including the integrity of information that is collected, program integrity, and system integrity
  - Maintenance of documentation about system and information usage
  - Information storage, maintenance, and transmission
  - Synchronization and verification of patient profile data

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

[Home Telemonitoring Services Prior Authorization Request Form](#)

### 38.3 Claims Information

Telecommunication services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” and Section 5.7.2.7, “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 38.4 Reimbursement

Telecommunication services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates](http://www.tmhp.com/resources/rate-and-code-updates).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 38.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **TRANSPORTATION OF DECEASED CLIENTS**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**





# TRANSPORTATION OF DECEASED CLIENTS

## Table of Contents

- 39.1 Enrollment .....3**
- 39.2 Benefits, Limitations, and Authorization Requirements.....3**
  - 39.2.1 Authorization Requirements ..... 3
- 39.3 Claims Information.....3**
- 39.4 Reimbursement.....4**
- 39.5 TMHP-CSHCN Services Program Contact Center .....4**

## 39.1 Enrollment

Funeral home providers are not required to be actively enrolled in Texas Medicaid or the CSHCN Services Program.

## 39.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program provides coverage for the costs of transporting a deceased client who expires in a CSHCN Services Program-approved facility (including non-billing facilities such as MD Anderson, Shriner's Hospital, Scottish Rite) while receiving CSHCN Services Program health-care benefits, if client is not in the family's city of residence.

The program may also pay the transportation cost of a parent or other person accompanying the remains from the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment.

If the program prior authorized a treatment out-of-state and the client expires, the program may pay the costs of transporting the client's remains, and the transportation cost of a parent or other person accompanying the remains from the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment.

The CSHCN Services Program considers the following services for reimbursement:

- *First Call Charge.* This includes the removal of the body by the funeral home from the facility in which the client expired.
- *Air Transportation.* Transportation costs of moving the deceased from the funeral home to the airport, cost of an air tray provided by the funeral home, and cost of airline transportation for the body and an accompanying parent or other responsible person may all be paid.
- *Land Transportation.* If the body is transported over land, one-way mileage is paid based on the State Mileage Guide. Funeral homes or mortuary services use standard air-conditioned vehicles to transport bodies. It is common for the body to be transported on a cot; however, the CSHCN Services Program may pay for a container or coffin (not a casket) if one is used. It is legal in Texas for the family to transport the body themselves. If the family chooses to do this, the CSHCN Services Program may reimburse the family or a third party on the family's behalf at the standard CSHCN Services Program mileage rate for a one-way trip.
- *Rail Transportation.* If the body is transported by rail, the CSHCN Services Program may pay the cost of transportation of moving the deceased from the funeral home to the station and the cost of a container provided by the funeral home. The cost of rail transportation for the body and an accompanying parent or other responsible person may also be paid.
- *Bus Transportation.* It is not common practice for bodies to be transported by bus.
- *Embalming.* State law requires that a body be refrigerated between 34° to 40°F, or the body must be embalmed within 24 hours after death. Airlines and rail systems require embalming. Depending on the distance, a body may be transported over land without being embalmed.

*Note: The CSHCN Services Program does not pay for cremation or transporting the ashes of a deceased client.*

### 39.2.1 Authorization Requirements

Authorization is not required for the transportation of deceased clients.

## 39.3 Claims Information

Claims for the transportation of a deceased client must be submitted to TMHP on the approved [CSHCN Services Program Reimbursement Request for Transportation of the Remains of Deceased Clients form](#).

### 39.4 Reimbursement

Costs associated with the transportation of the remains of a deceased client are reimbursed the lower of the amount billed or the amount listed:

| Service                        | Reimbursement   |
|--------------------------------|-----------------|
| First call                     | \$150           |
| Embalming                      | \$100           |
| Container                      | \$150           |
| Mileage billed by funeral home | \$1.00 per mile |
| Air Freight                    | Billed amount   |

### 39.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **VISION SERVICES**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# VISION SERVICES

## Table of Contents

|             |   |           |
|-------------|---|-----------|
| <b>40.1</b> | <b>Enrollment</b> .....   | <b>3</b>  |
| <b>40.2</b> | <b>Benefits, Limitations, and Authorization Requirements</b> .....      | <b>3</b>  |
| 40.2.1      | Frames, Lenses, and Contact Lenses .....                                | 4         |
| 40.2.1.1    | Frames .....  | 4         |
| 40.2.1.2    | Eyeglass Lenses .....   | 4         |
| 40.2.1.3    | Special Eyeglass Lenses .....   | 5         |
| 40.2.1.4    | Contact Lenses .....  | 5         |
| 40.2.1.4.1  | Contact Fitting for Corneal Bandage Lens .....                          | 7         |
| 40.2.1.5    | Eye Wear .....  | 7         |
| 40.2.1.6    | Services Requiring Authorization .....                                  | 8         |
| 40.2.1.6.1  | Contact Lenses, Prescriptions, and Fittings .....                       | 8         |
| 40.2.1.6.2  | Scleral Lenses and Liquid Bandages .....                                | 8         |
| 40.2.1.7    | Services Not Requiring Authorization .....                              | 9         |
| 40.2.1.8    | Services Requiring Prior Authorization .....                            | 9         |
| 40.2.1.9    | Eye Prostheses .....  | 10        |
| 40.2.2      | Eye and Vision Examinations .....                                       | 10        |
| 40.2.2.1    | Vision Examinations with Refraction .....                               | 10        |
| 40.2.2.2    | Medical Eye Examinations .....  | 11        |
| 40.2.2.3    | Services Requiring Authorization .....                                  | 11        |
| 40.2.3      | Special Vision Services .....   | 11        |
| 40.2.3.1    | Ophthalmological Examination and Evaluation with General Anesthesia ... | 11        |
| 40.2.3.2    | Ophthalmic Ultrasound .....   | 12        |
| 40.2.3.3    | Corneal Topography .....  | 12        |
| 40.2.3.4    | Sensorimotor Examination .....  | 13        |
| 40.2.3.5    | Orthoptic Training .....  | 13        |
| 40.2.3.6    | Ophthalmoscopy .....  | 13        |
| 40.2.3.7    | Ocular Viewing and Diagnostic Testing Procedures .....                  | 14        |
| <b>40.3</b> | <b>Claims Information</b> .....   | <b>14</b> |
| <b>40.4</b> | <b>Reimbursement</b> .....  | <b>15</b> |
| <b>40.5</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....                 | <b>15</b> |

## 40.1 Enrollment

To enroll in the CSHCN Services Program, ophthalmologists, optometrists, and opticians are required to be actively enrolled in Texas Medicaid. They must have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Optometrists, ophthalmologists, and opticians may enroll either as an individual or as a group with performing providers. Opticians may also enroll as a facility. Out-of-state ophthalmologist, optometrists, and optician providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC) Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his/her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

**Referto:** Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

## 40.2 Benefits, Limitations, and Authorization Requirements

Vision related services are a benefit of the CSHCN Services Program. The CSHCN Services Program may consider the following services for reimbursement:

- Vision eye exams with refraction
- Other eye exams for medical reasons
- Medical eye treatments
- Frames
- Lenses
- Contact lenses
- High-power lenses
- Scleral lenses
- Repair and replacement of frames and lenses
- Other medically necessary vision services

The following services are not benefits of the CSHCN Services Program:

- Eyeglasses that do not significantly improve visual acuity or that do not impede the progression of visual problems
- Plano sunglasses
- Optional eyeglass features that are requested by the client but that do not increase visual acuity, such as tinting, decorative accessories or lettering, or eyeglass cases
- Polarization of lenses
- Extended color vision examination
- Dark adaptation examination
- Vision screening
- Contact lenses that correct color vision deficiency
- Services and procedures that are investigational or experimental
- Low vision aids

*Note: Clients in need of low vision aids may be referred to the Texas Health and Human Services Commission (HHSC) Division for Blind Services (DBS) for consideration of coverage.*

Vision services are a benefit when provided by ophthalmologists, optometrists, and opticians practicing according to standards established by their licensing boards and the state laws of Texas.

