Dear Manual User:

Welcome to the *2007 Texas Medicaid Provider Procedures Manual*. To enhance usability, this manual is available on a searchable CD-ROM and on the TMHP website at www.tmhp.com.

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

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

The Texas Medicaid Program policy published in this manual represents policy implemented as of October 31, 2006. Policy updates effective after October 31, 2006, are published bimonthly in the *Texas Medicaid Bulletin*.

The November/December 2006 *Texas Medicaid Bulletin* and all *Texas Medicaid Bulletins* through and including the September/October 2007 *Texas Medicaid Bulletin* supplement the *2007 Texas Medicaid Provider Procedures Manual* and update the policy contained herein.

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

Provider Manual Overview

The *2007 Texas Medicaid Provider Procedures Manual* is divided into three parts, including:

Part I: Provider Information

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

- Introduction
- TMHP Telephone and Address Guide
- Provider Enrollment and Responsibilities
- Texas Medicaid Reimbursement
- TMHP Electronic Data Interchange (EDI)
- Client Eligibility
- Claims Filing
- Appeals
- Managed Care

Part II: Texas Medicaid Services

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

Part III: Appendices

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

- *Appendix A.* State and Federal Offices Communication Guide
- *Appendix B.* Forms

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- *Appendix C.* THSteps Forms
- *Appendix D.* Claim Form Examples
- *Appendix E.* Vendor Drug Program
- *Appendix F.* Acronym Dictionary
- *Appendix G.* HIV/AIDS
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- *Appendix K.* Texas Health Steps Statutory State Requirements
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- *Appendix N.* THSteps Dental Guidelines

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Part

I

Provider Information

Introduction

TMHP Telephone and Address Guide

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Introduction

Medicaid Program Administration

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

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

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

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

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TMHP Telephone and Fax Communication

Contact	Telephone/Fax Number
TMHP Contact Center (general information) Automated Inquiry System (AIS)	1-800-925-9126
Provider Enrollment Fax	1-512-514-4214
Comprehensive Care Program (CCP) (CCP prior authorization status and general CCP and Home Health Services information)	1-800-846-7470
Children with Special Health Care Needs (CSHCN) Services Program AIS	1-800-568-2413
CSHCN Fax	1-512-514-4222
Comprehensive Care Inpatient Psychiatric (CCIP) Unit (prior authorization and general information)	1-800-213-8877
Home Health Services (includes Durable Medical Equipment [DME]) 1 – TMHP In-Home Care Customer Service 2 – DME Supplier with completed Title XIX form 3 – Registered Nurse (RN) with completed Plan of Care (POC)	1-800-925-8957
Health Insurance Premium Payment Systems (HIPPS) Employer	1-800-471-7792
Long Term Care (LTC) Operations	1-800-626-4117
LTC—Nursing Facilities	1-800-727-5436
Telephone Appeals	1-800-745-4452
TMHP Electronic Data Interchange (EDI) Help Desk	1-888-863-3638
TMHP EDI Help Desk Fax	1-512-514-4228 1-512-514-4230
Texas Health Steps (THSteps) Dental Inquiries	1-800-568-2460
THSteps Medical Inquiries	1-800-757-5691
Third Party Resources (TPR) (Option 2)	1-800-846-7307
TPR Fax	1-512-514-4225
Medicaid Audit/Cost Reports	1-512-506-6117
Medicaid Audit Fax	1-512-506-7811
Family Planning (Tubal Ligation/Vasectomy Consent Forms) Fax	1-512-514-4229
Hysterectomy Acknowledgment Statements Fax	1-512-514-4218

Primary Care Case Management (PCCM) Telephone Communication

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

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Prior Authorization Request Telephone and Fax Communication

Contact	Telephone/Fax Number
Ambulance Authorization (includes out-of-state transfers)	1-800-540-0694
Ambulance Authorization Fax	1-512-514-4205
Home Health Services Fax	1-512-514-4209
Comprehensive Care Program (CCP) Fax	1-512-514-4212
Comprehensive Care Inpatient Psychiatric (CCIP)	1-800-213-8877
CCIP Fax	1-512-514-4211
Outpatient Psychiatric Fax	1-512-514-4213
TMHP Special Medical Prior Authorization Fax (including transplants)	1-512-514-4213
Primary Care Case Management (PCCM) Utilization Management Option 1 – 2: Inpatient authorization request or notification of admission Option 2 – 2: Outpatient authorization request	1-888-302-6167
PCCM Utilization Management Fax	1-512-302-0319
Radiology Services Prior Authorization	1-800-572-2116
Radiology Services Prior Authorization Fax	1-888-693-3210

Prior Authorization Status Telephone Communication

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

Written Communication with TMHP

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

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

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

Contact	Address
Appeal/adjust claims (except zero paid/zero allowed on Remittance & Status [R&S] reports) Electronic claims and rejected reports past the 95-day filing deadline	Texas Medicaid & Healthcare Partnership Appeals/Adjustments PO Box 200645 Austin, TX 78720-0645
All first-time claims	Texas Medicaid & Healthcare Partnership Claims PO Box 200555 Austin, TX 78720-0555

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Contact	Address
Ambulance/Comprehensive Care Program (CCP) requests (for prior authorization and appeals)	Texas Medicaid & Healthcare Partnership Comprehensive Care Program (CCP) PO Box 200735 Austin, TX 78720-0735
Children with Special Health Care Needs (CSHCN) Services Program claims	Texas Medicaid & Healthcare Partnership CSHCN Claims PO Box 200855 Austin, TX 78720-0735
Dental prior authorization requests	Texas Medicaid & Healthcare Partnership Dental Prior Authorization PO Box 202917 Austin, TX 78720-2917
Home Health Services prior authorizations	Texas Medicaid & Healthcare Partnership Home Health Services PO Box 202977 Austin, TX 78720-2977
Medicaid Audit correspondence	Texas Medicaid & Healthcare Partnership Medicaid Audit PO Box 200345 Austin, TX 78720-0345
Medical Necessity forms 3652, 3618, and 3619, and purpose code E information	Texas Medicaid & Healthcare Partnership Long Term Care—Nursing Facilities PO Box 200765 Austin, TX 78720-0765
Medically Needy Clearinghouse (MNC) or Spend Down Unit correspondence	Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse PO Box 202947 Austin, TX 78720-2947
Provider enrollment correspondence	Texas Medicaid & Healthcare Partnership Provider Enrollment PO Box 200795 Austin, TX 78720-0795
Other provider correspondence	Texas Medicaid & Healthcare Partnership Provider Relations PO Box 202978 Austin, TX 78720-0978
Send all other written communication to TMHP	Texas Medicaid & Healthcare Partnership (Department) 12357-B Riata Trace Parkway, Suite 150 Austin, TX 78727
Third Party Resource (TPR)/Tort correspondence	Texas Medicaid & Healthcare Partnership Third Party Resources/Tort PO Box 202948 Austin, TX 78720-9981
Provider Enrollment Contract/Credentialing	Texas Medicaid & Healthcare Partnership PCCM Contracting/Credentialing PO Box 200795 Austin, TX 78720-4270

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Other TMHP Information

TMHP Contact Center

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

The TMHP Contact Center assists with questions such as:

- Provider enrollment procedures
- Claims filing procedures
- Policy information

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

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

Automated Inquiry System (AIS)

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

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

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

TMHP Provider Relations

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

Provider Relations activities include the following:

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

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

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TMHP EDI Help Desk

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

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

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

The TMHP Provider Relations Department assists with questions about demonstration and installation of the TDHconnect software.

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

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

State of Texas Access Reform (STAR) Program

Contact	Telephone
STAR, STAR+PLUS, and NorthSTAR Help Line (Texas Access Alliance [TAA])	1-800-964-2777

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

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1

Provider Enrollment and Responsibilities

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1.1 Provider Enrollment

1.1.1 TMHP Provider Enrollment

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

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

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

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

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

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

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

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

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

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

Providers who have not been assigned a provider identifier and have questions about submitting claims may call 1-800-925-9126. Providers who have already been assigned a provider identifier and have questions about submitting claims, may call the same number and select the option to speak with a TMHP call center representative.

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

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

1.1.2 Enrollment in Medicaid Managed Care Programs

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

1.1.3 Required Enrollment Forms

The following sections include forms required to enroll in the Texas Medicaid Program.

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

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1.1.3.1 Texas Medicaid Provider Enrollment Application

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

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

To assist with the application process, providers are advised to complete the enrollment application online at www.tmhp.com. In addition, providers can call the TMHP Contact Center at 1-800-925-9126, Option 2, for help with completing the application. Providers should retain a copy of the original application for future reference.

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

1.1.3.2 HHSC Medicaid Provider Agreement

The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in the Texas Medicaid Program and must be signed by the person applying for enrollment. If the applicant is an entity, a Principal of the entity must sign the application. "Principal" is defined in "Provider and Principal Information Forms" on page 1-3. This form is an agreement between HHSC and the provider performing services under the State Plan wherein the provider agrees to certain contract provisions as a condition for participation. All pages of the agreement must be present with the enrollment application.

1.1.3.3 Provider and Principal Information Forms

The Provider Information Form (PIF-1) must be personally completed by all providers enrolling in the Texas Medicaid Program. A separate Principal Information Form (PIF-2) must be personally completed by each Principal of the Provider before enrollment in the Texas Medicaid Program. Principals of the Provider include an owner with a direct or indirect ownership or control interest of 5 percent or more. Principals also include corporate officers and/or directors, limited or non-limited partners, or shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity. Principals further include any employee of the Provider who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity. The Provider Information Form and the Principal Information Form must be signed by the individual to whom it applies or, in the case of an entity, signed by a Principal of the entity and notarized before they are returned to TMHP. These forms were designed across multiple state agencies to help meet the requirements set forth by the 75th Legislature's Senate Bill (SB) 30 to enhance the enrollment requirements for potential providers, meet federal requirements for enrollment, and improve the integrity of the Medicaid program.

1.1.3.4 Disclosure of Ownership and Control Interest Statement

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

1.1.3.5 Internal Revenue Service (IRS) W-9 Form

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

1.1.3.6 Medicaid Audit Information Form

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

1.1.3.7 Corporate Board of Directors Resolution

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

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

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

1.1.3.9 Certificate of Formation or Certificate of Filing

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

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

1.1.3.10 Certificate of Authority

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

1.1.3.11 Copy of License/Temporary License/ Certification

A copy of the provider's license must be submitted for all licensed or certified professionals except for dentists licensed by the Texas State Board of Dental Examiners, physician assistants licensed by the Texas Medical Board, and nurses licensed by the Board of Nurse Examiners for the State of Texas. Medicaid accepts temporary or provisional licenses or certifications for physicians and psychologists. A signed official letter of certification from the Board of Nurse Examiners for the State of Texas is acceptable documentation of appropriate licensure and certification for advanced practice nurses that are licensed under the multi-state license compact in a state other than Texas. The license or certification issue date is required on the Provider Information Form. For providers participating in Medicare, the Medicare effective date cannot be prior to the license issue date unless a temporary license is furnished.

All providers are required to submit updated licensure and certification as they are renewed. Providers are also required to submit to TMHP, within 10 calendar days of occurrence, notice that the provider's license or certification has been partially or completely suspended, revoked, voluntarily surrendered, or retired. Not abiding by this license and certification update requirement may impact a provider's qualification for continued participation in the Texas Medicaid Program. Include the nine-digit provider identifier on submission of the license renewal.

1.1.3.12 Group Practices

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

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

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

1.2 Provider Responsibilities

1.2.1 Compliance with Texas Family Code

1.2.1.1 Child Support

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

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

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The law also requires that payments be stopped when notified that the contractor/provider is more than 30 days delinquent in paying child support. Medicaid payments are placed on hold when notified that a provider is delinquent in child support.

1.2.1.2 Reporting Child Abuse or Neglect

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

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

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

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

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

1.2.1.3 Procedures for Reporting Abuse or Neglect

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

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

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

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

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

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

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

Reports can be made anonymously.

A provider may not reveal whether the child has been tested or diagnosed with HIV or AIDS.

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

1.2.1.4 Procedures for Reporting Suspected Sexual Abuse

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

Sexual activity may include, but is not limited to, the actions described in *Penal Code* §21.11(a) relating to indecency with a child; §21.01(2) defining *sexual contact*;

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§43.01(1) or (3)-(5) defining various sexual activities; §22.011(a)(2) relating to sexual assault of a child; or §22.021(a)(2) relating to aggravated sexual assault of a child.

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

Refer to: "Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring" on page B-14.

1.2.1.5 Training

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

1.2.2 Maintenance of Provider Information

Providers must, within 10 calendar days of occurrence, report in writing to TMHP Provider Enrollment changes in address (physical location or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, performing providers). Failure to notify TMHP of changes affects accurate processing and timely claims payment. Fax notification of changes to: 1-512-514-4214, Attn: Provider Enrollment.

Providers can update their address information using either the Demographic Update (DU) Form on the TMHP website or the Provider Information Change (PIC) Form on page B-73.

Providers should use the PIC Form to update physical or mailing addresses, telephone numbers, names, tax identification numbers (TIN), provider status, and other provider information on file with the Texas Medicaid and CSHCN Services Programs. The DU Form is only used to make changes to provider addresses on file with TMHP. Providers can use the DU Form on the TMHP website at any time via the My Account link. Providers will be prompted to verify their address(es) and make necessary changes at least once a year. After the update has been completed, the form can be faxed to 1-512-514-4214, or mailed to the address below for processing.

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

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

Important: *Providers must create a provider administrator account to access the DU Form on the secure pages of the TMHP website. Non administrator users must be assigned by the provider administrator. Only providers or their authorized representatives can access the provider administrator accounts to obtain and complete the DU Form.*

1.2.3 Retention of Records and Access to Records and Premises

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

The provider is required to provide original records to representatives of the above organizations. As mentioned above, these records include, but are not limited to, documents related to clinical medical patient records, other records pertaining to the patient, any other records of services, items, or supplies provided to the patient and payments made for those services, diagnostic tests, documents related to diagnosis, charting billing records, invoices, documentation of delivery of items, equipment, supplies, treatment, service, laboratory results, and X-rays. Accessible information must include information that is necessary for the agencies specified in this paragraph to perform statutory functions. At the discretion of these representatives, the provider may be required to provide copies, in lieu of originals, notarized records/affidavits on each individual record documentation, promptly and at no cost to the state or federal agency. The required information may also include business and accounting records with backup support documentation, statistical documentation, computer records and data, patient sign-in sheets, and schedules. Additionally, it includes all requirements and elements described in Title 1 *Texas Administrative Code* (TAC) §§371.1617(a)(2) and 371.1601 (definition of "failure to grant immediate access"). Failure to supply these records or that which was requested, within the time frame specified, may result in payment hold to the provider's Medicaid payments, recoupment of payments for all claims related to the missing records, and/or contract cancellation and exclusion from the Medicaid program.

These records and claims must be retained for a minimum period of *five* years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding rural health clinics (RHCs) must retain their records for a minimum of *six* years, and hospital-based RHCs must retain their records

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for a minimum of *ten* years. These records must be made available immediately at the time of the request to employees or agents of HHSC Office of Inspector General (OIG), the Texas Attorney General's Medicaid Fraud Control Unit (MFCU) or Antitrust and Civil Medicaid Fraud Section, TMHP, DFPS, the Department of Aging and Disability Services (DADS), Department of State Health Services (DSHS), Department of Assistive and Rehabilitative Services (DARS), United States Department of Health and Human Services (HHS) representatives, any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person, or any agent or consultant of any agency or division delineated above. In addition, the provider must meet all requirements of 1 TAC, Part 15, §371.1643(f).

If the provider was originally requested to provide original documents and subsequent requests for copies of these records are made by the provider, any and all costs associated with copying or reproducing any portion of the original records will be at the expense of the provider. This would apply to any request for copies made by the provider at any point in the investigative process until such time as the agency deems the investigation to be finalized. A method of payment for the copying charge, that is approved by the agency, would be utilized to pay for the copying of the records. If copies of records are requested from the provider initially, the provider submits copies of such records at no cost to representatives of the above organizations.

The provider must provide immediate access to the provider's premises and records for purposes of reviewing, examining, and securing custody of records, documents, electronic data, equipment, or other requested items, as determined necessary by the requestor to perform statutory functions.

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

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

1.2.4 Release of Confidential Information

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

Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. The client's signature is not required on the claim form for payment of a claim, but HHSC recommends the provider obtain written authorization from the client before releasing confidential medical information. A release may be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information that is printed on the back of the form. The client's authorization for release of such information is not required when the release is requested by and made to DADS, HHSC, DSHS, TMHP, DFPS, DARS, HHSC OIG, the Texas Attorney General's Medicaid Fraud Control Unit or Antitrust and Civil Fraud Division, or HHS.

1.2.5 Compliance with Federal Legislation

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

- Title VI of the *Civil Rights Act of 1964* (Public Law 88-352), Section 504 of the *Rehabilitation Act of 1973* (Public Law 93-112), *The Americans with Disabilities Act of 1990* (Public Law 101-336), Title 40, Chapter 73, of the TAC, all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. The laws provide in part that no persons in the United States shall, on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service, or other benefits provided by federal and/or state funding, or otherwise be subjected to any discrimination.
- *Health and Safety Code 85.113* as described in "Model Workplace Guidelines for Businesses, State Agencies, and State Contractors" on page I-1 (relating to workplace and confidentiality guidelines on AIDS and HIV).

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

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

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

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1.2.6 Utilization Control — General Provisions

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

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

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

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

1.2.7 Provider Certification/Assignment

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

- Services were personally rendered by the *billing provider* or under the personal supervision of the billing provider if appropriate or under the substitute physician arrangement.
- The information on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the client's diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and Texas Health Steps [THSteps]).
- Medical records document all services billed.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.
- The provider will not bill the Medicaid program for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Medicaid clients.
- Services were provided without regard to race, color, sex, national origin, age, or handicap.
- The provider of medical care and services files a claim with the Medicaid program agreeing to accept the Medicaid reimbursement as payment in full for those services covered under the Medicaid program. The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is paid on allowed services or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. However, the client may be billed for noncovered services for which Medicaid does not make any payment. Before providing services, providers should *always* inform clients of their

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liability for services not covered by the Medicaid program, including use of the Client Acknowledgment Statement.

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

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

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

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

1.2.7.1 Delegation of Signature Authority

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

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

1.2.8 Billing Clients

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

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

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

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

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

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

Refer to: "Outpatient" on page 25-15 for more information about spell of illness.

"Medically Needy Program" on page 4-10.

"Private Pay Agreement" on page B-71.

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1.2.8.1 Client Acknowledgment Statement

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

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

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

- Any service that is not a benefit of the Texas Medicaid Program (for example, personal care items).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for THSteps-eligible clients younger than age 21 years.
- The reduction in payment that is because of the medically needy spend down (effective September 1, 2003, the Medically Needy Program [MNP] is limited to children younger than 19 years of age and pregnant women). The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Medicaid client.
- The client is accepted as a private pay patient pending Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the client becomes eligible, the provider *must* refund any money paid by the client and file Medicaid claims for all services rendered.

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

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

1.2.9 General Medical Record Documentation Requirements

The *Administrative Simplification Act* of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) *Current Procedural Terminology* (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

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

Important: *HHSC ultimately is responsible for Medicaid utilization review activities.*

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

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

1.2.10 Stale-Date Check Process

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

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

1.2.11 Informing Pregnant Clients About CHIP Benefits

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

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

To qualify for CHIP, a child must be:

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

CHIP benefits include:

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

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

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1.3 Medicare/Medicaid Waste, Abuse, and Fraud Policy

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

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

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

Providers may also refer cases of waste, abuse, and fraud to the OIG for civil damages and penalties (previously referred to as civil monetary penalties), authorized by state statute. Providers (individual or corporate) may be assessed in the amount that was paid, plus interest, plus up to double the amount paid, plus an amount not less than $5,000.00 or more than $15,000.00 for each violation that results in injury to an elderly or disabled person or a person younger than 18 years of age or not more than $10,000.00 for each violation that does not result in injury to a person as described above. The assessment for each violation means for each line item and/or occurrence identified on a claim, cost report, or other document resulting in or supporting fraudulent or abusive billing. Additional civil damages and penalties may be assessed under the Federal Civil Monetary Penalties Law contained in the *Social Security Act* for submitting fraudulent or abusive billings. A provider with assessed civil damages and penalties may be excluded or barred from participating in Medicare, Medicaid, or both.