## **40.2.1 Frames, Lenses, and Contact Lenses**

### **40.2.1.1 Frames**

Providers must offer frames that meet the following criteria:

- A choice of at least three styles that are appropriate to the client's age or gender
- Frames in sizes that are appropriate to the client's needs
- A choice of at least three colors

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of fabricated and finished spectacle lenses, frames, or other ophthalmic devices prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

Frames must be composed of all zylonite components, meet statutory quality standards, and be made of new materials. Clients or families may only choose frames that are metal or a combination of zylonite and metal if they are willing to pay the difference between the CSHCN Services Program's reimbursement for frames and the cost of metal or metal and zylonite frames.

Providers may submit procedure codes V2020 and V2025 for the reimbursement of eyeglass frames.

### **40.2.1.2 Eyeglass Lenses**

Lenses must meet the American National Standards Institute (ANSI) specifications (see [www.ansi.org](http://www.ansi.org)) for first quality prescription ophthalmic lenses, including, but not limited to, the following:

- Lenses must be made of clear glass or plastic.
- Lenses must be composed of new materials.
- Bifocals must be flat-tops or an equivalent style with a near segment of at least 25 mm width.
- Trifocals must be flat-tops or an equivalent style with an intermediate segment of at least 7 X 25 mm.

Providers may submit the following procedure codes for the reimbursement of eyeglass lenses. Providers must bill with a quantity of two when billing for bilateral lenses with the same prescription.

| Single Vision Lenses Procedure Codes |       |       |       |       |       |       |       |       |
|--------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|
| V2100                                | V2101 | V2103 | V2104 | V2107 | V2108 | V2115 | V2118 | V2121 |

| Bifocal Lenses Procedure Codes |       |       |       |       |       |       |       |       |       |
|--------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| V2200                          | V2201 | V2203 | V2204 | V2207 | V2208 | V2215 | V2218 | V2219 | V2220 |
| V2221                          |       |       |       |       |       |       |       |       |       |

| Trifocal Lenses Procedure Codes |       |       |       |       |       |       |       |       |       |
|---------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| V2300                           | V2301 | V2303 | V2304 | V2307 | V2308 | V2315 | V2318 | V2319 | V2320 |
| V2321                           |       |       |       |       |       |       |       |       |       |

#### 40.2.1.3 Special Eyeglass Lenses

Special lenses, such as high-index, polycarbonate, and high-powered lenses, are a benefit of the CSHCN Services Program if they are ordered by the treating physician because they are medically necessary and not solely because of a client's preference.

- High-power lenses have a sphere greater than 7.00 diopters or a cylinder greater than 4.00 diopters.
- High-index lenses allow lighter-weight lenses for clients who have unusually heavy lenses.
- Polycarbonate lenses are considered the standard for children's eyewear because polycarbonate provides extra strength, flexibility, and inherent UV protection.

Ophthalmologists, optometrists, and opticians may submit the following procedure codes for the reimbursement of special eyeglass lenses:

| High-Power Lenses Procedure Codes |       |       |       |       |       |       |       |       |       |
|-----------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| V2102                             | V2105 | V2106 | V2109 | V2110 | V2111 | V2112 | V2113 | V2114 | V2202 |
| V2205                             | V2206 | V2209 | V2210 | V2211 | V2212 | V2213 | V2214 | V2302 | V2305 |
| V2306                             | V2309 | V2310 | V2311 | V2312 | V2313 | V2314 |       |       |       |

The following procedure codes will not be reimbursed unless billed with the appropriate lens procedure code by the same provider for the same date of service:

| Procedure Codes for Add-On Lenses |       |       |       |       |
|-----------------------------------|-------|-------|-------|-------|
| V2410                             | V2430 | V2715 | V2755 | V2784 |

Procedure codes V2410, V2430, V2715, V2755, and V2784 will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

Ultraviolet (UV) lenses (procedure code V2755) may be reimbursed when billed with a diagnosis of aphakia. UV lenses will be denied when billed for the same date of service as polycarbonate lenses (procedure code V2784).

#### 40.2.1.4 Contact Lenses

Dispensing of contact lenses includes the fabrication, ordering, adjustment, dispensing, sale, and delivery to the client of the contact lenses prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.



Contact lenses that are made of hydrophilic and rigid materials are a benefit of the CSHCN Services Program.

- Hydrophilic contact lenses that have been reviewed by the U.S. Food and Drug Administration (FDA) and released for sale in the U.S. will be considered for reimbursement only for those uses for which they have been reviewed.
- Hard and gas permeable lenses must conform to the ANSI requirements for first quality contact lenses.

Examinations for contact lens prescriptions and fittings include:

- The specific optical and physical characteristics of the contact lens including power, size, curvature, flexibility, and gas-permeability.
- Medically necessary tests including multiple ophthalmometry, measurement of tear flow, measurement of ocular adnexa, and initial tolerance evaluation.
- The instruction and training of the client and incidental revision during the training period.
- Follow-up care for a period of six months.

Fitting and modification of contact lenses may be reimbursed to providers using the following procedure codes:

| Contact Lens Fitting Exam Procedure Codes |       |       |       |       |       |       |       |       |       |
|---|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 92310                                     | 92311 | 92312 | 92313 | 92314 | 92315 | 92316 | 92317 | 92325 | 92326 |

Providers may submit the following procedure codes with a quantity of two for the reimbursement of a pair of contact lenses:

| Contact Lens Procedure Codes |       |       |       |       |       |       |       |       |       |
|------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| V2500                        | V2501 | V2502 | V2510 | V2511 | V2512 | V2513 | V2520 | V2521 | V2522 |
| V2523                        | V2530 | V2531 | V2599 |       |       |       |       |       |       |

Contact lenses and their prescription and fitting are limited to the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| H18601          | H18602 | H18603 | H18611 | H18612 | H18613 | H18621 | H18622 |
| H18623          | H2701  | H2702  | H2703  | H27111 | H27112 | H27113 | H27121 |
| H27122          | H27123 | H27131 | H27132 | H27133 | H35101 | H35102 | H35103 |
| H35141          | H35142 | H35143 | H35151 | H35152 | H35153 | H35161 | H35162 |
| H35163          | H35171 | H35172 | H35173 | H4421  | H4422  | H4423  | H442A1 |
| H442A2          | H442A3 | H442A9 | H442B1 | H442B2 | H442B3 | H442B9 | H442C1 |
| H442C2          | H442C3 | H442C9 | H442D1 | H442D2 | H442D3 | H442D9 | H442E1 |
| H442E2          | H442E3 | H442E9 | H5201  | H5202  | H5203  | H5211  | H5212  |
| H5213           | H52201 | H52202 | H52203 | H52211 | H52212 | H52213 | H52221 |
| H52222          | H52223 | H5231  | H5232  | H524   | H53001 | H53002 | H53003 |
| H53011          | H53012 | H53013 | H53021 | H53022 | H53023 | H53031 | H53032 |
| H53033          | H53041 | H53042 | H53043 | H53049 | Q123   | Q134   | Z961   |

Scleral lenses that are prescribed as a liquid bandage must be billed using procedure code S0515. Scleral lenses that are used therapeutically in other ways should be billed using procedure code V2530 or V2531. Reimbursement for scleral lenses requires authorization.