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

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

Important: *A provider who delegates signature authority for claims preparation to an office staff member or to a billing service is responsible for the accuracy of all information on a claim submitted for payment. This, however, does not absolve these other individuals for their participation in any documents provided to the state or designee with false, inaccurate, or misleading information; or pertinent omissions.*

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

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

1) Claims and Billing.
    a) submitting or causing to be submitted a false statement or misrepresentation, or omitting pertinent facts when claiming payment under Medicaid or other HHS program or when supplying information used to determine the

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right to payment under Medicaid or other HHS program;

b) submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;

c) submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;

d) submitting or causing to be submitted under Title XVIII (Medicare) or a state health care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or the private pay patients unless otherwise authorized by law;

e) submitting or causing to be submitted claims with a pattern of inappropriate coding or billing that results in excessive costs to the Medicaid or other HHS program;

f) billing or causing claims to be filed for services or merchandise that were not provided to the recipient;

g) submitting or causing to be submitted a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;

h) submitting or causing to be submitted to the Medicaid or other HHS program a cost report containing costs not associated with the Medicaid or other HHS program or not permitted by Medicaid or other HHS program policies;

i) presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;

j) billing or causing claims to be submitted to the Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from the Texas Medicaid, other HHS program, or Medicare or has been excluded from and not reinstated within the Texas Medicaid, other HHS program, or Medicare;

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

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

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

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

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

2) Records and Documentation.

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

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

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

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

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

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

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

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

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

3) Program-Related Convictions.

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

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

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

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

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

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

4) Provider Eligibility.

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

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

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

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

e) loss or forfeiture of corporate charter.

5) Program Compliance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6) Delivery of Health Care Services.

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

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

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

7) Improper Collection and Misuse of Funds.

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

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

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

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

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

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

8) Licensure Actions

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

b) having its license to provide health care revoked, suspended, or probated by any state licensing or certification authority, or losing a license or certification, because of action based on assessment of the person’s professional competence, professional performance, or financial integrity, non-compliance with Health and Safety Code, statutes governing occupations, or surren-

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dering a license or certification while a formal disciplinary proceeding is pending before licensing or certification authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity.

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

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

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

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

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

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

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

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

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

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

10) Cost Report Violations.

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

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

   c) including unallowable cost items on a cost report;

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

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

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

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

11) Kickbacks and Referrals.

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

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

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prohibitions on referrals established within those rules.

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

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

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

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

1.3.1 Suspected Cases of Provider Waste, Abuse, and Fraud

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

1.3.2 Employee Education on False Claims Recovery

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

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

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

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

1.4 Medicaid Program Limitations and Exclusions

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

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

- Autopsies
- Biofeedback therapy
- Bladder stimulators (Pacemaker)
- Breast implants
- Cardiac rehabilitation programs
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Chemonucleolysis intervertebral disc
- Custodial care
- Dentures or endosteal implants for adults
- Dermabrasion
- Direct graduate medical education for teaching hospitals
- DME such as wheelchairs, crutches, and walkers, except when these items are prior authorized as a home health benefit
- DME (except THSteps-CCP and home health
- Dressings/supplies billed in physician's office
- Ergonovine provocation test

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- Excise tax
- Fabric wrapping of abdominal aneurysms
- Fetal fibronectin
- Gastric stapling/bypass
- Hair analysis
- Heart–lung monitoring during surgery
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunizations or vaccines unless they are otherwise covered by the Texas Medicaid Program. (These limitations do not apply to services provided through the THSteps Program)
- Immunotherapy for malignant diseases
- Inborn errors of metabolism
- Infertility
- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for the mentally retarded
- Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client's condition
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
- Intragastric balloon for obesity
- Intravenous embolization–cerebral, maxillary, and renal
- Joint sclerotherapy
- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- More than $200,000 per client per benefit year (November 1 through October 31) for any medical and remedial care services provided to a hospital inpatient by the hospital. If the $200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to clients eligible for the THSteps-Comprehensive Care Program (THSteps-CCP)
- More than 30 days of inpatient hospital stay per spell of illness–each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital

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

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

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- Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services.

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

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

Refer to: "Organ/Tissue Transplants" on page 36-235.

"Genetic Services" on page 22-1.

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

"Elective Sterilization Services" on page 36-68 for sterilization requirements.

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

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

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Section

2

Texas Medicaid Reimbursement

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2.1 Reimbursement

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

2.1.1 Electronic Funds Transfer

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

2.1.1.1 Using EFT

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

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720–0765

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

2.1.1.2 Advantages of EFT

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

2.1.1.3 Enrollment Procedures

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

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

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

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

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

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

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

2.2 Reimbursement Methodology

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

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

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2.2.1 Fee Schedules

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

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

- *Ambulatory Surgical Center (ASC)*. The Medicaid rates for ASCs are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8121. The current ASC/hospital-based ASC (HASC) fee schedule is available on the TMHP website. There is also an insert to the fee schedule available on the TMHP website. (See also Section 9 of this manual.)
- *Birthing Center*. The Medicaid rates for birthing centers are calculated in accordance with 1 TAC §355.8181 and are listed in Section 10 of this manual.
- *Blind Children's Vocational Discovery and Development Program (BCVDDP)*. The Medicaid rate for this service is calculated in accordance with 1 TAC §355.8381 and is listed in Section 11 of this manual.
- *Case Management for Children and Pregnant Women (CPW)*. The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401 and are listed in Section 12 of this manual.
- *Case Management for Early Childhood Intervention (ECI)*. The Medicaid rate for this service is calculated in accordance with 1 TAC §§355.8421 and 355.8423 and is listed in Section 13 of this manual.
- *Certified Nurse-Midwife (CNM)*. The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161. The current CNM fee schedule is available on the TMHP website. (See also Section 14 of this manual.)
- *Certified Registered Nurse Anesthetist (CRNA)*. According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service. The current CRNA fee schedule is available on the TMHP website. (See also Section 15 of this manual.)
- *Certified Respiratory Care Practitioner (CRCP).* The Medicaid rate for CRCP is calculated in accordance with 1 TAC §355.8087 and is $66.68 per daily visit for 1-99503. (See also Section 16 of this manual.)
- *Chemical Dependency Treatment Facility (CDTF)*. The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241 and are listed in Section 17 of this manual.
- *Chiropractic Services*. The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8081 and 1 TAC §355.8085 and are listed in Section 18 of this manual.
- *Dental*. The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8085. The procedure codes covered for dentists and the applicable rates are listed in Section 19 of this manual.
- *Durable Medical Equipment (DME)*. The current DME fee schedule is available on the TMHP website at www.tmhp.com. A provider reimbursed according to the fee schedule is reimbursed the lower of the provider's billed charges or the published Medicaid fee. TMHP manually prices DME and expendable supplies other than nutritional products that have no established fee, based on the manufacturer's suggested retail price (MSRP) less 18 percent, with documentation of the MSRP submitted by the provider. If there is no MSRP available, reimbursement is at an established percentage of the provider's invoice cost. Nutritional products that require manual pricing are priced at 89.5 percent of the average wholesale price (AWP). Home Health Agencies (HHAs) are reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8021 (b)-(c). Texas Health Steps (THSteps) is reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8441 (4)-(5).
- *Family Planning Services*. The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8584 and are listed in Section 20 of this manual.
- *Genetic Services*. The procedure codes and Medicaid rates for genetic services are listed in Section 22 of this manual. TMHP manually prices genetic laboratory services that have no established fee.
- *Hearing Aid and Audiometric Evaluations*. Newborn hearing screenings are provided at the birthing facility before hospital discharge and, as such, are reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services. (See also Section 23 of this manual.)
- *Texas Medicaid (Title XIX) Home Health Services*. The reimbursement methodology for professional services delivered by home health agencies (HHAs) are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).
- *Independent Laboratory*. The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the *Deficit Reduction Act of 1984* (DEFRA). By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/THSteps medical and newborn screening

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laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on actual costs in accordance with 1 TAC §355.8610. (See also Sections 26 and 43 of this manual.)

- *Indian Health Services*. The reimbursement methodology for outpatient services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620. The procedure code for reimbursing these services is T1015, and the current encounter rate is $223.
- *In-Home Total Parenteral Hyperalimentation Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087. The procedure codes reimbursable to these providers are listed in Section 26 of this manual and are reimbursed as a package of services or a global fee of $145 per day, with an annual maximum of $53,000.
- *Licensed Marriage and Family Therapist (LMFT)*. According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. (See also Section 29 of this manual.)
- *Licensed Clinical Social Worker (LCSW)*. According to 1 TAC §355.8091, the Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. (See also Section 28 of this manual.)
- *Licensed Professional Counselors (LPCs)*. According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085. (See also Section 30 of this manual.)
- *Maternity Service Clinic (MSC)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8201. The procedure codes reimbursable to these providers are listed in Section 31 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Mental Health (MH) Mental Retardation (MR)*. The Medicaid rates for MH case management are calculated in accordance with 1 TAC §355.743 and those for mental retardation (MR) service coordination are calculated in accordance with 1 TAC §355.746. The Medicaid rates for MH rehabilitative services are calculated in accordance with 1 TAC §355.781. The procedure codes covered by these services are listed in Section 32 of this manual.
- *Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs).* According to Title 1 TAC §355.8281, the Medicaid rate for NPs and CNSs, is 92 percent of the rate paid to a physician (Doctor of Medicine [MD] or Doctor of Osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current fee schedule for NP and CNS is available on the TMHP website. (See also Section 34 of this manual.)
- *Physical Therapists/Independent Practitioners*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The procedure codes reimbursable to these providers are listed in Section 35 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Physician*. The Medicaid rates for physicians and certain other practitioners are calculated in accordance with 1 TAC §355.8085. The current fee schedule is available on the TMHP website. See Section 2.2.1.1, "Physician Services in Outpatient Hospital Setting" on page 2-5. (See also Section 36 of this manual.)
- *Physician Assistant (PA)*. According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current fee schedule for PAs is available on the TMHP website. (See also Section 34 of this manual.)
- *Psychologist*. The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085. The procedure codes reimbursable to psychologists are listed in Section 38 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Radiological and Physiological Laboratory and Portable X-Ray Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The procedure codes reimbursable to these providers are listed in Section 39 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *Renal Dialysis Facility*. The Medicaid rates for these providers are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS). The procedure codes reimbursable to these providers are listed in Section 40 of this manual, and the Medicaid rates are listed in the current fee schedule, which is available on the TMHP website.
- *School Health and Related Services (SHARS)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8301. The procedure codes reimbursable to these providers and the applicable rates are listed in Section 42 of this manual.
- *Texas Health Steps (THSteps)*. THSteps reimburses by provider type in accordance with 1 TAC §355.8441. Approved providers enrolled in the Texas Medicaid Program are reimbursed for THSteps services in the same manner as they are reimbursed for other Medicaid services. Some of the procedure codes reimbursable under THSteps are listed in Section 43 of this manual. THSteps-Comprehensive Care Program (CCP) reimburses for DME and expendable supplies in accordance with 1 TAC §355.8441(4)-(5).

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- *Tuberculosis (TB) Clinics*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8341. Procedure codes and applicable rates for these providers are listed in Section 44 of this manual.
- *Vision Care (Optometrists, Opticians)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085. The current fee schedule for optometrists is available on the TMHP website. (See also Section 45 of this manual.)

Call the TMHP Contact Center at 1-800-925-9126 to request one of the referenced fee schedules.

2.2.1.1 Physician Services in Outpatient Hospital Setting

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

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

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

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

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

2.2.1.2 Drugs/Biologicals

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

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

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

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

Payments for drugs/biologicals are excluded from the 2.5 percent Medicaid payment reduction.

Prescriptions are covered under the Texas Medicaid Vendor Drug Program (VDP). The reimbursement methodology for pharmacy services is located at

1 TAC §§355.8541-355.8551. Effective October 13, 2003, the dispensing fee was reduced by 2.5 percent (1 TAC §355.8551).

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2.2.2 Reasonable Cost/Interim Rates

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

2.2.3 Hospitals

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

2.2.4 Provider-Specific Visit Rates

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

2.2.5 Reasonable Charge Payment Methodology

Ambulance services are reimbursed according to a reasonable charge payment methodology in accordance with 1 TAC §355.8600. (See also Section 8 of this manual.)

2.2.6 Manual Pricing

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

2.3 Professional Providers and Outpatient Facilities Reimbursement Reduction

As per Article II of House Bill 1 and Section 2.03 of House Bill 2292, 78th Texas Legislature, Regular Session 2003, Medicaid payments for professional and outpatient services were reduced by 2.5 percent during the claims process.

These payment reductions apply to Medicaid fee-for-service, Medicaid Primary Care Case Management (PCCM), Medicaid Managed Care, Family Planning, and the Children with Special Health Care Needs (CSHCN) Services Programs, with the exceptions noted below. The following services are excluded from the 2.5 percent Medicaid payment reduction:

- Services provided by FQHCs and RHCs
- Services provided by public providers that certify the state portion of their payments
- Family Planning (Title X) services
- Targeted Case Management for ECI services
- DME and expendable supplies, including nutritional products
- Children's hospitals
- CSHCN outpatient and inpatient claims
- CSHCN hemophilia claims, drug co-payments, and transportation of remains
- Drugs/biologicals and supplies for physician/practitioner services
- Medicare crossover claims
- Indian Health Services

Providers should continue to bill their usual and customary charges and not make changes to their billed charges based on any Medicaid payment reduction. For those providers whose usual and customary charges exceed Medicaid fees but use Medicaid fees as their billed charges in order to lessen their accounting adjustments, the billed charges should not change because the Medicaid fees have not changed.

Payments for Medicaid and Medicaid Managed Care inpatient claims are not reduced during the claims payment process, rather the actual calculations of the standard dollar amount (SDA) and TEFRA cost reimbursement for inpatient hospitals are reduced. A notification letter was mailed later to each hospital stating its SDA amount, effective for services delivered on or after September 1, 2004.

Payments to pharmacies for prescriptions are not reduced during the claims process, rather the actual amount of the estimated dispensing expense and inventory management factor were reduced.

2.4 Additional Payments to High-Volume Providers

Primary care providers include the following medical professionals:

- Medical doctors
- Doctors of osteopathy

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- Independently practicing advanced practice nurses (APNs) defined as family/general practice, internal medicine, obstetrics/gynecology, pediatrics, certified registered nurse midwives, and family and pediatric APNs

Note: *PAs are not eligible for high-volume provider status for dates of service prior to July 1, 2006, because PAs were not eligible to enroll as Medicaid providers during the qualification period, which was State Fiscal Year 2004. However, PAs will be eligible for high-volume provider status for any future qualification period that includes dates of service on or after July 1, 2006.*

To receive high-volume add-on payments, high-volume primary care providers are those providers who were paid a minimum of 3,600 Medicaid units of service for the qualification period. High-volume primary care providers get a 1.9 percent add-on payment for all Medicaid services performed.

High-volume specialty care providers are medical professionals enrolled with a provider specialty from the following list:

- Allergy
- Anesthesiology
- Cardiovascular disease
- CRNA
- Dermatology
- Ear, nose and throat
- Gastroenterology
- General surgery
- Geriatrics
- Hand surgery
- Nephrology
- Neurosurgery
- Nuclear medicine
- Ophthalmology
- Orthopedic surgery
- Pathology
- Physical medicine and rehabilitation
- Plastic surgery
- Proctology
- Psychiatry
- Pulmonary disease
- Radiology
- Thoracic surgery
- Urology

To receive high-volume add-on payments, high-volume specialists are those specialty care providers who provided units of service in the top 50 percent of total services paid within the specialty during the qualification period. High-volume specialists get a 6.1 percent add-on payment for all Medicaid services performed.

To receive high-volume dentist payments, high-volume dentists are those dental providers who were paid a minimum of 3,600 units of service during the qualification period. High-volume dental providers get a 3.7 percent add-on payment for all Medicaid services performed.

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

Medicaid payments for services provided by physicians, dentists, and other professionals and outpatient services provided in hospitals and ASCs/HASCs are reduced by 2.5 percent at the end of the claims payment process. Therefore, any applicable high-volume add-on payments are first added to the payment amount before being reduced by 2.5 percent.

2.5 Medicaid Service Provided Outside Texas

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

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

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

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

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

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

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

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

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

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

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

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

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

Refer to: "Procedure Codes Requiring Prior Authorization" on page 36-343.

2.6 Medicare Crossover Reimbursement

2.6.1 Part A

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

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

2.6.2 Part B

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

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

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

2.7 Federal Financial Participation (FFP) Rate

The FFP rate for providers who receive the federal matching share portion of Medicaid reimbursement or the enhanced federal matching share portion of Medicaid reimbursement for services provided to Children's Health Insurance Program (CHIP) clients are effective for dates of service on or after October 1, 2006, at an FFP rate of 60.78 percent and an enhanced FFP rate of 72.55 percent The FFP is subject to change on October 1 of each year or as otherwise directed by CMS.

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Section

3

TMHP Electronic Data Interchange (EDI)

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3.1 Paper Or Electronic Submissions

Providers may submit claims and other requests using paper forms or faster electronic methods. HHSC and TMHP encourage providers to submit claims and other requests electronically. Providers can participate in the most efficient and effective method of submitting requests to TMHP by submitting through the TMHP Electronic Data Interchange (EDI) claims processing system. TMHP uses the Health Insurance Portability and Accountability Act (HIPAA) compliant ANSI ASC X12 4010A file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security. Providers can access TMHP's electronic services through www.tmhp.com, TDHconnect, vendor software, and billing agents.

3.1.1 Advantages of Electronic Services

- *It's fast.* No more waiting by the mailbox or phone inquiries; know what's happening to claims in less than 24 hours and get paid for approved claims within a week. TDHconnect users can submit individual requests interactively and receive a response immediately.
- *It's free.* All electronic services offered by TMHP are free, as well as the TDHconnect software and it's technical support, upgrades, and training. TDHconnect users can access our website directly, without having to pay for an internet connection.
- *It's easy.* TMHP offers free workshops for TDHconnect, Medicaid billing, and many other topics, as well as a large library of reference materials and manuals on www.tmhp.com.
- *It's safe.* TMHP EDI services use VPN and SSL connections, just like the United States government, banks, and other financial institutions, for maximum security.
- *It's accurate.* TDHconnect and many other software programs have features that let providers know when they've made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what's wrong, so the claim can be corrected and resubmitted right away.
- *It's there when it's needed.* Electronic services are available day and night; from home, the office, or anywhere in the world.
- *It makes record keeping and research easy.* Not only can software be used to send and receive claims, it can retrieve your Remittance and Status (R&S) report electronically, perform claim status inquiries, and archive claims. TDHconnect can generate and print reports on everything it sends, receives, and archives.

3.1.2 Electronic Services Available

- Eligibility Verification
- Claims Submission
- Claim Status Inquiry (CSI)
- Electronic Remittance & Status (ER&S)
- Appeals

3.2 TMHP Website

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

- Information and registration for upcoming provider education/training sessions
- Publications such as bulletins, banner messages, and provider manuals
- A Headline News section with announcements of program changes and other important information
- TDHconnect 3.0 updates (service packs) and workbooks

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

- Medicaid enrollment information
- CSI
- Eligibility verification
- R&S report download option
- CMS-1500 professional claims submission

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

Claim submission on the TMHP website is available for select claim types. Please refer to www.tmhp.com for further details and instructions on how to submit claims on the website.

3.3 Electronic Billing

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

3.3.1 Software

Providers that intend to use TMHP's electronic services will need software to create, submit, and retrieve data files. Providers can use TDHconnect (TMHP's free software) or software from any vendor listed on the EDI Submitter List at www.tmhp.com/EDI. Providers who plan to use software other than TDHconnect to submit EDI transactions to TMHP should contact the software vendor for details.

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3.3.1.1 TDHconnect

TDHconnect is the free Windows-based claims submission software provided by TMHP. Technical support, upgrades, and training for TDHconnect are also available free from TMHP. TDHconnect has a wide variety of features, some of which are not available in most vendor software. Providers can use the software to submit claims, eligibility requests, claim status inquiries, adjustments, appeals, and retrieve ER&S reports. The program includes a reference database of current billing codes, procedure codes, Explanation Of Benefit (EOB) codes, and much more. Providers can even use TDHconnect to interactively submit individual claims that are processed in seconds. To order TDHconnect or to learn more about the program, visit www.tmhp.com, call the EDI Help Desk at 1-888-863-3638, or use the "TDHconnect Order Form" on page B-105. Before attempting to install TDHconnect, verify that the computer on which it will be installed meets the minimum software and hardware requirements listed on the order form. TDHconnect 3.0 is not supported on non-Windows® operating systems or on systems that do not meet the minimum system requirements. Microsoft® and Windows® are either registered trademarks or trademarks of Microsoft® Corporation in the United States and/or other countries.

Important: *A basic knowledge of Windows® operating systems is required to use TDHconnect 3.0. TDHconnect 3.0 (with the latest service pack) works with a standard telephone line and existing internet connections. Providers in rotary dial areas cannot use the direct dial features of TDHconnect 3.0 but may use an existing internet connection.*

3.3.1.2 Vendor Software

Providers may also use vendor software to access TMHP's electronic services. There are hundreds of vendors with a wide assortment of services that have been approved to submit electronic files to TMHP. A complete list of vendors who have completed the testing process and been certified by TMHP can be found on the EDI Submitter List at www.tmhp.com/edi. 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 it will meet their needs, and that it has completed testing with TMHP.

3.3.2 Billing Agents

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

3.4 Setting up Access

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

Providers who use TDHconnect may use the Quick Start Guide that accompanies the software or contact the EDI Help Desk at 1-888-863-3638. After TDHconnect is installed, providers can access the help manual built into TDHconnect by clicking on the **Help** button and selecting **Contents and Index**.

Providers who use TDHconnect or vendor software must also request a submitter ID. A submitter ID is necessary for all of TMHP's electronic services. It serves as an electronic mailbox for the provider and TMHP to exchange data files. Providers must call the EDI Help Desk at 1-888-863-3638 to order a submitter ID. Providers who use a billing agent do not need a submitter ID.

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

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

3.5 Training

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

3.6 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 TMHP are received and accepted. Additionally, providers must also track claims transmissions against claims payments to detect and correct all claim errors. For further information about provider responsibility and electronic transmissions, refer to "Provider Responsibilities" on page 1-4. If an electronic file transmission record is missing, providers can request a copy of the transmission report(s) by contacting the TMHP EDI Help Desk at 1-888-863-3638 and requesting

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

3.7 Vendor Implementation

TMHP requires all software vendors and billing agents to complete EDI testing before access to the production server is allowed. An EDIFECS account will be created for the vendor to begin testing EDI formats once they have enrolled for testing. Upon successful completion of EDIFECS testing and the submission of a Trading Partner Agreement, vendors must then complete end-to-end testing on the TMHP test server. Vendors and billing agents must be partnered with at least one Texas provider before a test submitter ID can be issued. Once end-to-end testing has been completed, the vendor or billing agent will be added to the EDI Submitter List. Providers and billing agents may then order production submitter IDs for use with the vendor's software. Companion guides and vendor specifications are available at www.tmhp.com/EDI. Vendors who 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 and use the *TMHP Support* link.

3.7.1 Supported File Types

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

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

3.8 Forms

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

- “Texas Medicaid & Healthcare Partnership Electronic Remittance and Status (ER&S) Agreement (2 Pages)” on page B-100
- “TDHconnect Order Form” on page B-105
- “Claim Status Inquiry (CSI) Authorization Form” on page B-15

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

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Section

4

Client Eligibility

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4.1 General Medicaid Eligibility

Providers are responsible for requesting and verifying current Medicaid eligibility information about the client by asking the client to produce the Medicaid Identification form issued for the month that services are being rendered. Clients should share eligibility information with providers. If clients have lost their identification or forgotten to bring it to appointments, providers may verify their eligibility through the Automated Inquiry System (AIS), TMHP Electronic Data Interchange (EDI) Gateway, or by accessing the TMHP website and treat the clients the same as though they had presented a Medicaid Identification (Form H3087) or Medicaid Verification Letter (H1027A-C).

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

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

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

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

Retroactive Eligibility

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

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

If a person is not eligible for medical services under the Texas Medicaid Program on the date of service, reimbursement for all care and services provided must be resolved between the provider and the client receiving the services. Providers are not required to accept Medicaid for services provided during the retroactive eligibility period and may continue to bill the client for those services. If providers accept Medicaid assignment for the services and want to submit a claim for Medicaid-covered services for clients who receive retroactive eligibility, providers must refund payments received from the client before billing Medicaid for the services. Also, if it is the provider's practice not to accept Medicaid for services during the retroactive eligibility period, the provider must use the policy consistently with all clients who request retroactive eligibility. Providers must inform the client about the policy before rendering services.

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

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

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

The provider should also check the date on the Form H3087 under Medicaid Date to see if the client has retroactive coverage for previous bills. Clients with retroactive coverage are only issued one Medicaid Identification showing the retroactive period. Texas Medicaid considers all services between the Medicaid Date and the Valid Through Date for reimbursement. Providers may contact AIS or the TMHP Contact Center, verify eligibility on

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www.tmhp.com, or transmit an electronic eligibility request to determine if the client has retroactive coverage for previous bills.

Refer to: “Medicaid Identification Form H3087” on page 4-18.

“Medicaid Managed Care” on page 7-4.

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

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

Medicaid Buy-In Program for Employed Individuals with Disabilities

The Medicaid Buy-In Program allows employed individuals with disabilities to receive Medicaid services by paying a monthly premium. Individuals with earnings of up to 250 percent of the federal poverty level are eligible to participate in the program. Applications for the program are accepted through HHSC’s regular Medicaid application process.

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

4.1.1 Eligibility Verification

To verify client Medicaid eligibility, use the following options:

- Verify the client’s Medicaid Identification using form H1027-A, H1027-B, H1027-C, H1027, or H3087.
- Verify electronically via TMHP EDI. Providers may inquire about a client’s eligibility by electronically submitting the following information for each client:
  - Medicaid or Children with Special Health Care Needs (CSHCN) identification number, *or*
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Narrow the search by entering the client’s county code or sex.
- Submit verifications in batches limited to 5,000 inquiries per transmission.
- Contact AIS at 1-800-925-9126, 1-512-335-5986, 1-512-335-6033, 1-512-335-6217, or 1-512-345-6476.
- Contact the TMHP Contact Center at 1-800-925-9126.
- Submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is *difficult* to verify. A charge of $15 per hour plus $0.20 per page payable to TMHP applies to this eligibility verification. The list includes names, gender, and dates of birth if the Social Security and Medicaid identification numbers are unavailable. TMHP can check the client’s eligibility manually, verify eligibility, and provide the Medicaid identification numbers. Mail the lists to the following address:

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

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

Refer to: “Monthly Client Panel Report” on page 7-27

4.2 Medicaid Identification, Verification

Providers are responsible for requesting and verifying current eligibility information from the client by asking the client to produce Medicaid Identification (Form H3087 or H1027) issued for the month that services are provided. Providers must accept either of these documents as valid proof of eligibility. Providers should retain a copy for their records to ensure the person is eligible for Medicaid when the services are provided. The provider should request additional identification when unsure the person presenting the form is the person identified on the form. The provider should check the Eligibility Date to see if the client has possible retroactive coverage for previous bills.

Important: *Providers must review limitations identified on the client’s Form H3087. Clients may be limited to one primary provider or pharmacy.*

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

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

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

Form H1027-A, B, or C (Medicaid Verification Letter) is acceptable as evidence of eligibility during the eligibility period of the letter unless the letter contains limitations that affect the eligibility for the intended service. Providers must accept either of these documents as valid proof of

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eligibility. If the client is not eligible for medical assistance or certain benefits, the client is treated as a private-pay patient.

Refer to: DSHS's website, www.dshs.state.tx.us/famplan, for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding.

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

If the client is reported as eligible and no other limitations of eligibility affect the intended service, proceed with the service. Eligibility during a previous month does not guarantee eligibility for the current month. Forms H1027A, H1027B, H1027C, H3087, and the PCCM Monthly Panel Report are the *only* documents that are honored as verification of Medicaid eligibility. Check the third party resource (TPR) column on the Form H3087 to determine if the client has other health insurance.

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

- Reminders of medical and dental checkups appear under the client's name during the month the client is eligible for routine checkups.
- All Medicaid clients who are younger than 21 years of age and eligible for THSteps are eligible to receive medically necessary dental services.

Providers should update the appropriate columns of the Medicaid Identification to indicate services received by the client. Providers put a slash (/) with an initial and date in the column to indicate the service was provided.

Refer to: "Third Party Resources" on page 4-13 for more information and "Medicaid Identification Form H3087" on page 4-18. The right side of Form H3087 consists of information about limited services provided to clients. A check mark on the line to the right of the client's name indicates eligibility for a particular service.

4.3 Restricted Medicaid Coverage

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

4.3.1 Emergency Only

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

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

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

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

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

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

4.3.2 Client Limited Program

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

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

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

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

4.3.2.1 Limited Medicaid Identification

Clients with limited status receive a Form H3087 with the printed word "LIMITED." A *limited client is* defined as "a client who is limited to a designated primary care provider and/or primary care pharmacy." The designated provider names are printed on the form under the word "LIMITED." The limited Medicaid Identification identifies a client who has overutilized the services. Only one client is identified

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on a LIMITED Form H3087. For questions about pharmacy services for clients limited to a primary care pharmacy, contact the Limited Program Hotline at 1-800-436-6184, option 4.

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

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

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

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

4.3.2.2 Exceptions to Limited Status

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

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

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

For referrals or questions, contact:

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

4.3.2.3 Selection of Designated Provider, Pharmacy

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

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

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

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

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

4.3.2.4 Duration of Limited Status

The Limited Program duration of limited status is the following:

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

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

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

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

4.3.2.5 Referral to Other Providers

Traditional Medicaid clients in limited status may be referred by their designated provider to other providers. For the referral or second provider to be paid, the nine-character provider identifier of the referring designated provider must be in Block 17 or 17a of the CMS-1500 claim form. Claims submitted electronically (see “TMHP Electronic Claims Submission” on page 5-10) must have the six-digit Medicare core number of the referring designated provider in the Referring Provider Field. Consult with your vendor for the location of this field in your electronic claims format.

4.3.2.6 Emergency Care

If an emergency medical condition occurs, the limited restriction does not apply. The term *emergency medical condition is defined* as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in any of the following conditions:

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

Important: *A provider who sends in an appeal because a claim was denied with 00066 must include the performing provider identifier, not just a name or group provider identifier. Appeals without a performing provider identifier are denied. The license number of the designated provider must be entered in Block 83 on the HCFA-1450 (UB-92) or in the appropriate electronic field for nonemergency inpatient and outpatient claims to be considered for reimbursement.*

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

4.3.2.7 Hospital Services

An inpatient hospital claim for a limited traditional Medicaid client is considered for reimbursement if the client meets Medicaid eligibility and admission criteria. Hospital admitting personnel are asked to check the name of the designated provider printed under the word “LIMITED” on the client's LIMITED Medicaid Identification and inform the admitting physician of the designated provider's name if the two are different.

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

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

4.3.3 QMB, MQMB

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

- Client is enrolled in Medicare Part A.
- Income does not exceed 100 percent of the federal poverty level (consistent with federal law).

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- Resources do not exceed twice the resource limit of Supplemental Security Income (SSI) Program.

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

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

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

4.3.4 Hospice Program

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

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

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

Direct policy questions about the hospice program to DADS at 1-512-438-3169.

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

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

When the services are unrelated to the terminal illness, Medicaid (TMHP) pays its providers directly. For questions about hospice billing, call TMHP at 1-800-626-4117.

Providers are required to follow Medicaid guidelines for prior authorization when filing claims to TMHP for hospice clients. Fax authorization requests to 1-512-514-4209.

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

Mail paper claims to the following address:

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

Appeal claims by writing to the following address:

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

4.3.4.1 Medical Services Not Related to the Terminal Illness

Submit a claim for Medicaid services to TMHP with a statement and documentation from the hospice that the services billed are not related to the client's terminal illness. If TMHP denies the claim, send an appeal with the following information:

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

4.3.4.2 Medical Services when Client is Discharged from Hospice

Submit claims to TMHP for Medicaid services with a statement that the services billed were provided after the client was discharged from the hospice program. The nonhospice provider must obtain from the hospice a copy of Form 3071, Medicaid Hospice Cancellation, to support the discharge. If TMHP denies the claim, the nonhospice provider may appeal the decision with the following information:

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

4.3.4.3 Lab and X-Ray

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

4.3.4.4 Physician Claims

Hospice pays physician claims regardless of hospice status.

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4.3.4.5 Physician Oversight Services

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

4.3.5 Presumptive Eligibility

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

4.3.5.1 Services

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

4.3.5.2 Qualified Provider Enrollment

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

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

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

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

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

4.3.5.3 Process

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

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

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

4.3.5.4 Medicaid Identification (Form H3087)

A Form H3087 with PE printed on top is issued for presumptive eligibility coverage. Medicaid coverage for PE continues through the last day of the month indicated on the form. Form H3087 with PE indicates that Medicaid-covered services during the presumptive eligibility period

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do not include labor, delivery, inpatient services, and THSteps medical and dental services. The PE ID indicates eligibility for limited Medicaid services during the presumptive eligibility period (e.g., eye exams, eyeglasses, hearing aids, and family planning services). If the woman is certified for regular Medicaid, she receives the regular Form H3087.

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

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

4.4 Medically Needy Program

Important: *The Medically Needy Program (MNP) with spend down is limited to children younger than age 19 years and pregnant women.*

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

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

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

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

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

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

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

If spend down is applicable, the HHSC caseworker issues a Medical Bills Transmittal (Form 1120) to the MNP applicant that indicates the spend down amount, months of potential coverage (limited to the month of application and any of the three months before the application month that the applicant has unpaid medical bills), and the caseworker name and telephone number.

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

Newborns of mothers who must meet a spend down before becoming eligible for Medicaid are *not* automatically eligible for the full year of newborn coverage because the child's mother would not be continuously eligible for Medicaid. If the mother meets spend down in the month pregnancy terminates and the Medicaid effective date is before or on the day pregnancy terminates, then the newborn and mother are eligible for the birth month and the two following months. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in "Eligibility Process" on page 25-8 of this manual for these newborns.

4.4.1 Spend Down Processing

Applicants are instructed to submit all their medical bills or completed Centers for Medicare & Medicaid Services (CMS) claim forms for application toward their spend down to TMHP MNC along with Form 1120. Charges from the bills or completed CMS claim forms are applied in date of service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.4.2 Closing a Medically Needy Program Case

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

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

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

4.4.3 Medically Needy Program for CSHCN Services Program Clients

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

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

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

Refer to: "Medically Needy Claims Filing" on page 5-81.

4.5 Medicare/Medicaid Clients

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

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

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

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

Refer to: "Reimbursement Methodology" on page 2-2 and "Claims Filing Instructions" on page 5-23.

4.5.1 QMB, MQMB Clients

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

These guidelines are for clients not living in a nursing facility who receive a vendor rate for client care through DADS.

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

4.5.2 Medicare Part B Crossovers

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

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

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

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

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

4.5.3 Clients Without QMB, MQMB Status

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

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

Refer to: "Medicare Crossover Reimbursement" on page 2-8.

4.6 Contract with Outside Parties

The *State Medicaid Manual* allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client (Section 2080.18). Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains respon-

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sible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

4.7 Third Party Resources

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

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

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

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

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

- Texas Rehabilitation Commission
- Department of Assistive and Rehabilitative Services (DARS), Blind Services
- Texas Kidney Health Care Program
- Crime Victims' Compensation Program
- Muscular Dystrophy Association
- CSHCN Services Program
- Texas Band of Kickapoo Equity Health Program
- Maternal and Child Health (Title V)
- State Legalization Impact Assistance Grant (SLIAG)
- Adoption Agencies
- Community-Based Alternatives (CBA)
- Community Living Assistance and Support Services (CLASS)

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

If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP using the filing deadlines identified under "Filing Deadlines" on page 5-78.

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

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

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

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

4.7.1 Workers' Compensation

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

4.7.2 Adoption Cases

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

Refer to: "Claims Filing Deadlines" on page 5-4.

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

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4.7.3 Medicaid Identification (Form H3087)

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

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

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

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

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

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

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

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

4.7.4 THSteps Requirements

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

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

Refer to: "Other Insurance" on page 42-11 for more information.

4.7.5 Other Insurance Reimbursement

To the extent allowed by federal law, a health care service provider must seek reimbursement from available third-party health coverage or insurance that the provider knows about or should know about before billing the Texas Medicaid Program. All claims for clients with other insurance coverage must reference the information (see "Other Insurance Claims Filing" on page 5-76), regardless of whether a copy of the EOB from the insurance company is submitted with the claim.

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

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

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

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

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

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

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

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

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

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

Include the following information with the TPR refund:

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

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

4.7.7 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 claim form, and Blocks 32ab to 35ab on the HCFA-1450 (UB-92) claim form.

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

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

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

4.7.8 Accident Resources, Refunds

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

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

The provider furnishes TMHP with the following information:

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

This information enables TMHP to pursue reimbursement from any settlement. Use the "Tort Response Form" on page B-114 to report accident information to TMHP. When the form is completed, remit it to the TMHP Third Party Resources Unit (the address and fax number are on the form).

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

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

4.7.8.1 Providers Filing Liens for Third Party Reimbursement

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

A provider may file a lien for the entire billed amount only after meeting the criteria in 1 TAC §354.2322, summarized below. Providers who identify a third party, within 12 months from the date of service, and wish to submit a bill or other written demand for payment or collection of debt to a third party after a claim for payment has been submitted and paid by Medicaid must refund any amounts paid before submitting a bill or other written demand for payment or collection of debt to the third party for

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payment, and they must comply with the provisions set forth in 1 TAC §354.2322, which states: Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

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

4.7.8.2 Submission of Informational Claims

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

An informational claim is a paper claim form UB-92 or CMS-1500 submitted to the HHSC/TPR address with an indication that the provider is seeking payment from a third party for a tort-related liability. Providers cannot submit informational claims electronically. *Do not send informational claims to TMHP.* When sending an informational claim, the provider must complete an Informational Inquiry Form. Only one Inquiry Form per client is required.

Refer to: "Informational Inquiry Form" on page B-53.

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

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

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

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

4.7.8.3 Informational Claim Conversion to Claim for Payment

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

- Continue to pursue a claim against the third party for payment and forego the right to submit a written request for the conversion of the informational claim for payment by Medicaid.
- Submit a letter on hospital letterhead by fax or mail requesting the conversion of the informational claim to a claim for payment by Medicaid. The letter must include the following information: client's name, Medicaid ID, Date of Service, and Total Billed amount as originally stated on the UB-92 or CMS-1500. HHSC does not accept or pay any claim for payment after 18 months from the date of service has elapsed, regardless of whether an informational claim has been timely filed. All other filing deadlines apply.

Mailing Address:
HHSC/OIG/TPR
INFOC
PO Box 85200
Austin, TX 78708-5200

Fax: 1-512-833-6043

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

4.7.9 Long Term Care Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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4.9 Medicaid Identification Form H3087

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

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

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	**GOOD THROUGH:** VÁLIDA HASTA:
07/24/2006	610098	40	30	02	123456789	AUGUST 31, 2006

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

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JOHN DOE	08-27-1997	M	07-09-2006			✔	✔	✔		✔	✔

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

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

Form H3087-G1/January 2006

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FOR THE CLIENT: About your Medicaid ID Form

This is your MEDICAID IDENTIFICATION form. When you get any health care services, you must have this form with you if you want Medicaid to pay for your serivces.

WHAT IF YOU GET A BILL? If you get a bill from a doctor, hospital, or other health care provider, ask the provider why they are billing you. If you still get a bill, call 1-800-335-8957 for help.

WHAT IF THE SERVICES REQUESTED FOR YOU ARE DENIED? You will receive a letter telling you the request was denied and that you have the right to ask for a fair hearing. You may ask for a hearing in writing or by calling. The address and telephone number will be listed on the letter that you get.