**Referto:** Section 40.2.1.6.2, “Scleral Lenses and Liquid Bandages” in this chapter for detailed information on prior authorization requirements

Providers may bill for the replacement of contact lenses under current prescription due to damage or loss using procedure code 92326 with one of the diagnosis codes above.

If disposable contact lenses are deemed medically necessary and are prior-authorized, procedure code V2599 must be used to bill for their reimbursement.

#### 40.2.1.4.1 Contact Fitting for Corneal Bandage Lens

The fitting of contact lenses for corneal bandages may be reimbursed using procedure codes 92071 and 92072.

Procedure code 92071 may be reimbursed for one service per day, each eye, any provider and must be billed with modifier LT or RT. If both eyes are billed for the same date of service, one procedure may be reimbursed at the full rate and the second procedure may be reimbursed at half rate.

Procedure code 92072 may be reimbursed for one service per day when billed by the same provider when one or both eyes are fitted for keratoconus lenses.

**Note:** *Follow-up visits should be billed separately using the most appropriate office visit code.*

#### 40.2.1.5 Eye Wear

The CSHCN Services Program will consider one form of eyewear for reimbursement per calendar year.

If a client wants frames or lenses that exceed the benefit limitations, the client must pay the difference between the amount allowed by the CSHCN Services Program and the actual cost. CSHCN Services Program clients or their parents or guardians must acknowledge that their choice exceeds the program requirements by signing the CSHCN Services Program Vision Care Eyeglass Client Certification Form.

**Referto:** [Vision Care Eyeglass Client Certificate Form \(English\)](#) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

**Referto:** [Vision Care Eyeglass Client Certificate Form \(Spanish\)](#) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

Providers must maintain a copy of this signed form in the client’s medical record. The provider may withhold the noncovered eyewear until the client pays the difference. If the client fails to pay for the noncovered items within three months, the provider may return any reusable items to stock. Any payment made by the CSHCN Services Program must be refunded to the CSHCN Services Program.

More than one pair of eyeglasses may be authorized if there is a change in lens power that is generally equal to or greater than 0.5 diopters in either eye (e.g., progressive myopia, cataract development).

Providers may be reimbursed for custom-made eyewear based on the services that were performed and the materials that were used until the time the provider received a notice of cancellation for the eyewear (because the client has died or because the prescription changed before the eyewear was completed and delivered). This applies only to custom items. Items not made to order for a specific client will be denied.

One pair of contact lenses and one contact lens prescription and fitting may be covered in a calendar year for a payable diagnosis listed in the table above in Section 40.2.1.4, “Contact Lenses” in this chapter. Additional contact lenses and contact lens prescriptions and fittings within the same calendar year may be prior authorized with proof of medical necessity.

Contact lenses may require more frequent replacement than one new pair per calendar year, depending on the style and the prescribed use. More frequent replacement must be medically necessary and prior authorization must be obtained.

The repair of lost or destroyed eyeglass frames, eyeglass lenses, or contact lenses outside of their normal replacement schedule will be allowed only if modifier RB is submitted with the appropriate procedure codes.

#### **40.2.1.6 Services Requiring Authorization**

##### **40.2.1.6.1 Contact Lenses, Prescriptions, and Fittings**

Authorization is required for medically necessary contact lenses and their prescriptions and fittings for diagnoses that are not listed in the diagnosis table above in Section 40.2.1.4, “Contact Lenses” in this chapter. Requests for authorization must be submitted using a [CSHCN Services Program Authorization and Prior Authorization Request form](#) with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- For an established patient, current and new prescriptions that show a change of 0.5d or more in the sphere, cylinder, or prism measurements from a previous exam
- For a new patient, the new prescription including prescriptive measurements
- Which eyes are being treated: left, right, or both
- The specific procedure codes for which the authorization is being requested
- The medical necessity of contact lenses for the correction of the client’s vision or for the treatment of the client’s medical condition, and why eyeglasses are inappropriate or contraindicated in this case

##### **40.2.1.6.2 Scleral Lenses and Liquid Bandages**

Authorization is required for scleral lenses (procedure codes V2530 and V2531) and scleral lenses used as liquid bandage devices (procedure code S0515). Providers must submit the [CSHCN Services Program Authorization and Prior Authorization Request form](#). Claims must be submitted with documentation of all of the following:

- The client has a condition that requires a scleral lens or a liquid bandage and is refractive to conservative treatment.
- The client has a condition that indicates a severe ocular surface disease, including, but not limited to, the following conditions:
  - Corneal ectasia such as keratoconus, pellucid marginal degeneration, keratoglobus (The use of scleral lenses does not achieve precise vision correction for high-order aberrations related to these diagnoses.)
  - Post keratoplasty astigmatism (Scleral lenses generally provide excellent visual acuity for the treatment of this condition and should be considered in lieu of wedge resections, relaxing incisions, and laser ablations.)
  - Terrien’s marginal degeneration
  - Corneal surface irregularities that are due to ocular surface disease, anterior corneal dystrophies, scars, and other causes
  - Aphakia, high myopia or astigmatism
  - Corneal stem cell deficiencies that are a result of Stevens-Johnson syndrome and toxic epidermal necrosis (TEN), chemical and thermal injuries, ocular pemphigoid, aniridia, and other causes
  - Keratitis sicca that is a result of disorders of the lacrimal gland such as Sjogren’s syndrome, graft vs. host disease, irradiation, surgery, and meibomian gland deficiency

- Neurotrophic corneas resulting from herpes simplex or zoster keratitis, congenital corneal anesthesia (dysautonomia), diabetes, acoustic neuroma surgery, trigeminal ganglionectomy, trigeminal rhizotomy, and other causes
- Persistent noninfectious corneal ulcers and epithelial defects that are associated with stem cell-deficient and neurotrophic corneas

#### **40.2.1.7 Services Not Requiring Authorization**

Authorization is not required for the following:

- One annual vision exam with refraction
- One medically necessary pair of prescription eyewear per calendar year
- One medically necessary pair of contact lenses per calendar year
- Eye exams and eye treatments for medical reasons (Medical eye exams and treatments may also include special vision services and ocular viewing and diagnostic procedures.)

**Referto:** Section 4.3, “Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information on prior authorization requirements.

#### **40.2.1.8 Services Requiring Prior Authorization**

A separate prior authorization request must be submitted for all contact lens replacements and for additional prescriptions and fittings of contact lenses within the calendar year. Requests must be submitted using a [CSHCN Services Program Authorization and Prior Authorization Request form](#) with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- Which eyes are being treated: left, right, or both
- The procedure codes for which the prior authorization is being requested
- The medical necessity of either the replacement of the contact lenses or of an additional contact lens prescription and fitting within the calendar year

If a pattern of contact lens replacement is requested, the medical necessity of the pattern of replacement (e.g., monthly, every three months, or any other frequency) for the correction of a client’s vision or for the treatment of a client’s medical condition must be established. If the request for replacement is because of a change in prescription during the calendar year, the provider must include current and new prescriptions that show:

- A change of 0.50 diopters or more in any corresponding meridian
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

**Note:** *A cylinder power of 0.12-0.37 diopters with a change in axis does not warrant replacement glasses.*

Providers must submit an invoice that shows the manufacturer’s suggested retail price (MSRP) of the prescribed contact lenses with the prior authorization request.