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

FOR QUESTIONS REGARDING MEDICAID ELIGIBILITY, ID FORMS, AND ADDRESS CHANGES: Please contact the Texas Health and Human Services Commission (HHSC) office in your area. The telephone numbers and addresses are listed in your local telephone book.

For Questions About Other Medicaid Programs, You May Call the Following Toll-Free Numbers:

1-800-252-8263	**BENEFITS/POLICY—To find out what Medicaid pays for, or to find a provider.**
1-800-335-8957	**MEDICAID BILLING PROBLEMS—Any medical bills you may receive.**
1-877-847-8377	**TEXAS HEALTH STEPS—Care for clients up to age 21 including medical and dental checkups.**
1-877-633-8747	**MEDICAL TRANSPORTATION—For help with rides when you have no other way to get to and from the doctor, dentist, or drug store at no cost to you.**
1-866-566-8989	**STARLINK—Problems with the Managed Care STAR Program.**
1-800-335-8957	**MEDICALLY NEEDY PROGRAM (MNP)—About your spend down case.**
1-800-458-9858	**LONG TERM CARE (LTC)—Nursing Home Care.**
1-877-511-8858	**THIRD PARTY RESOURCES (TPR)—If you have other insurance.**
1-800-436-6184	**FRAUD – Medicaid, Food Stamps, and TANF.**
1-800-440-0493	**HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPP)—For help with private health insurance premiums.**
1-800-772-1213	**SOCIAL SECURITY ADMINISTRATION (SSA)—To report an address change if you are an SSI client.**

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

Ésta es su forma de IDENTIFICACIÓN DE MEDICAID. Cuando obtenga cualquier servicio de atención médica, tiene que presentar esta forma si quiere Medicaid pague los servicios que reciba.

¿QUÉ PASA SI RECIBE UNA CUENTA? Si recibe una cuenta de un doctor, un hospital u otro proveedor de atención médica, pregúntele al proveedor por qué le está cobrando. Si de todos modos recibe una cuenta, llame al 1-800-335-8957 para pedir ayuda.

¿QUÉ PASA SI LOS SERVICIOS SOLICITADOS PARA USTED SE NIEGAN? Usted recibirá una carta en la que se le informa que la solicitud fue negada y que tiene el derecho de pedir una audiencia imparcial. Puede pedir una audiencia por escrito o por teléfono. La dirección y el número de teléfono aparecerán el la carta que reciba.

AVERTENCIA. Si usted acepta los beneficios (servicios o artículos), de Medicaid, el estado de Texas tiene el derecho de recibir el pago de esos servicios o artículos de parte de otras compañías de seguro y otras fuentes responsables, hasta la suma necesaria para cubrir la cantidad que gastó Medicaid.

SI TIENE PREGUNTAS SOBRE LA ELEGIBILDAD PARA MEDICAID, LA FORMA DE IDENTIFICACIÓN O CAMBIOS DE DIRECCIÓN: Por favor, comuníquese con la ofician de la Comisión de Salud y Servicios Humanos de Texas (HHSC) de su región. El número de teléfono y la dirección se encuentran en el directorio telefónico de su comunidad.

Si tiene preguntas sobre otros programas de Medicaid, puede llamar gratis a los siguientes números de teléfono:

1-800-252-8263	BENEFICIOS Y NORMAS: para saber qué paga Medicaid o para encontrar a un proveedor.
1-800-335-8957	PROBLEMAS DE CUENTAS DE MEDICAID: para tratar cualquier cuenta médica que reciba.
1-877-847-8377	PASOS SANOS DE TEXAS: para saber sobre los servicios para clientes menores de 21 años, incluso los chequeos médicos y dentales.
1-877-633-8747	PROGRAMA DE TRANSPORTACIÓN MÉDICA: para conseguir ayuda de transporte gratis cuando no tiene ninguna otra manera de ir y venir al doctor, dentista o farmacia.
1-866-566-8989	STARLINK: para tratar problemas relactionados con el Program STAR de atención médica administrada.
1-800-335-8957	PROGRAMA DE SERVICIOS POR NECESIDAD MÉDICA (MNP): para hablar de su caso de cuota prescrita.
1-800-458-9858	ATENCIÓN A LARGO PLAZO (LTC): para hablar de los servicios de una casa para convalecientes.
1-877-511-8858	RECURSOS DE UN TERCERO (TPR): si tiene otro seguro.
1-800-436-6184	FRAUDE: para tratar casos de Medicaid, estampillas para comida, y TANF.
1-800-440-0493	SISTEMA DEL PAGO DE LA PRIMA DEL SEGURO MÉDICO (HIPP): para conseguir ayuda con las primas del seguro médico comercial.
1-800-772-1213	ADMINISTRACIÓN DE SEGURO SOCIAL (SSA): para informar de un cambio de dirección si es cliente de SSI.

HHSC **Form 3087**, Page 2/11-2004

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

1 ATFF 01-00001

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/05/2006	610098		40	02	123456789	JULY 31, 2006

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

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	12-09-1997	F	06-01-2006			✔	✔	✔		✔	✔
THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS												

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

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

Form H3087-G2/January 2006

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

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

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		37	02	123456789	JULY 31, 2006

LIMITED

4

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

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1997	F	06-01-2006				✔	✔		✔	✔

LIMITED

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

TO PHARMACY:
HAPPY PHARMACY
11223 WEST 27th
AUSTIN TX 78759

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

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

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

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

Form H3087-GL/January 2006

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

198 ATFF 01-00198

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		01	02	123456789	JULY 31, 2006

Primary Care Case Management (PCCM)

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

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

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

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

READ BACK OF THIS FORM!

TODA PERSONA NOMBRADA A CONTINUACIÓN PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	02-04-1983	F	07-01-2005			✔	✔	✔		✔	✔
PCCM /1-800-123-4567 / Dr. Jeremy Irons												

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

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

Form H3087-S4/January 2006

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

15 ATFF 01-00015

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/24/2006	610098	13	13	04	123456789	JULY 31, 2006

4

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

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-14-1944	F	09-01-2006		123456789HIC	✔				✔	✔

NOTICE TO PROVIDER

This recipient is eligible for regular Medicaid benefits.

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

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

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

Form H3087-GM/January 2006

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4.9.1 Medicaid Eligibility Verification (Form H1027-A)

Texas Health and Human Services Commission/**Form H1027-A**/09-2005

Medicaid Eligibility Verification
Confirmación de elegibilidad para Medicaid

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

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

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

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

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

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

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

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

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

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

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

Office Address and Telephone No./Oficina y Teléfono

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

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

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Form H1027-A
Page 2/09-2005

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

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

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

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

Provider Information/Información para el proveedor

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

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

Key to terms that may appear on this form:

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

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

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

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

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

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

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

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

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Section

5

Claims Filing

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5.1 Claims Information

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

5.1.1 TMHP Processing Procedures

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

Medicaid claims are subject to the following procedures:

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

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

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

5.1.1.1 Fiscal Agent

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

Note: *The fiscal agent arrangement does not affect Long Term Care (LTC) and Family Planning (Titles V, X, XX) providers, since these providers are not reimbursed through the Compass21 (C21).*

Provider Designations

The fiscal agent arrangement requires that providers be designated as either public or nonpublic. By definition, public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations. In addition, any provider or agency that can do intergovernmental transfers to the state would be considered a public provider. This includes those agencies that can certify and provide state matching funds, (i.e., other state agencies). New providers enrolling after January 2004 self-designate (public or private) on the provider enrollment application. Providers who are already enrolled do not need to take any action regarding their designation at this time.

The fiscal agent:

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

5.1.2 Claims Filing Instructions

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

Providers can participate in the most efficient and effective method of submitting claims to TMHP by submitting claims through the TMHP Electronic Data Interchange (EDI) claims processing system. The proceeding claim filing instructions in this provider procedures manual apply to paper and electronic submitters. Although the examples of claims filing instructions refer to their inclusion on the paper claim form, claim data requirements apply to all claim submissions, regardless of the media.

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Claims must contain the provider's complete name, address, and nine-digit provider identifier to avoid unnecessary delays in processing and payment.

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

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

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

5.1.2.1 Quick Tips on Expediting Paper Claims

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

Do
Use 10 X 13-inch envelopes to send quantities of claims.
Circle only one claim per page, when sending Remittance Advice (RA) from Medicare (claims normally filed on a HCFA-1450 [UB-92] must accompany the Medicare RA).
Use black ink only.
Place the claim on top when sending new claims, followed by any medical records or attachments.
Circle the claim on the R&S report page when appealing a claim. Place the R&S report page on top of the appeal.
Number pages appropriately when sending attachments (e.g., 1 of 2, 2 of 2).
Paper clip claims or appeals if they include attachments.
Detach claims at perforated lines before mailing.
Use only approved standard forms.

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

Do Not
Fold claims, appeals, or correspondence.
Send duplicate copies of information.
Use red ink. Because scanners do not detect red ink, any note or correction written in red will be ignored.
Use paper sizes smaller or larger than 8 1/2 X 11. Scanner machines used for processing claims only accept 8 1/2 X 11 paper (including pictures and memos).
Mail a claim or other correspondence that goes to another department in the same envelope. When items going to different departments are sent together, they might become delayed or misrouted.
Use highlighters. Scanners will not pick up information that is highlighted (circle information to be highlighted instead).
Use glue, tape, or staples.
Print claim data outside of claim form field boxes.

5.1.3 Claims Filing Deadlines

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

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

Exception: *The Texas Administrative Code allows HHSC to consider exceptions to the 95-day filing deadline under special circumstances. Unless otherwise stated below, claims must be received by TMHP within 95 days from each date of service (DOS). Appeals must be received by TMHP within 120 days of the disposition date on the R&S report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.*

Only the following holidays extend the deadlines in 2007:

Date	Holiday
January 1, 2007	New Year's Day
January 15, 2007	Martin Luther King, Jr. Day
February 19, 2007	President's Day
May 28, 2007	Memorial Day
July 4, 2007	Independence Day
September 3, 2007	Labor Day
October 8, 2007	Columbus Day
November 22, 2007	Thanksgiving Day
November 23, 2007	Day After Thanksgiving
December 24, 2007	Christmas Eve
December 25, 2007	Christmas Day
December 26, 2007	Day After Christmas

The following are time limits for submitting claims:

- Inpatient claims filed by the hospital must be received by TMHP within 95 days from the discharge date or last DOS on the claim.
- Hospitals reimbursed according to diagnosis-related group (DRG) payment methodology may submit an interim claim because the client has been in the facility 30 consecutive days or longer. A total stay claim is needed after discharge to ensure accurate calculation for potential outlier payments for clients younger than 21 years of age.

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- Children's hospitals reimbursed according to *Tax Equity and Fiscal Responsibility Act* (TEFRA) *of 1982* methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital's fiscal year end.
- When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim. Claims submitted by newly enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service.
- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.
- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date). Providers should verify eligibility and add date by contacting TMHP (Automated Inquiry System [AIS], TMHP EDI's electronic eligibility verification, or TMHP Contact Center) when the number is received. Not all *applicants* become eligible *clients*.

Important: *Providers should request and keep copies of any Forms 1027 and 3087 submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.*

- If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date).
- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP only processes one client per Medicare RA. For multiple clients, submit one copy per client. TMHP *must* receive Medicaid claims within 95 days from the date of Medicare disposition. Providers submit the Medicare Remittance Advice Notice (MRAN) with the client's Medicaid number to TMHP.
- When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and subject to the 95-day filing deadline (from date of discharge).

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

- If the provider is trying to obtain prior authorization for services performed or will be performed, TMHP must receive the claim according to the usual 95-day filing deadline.
- The provider bills TMHP directly within 95 days from the DOS. However, if a nonthird party resource (TPR) is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity. The provider submits a copy of the disposition with the claim. A non-TPR is secondary to Texas Medicaid and may only pay benefits after the Texas Medicaid Program. Examples of non-TPRs are the Texas Rehabilitation Commission and the Children with Special Health Care Needs (CSHCN) Services Program.
- When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.
- When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. However, the federal 365-day filing requirement must still be met.
- A C21 process allows a Title V, X, or XX Family Planning claim to be paid by Title XIX (Medicaid) if the client is eligible for Title XIX (Medicaid) when those services are provided and billed under Title V, X, or XX. In this instance, the Medicaid 95-day filing deadline is in effect and must be met or the claim will be denied.

Refer to: "Claims Filing Instructions" on page 5-3 for more information.

"Provider Enrollment" on page 1-2 for information on the provider enrollment process.

"Appeal Methods" on page 6-2 for information on the process for submitting appeals.

"Exceptions to the 95-Day Filing Deadline" on page 5-5.

"Automated Inquiry System (AIS)" on page xiii to learn how to retrieve client eligibility information by telephone.

"Third Party Resources" on page 4-13.

"Eligibility Verification" on page 4-4.

"Provider Inquiries—Status of Claims" on page 5-76.

5.1.3.1 Exceptions to the 95-Day Filing Deadline

TMHP is not responsible for appeals about exceptions to the 95-day filing deadline. These appeals must be submitted to the HHSC Claims Administrator Contract Management.

HHSC Claims Administrator Contract Management makes the final decision about whether claims fall within one of the exceptions to the 95-day filing deadline. Only providers can submit exception requests. Requests from billing

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companies, vendors, or clearinghouses are not accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

HHSC considers exceptions only when one of the following situations exists. The provider must submit an affidavit or statement and any additional information identifying details of cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. The person who knows the facts must make the affidavit or statement.

HHSC Claims Administrator Contract Management determines if the claim falls within one of the following exceptions:

1) Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circumstances that are clearly beyond the provider's control including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these people are presumed to be within the provider's control. The presumption can be rebutted only when the intentional acts of the employee or agent leads to termination of employment and filing of criminal charges against the employee or agent.

   Providers requesting an exception based on exception (1) must submit independent evidence of insurable loss claims; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

2) Delay or error in the eligibility determination of a client or delay because of erroneous written information from the department, another state agency, or health insuring agent.

   Providers requesting an exception based on exception (2) must submit the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.

3) Delay because of electronic claim or system implementation problems.

   Providers requesting an exception based on exception (3) must submit the written repair statement, invoice, computer or modem-generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

4) Submission of claims within the 365-day federal filing deadline when services are authorized retroactively.

   Providers requesting an exception based on exception (4) must submit a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline was met.

5) Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

   Providers requesting an exception based on exception (5) must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

Exception requests must be submitted in writing to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
PO Box 204077
Austin, TX 78720-4077

Note: *HHSC will only consider exceptions to the 95-day filing deadline for claims that were submitted within the 365-day federal filing deadline from the date of service as outlined in Title 1 Texas Administrative Code (TAC) §354.1003.*

5.1.3.2 Appeal Time Limits

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

Refer to: "Claims Filing Instructions" on page 5-23.

Hospitals appealing final technical denials, admission denials, DRG changes, continued-stay denials, or cost/day outlier denials refer to "Appeals" on page 6-1 for complete appeal information.

5.1.3.3 Claims with Incomplete Information and Zero Paid Claims

Claims lacking the information necessary for processing are listed on the R&S report with an Explanation of Benefits (EOB) code requesting the missing information. Providers must resubmit a signed, completed/corrected claim with a copy of the R&S report on which the denied claim appears to TMHP within 120 days from the date on the R&S report to be considered for payment. These claims may be filed electronically only if the following infor-

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mation remains the same from the original claim: 1) provider identifier, 2) client Medicaid number, 3) dates of service, 4) total billed amount, or these claims may be resubmitted on paper for payment consideration to the following address:

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

Each corrected claim submitted must be accompanied by a copy of the corresponding page from the R&S report. Providers are not allowed to designate or resubmit these claims as appeals.

5.1.3.4 Claims Filing Reminders

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

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

Electronic billers notify TMHP about missing claims when:

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

5.1.4 HHSC Payment Deadline

Payment deadline rules, as defined by HHSC, affect all providers with the exception of Long Term Care and Family Planning Titles V, X, and XX.

The new HHSC payment deadline rules for the fiscal agent arrangement ensure that state and federal financial requirements are met. TMHP is required to finalize and/or pay claims, within a determined time frame (see table below), based on provider, claim, or eligibility type.

The following table describes the new payment deadline rules:

Type	Description
All Providers	Medicaid/CSHCN payments, excluding crossovers, cannot be made after 24 months from each DOS on the claim (discharge date for inpatient claims.)
Refugee Clients	The payable period for all refugee Medicaid payments is the federal fiscal year (October-September) in which each DOS (discharge date for inpatient claims) occurs plus 1 additional federal fiscal year.
Medicaid Crossover Claims	The crossover file create date is the date in which the file is received by Medicaid. The state has 24 months from the create date to pay the crossover claim. For paper submissions, the state has 24 months from the MRAN date (attachment date) to pay a crossover claim.
Retroactive SSI Eligibility (clients)	The payment deadline is derived from the client’s eligibility “add date”; to allow 24 months from the add date for the retroactive Supplemental Security Income (SSI)-eligible client.
County Indigent SSI Eligibility (clients)	The payment deadline is derived from the client’s eligibility add date; to allow 24 months from the add date to pay the claim.

Claims and appeals submitted after the designated payment deadlines are denied.

Note: *Providers may appeal HHSC Office of Inspector General (OIG) initiated claims adjustments (recoupments) after the 24-month deadline but must do so within 120 days from the date of the recoupment. Refer to “Paper Appeals” on page 6-3 for instructions. All appeals of OIG recoupments must be submitted by paper, no electronic or telephone appeals will be accepted.*

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5.1.4.1 Filing Deadline Calendar for 2006

NOTE: IF THE 95TH OR 120TH DAY FALLS ON A WEEKEND OR HOLIDAY, THE FILING OR APPEAL DEADLINE IS EXTENDED TO THE NEXT BUSINESS DAY.

Date of Service or Disposition	95 Days	120 Days
01/01 (001)	04/06 (096)	05/01 (121)
01/02 (002)	04/07 (097)	05/02 (122)
01/03 (003)	04/10 (100)	05/03 (123)
01/04 (004)	04/10 (100)	05/04 (124)
01/05 (005)	04/10 (100)	05/05 (125)
01/06 (006)	04/11 (101)	05/08 (128)
01/07 (007)	04/12 (102)	05/08 (128)
01/08 (008)	04/13 (103)	05/08 (128)
01/09 (009)	04/14 (104)	05/09 (129)
01/10 (010)	04/17 (107)	05/10 (130)
01/11 (011)	04/17 (107)	05/11 (131)
01/12 (012)	04/17 (107)	05/12 (132)
01/13 (013)	04/18 (108)	05/15 (135)
01/14 (014)	04/19 (109)	05/15 (135)
01/15 (015)	04/20 (110)	05/15 (135)
01/16 (016)	04/21 (111)	05/16 (136)
01/17 (017)	04/24 (114)	05/17 (137)
01/18 (018)	04/24 (114)	05/18 (138)
01/19 (019)	04/24 (114)	05/19 (139)
01/20 (020)	04/25 (115)	05/22 (142)
01/21 (021)	04/26 (116)	05/22 (142)
01/22 (022)	04/27 (117)	05/22 (142)
01/23 (023)	04/28 (118)	05/23 (143)
01/24 (024)	05/01 (121)	05/24 (144)
01/25 (025)	05/01 (121)	05/25 (145)
01/26 (026)	05/01 (121)	05/26 (146)
01/27 (027)	05/02 (122)	05/30 (150)
01/28 (028)	05/03 (123)	05/30 (150)
01/29 (029)	05/04 (124)	05/30 (150)
01/30 (030)	05/05 (125)	05/30 (150)
01/31 (031)	05/08 (128)	05/31 (151)
02/01 (032)	05/08 (128)	06/01 (152)
02/02 (033)	05/08 (128)	06/02 (153)
02/03 (034)	05/09 (129)	06/05 (156)
02/04 (035)	05/10 (130)	06/05 (156)
02/05 (036)	05/11 (131)	06/05 (156)
02/06 (037)	05/12 (132)	06/06 (157)
02/07 (038)	05/15 (135)	06/07 (158)
02/08 (039)	05/15 (135)	06/08 (159)
02/09 (040)	05/15 (135)	06/09 (160)
02/10 (041)	05/16 (136)	06/12 (163)
02/11 (042)	05/17 (137)	06/12 (163)
02/12 (043)	05/18 (138)	06/12 (163)
02/13 (044)	05/19 (139)	06/13 (164)
02/14 (045)	05/22 (142)	06/14 (165)
02/15 (046)	05/22 (142)	06/15 (166)
02/16 (047)	05/22 (142)	06/16 (167)
02/17 (048)	05/23 (143)	06/19 (170)
02/18 (049)	05/24 (144)	06/19 (170)
02/19 (050)	05/25 (145)	06/19 (170)
02/20 (051)	05/26 (146)	06/20 (171)
02/21 (052)	05/30 (150)	06/21 (172)
02/22 (053)	05/30 (150)	06/22 (173)
02/23 (054)	05/30 (150)	06/23 (174)
02/24 (055)	05/30 (150)	06/26 (177)
02/25 (056)	05/31 (151)	06/26 (177)
02/26 (057)	06/01 (152)	06/26 (177)
02/27 (058)	06/02 (153)	06/27 (178)
02/28 (059)	06/05 (156)	06/28 (179)
03/01 (060)	06/05 (156)	06/29 (180)
03/02 (061)	06/05 (156)	06/30 (181)
03/03 (062)	06/06 (157)	07/04 (185)
03/04 (063)	06/07 (158)	07/04 (185)
03/05 (064)	06/08 (159)	07/04 (185)
03/06 (065)	06/09 (160)	07/04 (185)
03/07 (066)	06/12 (163)	07/05 (186)
03/08 (067)	06/12 (163)	07/06 (187)
03/09 (068)	06/12 (163)	07/07 (188)
03/10 (069)	06/13 (164)	07/10 (191)
03/11 (070)	06/14 (165)	07/10 (191)
03/12 (071)	06/15 (166)	07/10 (191)
03/13 (072)	06/16 (167)	07/11 (192)
03/14 (073)	06/19 (170)	07/12 (193)
03/15 (074)	06/19 (170)	07/13 (194)

Date of Service or Disposition	95 Days	120 Days
03/16 (075)	06/19 (170)	07/14 (195)
03/17 (076)	06/20 (171)	07/17 (198)
03/18 (077)	06/21 (172)	07/17 (198)
03/19 (078)	06/22 (173)	07/17 (198)
03/20 (079)	06/23 (174)	07/18 (199)
03/21 (080)	06/26 (177)	07/19 (200)
03/22 (081)	06/26 (177)	07/20 (201)
03/23 (082)	06/26 (177)	07/21 (202)
03/24 (083)	06/27 (178)	07/24 (205)
03/25 (084)	06/28 (179)	07/24 (205)
03/26 (085)	06/29 (180)	07/24 (205)
03/27 (086)	06/30 (181)	07/25 (206)
03/28 (087)	07/03 (184)	07/26 (207)
03/29 (088)	07/03 (184)	07/27 (208)
03/30 (089)	07/03 (184)	07/28 (209)
03/31 (090)	07/05 (186)	07/31 (212)
04/01 (091)	07/05 (186)	07/31 (212)
04/02 (092)	07/06 (187)	07/31 (212)
04/03 (093)	07/07 (188)	08/01 (213)
04/04 (094)	07/10 (191)	08/02 (214)
04/05 (095)	07/10 (191)	08/03 (215)
04/06 (096)	07/10 (191)	08/04 (216)
04/07 (097)	07/11 (192)	08/07 (219)
04/08 (098)	07/12 (193)	08/07 (219)
04/09 (099)	07/13 (194)	08/07 (219)
04/10 (100)	07/14 (195)	08/08 (220)
04/11 (101)	07/17 (198)	08/09 (221)
04/12 (102)	07/17 (198)	08/10 (222)
04/13 (103)	07/17 (198)	08/11 (223)
04/14 (104)	07/18 (199)	08/14 (226)
04/15 (105)	07/19 (200)	08/14 (226)
04/16 (106)	07/20 (201)	08/14 (226)
04/17 (107)	07/21 (202)	08/15 (227)
04/18 (108)	07/24 (205)	08/16 (228)
04/19 (109)	07/24 (205)	08/17 (229)
04/20 (110)	07/24 (205)	08/18 (230)
04/21 (111)	07/25 (206)	08/21 (233)
04/22 (112)	07/26 (207)	08/21 (233)
04/23 (113)	07/27 (208)	08/21 (233)
04/24 (114)	07/28 (209)	08/22 (234)
04/25 (115)	07/31 (212)	08/23 (235)
04/26 (116)	07/31 (212)	08/24 (236)
04/27 (117)	07/31 (212)	08/25 (237)
04/28 (118)	08/01 (213)	08/28 (240)
04/29 (119)	08/02 (214)	08/28 (240)
04/30 (120)	08/03 (215)	08/28 (240)
05/01 (121)	08/04 (216)	08/29 (241)
05/02 (122)	08/07 (219)	08/30 (242)
05/03 (123)	08/07 (219)	08/31 (243)
05/04 (124)	08/07 (219)	09/01 (244)
05/05 (125)	08/08 (220)	09/05 (248)
05/06 (126)	08/09 (221)	09/05 (248)
05/07 (127)	08/10 (222)	09/05 (248)
05/08 (128)	08/11 (223)	09/05 (248)
05/09 (129)	08/14 (226)	09/06 (249)
05/10 (130)	08/14 (226)	09/07 (250)
05/11 (131)	08/14 (226)	09/08 (251)
05/12 (132)	08/15 (227)	09/11 (254)
05/13 (133)	08/16 (228)	09/11 (254)
05/14 (134)	08/17 (229)	09/11 (254)
05/15 (135)	08/18 (230)	09/12 (255)
05/16 (136)	08/21 (233)	09/13 (256)
05/17 (137)	08/21 (233)	09/14 (257)
05/18 (138)	08/21 (233)	09/15 (258)
05/19 (139)	08/22 (234)	09/18 (261)
05/20 (140)	08/23 (235)	09/18 (261)
05/21 (141)	08/24 (236)	09/18 (261)
05/22 (142)	08/25 (237)	09/19 (262)
05/23 (143)	08/28 (240)	09/20 (263)
05/24 (144)	08/28 (240)	09/21 (264)
05/25 (145)	08/28 (240)	09/22 (265)
05/26 (146)	08/29 (241)	09/25 (268)
05/27 (147)	08/30 (242)	09/25 (268)
05/28 (148)	08/31 (243)	09/25 (268)

Date of Service or Disposition	95 Days	120 Days
05/29 (149)	09/01 (244)	09/26 (269)
05/30 (150)	09/05 (248)	09/27 (270)
05/31 (151)	09/05 (248)	09/28 (271)
06/01 (152)	09/05 (248)	09/29 (272)
06/02 (153)	09/05 (248)	10/02 (275)
06/03 (154)	09/06 (249)	10/02 (275)
06/04 (155)	09/07 (250)	10/02 (275)
06/05 (156)	09/08 (251)	10/03 (276)
06/06 (157)	09/11 (254)	10/04 (277)
06/07 (158)	09/11 (254)	10/05 (278)
06/08 (159)	09/11 (254)	10/06 (279)
06/09 (160)	09/12 (255)	10/09 (282)
06/10 (161)	09/13 (256)	10/09 (282)
06/11 (162)	09/14 (257)	10/09 (282)
06/12 (163)	09/15 (258)	10/10 (283)
06/13 (164)	09/18 (261)	10/11 (284)
06/14 (165)	09/18 (261)	10/12 (285)
06/15 (166)	09/18 (261)	10/13 (286)
06/16 (167)	09/19 (262)	10/16 (289)
06/17 (168)	09/20 (263)	10/16 (289)
06/18 (169)	09/21 (264)	10/16 (289)
06/19 (170)	09/22 (265)	10/17 (290)
06/20 (171)	09/25 (268)	10/18 (291)
06/21 (172)	09/25 (268)	10/19 (292)
06/22 (173)	09/25 (268)	10/20 (293)
06/23 (174)	09/26 (269)	10/23 (296)
06/24 (175)	09/27 (270)	10/23 (296)
06/25 (176)	09/28 (271)	10/23 (296)
06/26 (177)	09/29 (272)	10/24 (297)
06/27 (178)	10/02 (275)	10/25 (298)
06/28 (179)	10/02 (275)	10/26 (299)
06/29 (180)	10/02 (275)	10/27 (300)
06/30 (181)	10/03 (276)	10/30 (303)
07/01 (182)	10/04 (277)	10/30 (303)
07/02 (183)	10/05 (278)	10/30 (303)
07/03 (184)	10/06 (279)	10/31 (304)
07/04 (185)	10/09 (282)	11/01 (305)
07/05 (186)	10/09 (282)	11/02 (306)
07/06 (187)	10/09 (282)	11/03 (307)
07/07 (188)	10/10 (283)	11/06 (310)
07/08 (189)	10/11 (284)	11/06 (310)
07/09 (190)	10/12 (285)	11/06 (310)
07/10 (191)	10/13 (286)	11/07 (311)
07/11 (192)	10/16 (289)	11/08 (312)
07/12 (193)	10/16 (289)	11/09 (313)
07/13 (194)	10/16 (289)	11/10 (314)
07/14 (195)	10/17 (290)	11/13 (317)
07/15 (196)	10/18 (291)	11/13 (317)
07/16 (197)	10/19 (292)	11/13 (317)
07/17 (198)	10/20 (293)	11/14 (318)
07/18 (199)	10/23 (296)	11/15 (319)
07/19 (200)	10/23 (296)	11/16 (320)
07/20 (201)	10/23 (296)	11/17 (321)
07/21 (202)	10/24 (297)	11/20 (324)
07/22 (203)	10/25 (298)	11/20 (324)
07/23 (204)	10/26 (299)	11/20 (324)
07/24 (205)	10/27 (300)	11/21 (325)
07/25 (206)	10/30 (303)	11/22 (326)
07/26 (207)	10/30 (303)	11/27 (331)
07/27 (208)	10/30 (303)	11/27 (331)
07/28 (209)	10/31 (304)	11/27 (331)
07/29 (210)	11/01 (305)	11/27 (331)
07/30 (211)	11/02 (306)	11/27 (331)
07/31 (212)	11/03 (307)	11/28 (332)
08/01 (213)	11/06 (310)	11/29 (333)
08/02 (214)	11/06 (310)	11/30 (334)
08/03 (215)	11/06 (310)	12/01 (335)
08/04 (216)	11/07 (311)	12/04 (338)
08/05 (217)	11/08 (312)	12/04 (338)
08/06 (218)	11/09 (313)	12/04 (338)
08/07 (219)	11/10 (314)	12/05 (339)
08/08 (220)	11/13 (317)	12/06 (340)
08/09 (221)	11/13 (317)	12/07 (341)
08/10 (222)	11/13 (317)	12/08 (342)

Date of Service or Disposition	95 Days	120 Days
08/11 (223)	11/14 (318)	12/11 (345)
08/12 (224)	11/15 (319)	12/11 (345)
08/13 (225)	11/16 (320)	12/11 (345)
08/14 (226)	11/17 (321)	12/12 (346)
08/15 (227)	11/20 (324)	12/13 (347)
08/16 (228)	11/20 (324)	12/14 (348)
08/17 (229)	11/20 (324)	12/15 (349)
08/18 (230)	11/21 (325)	12/18 (352)
08/19 (231)	11/22 (326)	12/18 (352)
08/20 (232)	11/27 (331)	12/18 (352)
08/21 (233)	11/27 (331)	12/19 (353)
08/22 (234)	11/27 (331)	12/20 (354)
08/23 (235)	11/27 (331)	12/21 (355)
08/24 (236)	11/27 (331)	12/22 (356)
08/25 (237)	11/28 (332)	12/27 (361)
08/26 (238)	11/29 (333)	12/27 (361)
08/27 (239)	11/30 (334)	12/27 (361)
08/28 (240)	12/01 (335)	12/27 (361)
08/29 (241)	12/04 (338)	12/27 (361)
08/30 (242)	12/04 (338)	12/28 (362)
08/31 (243)	12/04 (338)	12/29 (363)
09/01 (244)	12/05 (339)	01/02 (002)
09/02 (245)	12/06 (340)	01/02 (002)
09/03 (246)	12/07 (341)	01/02 (002)
09/04 (247)	12/08 (342)	01/02 (002)
09/05 (248)	12/11 (345)	01/03 (003)
09/06 (249)	12/11 (345)	01/04 (004)
09/07 (250)	12/11 (345)	01/05 (005)
09/08 (251)	12/12 (346)	01/08 (008)
09/09 (252)	12/13 (347)	01/08 (008)
09/10 (253)	12/14 (348)	01/08 (008)
09/11 (254)	12/15 (349)	01/09 (009)
09/12 (255)	12/18 (352)	01/10 (010)
09/13 (256)	12/18 (352)	01/11 (011)
09/14 (257)	12/18 (352)	01/12 (012)
09/15 (258)	12/19 (353)	01/16 (016)
09/16 (259)	12/20 (354)	01/16 (016)
09/17 (260)	12/21 (355)	01/16 (016)
09/18 (261)	12/22 (356)	01/16 (016)
09/19 (262)	12/27 (361)	01/17 (017)
09/20 (263)	12/27 (361)	01/18 (018)
09/21 (264)	12/27 (361)	01/19 (019)
09/22 (265)	12/27 (361)	01/22 (022)
09/23 (266)	12/27 (361)	01/22 (022)
09/24 (267)	12/28 (362)	01/22 (022)
09/25 (268)	12/29 (363)	01/23 (023)
09/26 (269)	01/02 (002)	01/24 (024)
09/27 (270)	01/02 (002)	01/25 (025)
09/28 (271)	01/02 (002)	01/26 (026)
09/29 (272)	01/02 (002)	01/29 (029)
09/30 (273)	01/03 (003)	01/29 (029)
10/01 (274)	01/04 (004)	01/29 (029)
10/02 (275)	01/05 (005)	01/30 (030)
10/03 (276)	01/08 (008)	01/31 (031)
10/04 (277)	01/08 (008)	02/01 (032)
10/05 (278)	01/08 (008)	02/02 (033)
10/06 (279)	01/09 (009)	02/05 (036)
10/07 (280)	01/10 (010)	02/05 (036)
10/08 (281)	01/11 (011)	02/05 (036)
10/09 (282)	01/12 (012)	02/06 (037)
10/10 (283)	01/16 (016)	02/07 (038)
10/11 (284)	01/16 (016)	02/08 (039)
10/12 (285)	01/16 (016)	02/09 (040)
10/13 (286)	01/16 (016)	02/12 (043)
10/14 (287)	01/17 (017)	02/12 (043)
10/15 (288)	01/18 (018)	02/12 (043)
10/16 (289)	01/19 (019)	02/13 (044)
10/17 (290)	01/22 (022)	02/14 (045)
10/18 (291)	01/22 (022)	02/15 (046)
10/19 (292)	01/22 (022)	02/16 (047)
10/20 (293)	01/23 (023)	02/20 (051)
10/21 (294)	01/24 (024)	02/20 (051)
10/22 (295)	01/25 (025)	02/20 (051)
10/23 (296)	01/26 (026)	02/20 (051)

Date of Service or Disposition	95 Days	120 Days
10/24 (297)	01/29 (029)	02/21 (052)
10/25 (298)	01/29 (029)	02/22 (053)
10/26 (299)	01/29 (029)	02/23 (054)
10/27 (300)	01/30 (030)	02/26 (057)
10/28 (301)	01/31 (031)	02/26 (057)
10/29 (302)	02/01 (032)	02/26 (057)
10/30 (303)	02/02 (033)	02/27 (058)
10/31 (304)	02/05 (036)	02/28 (059)
11/01 (305)	02/05 (036)	03/01 (060)
11/02 (306)	02/05 (036)	03/02 (061)
11/03 (307)	02/06 (037)	03/05 (064)
11/04 (308)	02/07 (038)	03/05 (064)
11/05 (309)	02/08 (039)	03/05 (064)
11/06 (310)	02/09 (040)	03/06 (065)
11/07 (311)	02/12 (043)	03/07 (066)
11/08 (312)	02/12 (043)	03/08 (067)
11/09 (313)	02/12 (043)	03/09 (068)
11/10 (314)	02/13 (044)	03/12 (071)
11/11 (315)	02/14 (045)	03/12 (071)
11/12 (316)	02/15 (046)	03/12 (071)
11/13 (317)	02/16 (047)	03/13 (072)
11/14 (318)	02/20 (051)	03/14 (073)
11/15 (319)	02/20 (051)	03/15 (074)
11/16 (320)	02/20 (051)	03/16 (075)
11/17 (321)	02/20 (051)	03/19 (078)
11/18 (322)	02/21 (052)	03/19 (078)
11/19 (323)	02/22 (053)	03/19 (078)
11/20 (324)	02/23 (054)	03/20 (079)
11/21 (325)	02/26 (057)	03/21 (080)
11/22 (326)	02/26 (057)	03/22 (081)
11/23 (327)	02/26 (057)	03/23 (082)
11/24 (328)	02/27 (058)	03/26 (085)
11/25 (329)	02/28 (059)	03/26 (085)
11/26 (330)	03/01 (060)	03/26 (085)
11/27 (331)	03/02 (061)	03/27 (086)
11/28 (332)	03/05 (064)	03/28 (087)
11/29 (333)	03/05 (064)	03/29 (088)
11/30 (334)	03/05 (064)	03/30 (089)
12/01 (335)	03/06 (065)	04/02 (092)
12/02 (336)	03/07 (066)	04/02 (092)
12/03 (337)	03/08 (067)	04/02 (092)
12/04 (338)	03/09 (068)	04/03 (093)
12/05 (339)	03/12 (071)	04/04 (094)
12/06 (340)	03/12 (071)	04/05 (095)
12/07 (341)	03/12 (071)	04/06 (096)
12/08 (342)	03/13 (072)	04/09 (099)
12/09 (343)	03/14 (073)	04/09 (099)
12/10 (344)	03/15 (074)	04/09 (099)
12/11 (345)	03/16 (075)	04/10 (100)
12/12 (346)	03/19 (078)	04/11 (101)
12/13 (347)	03/19 (078)	04/12 (102)
12/14 (348)	03/19 (078)	04/13 (103)
12/15 (349)	03/20 (079)	04/16 (106)
12/16 (350)	03/21 (080)	04/16 (106)
12/17 (351)	03/22 (081)	04/16 (106)
12/18 (352)	03/23 (082)	04/17 (107)
12/19 (353)	03/26 (085)	04/18 (108)
12/20 (354)	03/26 (085)	04/19 (109)
12/21 (355)	03/26 (085)	04/20 (110)
12/22 (356)	03/27 (086)	04/23 (113)
12/23 (357)	03/28 (087)	04/23 (113)
12/24 (358)	03/29 (088)	04/23 (113)
12/25 (359)	03/30 (089)	04/24 (114)
12/26 (360)	04/02 (092)	04/25 (115)
12/27 (361)	04/02 (092)	04/26 (116)
12/28 (362)	04/02 (092)	04/27 (117)
12/29 (363)	04/03 (093)	04/30 (120)
12/30 (364)	04/04 (094)	04/30 (120)
12/31 (365)	04/05 (095)	04/30 (120)
01/01 (001)	04/06 (096)	05/01 (121)

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5.1.4.2 Filing Deadline Calendar for 2007

NOTE: IF THE 95TH OR 120TH DAY FALLS ON A WEEKEND OR HOLIDAY, THE FILING OR APPEAL DEADLINE IS EXTENDED TO THE NEXT BUSINESS DAY.

Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days	Date of Service or Disposition	95 Days	120 Days
01/01 (001)	04/06 (096)	05/01 (121)	03/16 (075)	06/19 (170)	07/16 (197)	05/29 (149)	09/04 (247)	09/26 (269)	08/11 (223)	11/14 (318)	12/10 (344)	10/24 (297)	01/28 (028)	02/21 (052)
01/02 (002)	04/09 (099)	05/02 (122)	03/17 (076)	06/20 (171)	07/16 (197)	05/30 (150)	09/04 (247)	09/27 (270)	08/12 (224)	11/15 (319)	12/10 (344)	10/25 (298)	01/28 (028)	02/22 (053)
01/03 (003)	04/09 (099)	05/03 (123)	03/18 (077)	06/21 (172)	07/16 (197)	05/31 (151)	09/04 (247)	09/28 (271)	08/13 (225)	11/16 (320)	12/11 (345)	10/26 (299)	01/29 (029)	02/25 (056)
01/04 (004)	04/09 (099)	05/04 (124)	03/19 (078)	06/22 (173)	07/17 (198)	06/01 (152)	09/04 (247)	10/01 (274)	08/14 (226)	11/19 (323)	12/12 (346)	10/27 (300)	01/30 (030)	02/25 (056)
01/05 (005)	04/10 (100)	05/07 (127)	03/20 (079)	06/25 (176)	07/18 (199)	06/02 (153)	09/05 (248)	10/01 (274)	08/15 (227)	11/19 (323)	12/13 (347)	10/28 (301)	01/31 (031)	02/25 (056)
01/06 (006)	04/11 (101)	05/07 (127)	03/21 (080)	06/25 (176)	07/19 (200)	06/03 (154)	09/06 (249)	10/01 (274)	08/16 (228)	11/19 (323)	12/14 (348)	10/29 (302)	02/01 (032)	02/26 (057)
01/07 (007)	04/12 (102)	05/07 (127)	03/22 (081)	06/25 (176)	07/20 (201)	06/04 (155)	09/07 (250)	10/02 (275)	08/17 (229)	11/20 (324)	12/17 (351)	10/30 (303)	02/04 (035)	02/27 (058)
01/08 (008)	04/13 (103)	05/08 (128)	03/23 (082)	06/26 (177)	07/23 (204)	06/05 (156)	09/10 (253)	10/03 (276)	08/18 (230)	11/21 (325)	12/17 (351)	10/31 (304)	02/04 (035)	02/28 (059)
01/09 (009)	04/16 (106)	05/09 (129)	03/24 (083)	06/27 (178)	07/23 (204)	06/06 (157)	09/10 (253)	10/04 (277)	08/19 (231)	11/26 (330)	12/17 (351)	11/01 (305)	02/04 (035)	02/29 (060)
01/10 (010)	04/16 (106)	05/10 (130)	03/25 (084)	06/28 (179)	07/23 (204)	06/07 (158)	09/10 (253)	10/05 (278)	08/20 (232)	11/26 (330)	12/18 (352)	11/02 (306)	02/05 (036)	03/03 (063)
01/11 (011)	04/16 (106)	05/11 (131)	03/26 (085)	06/29 (180)	07/24 (205)	06/08 (159)	09/11 (254)	10/09 (282)	08/21 (233)	11/26 (330)	12/19 (353)	11/03 (307)	02/06 (037)	03/03 (063)
01/12 (012)	04/17 (107)	05/14 (134)	03/27 (086)	07/02 (183)	07/25 (206)	06/09 (160)	09/12 (255)	10/09 (282)	08/22 (234)	11/26 (330)	12/20 (354)	11/04 (308)	02/07 (038)	03/03 (063)
01/13 (013)	04/18 (108)	05/14 (134)	03/28 (087)	07/02 (183)	07/26 (207)	06/10 (161)	09/13 (256)	10/09 (282)	08/23 (235)	11/26 (330)	12/21 (355)	11/05 (309)	02/08 (039)	03/04 (064)
01/14 (014)	04/19 (109)	05/14 (134)	03/29 (088)	07/02 (183)	07/27 (208)	06/11 (162)	09/14 (257)	10/09 (282)	08/24 (236)	11/27 (331)	12/27 (361)	11/06 (310)	02/11 (042)	03/05 (065)
01/15 (015)	04/20 (110)	05/15 (135)	03/30 (089)	07/03 (184)	07/30 (211)	06/12 (163)	09/17 (260)	10/10 (283)	08/25 (237)	11/28 (332)	12/27 (361)	11/07 (311)	02/11 (042)	03/06 (066)
01/16 (016)	04/23 (113)	05/16 (136)	03/31 (090)	07/05 (186)	07/30 (211)	06/13 (164)	09/17 (260)	10/11 (284)	08/26 (238)	11/29 (333)	12/27 (361)	11/08 (312)	02/11 (042)	03/07 (067)
01/17 (017)	04/23 (113)	05/17 (137)	04/01 (091)	07/05 (186)	07/30 (211)	06/14 (165)	09/17 (260)	10/12 (285)	08/27 (239)	11/30 (334)	12/27 (361)	11/09 (313)	02/12 (043)	03/10 (070)
01/18 (018)	04/23 (113)	05/18 (138)	04/02 (092)	07/06 (187)	07/31 (212)	06/15 (166)	09/18 (261)	10/15 (288)	08/28 (240)	12/03 (337)	12/27 (361)	11/10 (314)	02/13 (044)	03/10 (070)
01/19 (019)	04/24 (114)	05/21 (141)	04/03 (093)	07/09 (190)	08/01 (213)	06/16 (167)	09/19 (262)	10/15 (288)	08/29 (241)	12/03 (337)	12/27 (361)	11/11 (315)	02/14 (045)	03/10 (070)
01/20 (020)	04/25 (115)	05/21 (141)	04/04 (094)	07/09 (190)	08/02 (214)	06/17 (168)	09/20 (263)	10/15 (288)	08/30 (242)	12/03 (337)	12/28 (362)	11/12 (316)	02/15 (046)	03/11 (071)
01/21 (021)	04/26 (116)	05/21 (141)	04/05 (095)	07/09 (190)	08/03 (215)	06/18 (169)	09/21 (264)	10/16 (289)	08/31 (243)	12/04 (338)	12/31 (365)	11/13 (317)	02/19 (050)	03/12 (072)
01/22 (022)	04/27 (117)	05/22 (142)	04/06 (096)	07/10 (191)	08/06 (218)	06/19 (170)	09/24 (267)	10/17 (290)	09/01 (244)	12/05 (339)	12/31 (365)	11/14 (318)	02/19 (050)	03/13 (073)
01/23 (023)	04/30 (120)	05/23 (143)	04/07 (097)	07/11 (192)	08/06 (218)	06/20 (171)	09/24 (267)	10/18 (291)	09/02 (245)	12/06 (340)	12/31 (365)	11/15 (319)	02/19 (050)	03/14 (074)
01/24 (024)	04/30 (120)	05/24 (144)	04/08 (098)	07/12 (193)	08/06 (218)	06/21 (172)	09/24 (267)	10/19 (292)	09/03 (246)	12/07 (341)	01/02 (002)	11/16 (320)	02/19 (050)	03/17 (077)
01/25 (025)	04/30 (120)	05/25 (145)	04/09 (099)	07/13 (194)	08/07 (219)	06/22 (173)	09/25 (268)	10/22 (295)	09/04 (247)	12/10 (344)	01/02 (002)	11/17 (321)	02/20 (051)	03/17 (077)
01/26 (026)	05/01 (121)	05/29 (149)	04/10 (100)	07/16 (197)	08/08 (220)	06/23 (174)	09/26 (269)	10/22 (295)	09/05 (248)	12/10 (344)	01/03 (003)	11/18 (322)	02/21 (052)	03/17 (077)
01/27 (027)	05/02 (122)	05/29 (149)	04/11 (101)	07/16 (197)	08/09 (221)	06/24 (175)	09/27 (270)	10/22 (295)	09/06 (249)	12/10 (344)	01/04 (004)	11/19 (323)	02/22 (053)	03/18 (078)
01/28 (028)	05/03 (123)	05/29 (149)	04/12 (102)	07/16 (197)	08/10 (222)	06/25 (176)	09/28 (271)	10/23 (296)	09/07 (250)	12/11 (345)	01/07 (007)	11/20 (324)	02/25 (056)	03/19 (079)
01/29 (029)	05/04 (124)	05/29 (149)	04/13 (103)	07/17 (198)	08/13 (225)	06/26 (177)	10/01 (274)	10/24 (297)	09/08 (251)	12/12 (346)	01/07 (007)	11/21 (325)	02/25 (056)	03/20 (080)
01/30 (030)	05/07 (127)	05/30 (150)	04/14 (104)	07/18 (199)	08/13 (225)	06/27 (178)	10/01 (274)	10/25 (298)	09/09 (252)	12/13 (347)	01/07 (007)	11/22 (326)	02/25 (056)	03/21 (081)
01/31 (031)	05/07 (127)	05/31 (151)	04/15 (105)	07/19 (200)	08/13 (225)	06/28 (179)	10/01 (274)	10/26 (299)	09/10 (253)	12/14 (348)	01/08 (008)	11/23 (327)	02/26 (057)	03/24 (084)
02/01 (032)	05/07 (127)	06/01 (152)	04/16 (106)	07/20 (201)	08/14 (226)	06/29 (180)	10/02 (275)	10/29 (302)	09/11 (254)	12/17 (351)	01/09 (009)	11/24 (328)	02/27 (058)	03/24 (084)
02/02 (033)	05/08 (128)	06/04 (155)	04/17 (107)	07/23 (204)	08/15 (227)	06/30 (181)	10/03 (276)	10/29 (302)	09/12 (255)	12/17 (351)	01/10 (010)	11/25 (329)	02/28 (059)	03/24 (084)
02/03 (034)	05/09 (129)	06/04 (155)	04/18 (108)	07/23 (204)	08/16 (228)	07/01 (182)	10/04 (277)	10/29 (302)	09/13 (256)	12/17 (351)	01/11 (011)	11/26 (330)	02/29 (060)	03/25 (085)
02/04 (035)	05/10 (130)	06/04 (155)	04/19 (109)	07/23 (204)	08/17 (229)	07/02 (183)	10/05 (278)	10/30 (303)	09/14 (257)	12/18 (352)	01/14 (014)	11/27 (331)	03/03 (063)	03/26 (086)
02/05 (036)	05/11 (131)	06/05 (156)	04/20 (110)	07/24 (205)	08/20 (232)	07/03 (184)	10/09 (282)	10/31 (304)	09/15 (258)	12/19 (353)	01/14 (014)	11/28 (332)	03/03 (063)	03/27 (087)
02/06 (037)	05/14 (134)	06/06 (157)	04/21 (111)	07/25 (206)	08/20 (232)	07/04 (185)	10/09 (282)	11/01 (305)	09/16 (259)	12/20 (354)	01/14 (014)	11/29 (333)	03/03 (063)	03/28 (088)
02/07 (038)	05/14 (134)	06/07 (158)	04/22 (112)	07/26 (207)	08/20 (232)	07/05 (186)	10/09 (282)	11/02 (306)	09/17 (260)	12/21 (355)	01/15 (015)	11/30 (334)	03/04 (064)	03/31 (091)
02/08 (039)	05/14 (134)	06/08 (159)	04/23 (113)	07/27 (208)	08/21 (233)	07/06 (187)	10/09 (282)	11/05 (309)	09/18 (261)	12/27 (361)	01/16 (016)	12/01 (335)	03/05 (065)	03/31 (091)
02/09 (040)	05/15 (135)	06/11 (162)	04/24 (114)	07/30 (211)	08/22 (234)	07/07 (188)	10/10 (283)	11/05 (309)	09/19 (262)	12/27 (361)	01/17 (017)	12/02 (336)	03/06 (066)	03/31 (091)
02/10 (041)	05/16 (136)	06/11 (162)	04/25 (115)	07/30 (211)	08/23 (235)	07/08 (189)	10/11 (284)	11/05 (309)	09/20 (263)	12/27 (361)	01/18 (018)	12/03 (337)	03/07 (067)	04/01 (092)
02/11 (042)	05/17 (137)	06/11 (162)	04/26 (116)	07/30 (211)	08/24 (236)	07/09 (190)	10/12 (285)	11/06 (310)	09/21 (264)	12/27 (361)	01/22 (022)	12/04 (338)	03/10 (070)	04/02 (093)
02/12 (043)	05/18 (138)	06/12 (163)	04/27 (117)	07/31 (212)	08/27 (239)	07/10 (191)	10/15 (288)	11/07 (311)	09/22 (265)	12/27 (361)	01/22 (022)	12/05 (339)	03/10 (070)	04/03 (094)
02/13 (044)	05/21 (141)	06/13 (164)	04/28 (118)	08/01 (213)	08/27 (239)	07/11 (192)	10/15 (288)	11/08 (312)	09/23 (266)	12/27 (361)	01/22 (022)	12/06 (340)	03/10 (070)	04/04 (095)
02/14 (045)	05/21 (141)	06/14 (165)	04/29 (119)	08/02 (214)	08/27 (239)	07/12 (193)	10/15 (288)	11/09 (313)	09/24 (267)	12/28 (362)	01/22 (022)	12/07 (341)	03/11 (071)	04/07 (098)
02/15 (046)	05/21 (141)	06/15 (166)	04/30 (120)	08/03 (215)	08/28 (240)	07/13 (194)	10/16 (289)	11/12 (316)	09/25 (268)	12/31 (365)	01/23 (023)	12/08 (342)	03/12 (072)	04/07 (098)
02/16 (047)	05/22 (142)	06/18 (169)	05/01 (121)	08/06 (218)	08/29 (241)	07/14 (195)	10/17 (290)	11/12 (316)	09/26 (269)	12/31 (365)	01/24 (024)	12/09 (343)	03/13 (073)	04/07 (098)
02/17 (048)	05/23 (143)	06/18 (169)	05/02 (122)	08/06 (218)	08/30 (242)	07/15 (196)	10/18 (291)	11/12 (316)	09/27 (270)	12/31 (365)	01/25 (025)	12/10 (344)	03/14 (074)	04/08 (099)
02/18 (049)	05/24 (144)	06/18 (169)	05/03 (123)	08/06 (218)	08/31 (243)	07/16 (197)	10/19 (292)	11/13 (317)	09/28 (271)	01/02 (002)	01/28 (028)	12/11 (345)	03/17 (077)	04/09 (100)
02/19 (050)	05/25 (145)	06/19 (170)	05/04 (124)	08/07 (219)	09/04 (247)	07/17 (198)	10/22 (295)	11/14 (318)	09/29 (272)	01/02 (002)	01/28 (028)	12/12 (346)	03/17 (077)	04/10 (101)
02/20 (051)	05/29 (149)	06/20 (171)	05/05 (125)	08/08 (220)	09/04 (247)	07/18 (199)	10/22 (295)	11/15 (319)	09/30 (273)	01/03 (003)	01/28 (028)	12/13 (347)	03/17 (077)	04/11 (102)
02/21 (052)	05/29 (149)	06/21 (172)	05/06 (126)	08/09 (221)	09/04 (247)	07/19 (200)	10/22 (295)	11/16 (320)	10/01 (274)	01/04 (004)	01/29 (029)	12/14 (348)	03/18 (078)	04/14 (105)
02/22 (053)	05/29 (149)	06/22 (173)	05/07 (127)	08/10 (222)	09/04 (247)	07/20 (201)	10/23 (296)	11/19 (323)	10/02 (275)	01/07 (007)	01/30 (030)	12/15 (349)	03/19 (079)	04/14 (105)
02/23 (054)	05/29 (149)	06/25 (176)	05/08 (128)	08/13 (225)	09/05 (248)	07/21 (202)	10/24 (297)	11/19 (323)	10/03 (276)	01/07 (007)	01/31 (031)	12/16 (350)	03/20 (080)	04/14 (105)
02/24 (055)	05/30 (150)	06/25 (176)	05/09 (129)	08/13 (225)	09/06 (249)	07/22 (203)	10/25 (298)	11/19 (323)	10/04 (277)	01/07 (007)	02/01 (032)	12/17 (351)	03/21 (081)	04/15 (106)
02/25 (056)	05/31 (151)	06/25 (176)	05/10 (130)	08/13 (225)	09/07 (250)	07/23 (204)	10/26 (299)	11/20 (324)	10/05 (278)	01/08 (008)	02/04 (035)	12/18 (352)	03/24 (084)	04/16 (107)
02/26 (057)	06/01 (152)	06/26 (177)	05/11 (131)	08/14 (226)	09/10 (253)	07/24 (205)	10/29 (302)	11/21 (325)	10/06 (279)	01/09 (009)	02/04 (035)	12/19 (353)	03/24 (084)	04/17 (108)
02/27 (058)	06/04 (155)	06/27 (178)	05/12 (132)	08/15 (227)	09/10 (253)	07/25 (206)	10/29 (302)	11/26 (330)	10/07 (280)	01/10 (010)	02/04 (035)	12/20 (354)	03/24 (084)	04/18 (109)
02/28 (059)	06/04 (155)	06/28 (179)	05/13 (133)	08/16 (228)	09/10 (253)	07/26 (207)	10/29 (302)	11/26 (330)	10/08 (281)	01/11 (011)	02/05 (036)	12/21 (355)	03/25 (085)	04/21 (112)
03/01 (060)	06/04 (155)	06/29 (180)	05/14 (134)	08/17 (229)	09/11 (254)	07/27 (208)	10/30 (303)	11/26 (330)	10/09 (282)	01/14 (014)	02/06 (037)	12/22 (356)	03/26 (086)	04/21 (112)
03/02 (061)	06/05 (156)	07/02 (183)	05/15 (135)	08/20 (232)	09/12 (255)	07/28 (209)	10/31 (304)	11/26 (330)	10/10 (283)	01/14 (014)	02/07 (038)	12/23 (357)	03/27 (087)	04/21 (112)
03/03 (062)	06/06 (157)	07/02 (183)	05/16 (136)	08/20 (232)	09/13 (256)	07/29 (210)	11/01 (305)	11/26 (330)	10/11 (284)	01/14 (014)	02/08 (039)	12/24 (358)	03/28 (088)	04/22 (113)
03/04 (063)	06/07 (158)	07/02 (183)	05/17 (137)	08/20 (232)	09/14 (257)	07/30 (211)	11/02 (306)	11/27 (331)	10/12 (285)	01/15 (015)	02/11 (042)	12/25 (359)	03/31 (091)	04/23 (114)
03/05 (064)	06/08 (159)	07/03 (184)	05/18 (138)	08/21 (233)	09/17 (260)	07/31 (212)	11/05 (309)	11/28 (332)	10/13 (286)	01/16 (016)	02/11 (042)	12/26 (360)	03/31 (091)	04/24 (115)
03/06 (065)	06/11 (162)	07/05 (186)	05/19 (139)	08/22 (234)	09/17 (260)	08/01 (213)	11/05 (309)	11/29 (333)	10/14 (287)	01/17 (017)	02/11 (042)	12/27 (361)	03/31 (091)	04/25 (116)
03/07 (066)	06/11 (162)	07/05 (186)	05/20 (140)	08/23 (235)	09/17 (260)	08/02 (214)	11/05 (309)	11/30 (334)	10/15 (288)	01/18 (018)	02/12 (043)	12/28 (362)	04/01 (092)	04/28 (119)
03/08 (067)	06/11 (162)	07/06 (187)	05/21 (141)	08/24 (236)	09/18 (261)	08/03 (215)	11/06 (310)	12/03 (337)	10/16 (289)	01/22 (022)	02/13 (044)	12/29 (363)	04/02 (093)	04/28 (119)
03/09 (068)	06/12 (163)	07/09 (190)	05/22 (142)	08/27 (239)	09/19 (262)	08/04 (216)	11/07 (311)	12/03 (337)	10/17 (290)	01/22 (022)	02/14 (045)	12/30 (364)	04/03 (094)	04/28 (119)
03/10 (069)	06/13 (164)	07/09 (190)	05/23 (143)	08/27 (239)	09/20 (263)	08/05 (217)	11/08 (312)	12/03 (337)	10/18 (291)	01/22 (022)	02/15 (046)	12/31 (365)	04/04 (095)	04/29 (120)
03/11 (070)	06/14 (165)	07/09 (190)	05/24 (144)	08/27 (239)	09/21 (264)	08/06 (218)	11/09 (313)	12/04 (338)	10/19 (292)	01/22 (022)	02/19 (050)	01/01 (001)	04/07 (098)	04/30 (121)
03/12 (071)	06/15 (166)	07/10 (191)	05/25 (145)	08/28 (240)	09/24 (267)	08/07 (219)	11/12 (316)	12/05 (339)	10/20 (293)	01/23 (023)	02/19 (050)			
03/13 (072)	06/18 (169)	07/11 (192)	05/26 (146)	08/29 (241)	09/24 (267)	08/08 (220)	11/12 (316)	12/06 (340)	10/21 (294)	01/24 (024)	02/19 (050)			
03/14 (073)	06/18 (169)	07/12 (193)	05/27 (147)	08/30 (242)	09/24 (267)	08/09 (221)	11/12 (316)	12/07 (341)	10/22 (295)	01/25 (025)	02/19 (050)			
03/15 (074)	06/18 (169)	07/13 (194)	05/28 (148)	08/31 (243)	09/25 (268)	08/10 (222)	11/13 (317)	12/10 (344)	10/23 (296)	01/28 (028)	02/20 (051)			

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5.2 TMHP Electronic Claims Submission

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

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information.