Procedure code 76999 requires prior authorization. The provider must submit the following documentation with their request:

- The client’s diagnosis

- A clear, concise description of the ophthalmic ultrasound being performed
- A CPT or HCPCS procedure code which is comparable to the ophthalmic ultrasound being requested
- The physician's intended fee for this procedure
- Reason for recommending this particular procedure

**Note:** *Services and procedures that are investigational or experimental are not a benefit of the CSHCN Services Program.*

**Referto:** Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

#### **40.2.1.9 Eye Prostheses**

Eye prostheses may be authorized when prescribed by the treating physician and when there is documentation of medical necessity and appropriateness.

There are no specific time limitations on replacement of eye prostheses. A child's eye socket may change size at variable times because of differences in bone growth rate and soft tissue change.

#### **40.2.2 Eye and Vision Examinations**

Vision services that are medically necessary for the treatment of a client include, but are not limited to, the following:

- Eye examinations and the treatment of the eye for medical reasons (i.e., aphakia diagnoses, diseases of the eye, or as a result of eye surgery or an injury to the eye). Eye examinations that are performed for medical reasons may be reimbursed as medically necessary.
- One vision examination with refraction per calendar year to obtain a prescription for eyewear for disorders of refraction and accommodation. More frequent vision exams may be reimbursed if they are recommended by a school nurse, teacher, or parent.
- One pair of nonprosthetic eyewear per calendar year.

A client who experiences vision-related difficulty with activities of daily living (ADLs) or with employment may be referred to HHSC DBS for evaluation and appropriate resources.

Special vision services, ocular viewing, and diagnostic testing include, but are not limited to, the following:

- Examination and evaluation with general anesthesia
- Ophthalmic ultrasound
- Corneal topography
- Sensorimotor examination
- Orthoptic training
- Ophthalmoscopy

##### **40.2.2.1 Vision Examinations with Refraction**

Vision examinations with refraction to obtain a prescription for eyewear (procedure code S0620 or S0621) may be reimbursed once per calendar year when billed with diagnosis codes Z0100 or Z0101.

Procedure codes S0620 and S0621 will deny if billed on the same date of service as procedure code 92020, 92273, and 92274.

### 40.2.2.2 Medical Eye Examinations

Medical eye examinations performed for medical reasons may be reimbursed to providers using procedure codes 92002, 92004, 92012, 92014, and 92015. These examinations may be reimbursed as medically necessary with a valid diagnosis code that describes the medical reason for the eye examination.

A new patient is one who has not received any professional services within the past three years from the provider or another provider of the same specialty who belongs to the same group practice. Providers must use procedure codes 92002, 92004, or S0620 to bill for new patient ophthalmological eye exams provided in the office, or in an outpatient or other ambulatory facility.

An established patient is one who has received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years. Providers must use procedure codes 92012, 92014, or S0621 to bill for established patient ophthalmological eye exams that were provided in the office, or in an outpatient or other ambulatory facility.

Routine vision examinations, with refraction (procedure codes S0620 and S0621) will be denied as part of another service if they are billed with the same date of service as an ophthalmological medical exam (procedure codes 92002, 92004, 92012, and 92014).

A refractive state (procedure code 92015) will be denied as part of another service when billed with the same date of service by the same provider as a routine vision examination, with refraction (procedure codes S0620 or S0621).

A refractive state (procedure code 92015) may be reimbursed in addition to procedure codes 92002, 92004, 92012, and 92014.

### 40.2.2.3 Services Requiring Authorization

Authorization is required if a school nurse, teacher, or parent recommends an additional eye examination with refraction within a calendar year. If a new pair of eyeglasses is required as a result of the exam, an authorization is required. Requests for either authorization must be submitted using a [CSHCN Services Program Authorization and Prior Authorization Request form](#) with documentation of the following:

- The medical diagnosis of the cause of the disorder of refraction
- The new prescription that shows at least one of the following:
  - A change of 0.50 diopters or more in any corresponding meridian
  - A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters
  - A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters
  - A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters
  - A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

*Note: A cylinder power of 0.12-0.37 diopters with a change in axis does not warrant replacement glasses.*

- The specific procedure codes for which the authorization is being requested

## 40.2.3 Special Vision Services

### 40.2.3.1 Ophthalmological Examination and Evaluation with General Anesthesia

Ophthalmological examination and evaluation with general anesthesia (procedure codes 92018 and 92019) may be reimbursed to ophthalmologists if a client has significant injury or cannot otherwise tolerate the procedure while conscious. Ophthalmological examination and evaluation with general anesthesia is limited to one service per day by any provider.

### 40.2.3.2 Ophthalmic Ultrasound

Ophthalmic ultrasound may be reimbursed to providers using the following procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 76510           | 76511 | 76512 | 76513 | 76514 | 76516 | 76519 | 76529 | 76999 |

Ophthalmic ultrasounds may be reimbursed on the same date of service by the same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds professional components may be reimbursed for services rendered in the office, outpatient, and inpatient hospital settings. The technical component of ophthalmic ultrasounds may be reimbursed for services rendered in the office setting.

Procedure codes 76514, 76516, and 76519 are limited to one service per day, any provider. Procedure codes 76510, 76511, 76512, 76513, 76514, 76516, and 76519 are limited to two services per calendar year by any provider.

Procedure code 76519 may be reimbursed as follows:

- The professional component must be billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed once when one or both eyes are performed on the same date of service by any provider.
- The total component may be reimbursed with an additional professional service when both eyes are performed on the same date of service by any provider.

### 40.2.3.3 Corneal Topography

Corneal topography (procedure code 92025) may be reimbursed to providers and is limited to one service per day, and two services per calendar year by any provider. Corneal topography is limited to the following diagnosis codes:

| Diagnosis Codes |        |        |        |        |        |        |        |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| H10211          | H10212 | H10213 | H10811 | H10812 | H10813 | H10821 | H10822 |
| H10823          | H10829 | H11001 | H11002 | H11003 | H11011 | H11012 | H11013 |
| H11021          | H11022 | H11023 | H11031 | H11032 | H11033 | H11041 | H11042 |
| H11043          | H11051 | H11052 | H11053 | H11061 | H11062 | H11063 | H1189  |
| H16001          | H16002 | H16003 | H16011 | H16012 | H16013 | H16021 | H16022 |
| H16023          | H16031 | H16032 | H16033 | H16041 | H16042 | H16043 | H16051 |
| H16052          | H16053 | H16061 | H16062 | H16063 | H16071 | H16072 | H16073 |
| H16101          | H16102 | H16103 | H16111 | H16112 | H16113 | H16121 | H16122 |
| H16123          | H16131 | H16132 | H16133 | H16141 | H16142 | H16143 | H16201 |
| H16202          | H16203 | H16211 | H16212 | H16213 | H16221 | H16222 | H16223 |
| H16231          | H16232 | H16233 | H16251 | H16252 | H16253 | H16261 | H16262 |
| H16263          | H16291 | H16292 | H16293 | H16301 | H16302 | H16303 | H16311 |
| H16312          | H16313 | H16321 | H16322 | H16323 | H16331 | H16332 | H16333 |
| H16391          | H16392 | H16393 | H16401 | H16402 | H16403 | H16411 | H16412 |
| H16413          | H16421 | H16422 | H16423 | H16431 | H16432 | H16433 | H16441 |
| H16442          | H16443 | H168   | H169   | H1701  | H1702  | H1703  | H1711  |
| H1712           | H1713  | H17811 | H17812 | H17813 | H17821 | H17822 | H17823 |