5.2.1 Electronic Claim Acceptance

Providers should verify that their electronic professional claims were accepted by Texas Medicaid for payment consideration by referring to their Claim Response report, which is in the 27S batch response file (e.g. file name E085LDS1.27S). Providers should also check their Accepted and Rejected reports in the rej and acc batch response files (e.g. E085LDS1.REJ and E085LDS1.ACC) for additional information. Only claims which have been accepted on the Claim Response report (27S file) will be considered for payment and made available for claim status inquiry. Claims that are rejected must be corrected and resubmitted for payment consideration. For more information on electronic claims submissions refer to "Electronic Billing" on page 3-2, visit www.tmhp.com, or call the EDI Help Desk at 1-888-863-3638.

5.2.2 Electronic Rejections

The most common reasons for electronic professional claim rejections are:

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

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

Refer to: "Modifier Requirements for TOS Assignment" on page 5-11 for TMHP EDI modifier information.

5.2.2.1 Newborn Claim Hints

The following are to be used for newborns:

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

The following are the most common reasons for electronic hospital HCFA-1450 (UB-92) claim rejections:

- *Admit hour outside allowable range.* (such as 24 hours)
- *Billed amount blank.*
- *Health coverage ID blank or invalid.* This number *must* be the valid nine-digit Medicaid client number. *Incorrect data* includes: a number less than nine digits; PENDING; 999999999; and Unknown.
- *Referring physician information on outpatient claim is blank* when laboratory/radiology services are ordered or a surgical procedure is performed. The referring physician's medical license number or UPIN number is required in Record 80. Consult the software vendor for the location of this field on the electronic claims entry form.

Refer to: "PCCM Expansion" on page 7-21.

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5.2.3 Resubmission of TMHP EDI Rejections

Providers receiving TMHP EDI rejections must resubmit corrected claims electronically within 120 days of the rejection report to avoid late filing.

5.2.4 TMHP EDI Batch Numbers, Julian Dates

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

- *JJJ—Julian date.* The three J characters represent the Julian date that the file was received by the TMHP EDI Gateway. The first character (J) is displayed as a letter, where E = 0, F = 1, G = 2, and H = 3. The last two characters (JJ) are displayed as numbers. All three characters (JJJ) together represent the Julian date.
- *Y—Year.* The Y character represents the last digit of the calendar year when the TMHP EDI Gateway receives the file. For example, a "5" in this position indicates the year 2005.
- *H—Hour.* The H character is displayed as a letter, representing the hour of the day that the TMHP EDI gateway received the file. The following letter codes represent the 24 hours of military time:

Letter to Hour Conversion			
A = 0	B = 1	C = 2	D = 3
E = 4	F = 5	G = 6	H = 7
I = 8	J = 9	K = 10	L = 11
M = 12	N = 13	O = 14	P = 15
Q = 16	R = 17	S = 18	T = 19
U = 20	V = 21	W = 22	X = 23

- *SSS—Sequence number.* This part of the batch ID is a unique sequence number that is EDI-assigned and does not impact determining the Julian date, year, or hour.

For example, the batch ID E085LDS1 means that the TMHP EDI gateway received the file on January 8, 2005, during the hour of 11 a.m.

Refer to: "Electronic Appeal Submission" on page 6-2 for instructions for using TMHP EDI batch IDs to prove timely filing.

5.2.5 Modifier Requirements for TOS Assignment

Modifiers for type of service (TOS) assignment are *not* required for Texas Health Steps (THSteps) Dental claims (claim type [CT] 021), Inpatient Hospital claims (CT 040), or Medicare Crossover claims (CT 030, 031, 050). Additionally, procedures submitted by specific provider types such as genetics, eyeglass, THSteps medical, and birthing centers are assigned the appropriate type of service based on the provider type and/or specific procedure code, and will not require modifiers.

Most procedure codes do not require a modifier for TOS assignment, but modifiers *are* required for *some* services submitted on professional claims (CT 020) and outpatient hospital claims (CT 023). Services that *require* a modifier for type of service assignment are listed below.

5.2.5.1 Assistant Surgery

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

5.2.5.2 Anesthesia

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

5.2.5.3 Interpretations

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

Exception: *The following procedure codes do not require a modifier for TOS assignment and are automatically processed as a professional component with a TOS I:*

Procedure Codes		
I-93014	I-93018	I-93227
I-93233	I-93237	I-93722

5.2.5.4 Technical Components

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

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

Additionally, the following procedure codes do not require a modifier for TOS assignment and are processed automatically as a technical component with a TOS T:

Procedure Codes		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-93005
T-93017	T-93041	T-93225

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Procedure Codes		
T-93226	T-93231	T-93232
T-93236	T-93721	T-95824

5.2.5.5 Durable Medical Equipment

For durable medical equipment (DME), use one of the following modifiers: NU, RR, or UE.

Using modifier NU results in TOS J being assigned, modifier RR results in TOS L, and modifier UE results in TOS 9.

5.2.5.6 Telemedicine

For telemedicine services, Texas Medicaid-enrolled providers bill using the GT modifier with the appropriate evaluation and management code. Rural health clinic (RHC) and federally qualified health clinic (FQHC) providers bill using encounter codes with the AM and SA modifiers.

Place modifier AM or SA in the *first* modifier field on the claim form together with modifier GT in the *second* modifier field.

5.2.5.7 THSteps Medical Modifiers

The following are modifiers to be used for filing THSteps medical claims: AM, SA, and U7.

An FQHC provider must also use modifier EP.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for more instructions on billing THSteps medical claims.

5.2.6 Preferred Provider Organization (PPO)

Effective November 03, 2003, PPO discounts are no longer considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

5.3 Coding

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

Important: *Claims for anesthesia must have the Current Procedural Terminology (CPT) anesthesia procedure code narrative descriptions, or CPT surgical codes or the claim will be denied.*

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

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

5.3.1 Diagnosis Coding

Texas Medicaid requires providers to provide *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis codes on their claims. The *only* diagnosis coding structure accepted by the Texas Medicaid Program is the ICD-9-CM. Diagnosis codes must be to the highest level of specificity available. In most cases a written description of the diagnosis is not required. ICD-9-CM evaluation and management codes are not payable as a primary diagnosis.

All V-codes are acceptable as diagnoses except the following nonspecific codes:

Diagnosis Code	Description
V030	Need for prophylactic vaccination and inoculation against cholera alone
V031	Need for prophylactic vaccination with typhoid-paratyphoid (TAB) vaccine
V032	Need for prophylactic vaccination with tuberculosis (BCG) vaccine
V033	Need for prophylactic vaccination and inoculation against plague
V034	Need for prophylactic vaccination and inoculation against tularemia
V035	Need for prophylactic vaccination and inoculation against diphtheria alone
V036	Need for prophylactic vaccination and inoculation against pertussis alone
V037	Need for prophylactic vaccination with tetanus toxoid alone
V0381	Need for prophylactic vaccination and inoculation against hemophilus influenza, type b [Hib]
V0382	Need for prophylactic vaccination and inoculation against streptococcus pneumoniae [pneumococcus]
V0389	Need for prophylactic vaccination and inoculation against other specified single bacterial disease

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Diagnosis Code	Description
V039	Need for prophylactic vaccination and inoculation against unspecified single bacterial disease
V040	Need for prophylactic vaccination and inoculation against poliomyelitis
V041	Need for prophylactic vaccination and inoculation against smallpox
V042	Need for prophylactic vaccination and inoculation against measles alone
V043	Need for prophylactic vaccination and inoculation against rubella alone
V044	Need for prophylactic vaccination and inoculation against yellow fever
V045	Need for prophylactic vaccination and inoculation against rabies
V046	Need for prophylactic vaccination and inoculation against mumps alone
V047	Need for prophylactic vaccination and inoculation against common cold
V048	Need for prophylactic vaccination and inoculation against other viral diseases
V0481	Need for prophylactic vaccination and inoculation, influenza
V0482	Need for prophylactic vaccination and inoculation, respiratory syncytial virus (RSV)
V0489	Need for prophylactic vaccination and inoculation, other viral diseases
V050	Need for prophylactic vaccination and inoculation against arthropod-borne viral encephalitis
V051	Need for prophylactic vaccination and inoculation against other arthropod-borne viral diseases
V052	Need for prophylactic vaccination and inoculation against leishmaniasis
V053	Need for prophylactic vaccination and inoculation against viral hepatitis
V054	Need for prophylactic vaccination and inoculation against varicella
V058	Need for prophylactic vaccination and inoculation against other specified disease
V059	Need for prophylactic vaccination and inoculation against unspecified single disease
V060	Need for prophylactic vaccination against cholera with typhoid-paratyphoid (cholera + TAB) vaccine
V061	Need for prophylactic vaccination with combined diphtheria-tetanus-pertussis (DTP) (DTaP) vaccine
V062	Need for prophylactic vaccination with diptheria-tetanus- pertussis with typhoid-paratyphoid (DTP + TAB) vaccine
V063	Need for prophylactic vaccination with diptheria-tetanus- pertussis with poliomyelitis (DTP + polio) vaccine
V064	Need for prophylactic vaccination with measles-mumps-rubella (MMR) vaccine
V065	Need for prophylactic vaccination and inoculation against tetanus-diphtheria (TD) (DT)
V066	Need for prophylactic vaccination and inoculation against streptococcus pneumoniae and influenza
V068	Need for prophylactic vaccination and inoculation against other combinations of diseases
V069	Need for prophylactic vaccination with unspecified combined vaccine
V070	Need for isolation
V071	Need for desensitization to allergens
V078	Need for other specified prophylactic measure
V079	Need for unspecified prophylactic measure
V109	Unspecified personal history of malignant neoplasm
V1200	Personal history of unspecified infectious and parasitic disease
V1201	Personal history of tuberculosis
V1202	Personal history of poliomyelitis
V1203	Personal history of malaria
V1209	Personal history of other specified infectious and parasitic disease
V121	Personal history of nutritional deficiency
V122	Personal history of endocrine, metabolic, and immunity disorders
V1260	Personal history, unspecified disease of respiratory system
V1261	Personal history, pneumonia (recurrent)
V1269	Personal history, other diseases of respiratory system
V1270	Personal history of unspecified digestive disease

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Diagnosis Code	Description
V1271	Personal history of peptic ulcer disease
V1272	Personal history of colonic polyps
V1279	Personal history of other specified digestive system diseases
V1300	Personal history of unspecified urinary disorder
V1321	Personal history of pre-term labor
V1329	Personal history of other genital system and obstetric disorders
V133	Personal history of diseases of skin and subcutaneous tissue
V134	Personal history of arthritis
V135	Personal history of other musculoskeletal disorders
V1361	Personal history of hypospadias
V1369	Personal history of other congenital malformations
V137	Personal history of perinatal problems
V138	Personal history of other specified diseases
V139	Personal history of unspecified disease
V140	Personal history of allergy to penicillin
V141	Personal history of allergy to other antibiotic agent
V142	Personal history of allergy to sulfonamides
V143	Personal history of allergy to other anti-infective agent
V144	Personal history of allergy to anesthetic agent
V145	Personal history of allergy to narcotic agent
V146	Personal history of allergy to analgesic agent
V147	Personal history of allergy to serum or vaccine
V148	Personal history of allergy to other specified medicinal agents
V149	Personal history of allergy to unspecified medicinal agent
V1501	Allergy to peanuts
V1502	Allergy to milk products
V1503	Allergy to eggs
V1504	Allergy to seafood
V1505	Allergy to other foods
V1506	Allergy to insects
V1507	Allergy to latex

Diagnosis Code	Description
V1508	Allergy to radiographic dye
V1509	Other allergy, other than to medicinal agents
V1541	History of physical abuse
V1542	History of emotional abuse
V156	Personal history of poisoning, presenting hazards to health
V157	Personal history of contraception, presenting hazards to health
V1581	Personal history of noncompliance with medical treatment, presenting hazards to health
V1582	Personal history of tobacco use
V1584	Personal history of exposure to asbestos
V1585	Personal history of exposure to potentially hazardous body fluids
V1586	Personal history of exposure to lead
V1587	History of extracorporeal membrane oxygenation (ECMO)
V1588	History of fall
V1589	Other specified personal history presenting hazards to health
V159	Unspecified personal history presenting hazards to health
V160	Family history of malignant neoplasm of gastrointestinal tract
V161	Family history of malignant neoplasm of trachea, bronchus, and lung
V162	Family history of malignant neoplasm of other respiratory and intrathoracic organs
V1640	Family history of malignant neoplasm of genital organ, unspecified
V1641	Family history of malignant neoplasm of ovary
V1642	Family history of malignant neoplasm of prostate
V1643	Family history of malignant neoplasm of testis
V1649	Family history of malignant neoplasm of other
V1651	Family history of malignant neoplasm of kidney
V1659	Family history of malignant neoplasm of other
V166	Family history of leukemia
V167	Family history of other lymphatic and hematopoietic neoplasms

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Diagnosis Code	Description
V168	Family history of other specified malignant neoplasm
V169	Family history of unspecified malignant neoplasm
V171	Family history of stroke (cerebrovascular)
V172	Family history of other neurological diseases
V173	Family history of ischemic heart disease
V174	Family history of other cardiovascular diseases
V175	Family history of other cardiovascular diseases
V176	Family history of other chronic respi-ratory conditions
V177	Family history of arthritis
V1781	Family history, osteoporosis
V1789	Family history, other musculoskeletal diseases
V1859	Family history, other digestive disorders
V200	Health supervision of foundling
V201	Other healthy infant or child receiving care
V202	Routine infant or child health check
V210	Period of rapid growth in childhood
V211	Puberty
V212	Other development of adolescence
V2130	Unspecified low birth weight status
V2131	Low birth weight status, less than 500 grams
V2132	Low birth weight status, 500 to 999 grams
V2133	Low birth weight status, 1000 to 1499 grams
V2134	Low birth weight status, 1500 to 1999 grams
V2135	Low birth weight status, 2000 to 2500 grams
V218	Other specified constitutional states in development
V219	Unspecified constitutional state in development
V260	Tuboplasty or vasoplasty after previous sterilization
V261	Artificial insemination
V2621	Fertility testing

Diagnosis Code	Description
V2622	Aftercare following sterilization reversal
V2629	Other investigation and testing
V2631	Testing of female for genetic disease carrier status
V2632	Other genetic testing of female
V2633	Genetic counseling
V2634	Testing of male for genetic disease carrier status
V2635	Encounter for testing of male partner of habitual aborter
V2639	Other genetic testing of male
V264	General counseling and advice on procreative management
V2651	Tubal ligation status
V2652	Vasectomy status
V268	Other specified procreative management
V269	Unspecified procreative management
V289	Unspecified antenatal screening
V426	Lung replaced by transplant
V4281	Bone marrow replaced by transplant
V4282	Peripheral stem cells replaced by transplant
V4283	Pancreas replaced by transplant
V4284	Organ or tissue replaced by trans-plant, intestines
V4289	Other specified organ or tissue replaced by transplant
V4574	Acquired absence of organ, other parts of urinary tract
V4575	Acquired absence of organ, stomach
V4576	Acquired absence of organ, lung
V4577	Acquired absence of organ, genital organs
V4578	Acquired absence of organ, eye
V4579	Other acquired absence of organ
V4586	Bariatric Surgery status
V460	Dependence on aspirator
V4611	Dependence on respirator, status
V4612	Encounter for respirator dependence during power failure
V4613	Encounter for weaning from respirator [ventilator]
V4614	Mechanical complication of respirator [ventilator]
V462	Other dependence on machines, supplemental oxygen

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Diagnosis Code	Description
V468	Dependence on other enabling machines
V469	Unspecified machine dependence
V4981	Postmenopausal status (age-related) (natural)
V4982	Dental sealant status
V4983	Awaiting organ transplant status
V4984	Bed confinement status
V4989	Other specified conditions influencing health status
V499	Unspecified problems with limbs and other problems
V500	Elective hair transplant for purposes other than remedying health states
V501	Other plastic surgery for unacceptable cosmetic appearance
V503	Ear piercing
V5041	Prophylactic breast removal
V5042	Prophylactic ovary removal
V5049	Other prophylactic gland removal
V508	Other elective surgery for purposes other than remedying health states
V509	Unspecified elective surgery for purposes other than remedying health states
V520	Fitting and adjustment of artificial arm (complete) (partial)
V521	Fitting and adjustment of artificial leg (complete) (partial)
V522	Fitting and adjustment of artificial eye
V523	Fitting and adjustment of dental prosthetic device
V524	Fitting and adjustment of breast prosthesis and implant
V528	Fitting and adjustment of other specified prosthetic device
V529	Fitting and adjustment of unspecified prosthetic device
V534	Fitting and adjustment of orthodontic devices
V538	Fitting and adjustment of wheelchair
V539	Fitting and adjustment of other and unspecified device
V570	Care involving breathing exercises
V5721	Care involving occupational therapy
V5722	Care involving vocational therapy
V574	Care involving orthoptic training
V5781	Care involving orthotic training

Diagnosis Code	Description
V5789	Care involving other specified rehabilitation procedure
V579	Care involving unspecified rehabilitation procedure
V582	Blood transfusion, without reported diagnosis
V5830	Encounter for change or removal of nonsurgical wound dressing
V5831	Encounter for change or removal of surgical wound dressing
V5832	Encounter for removal of sutures
V585	Orthodontics aftercare
V589	Unspecified aftercare
V5901	Blood donors, whole blood
V5902	Blood donors, stem cells
V5909	Other blood donors
V591	Skin donors
V592	Bone donors
V593	Bone marrow donors
V594	Kidney donors
V595	Cornea donors
V596	Liver donors
V5970	Egg (oocyte) (ovum) donor, unspecified
V5971	Egg (oocyte) (ovum) donor, under age 35,anonymous recipient
V5972	Egg (oocyte) (ovum) donor, under age 35,designated recipient
V5973	Egg (oocyte) (ovum) donor, age 35 and over, anonymous recipient
V5974	Egg (oocyte) (ovum) donor, age 35 and over, designated recipient
V598	Donors of other specified organ or tissue
V599	Donors of unspecified organ or tissue
V600	Lack of housing
V601	Inadequate housing
V602	Inadequate material resources
V603	Person living alone
V604	No other household member able to render care
V605	Holiday relief care
V606	Person living in residential institution
V608	Other specified housing or economic circumstances
V609	Unspecified housing or economic circumstance
V610	Family disruption

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Diagnosis Code	Description
V6110	Unspecified counseling for marital and partner problems
V6111	Counseling for victim of spousal and partner abuse
V6112	Counseling for perpetrator of spousal and partner abuse
V6120	Counseling for parent-child problem, unspecified
V6129	Other parent-child problems
V613	Problems with aged parents or in-laws
V6141	Alcoholism in family
V6149	Other health problems within the family
V616	Illegitimacy or illegitimate pregnancy
V617	Other unwanted pregnancy
V618	Other specified family circumstances
V619	Unspecified family circumstance
V620	Unemployment
V621	Adverse effects of work environment
V622	Other occupational circumstances or maladjustment
V623	Educational circumstances
V624	Social maladjustment
V625	Legal circumstances
V626	Refusal of treatment for reasons of religion or conscience
V6281	Interpersonal problems, not elsewhere classified
V6282	Bereavement, uncomplicated
V6283	Counseling for perpetrator of physical/sexual abuse
V6284	Suicidal ideation
V6289	Other psychological or physical stress, not elsewhere classified
V629	Unspecified psychosocial circumstance
V630	Residence remote from hospital or other health care facility
V631	Medical services in home not available
V632	Person awaiting admission to adequate facility elsewhere
V638	Other specified reasons for unavailability of medical facilities
V639	Unspecified reason for unavailability of medical facilities
V650	Healthy person accompanying sick person