| Diagnosis Codes |         |         |         |         |         |         |         |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| H1789           | H179    | H1811   | H1812   | H1813   | H1820   | H18221  | H18222  |
| H18223          | H18231  | H18232  | H18233  | H1840   | H18451  | H18452  | H18453  |
| H18461          | H18462  | H18463  | H1849   | H18501  | H18502  | H18503  | H18509  |
| H18511          | H18512  | H18513  | H18519  | H18521  | H18522  | H18523  | H18529  |
| H18531          | H18532  | H18533  | H18539  | H18541  | H18542  | H18543  | H18549  |
| H18551          | H18552  | H18553  | H18559  | H18591  | H18592  | H18593  | H18599  |
| H18601          | H18602  | H18603  | H18611  | H18612  | H18613  | H18621  | H18622  |
| H18623          | H1870   | H18711  | H18712  | H18713  | H18721  | H18722  | H18723  |
| H18731          | H18732  | H18733  | H18791  | H18792  | H18793  | H18831  | H18832  |
| H18833          | H52201  | H52202  | H52203  | H52211  | H52212  | H52213  | L511    |
| L512            | L513    | Q134    | S0521XA | S0521XD | S0521XS | S0522XA | S0522XD |
| S0522XS         | S0531XA | S0531XD | S0531XS | S0532XA | S0532XD | S0532XS | T2611XA |
| T2611XD         | T2611XS | T2612XA | T2612XD | T2612XS | T2661XA | T2661XD | T2661XS |
| T2662XA         | T2662XD | T2662XS | T85310A | T85310D | T85310S | T85311A | T85311D |
| T85311S         | T85318A | T85318D | T85318S | T85320A | T85320D | T85320S | T85321A |
| T85321D         | T85321S | T85328A | T85328D | T85328S | T85390A | T85390D | T85390S |
| T85391A         | T85391D | T85391S | T85398A | T85398D | T85398S | Z48810  | Z947    |
| Z9841           | Z9842   | Z9849   | Z9883   |         |         |         |         |

Corneal topography may be reimbursed on the same date of service by the same provider as a medical eye exam or simple refraction (procedure codes 92002, 92004, 92012, 92014, or 92015).

#### 40.2.3.4 Sensorimotor Examination

Sensorimotor examinations (procedure code 92060) may be reimbursed in addition to a medical eye examination or simple refraction.

Sensorimotor examination is limited to once per day and two per calendar year by any provider.

#### 40.2.3.5 Orthoptic Training

Orthoptic training (procedure codes 92065 and 92066) may be reimbursed in addition to a medical eye examination visit.

Orthoptic training is limited to once per day and 36 per year by any provider.

#### 40.2.3.6 Ophthalmoscopy

Ophthalmoscopy may be reimbursed to providers using the following procedure codes:

| Procedure Codes |       |       |       |       |       |       |       |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 92201           | 92202 | 92230 | 92235 | 92240 | 92242 | 92250 | 92260 |

Ophthalmoscopy, fluorescein angiography, indocyanin-green angiography, and fluorescein angiography (procedure codes 92230, 92235, 92240, and 92242) may be reimbursed for a quantity of two if both the left and right eyes are evaluated. Modifiers LT and RT must be included on the claim to identify the eye on which the service was performed.

Ophthalmoscopy, fluorescein angiography, indocyanin-green angiography, and fluorescein angiography (procedure codes 92230, 92235, 92240, and 92242) are limited to one service per eye per day and two services per eye per calendar year by any provider.



Ophthalmoscopy, extended (procedure codes 92201 and 92202) are limited to one service per day and two services per calendar year by any provider.

Fundus photography (procedure code 92250) and ophthamodynamometry (procedure code 92260) are limited to one service per day and two services per calendar year by any provider.

#### **40.2.3.7 Ocular Viewing and Diagnostic Testing Procedures**

Ophthalmologists and optometrists may submit the following procedure codes for the reimbursement of ocular viewing and diagnostic testing:

| <b>Ocular Viewing and Diagnostic Testing Procedure Codes</b> |       |       |       |       |       |       |       |       |       |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 92020  | 92081 | 92082 | 92083 | 92100 | 92132 | 92133 | 92134 | 92136 | 92227 |
| 92228  | 92229 | 92265 | 92270 | 92273 | 92274 | 92285 | 92286 | 92287 |       |

Gonioscopy (procedure code 92020) is limited to two services per calendar year by any provider.

Visual field examinations (procedure codes 92081, 92082, 92083), serial tonometry (procedure code 92100), scanning computerized ophthalmic diagnostic imaging (procedure codes 92132, 92133, and 92134) are limited to one service per day and two services per calendar year by any provider.

Ophthalmic biometry (procedure code 92136) is limited to two services per eye per calendar year by any provider.

Procedure code 92136 may be reimbursed as follows:

- The professional component must be billed with modifier LT or RT to identify the eye on which the service was performed.
- The technical component may be reimbursed when one or both eyes are performed on the same date of service by any provider.
- The total component may be reimbursed with an additional professional service when both eyes are performed on the same date of service by any provider.

Procedure codes 92227, 92228, and 92229 are limited to two services per calendar year by any provider.

Procedure codes 92265, 92270, 92273, 92274, 92285, 92286, and 92287 are limited to one service per day and two services per calendar year when billed by any provider.

### **40.3 Claims Information**

The repair or replacement of lost or destroyed eyeglass frames, eyeglass lenses, or contact lenses outside of their normal replacement schedule will be allowed only if the RB modifier is submitted with the appropriate procedure codes.

Eyewear for a diagnosis of aphakia must be billed with modifier VP.

The MSRP must be submitted for the consideration of the purchase of high-powered and aphakic lenses with the appropriate procedure codes.

Opticians enrolled as a facility must submit claims with their NPI in both the billing provider field (Block 33 on a paper claim or the electronic equivalent) and in the performing provider field (Block 24J on a paper claim or the electronic equivalent.)

Vision services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [Centers for Medicare & Medicaid Services \(CMS\) NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

**Referto:** Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

## 40.4 Reimbursement

Contact lenses, frames, and eyeglass lenses, except for high-power and aphakic lenses, may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. High-powered lenses and lenses for aphakia are manually priced. Manually-priced items are reimbursed at the retail price minus a discount as determined by the CSHCN Services Program rule. An invoice that shows the actual MSRP must be filed with every claim of this type.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/resources/rate-and-code-updates/rate-changes](http://www.tmhp.com/resources/rate-and-code-updates/rate-changes).

**Note:** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

## 40.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **TMHP ELECTRONIC DATA INTERCHANGE (EDI)**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



# TMHP ELECTRONIC DATA INTERCHANGE (EDI)

## Table of Contents

|             |   |          |
|-------------|---|----------|
| <b>41.1</b> | <b>TMHP EDI Overview</b> .....  | <b>3</b> |
| <b>41.2</b> | <b>Advantages of Electronic Services</b> .....  | <b>3</b> |
| 41.2.1      | Getting Help .....  | 3        |
| 41.2.2      | Electronic Services Available .....   | 3        |
| <b>41.3</b> | <b>Electronic Billing</b> .....   | <b>4</b> |
| 41.3.1      | Step 1—Choose How Claims Are Submitted .....  | 4        |
| 41.3.1.1    | TexMedConnect .....   | 4        |
| 41.3.1.2    | Vendor Software .....   | 4        |
| 41.3.1.3    | Third-Party Billing Agents .....  | 5        |
| 41.3.1.4    | Automated Maintenance Process for All Electronic Submitters .....   | 5        |
| 41.3.2      | Step 2—Gaining Access .....   | 5        |
| 41.3.3      | Step 3—Training .....   | 5        |
| <b>41.4</b> | <b>Request for Electronic Transmission Reports</b> .....  | <b>6</b> |
| <b>41.5</b> | <b>Provider Check Amounts Available Online</b> .....  | <b>6</b> |
| <b>41.6</b> | <b>Third-Party Vendor Implementation</b> .....  | <b>6</b> |
| 41.6.1      | EDI Version 5010 Claims Response and Electronic Remittance & Status (R&S)<br>Files .....  | 7        |
| 41.6.1.1    | Batch ID Included in Filename for 227CA Claims Response File .....  | 7        |
| 41.6.1.2    | Setting up the 835 File (ER&S) .....  | 7        |
| 41.6.1.3    | Trading Partners Who Submit 837 Files and Receive 835 Files .....   | 7        |
| 41.6.1.4    | Trading Partners Who Have a Clearinghouse or Third Party Submit<br>Their Claims but Receive Their Own 835 Files .....           | 7        |
| 41.6.1.5    | Clearinghouses or Third-Party Billers That Submit Transactions and<br>Receive the 835 Files on Behalf of Trading Partners ..... | 7        |
| <b>41.7</b> | <b>Supported File Types</b> .....   | <b>7</b> |
| <b>41.8</b> | <b>Forms</b> .....  | <b>8</b> |
| <b>41.9</b> | <b>TMHP-CSHCN Services Program Contact Center</b> .....   | <b>8</b> |

## 41.1 TMHP EDI Overview

Providers can submit claims and other requests using paper forms or faster electronic methods. Providers are encouraged to submit claims and other requests electronically. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP EDI Gateway. TMHP uses the *Health Insurance Portability and Accountability Act* (HIPAA)-compliant American National Standards Institute or ANSI X12 5010 (if provider has passed 5010 testing) 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.

## 41.2 Advantages of Electronic Services

*It's fast.* No more waiting by the mailbox or making 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, CSHCN Services Program, and many other topics, as well as a large library of reference materials and manuals on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

*It's safe.* TMHP EDI services use VPN and SSL connections, just like the U.S. government, banks, and other financial institutions, for maximum security.

*It's accurate.* TexMedConnect and most third-party vendor software 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 retrieve Electronic Remittance and Status (ER&S) reports, perform claim status inquiries, verify client eligibility, and archive claims. TexMedConnect can generate and print reports on everything it sends, receives, and archives.

### 41.2.1 Getting Help

Contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, or visit the TMHP website at [www.tmhp.com](http://www.tmhp.com) for more information about EDI services.

The TMHP EDI Help Desk does not provide training or help with billing questions. Providers should contact the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 for billing and training questions. Information about provider education opportunities is available on the TMHP website at [www.tmhp.com/resources/provider-education-and-training](http://www.tmhp.com/resources/provider-education-and-training).

### 41.2.2 Electronic Services Available

The services available through EDI are:

- Eligibility verification (EV)
- Claims submission
- Claim status inquiry (CSI)
- ER&S reports

- Appeals (also known as correction and resubmission)

### 41.3 Electronic Billing

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

The previously announced dual strategy for EDI claims submissions is now in effect.

Trading partners that have passed ANSI X12 version 5010 testing may submit ANSI X12 version 5010 files.

TMHP no longer accepts ANSI X12 version 4010 files. Effective April 1, 2012, electronic claims that are submitted by providers that are not both compliant and certified will not be accepted by TMHP, and, as a result, will not be adjudicated or paid by the CSHCN Services Program.

It is the responsibility of providers to ensure that their method of submitting electronic claims is both EDI compliant and certified by TMHP.

*Note: All CSHCN Services Program electronic claims must include the appropriate benefit code as follows:*

- DM3 for CSHCN Services Program home health durable medical equipment (DME) services
- CSN for all other CSHCN Services Program services

TexMedConnect provides a drop-down box that allows the submitter to choose the appropriate combination of provider numbers and benefit code. For CSHCN Services Program submissions, providers must choose the appropriate combination that includes either the CSN or DM3 benefit code.

Providers that use other vendor software must add the appropriate CSHCN Services Program benefit code (i.e., CSN or DM3) in the appropriate field as designated by the software.

#### 41.3.1 Step 1—Choose How Claims Are Submitted

##### 41.3.1.1 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 Internet access and one of the following Internet browsers:

- Microsoft® Internet Explorer®
- Google Chrome®
- Mozilla Firefox®

Although many TexMedConnect features will work with earlier versions of Microsoft Internet Explorer, TMHP only offers technical support for TexMedConnect when used with Microsoft Internet Explorer 11. A broadband connection is recommended but not required. Providers that use TexMedConnect can find the online instruction manual on the homepage and on the EDI page of the TMHP website at [www.tmhp.com](http://www.tmhp.com).

##### 41.3.1.2 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 in the [Completed Testing](#) link, which is located on the EDI page of the TMHP website at [www.tmhp.com](http://www.tmhp.com). There are hundreds of software vendors with

a wide assortment of services 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 the details of their 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 have been certified by TMHP.

*Note:* Software vendors should refer to Section 41.6, "Third-Party Vendor Implementation" in this chapter

### **41.3.1.3 Third-Party Billing Agents**

Billing agents are companies or individuals that 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 that processes it and then transmits it to TMHP and other institutions. 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. A complete list of billing agents that have completed the testing process and been certified by TMHP can be found on the [Completed Testing](#) link, which is located on the EDI page of the TMHP website at [www.tmhp.com](http://www.tmhp.com). TMHP does not make billing agent recommendations or provide any assistance for billing agent's software or services.

### **41.3.1.4 Automated Maintenance Process for All Electronic Submitters**

All electronic submitters are responsible for the maintenance of their submitter folders. Folders are limited to 7,500 files and cannot contain files older than 30 days. Files that exceed these limits are systematically archived on a daily basis. Providers should review, retrieve, and backup their electronic response files regularly.

Providers must pay a fee for transmission reports that are produced after the 30-day period or as a result of the systematic archive of files over the 7,500 limit. File submitted using EDI version 5010 are limited to a maximum 5,000 transactions per file. Files that have more than 5,000 files will be rejected.

*Referto:* Section 41.4, "Request for Electronic Transmission Reports" in this chapter.

## **41.3.2 Step 2—Gaining Access**

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

Providers that download the ANSI 835 file through TexMedConnect and providers that use vendor software must request a submitter ID. A submitter ID is necessary for vendor software to access TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. To order a submitter ID, providers must call the EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time. Providers that use a billing agent do not need a submitter ID. Providers that use TexMedConnect can access the online instruction manual on the EDI webpage of the TMHP website at [www.tmhp.com](http://www.tmhp.com).

## **41.3.3 Step 3—Training**

Providers should contact the TMHP-CSHCN Contact Center at 1-800-568-2413 for assistance with resolving billing issues. Information about training opportunities is available on the TMHP website at [www.tmhp.com/resources/provider-education-and-training](http://www.tmhp.com/resources/provider-education-and-training). Providers may also use the many reference materials available on the website in the reference materials section.

*Referto:* Section 1.2.1, "Publications" in Chapter 1, "TMHP and HHSC Contact Information."

The TMHP EDI Help Desk provides technical assistance, but does not provide training.

## 41.4 Request for Electronic Transmission Reports

Providers are required to retain all claim and electronic file transmission records. Providers must verify that all claims submitted to the CSHCN Services Program or its agent are received and accepted. Providers must also track claims submissions against their claims payments to detect and correct all claim errors.

*Referto:* Section 2.3, “Provider Responsibilities” in Chapter 2, “Provider Enrollment and Responsibilities” for more information about provider responsibilities and electronic submissions.

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

## 41.5 Provider Check Amounts Available Online

Acute care providers can search, view, and print all payment amounts that were issued during the previous year by going to the TMHP website at [www.tmhp.com](http://www.tmhp.com).

The features of the online check amount include:

- The ability to search information up to 1 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 a Provider Administrator 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 clicking **My Account** and then **View Payment Amounts**.

Provider check amounts will continue to be available through the Automated Inquiry System (AIS) telephone line and on Electronic Remittance and Status (ER&S) Reports.

## 41.6 Third-Party Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before granting access to the production server. Vendors that wish to begin testing may either call the EDI Help Desk at 1-888-863-3638 or visit the EDIFECS testing site at <https://editesting.tmhp.com/index.jsp> and use the *TMHP Support* link. An EDIFECS account is created for the vendor to begin testing EDI formats. After the successful completion of EDIFECS testing and the submission of a Trading Partner Agreement, vendors must 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 billing organization or agent is added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor software.

**41.6.1 EDI Version 5010 Claims Response and Electronic Remittance & Status (R&S) Files**

**41.6.1.1 Batch ID Included in Filename for 227CA Claims Response File**

The Batch ID (BID) is located in the file name of the returned 227CA response. The 227CA claims response file does not include the batch ID within the file.

*Note: When calling the EDI helpdesk for assistance, providers should have the 227CA filename available so the EDI Helpdesk can provide assistance.*

**41.6.1.2 Setting up the 835 File (ER&S)**

After completing the EDI 5010 testing and certification process, providers need to submit a request to establish their ER&S report for their new submitter ID. Acute care providers must submit the Electronic Remittance and Status (ER&S) Agreement, which is available on the TMHP website at [www.tmhp.com](http://www.tmhp.com). Providers should fax the completed forms to (512) 506-7808. The process for setting up the ER&S report for EDI 5010 depends upon the designated recipient.

**41.6.1.3 Trading Partners Who Submit 837 Files and Receive 835 Files**

The trading partner must complete the appropriate 835 form and submit it to TMHP. The 835 form must contain the trading partner’s EDI 5010 submitter ID.

**41.6.1.4 Trading Partners Who Have a Clearinghouse or Third Party Submit Their Claims but Receive Their Own 835 Files**

Each provider that uses a clearinghouse or third-party biller to submit claims must submit their own updated 835 form. A clearinghouse or third-party biller may not submit 835 forms on behalf of the trading partners for which it submits claims.

To be able to receive 835 files directly, providers must first request an EDI 5010 submitter ID to be used for accessing their 835 files. After the EDI 5010 submitter ID is received, providers must complete the appropriate 835 form and submit it to TMHP.

The 835 form must contain the provider’s EDI 5010 submitter ID.

**41.6.1.5 Clearinghouses or Third-Party Billers That Submit Transactions and Receive the 835 Files on Behalf of Trading Partners**

Each provider that uses a clearinghouse or third-party biller to submit claims must submit their own updated 835 form. Even if a clearinghouse or third-party biller receives 835 files for its trading partners, it may not submit 835 forms on behalf of the trading partner for which it submits claims.

The 835 form must contain the clearinghouse or third-party biller’s EDI 5010 submitter ID.

**41.7 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 |

| Electronic Transaction Types |                      |
|------------------------------|----------------------|
| 835                          | ER&S report          |
| 837D                         | Dental claims        |
| 837I                         | Institutional claims |
| 837P                         | Professional claims  |

## 41.8 Forms

The following forms are available on the TMHP website:

- [Claim Status Inquiry \(CSI\) Authorization](#)
- [Electronic Funds Transfer \(EFT\) Notification](#)

*Note:* Photocopy these forms and retain the originals for reuse. Forms are also available at [www.tmhp.com](http://www.tmhp.com).

*Referto:* Section 5.8, “Reimbursement” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement.”

## 41.9 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

# **APPENDIX A: ACRONYMS AND INITIALISMS DICTIONARY**

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**FEBRUARY 2024**



## A.1 Acronym Dictionary

| Term  | Definition   |
|-------|--|
| A/R   | Accounts Receivable                                      |
| AAP   | American Academy of Pediatrics                           |
| ACA   | Affordable Care Act of 2010                              |
| ACD   | Augmentative Communication Device                        |
| ACIP  | Advisory Committee on Immunization Practices             |
| ACSW  | Academy of Certified Social Workers                      |
| AFP   | Abdominal Flat Plates                                    |
| AIDS  | Acquired Immunodeficiency Syndrome                       |
| AIS   | Automated Inquiry System                                 |
| ALL   | Acute Lymphoblastic Leukemia                             |
| AMA   | American Medical Association                             |
| ANSI  | American National Standards Institute                    |
| APN   | Advanced Practice Nurse (former name for APRN)           |
| APRN  | Advanced Practice Registered Nurse                       |
| ASA   | American Society of Anesthesiologists                    |
| ASBMT | American Society for Blood and Marrow Transplantation    |
| ASC   | Ambulatory Surgical Center                               |
| ATP   | Assistive Technology Professional                        |
| AWP   | Average Wholesale Price                                  |
| BCBS  | Blue Cross Blue Shield                                   |
| BCG   | Bacille Calmette-Guérin                                  |
| BiPAP | Bi-level Positive Airway Pressure                        |
| BON   | (Texas) Board of Nursing                                 |
| BSSW  | Bachelor of Science in Social Work                       |
| CAPD  | Continuous Ambulatory Peritoneal Dialysis                |
| CBC   | Complete Blood Count                                     |
| C/C   | Cleft/Craniofacial                                       |
| CCP   | Comprehensive Care Program                               |
| CCPD  | Continuous Cycling Peritoneal Dialysis                   |
| CDT   | Current Dental Terminology                               |
| CHIP  | Children's Health Insurance Program                      |
| CLIA  | <i>Clinical Laboratory Improvement Amendments</i>        |
| CML   | Chronic Myelogenous Leukemia                             |
| CMS   | Centers for Medicare & Medicaid Services (formerly HCFA) |
| CNS   | Clinical Nurse Specialist                                |
| CPAP  | Continuous Positive Airway Pressure                      |
| CPR   | Cardiopulmonary Resuscitation                            |
| CPT   | Current Procedural Terminology                           |
| CRCP  | Certified Respiratory Care Practitioner                  |

| <b>Term</b> | <b>Definition</b>   |
|-------------|---|
| CRNA        | Certified Registered Nurse Anesthetist  |
| CSHCN       | Children with Special Health Care Needs   |
| CSI         | Claim Status Inquiry  |
| CT          | Computed Tomography   |
| CVA         | Cerebrovascular Accident  |
| DDS         | Doctor of Dental Surgery  |
| DEFRA       | <i>Deficit Reduction Act of 1984</i>  |
| DMD         | Doctor of Dental Medicine   |
| DME         | Durable Medical Equipment   |
| DO          | Doctor of Osteopathy  |
| DOB         | Date of Birth   |
| DOS         | Date of Service   |
| DPM         | Doctor of Podiatric Medicine  |
| DRG         | Diagnosis-Related Group   |
| DSHS        | Department of State Health Services   |
| DSM-IV-TR   | <i>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision</i> |
| E/M         | Evaluation and Management (Services)  |
| ECG         | Electrocardiogram   |
| EDI         | Electronic Data Interchange   |
| EEG         | Electroencephalogram  |
| EFT         | Electronic Funds Transfer   |
| EMG         | Electromyography  |
| EMTALA      | <i>Emergency Medical Treatment and Labor Act</i>  |
| EOB         | Explanation of Benefits   |
| EOG         | Electro-oculogram   |
| EOPS        | Explanation of Pending Status   |
| EPO         | Erythropoietin Alfa   |
| EPSDT       | Early Periodic Screening, Diagnosis, and Treatment  |
| ER&S        | Electronic Remittance and Status report   |
| ESWL        | Extracorporeal Shock Wave Lithotripsy   |
| EV          | Eligibility Verification  |
| fMRI        | Functional Magnetic Resonance Imaging   |
| FNP         | Family Nurse Practitioner   |
| FQHC        | Federally Qualified Health Center   |
| FSS         | Family Support Services   |
| FYE         | Fiscal Year End   |
| HASC        | Hospital-based Ambulatory Surgical Center   |
| HBOT        | Hyperbaric Oxygen Therapy   |
| HCPCS       | Healthcare Common Procedure Coding System   |
| HCSSA       | Home and Community Services Support Agency  |

| <b>Term</b> | <b>Definition</b>  |
|-------------|--|
| HFCWCS      | High Frequency Chest Wall Compression Systems  |
| HHA         | Home Health Agency   |
| HHS         | Health and Human Services  |
| HHSC        | Health and Human Services Commission   |
| HIPAA       | <i>Health Insurance Portability and Accountability Act</i>                               |
| HIV         | Human Immunodeficiency Virus   |
| HKAFO       | Hip-Knee-Ankle-Foot Orthotics  |
| HLA         | Human Leukocyte Antigen  |
| HMO         | Health Maintenance Organization  |
| HO          | Hip Orthotics  |
| ICD-9-CM    | <i>International Classification of Diseases, Ninth Revision, Clinical Modification</i>   |
| ICD-10-CM   | <i>International Classification of Diseases, Tenth Revision, Clinical Modification</i>   |
| ICD-10-PCS  | <i>International Classification of Diseases, Tenth Revision, Procedure Coding System</i> |
| ICF         | Intermediate Care Facility (refer to <i>also SNF</i> )                                   |
| ICF/IID     | Intermediate Care Facility for Individuals with Intellectual Disabilities                |
| ICN         | Internal Control Number (as in, 24-digit ICN) assigned to a specific claim               |
| ID          | Intradermal  |
| IM          | Intramuscular  |
| iMRI        | Intraoperative Magnetic Resonance Imaging  |
| IOL         | Intraocular Lens   |
| IPD         | Intermittent Peritoneal Dialysis   |
| IPPA        | Insurance Premium Payment Assistance   |
| IPPB        | Intermittent Positive Pressure Breathing   |
| IPV         | Intrapulmonary Percussive Ventilation  |
| IRS         | Internal Revenue Service   |
| IV          | Intravenous  |
| JRA         | Juvenile Rheumatoid Arthritis  |
| KAFO        | Knee-Ankle-Foot Orthotics  |
| KO          | Knee Orthotics   |
| KUB         | Kidneys, Ureters, and Bladder  |
| LBSW        | Licensed Baccalaureate Social Worker   |
| LCSW        | Licensed Clinical Social Worker  |
| LDL         | Low Density Lipoprotein  |
| LMFT        | Licensed Marriage and Family Therapist   |
| LMSW        | Licensed Master Social Worker  |
| LMSW-AP     | Licensed Master Social Worker-Advanced Practitioner                                      |
| LPC         | Licensed Professional Counselor  |
| LVN         | Licensed Vocational Nurse  |
| MD          | Doctor of Medicine   |
| MMIS        | Medicaid Management Information System   |

| <b>Term</b> | <b>Definition</b>  |
|-------------|--|
| MNC         | Medically Needy Clearinghouse  |
| MNP         | Medically Needy Program  |
| MPH         | Master of Public Health  |
| MRA         | Magnetic Resonance Angiography   |
| MRI         | Magnetic Resonance Imaging   |
| MSRP        | Manufacturers Suggested Retail Price   |
| MSSW        | Master of Science in Social Work   |
| MSUD        | Maple Syrup Urine Disease (also called branched-chain ketoaciduria)          |
| MSW         | Master of Social Work  |
| MTP         | Medical Transportation Program   |
| NCCI        | National Correct Coding Initiative   |
| NDC         | National Drug Code   |
| NOS         | Not Otherwise Specified  |
| NP          | Nurse Practitioner   |
| NPI         | National Provider Identifier   |
| OI          | Other Insurance  |
| OMT         | Osteopathic Manipulation Treatment   |
| OT          | Occupational Therapy, Occupational Therapist                                 |
| PACT        | Program for Amplification for Children of Texas (Hearing Aids/Services)      |
| PAF         | Physician/Dentist Assessment Form  |
| PAN         | Prior Authorization Number   |
| PCN         | Patient Control Number   |
| PDA         | Personal Digital Assistant   |
| PDF         | Portable Document Format   |
| PET         | Positron Emission Tomography (PET scan)                                      |
| PKU         | Phenylketonuria  |
| PNP         | Pediatric Nurse Practitioner   |
| POC         | Plan of Care   |
| POS         | Place of Service   |
| PPMP        | Physician-Performed Microscopy Procedures                                    |
| PPO         | Preferred Provider Organization  |
| PT          | Physical Therapy, Physical Therapist   |
| RAST        | Radioallergosorbent Test   |
| RBRVS       | Resource-Based Relative Value Scale  |
| RESNA       | Rehabilitation Engineering and Assistive Technology Society of North America |
| RGO         | Reciprocating Gait Orthosis  |
| RHC         | Rural Health Clinic  |
| RN          | Registered Nurse   |
| RSV         | Respiratory Syncytial Virus  |
| RVU         | Relative Value Unit  |

| <b>Term</b> | <b>Definition</b>   |
|-------------|---|
| SC          | Subcutaneous  |
| SID         | Surface Identification  |
| SLP         | Speech-Language Pathology/Speech-Language Pathologist                                     |
| SNF         | Skilled Nursing Facility (refer to <i>also ICF</i> )                                      |
| SO          | Spinal Orthotics  |
| SSL         | Secure Socket Layer   |
| TAC         | <i>Texas Administrative Code</i>  |
| TANF        | Temporary Assistance to Needy Families (formerly AFDC)                                    |
| TEFRA       | <i>Tax Equity and Fiscal Responsibility Act of 1982</i>                                   |
| TENS        | Transcutaneous Electric Nerve Stimulator  |
| THKAO       | Thoracic-Hip-Knee-Ankle Orthotics   |
| THSteps     | Texas Health Steps (Texas name for EPSDT)   |
| THSteps-CCP | Texas Health Steps Comprehensive Care Program (Texas name for EPSDT-CCP) (now called CCP) |
| TMHP        | Texas Medicaid & Healthcare Partnership   |
| TMRM        | Texas Medicaid Reimbursement Methodology  |
| TOB         | Type of Bill  |
| TOS         | Type of Service   |
| TPN         | Total Parenteral Nutrition (i.e., Hyperalimentation)                                      |
| TPR         | Third-Party Resource  |
| TSBDE       | Texas State Board of Dental Examiners   |
| TVFC        | Texas Vaccines for Children   |
| UB-04       | Uniform Bill 04 CMS-1450  |
| UCB         | University of California at Berkeley  |
| VDP         | Vendor Drug Program   |
| VIPS        | Voice Inquiry Processing System   |
| VPN         | Virtual Private Networking  |