Diagnosis Code	Description
V651	Person consulting on behalf of another person
V6511	Pediatric pre-birth visit for expectant mother
V6519	Other person consulting on behalf of another person
V652	Person feigning illness
V653	Dietary surveillance and counseling
V6540	Other specified counseling
V658	Other reasons for seeking consultation
V659	Unspecified reason for consultation
V665	Convalescence following other treatment
V666	Convalescence following combined treatment
V667	Encounter for palliative care
V669	Unspecified convalescence
V680	Issue of medical certificates
V681	Issue of repeat prescriptions
V682	Request for expert evidence
V6881	Referral of patient without examination or treatment
V6889	Encounters for other specified administrative purpose
V689	Encounters for unspecified administrative purpose
V690	Lack of physical exercise
V691	Inappropriate diet and eating habits
V692	High-risk sexual behavior
V693	Gambling and betting
V694	Lack of adequate sleep
V695	Behavioral insomnia of childhood
V698	Other problems related to lifestyle
V699	Unspecified problem related to lifestyle
V700	Routine general medical examination at a health care facility
V702	General psychiatric examination, other and unspecified
V703	Other general medical examination for administrative purposes
V704	Examination for medicolegal reasons
V706	Health examination in population surveys
V707	Examination for normal comparison or control in clinical research

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Diagnosis Code	Description
V708	Other specified general medical examinations
V709	Unspecified general medical examination
V7211	Encounter for hearing examination following failed hearing screening
V7219	Other examination of ears and hearing
V729	Unspecified examination
V730	Screening examination for poliomyelitis
V731	Screening examination for smallpox
V732	Screening examination for measles
V733	Screening examination for rubella
V734	Screening examination for yellow fever
V735	Screening examination for other arthropod-borne viral diseases
V736	Screening examination for trachoma
V7388	Other specified chlamydial diseases
V7389	Other specified viral diseases
V7398	Screening examination for unspec-ified chlamydial disease
V7399	Screening examination for unspec-ified viral disease
V740	Screening examination for cholera
V741	Screening examination for pulmonary tuberculosis
V742	Screening examination for leprosy (Hansen's disease)
V743	Screening examination for diphtheria
V744	Screening examination for bacterial conjunctivitis
V745	Screening examination for venereal disease
V746	Screening examination for yaws
V748	Screening examination for other specified bacterial and spirochetal diseases
V749	Screening examination for unspec-ified bacterial and spirochetal diseases
V750	Screening examination for rickettsial diseases
V751	Screening examination for malaria
V752	Screening examination for leishmaniasis
V753	Screening examination for trypanosomiasis

Diagnosis Code	Description
V754	Screening examination for mycotic infections
V755	Screening examination for schistosomiasis
V756	Screening examination for filariasis
V757	Screening examination for intestinal helminthiasis
V758	Screening examination for other specified parasitic infections
V759	Screening examination for unspec-ified infectious disease
V762	Screening for malignant neoplasms of the cervix
V763	Screening for malignant neoplasms of the bladder
V7641	Screening for malignant neoplasms of the rectum
V7642	Screening for malignant neoplasms of the oral cavity
V7643	Screening for malignant neoplasms of the skin
V7644	Screening for malignant neoplasms of the prostate
V7645	Screening for malignant neoplasms of the testis
V7646	Special screening for malignant neoplasms, ovary
V7647	Special screening for malignant neoplasms, vagina
V7649	Special screening for malignant neoplasms, other sites
V7650	Special screening for malignant neoplasms, unspecified intestine
V770	Screening for thyroid disorders
V771	Screening for diabetes mellitus
V772	Screening for malnutrition
V773	Screening for phenylketonuria (PKU)
V774	Screening for galactosemia
V775	Screening for gout
V776	Screening for cystic fibrosis
V777	Screening for other inborn errors of metabolism
V778	Screening for obesity
V780	Screening for iron deficiency anemia
V781	Screening for other and unspecified deficiency anemia
V782	Screening for sickle-cell disease or trait

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Diagnosis Code	Description
V783	Screening for other hemoglobinopathies
V788	Screening for other disorders of blood and blood-forming organs
V789	Screening for unspecified disorder of blood and blood-forming organs
V800	Screening for neurological conditions
V801	Screening for glaucoma
V802	Screening for other eye conditions
V803	Screening for ear diseases
V810	Screening for ischemic heart disease
V811	Screening for hypertension
V812	Screening for other and unspecified cardiovascular conditions
V813	Screening for chronic bronchitis and emphysema
V814	Screening for other and unspecified respiratory conditions
V815	Screening for nephropathy
V816	Surinary conditions
V8271	Screening for genetic disease carrier status
V8279	Other genetic screening
V8551	Body Mass Index, less than 5th percentile for age
V8552	Body Mass Index, 5th percentile to less than 85th percentile for age
V8553	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
V8554	Body Mass Index, pediatric, greater than or equal to 95th percentile for age
V860	Estrogen receptor positive status (ER+)
V861	Estrogen receptor negative status (ER-)

These nonspecific codes can be used for a general description but may not be referenced to a specific procedure code. Generally, V-codes are supplementary and are used only when the client's condition cannot be classified to categories 001 through 999. The use of observation diagnosis codes V718 and V717 results in claim denial with EOB 00543, "Documentation insufficient to verify medical necessity. Resubmit the claim with signed claim copy, R&S report copy, and complete documentation of medical necessity."

Independent laboratories, pathologists, and radiologists are not required to provide diagnosis codes except when billing for procedures identified under "Diagnosis Requirements" on page 26-10.

5.3.1.1 Place of Service (POS) Coding

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

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

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

Place of Service	2-Digit Numeric Codes (Electronic Billers)	1-Digit Numeric Codes (Paper Billers)
Office	11, 15, 50, 60, 65, 71, 72	1
Home	12	2
Inpatient hospital	21, 51, 52, 55, 56, 61	3
Outpatient hospital	22, 23, 24, 62	5
Birthing center	25	7
Other location	03, 04, 05, 06, 07, 08, 26, 34, 41, 42, 53, 99	9
Skilled nursing facility, intermediate care facility, intermediate care facility for mentally retarded	31, 32, 54	4
Extended care facility (rest home, domiciliary or custodial care, nursing facility boarding home)	33	8
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

Note: *Family planning and THSteps medical services performed in an RHC are billed using national POS code 72.*

5.3.2 Type of Service (TOS)

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

Refer to: "Modifier Requirements for TOS Assignment" on page 5-11 for information about modifiers for TMHP EDI.

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5.3.2.1 TOS Table

Important: *TOS codes are not used for electronic billing but do appear on R&S reports.*

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations
4	Radiology (total component)
5	Laboratory (total component)
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery
9	Other (e.g., prosthetic eyewear, contacts, ambulance)
C	Home health services
D	TB clinic
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new
L	DME rental
P	Birthing center
R	Hearing aid
S	THSteps medical
T	Technical component for radiology, laboratory, or radiation therapy
W	THSteps dental

5.3.3 Procedure Coding

The procedure coding system used by Texas Medicaid is called the Healthcare Common Procedure Coding System (HCPCS). HCPCS provides health care providers and third party payers a common coding structure.

Important: *TMHP reformats deleted HCPCS codes for three months. The deleted codes are automatically changed to code equivalents or to an unlisted code if no equivalent is available.*

HCPCS is designed around a five-character numeric or alphanumeric base for all codes. HCPCS consists of two levels of codes. HCPCS is updated annually to ensure an up-to-date coding structure. It is updated using the latest edition of the CPT manual and nationally established HCPCS codes released by the Centers for Medicare & Medicaid Services (CMS). Scheduled updates are announced in Medicaid bi-monthly bulletins.

The two levels of codes are as follows:

5.3.3.1 Level I

CPT (The American Medical Association's *Physicians' Current Procedural Terminology*):

- All numeric—consist of five digits
- Represent 80 percent of HCPCS
- Maintenance—responsibility of the American Medical Association (AMA), which updates annually
- Updates by the AMA are coordinated with CMS before their distribution of modifications to third party payers
- Anesthesia codes from CPT

5.3.3.2 Level II

HCPCS Codes

- Approved and released by CMS
- Codes for both physician and non-physician services not contained in CPT (for example, ambulance, durable medical equipment, prosthetics, and some medical codes)
- *Updating*: Responsibility of the CMS Maintenance Task Force
- All *alphanumeric* consisting of a single alpha character (A through V) followed by four numeric digits
- The single alpha character represents the following:

Alpha	Description
A	Supplies, ambulance, administrative, miscellaneous
B	Enteral and parenteral therapy
E	DME and oxygen
G	Procedures/professional (temporary)
H	Rehab and behavioral health services
J	Drugs (administered other than orally)
K	Durable Medical Equipment Regional Carriers (DMERC)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
S	Private payer
T	State Medicaid agency
V	Vision and hearing services

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5.3.4 Modifiers

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

Modifier	Special Instructions/Notes (if applicable)
Surgeons	
50	
53	Used for physician reporting of a discontinued procedure. For outpatient/ASC reporting of a discontinued procedure, see modifier 73 and 74.
54+	Surgeons who do not provide the postoperative care for a patient *must* bill the surgery code with modifier 54. The modifier will reimburse the surgeon at 80 percent of the allowed amount.
55+	Physicians who provide only the postoperative care may bill the appropriate visit codes and *must* use modifier 55 to indicate only postoperative care services were provided. Services indicated as postoperative care only by use of this modifier will not be denied as part of the global surgical fee.
62+	Cosurgery. Two surgeons perform the specific procedure(s).
66+	Cosurgery. Two surgeons are necessary to perform the highly complex surgical procedure(s).
76+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
77+	Use modifier 76 or 77 for transplant procedures if it is a second transplant of the same organ.
SF	
Assistant Surgeons	
80 *and* KX+	Use modifier 80 and KX together to indicate an assistant surgeon in a teaching facility: • In a case involving exceptional medical circumstances such as emergency or life-threatening situations requiring immediate attention. • When the primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients. • In a case involving a complex surgical procedure that qualifies for more than one physician.
AS	
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

Modifier	Special Instructions/Notes (if applicable)
Excision of Lesions/Masses	
KX+	Use modifier KX if the excision/destruction is due to one of the following signs or symptoms: inflamed, infected, bleeding, irritated, growing, limiting motion or function. Use of this modifier is subject to retrospective review.
Routine Foot Care	
TT+	Use with routine foot care procedures rendered in a nursing home when multiple patients are seen.
Injections	
ET+	
KX+	Use modifier KX to indicate the injection was due to: • Oral route contraindicated or an acceptable oral equivalent is not available. • Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available. • Patient has a temperature over 102 degrees (documented on the claim) and a high level of antibiotic is needed quickly. • Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare up of a chronic condition.
Visits	
52+	Use with normal newborn care if the service did not comprise a THSteps screen.
76+	
FP+	
TH+	Use with evaluation and management procedures to specify antepartum or postpartum care.
Anesthesia	
One of the following modifiers must be used by physicians in conjunction with the CPT code for anesthesia services:	
AA	
AD	
QK	
Modifier FP must be used when billing anesthesia for a sterilization procedure	
FQHC and RHC	
Services provided by a health care professional require one of the following modifiers:	
AH	
+ Modifier is required for accurate claims processing. *** Description is defined by the state.**	

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Modifier	Special Instructions/Notes (if applicable)
AJ	
AM	
SA	
TD	For home services provided in areas with a shortage of home health agencies.
TE	For home services provided in areas with a shortage of home health agencies.
U1	
U2	
U7*	Physician assistant services for other than assistant at surgery
The following modifiers may be used in addition to the modifier identifying the health care professional that rendered the service:	
EP	
FP	
GT	If the encounter is using telemedicine, use GT in the second modifier field.
TH	
Certified Registered Nurse Anesthetist (CRNA)	
One of the following modifiers must be used by CRNAs in conjunction with the CPT code for anesthesia services:	
QX	
QZ	
The following modifier must be used when billing anesthesia for a sterilization procedure:	
FP	
Abortion	
G7	
Vision	
RP+	Use modifier RP to indicate replacement lenses and/or frames
VP+	
Laboratory/Radiology	
26+	Used with TOS I (interpretation) for laboratory and radiological procedures.
91+	
FP+	Use with 99000 for lab handling services related to family planning.
SU+	Indicates necessary equipment is in physician's office for RAST/MAST testing or Pap smears.
TC+	The modifier TC is used with TOS T (technical) for radiological procedures.
TS	Use with 76811 or 76812 to indicate a follow-up or repeat ultrasound exam.

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

Modifier	Special Instructions/Notes (if applicable)
Q4+	Use for lab/radiology/ultrasound interps by other than the attending physician.
Therapy	
AT+	Must be used to indicate the necessity of an acute condition for occupational therapy (OT), physical therapy (PT), osteopathic manipulation treatment (OMT), or chiropractic services.
GN	
GO	
GP	
U4*	Reassessment Use with 92506 to indicate SLP re-evaluation.
THSteps Medical	
AM	
EP	FQHCs must use modifier EP for services provided under THSteps.
SA	
U7*	Physician assistant services for other than assistant at surgery
Physicians	
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days)
Q6	Locum tenens or temporary arrangement (up to 90 days)

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

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

*** Must be used by providers rendering Early Childhood Intervention (ECI)-THSteps/Comprehensive Care Program (CCP) therapy and nutritional services.**

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

- *CC.* The code used by the provider was changed by TMHP.
- *PT.* The DRG payment was calculated on a per diem basis for an inpatient stay because of patient transfer.
- *PS.* The DRG payment was calculated on a per diem basis because the patient exhausted the 30-day inpatient benefit limitation during the stay (does not apply to admissions after September 1, 1989).

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- *PE.* The DRG payment was calculated on a per diem basis because the patient was ineligible for Medicaid during part of the stay (does not apply to admissions after September 1, 1989). Also used to adjudicate claims with adjustments to outlier payments.

Note: *Modifiers PT, PS, and PE will appear for DRG claims only.*

5.4 Claims Filing Instructions

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

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

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

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

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

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

5.4.1 Claim Form Requirements

When filing claims for a STAR or STAR+PLUS Program members, providers should follow the client's STAR or STAR+PLUS health plan's claim filing requirements.

5.4.1.1 Provider Signature on Claims

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

Printing the provider's name instead of "Signature on File" is unacceptable. Because space is limited in the signature block, providers should not type their names in the block. Claims not meeting these specifications are in the "Paid or Denied Claims (Hospital) R&S Report" on page 5-63 section of the R&S report.

Refer to: "Sample Letter - XUB Computer Billing Service Inc." on page B-82.

5.4.1.2 Clients Without Medicaid Numbers

If an individual has not been assigned a Medicaid number on the DOS, the provider must wait until a Medicaid client number is assigned to file the claim. The provider writes the number instead of "Pending." The 95-day filing period begins on the "add date," which is the date the eligibility is received and added to the TMHP eligibility file. Providers verify eligibility and add date through TDHconnect or by calling AIS or the TMHP Contact Center at 1-800-925-9126 after the number is received.

Providers must check Medicaid eligibility regularly to file claims within the required 95-day filing deadline.

Refer to: "Client Eligibility" on page 4-1.

5.4.1.3 Multipage Claim Forms

The CMS-1500 claim form is designed to list six line items in Block 24. An approved electronic claims format is designed to list 50 line items. If more than six line items are billed on a paper claim, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multipage claim must contain all the required billing information. On subsequent pages of the multipage claim, the provider should identify the client's name, diagnosis, information required for services in Block 24, and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form and indicate "continued" in Block 28. The combined total charges for all pages should be listed on the last page in Block 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

The paper HCFA-1450 (UB-92) 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.

An approved electronic format of the HCFA-1450 (UB-92) is designed to list 71 lines in Block 43 or its electronic equivalent. C21 merges like revenue codes together to

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reduce the lines to 28 or less. If the C21 merge cannot reduce the lines to 28 or less, the claim denies, and the provider needs to reduce the lines and resubmit the claim. Providers submitting electronic claims using TDHconnect may not submit more than 28 lines. If the services exceed the 28 lines, the provider may submit another claim for the additional lines or merge codes. When splitting a claim, all pages must contain the required information. Usually, there are logical breaks to a claim. For example, the provider may submit the surgery charges in one claim and the subsequent recovery days in the next claim.

TEFRA hospitals are required to submit all charges.

5.4.1.4 Attachments to Claims

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

- All claims for services associated with an elective sterilization must have a valid Sterilization Consent Form attached or on file at TMHP.
- Nonemergency ambulance transfers must have documentation of medical necessity including out-of-locality transfers.
- Providers filing for coinsurance, deductible, or both on Medicare claims to TMHP must attach the Intermediary RA. This requirement does not apply to claims transferred automatically to TMHP from the Medicare intermediary.
- Medically necessary abortions performed (on the basis of a physician's professional judgement, the life of the mother is endangered if the fetus were carried to term), or abortions provided for pregnancy related to rape or incest must have a signed physician certification statement. Elective abortions are *not* covered by Medicaid.
- Hysterectomies must have a Hysterectomy Acknowledgment Statement attached or on file at TMHP.

Refer to: "Physician Certification for Exceptions" on page 36-73.

5.5 CMS-1500 Claim Filing Instructions

The following providers bill for services using the American National Standards Institute (ANSI) ASC X12 837P 4010A electronic specifications or the CMS-1500 claim form:

Providers
Ambulance
Ambulatory surgical centers (ASC) (freestanding)
Birthing center
Case Management: blind and visually impaired (BVIC), ECI, and Children and Pregnant Women (CPW)
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Certified respiratory care practitioner (CRCP)
Chemical dependency treatment facilities
Chiropractor
Clinical nurse specialist (CNS)
Dentist (doctor of dentistry practicing as a limited physician)
DME or durable medical equipment–home health services (DMEH) supplier (CCP and home health services)
Family planning agency that does not also receive funds from Title V, X, or XX
FQHC
Genetic service agency
Hearing aid
In-home total parenteral hyperalimentation supplier
Laboratory
Licensed dietitian (CCP only)
Licensed clinical social worker (LCSW)
Licensed professional counselor (LPC)
Maternity service clinic (MSC)
Mental Health (MH) Rehabilitative services
Nurse practitioner (NP)
Occupational therapist (CCP only)
Optician/optometrist/opthamologist
Orthotic and prosthetic supplier (CCP only)
Physical therapist
Physician (group and individual)
Physician assistant (PA)
Tuberculosis clinic
Podiatrist
Private duty nurse (PDN) (CCP only)
Psychologist
Radiology
School Health and Related Services (SHARS)
Speech language pathologist (CCP only)
THSteps medical

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

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5.5.1 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 claim forms with TDHconnect or approved vendor software that uses the ANSI ASC X12 837P 4010A format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/EDI. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638. Providers may request TDHconnect by contacting the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: "Electronic Billing" on page 3-2 for information about electronic billing.

5.5.2 CMS-1500 Claim Form (Paper) Billing

Claims must contain the billing provider's complete name, address, or nine-digit provider identifier. A claim without a provider name, address, or provider identifier cannot be processed. Each claim form must have the appropriate signatory evidence in the signature certification block.

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

Refer to: "CMS-1500 Claim Form (Paper) Billing" on page 5-25.

"CMS-1500 Claim Filing Instructions" on page 5-24.

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5.5.3 CMS-1500 Blank Claim Form

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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5.5.4 CMS-1500 Instruction Table

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

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the patient's nine-digit client number from the Medicaid Identification.
2	Patient's name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid Identification Form (H3087).
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: • If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. • If the service is a sterilization, identify the date and time of surgery. • If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the Medicaid claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available (in Box 9 a-d). If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the TPR denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, TMHP will process the claim without the signature of the patient. The patient's signature authorizes the release of the claim's medical information.
14	Date of injury or date of last menstrual period	If the services provided are accident or maternity-related, indicate the date of injury of the accident or the date of the last menstrual period.

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Block No.	Description	Guidelines
17 or 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the nine-digit provider identifier or (UPIN in Block 17a) in the following situations: • Electronic billers must enter the provider identifier, six-digit Medicare number, or UPIN. • Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. • Nonemergency services provided to limited clients on referral from the designated physician must identify the designated physician's nine-digit provider identifier. • Consultation services must identify the referring physician. • Services provided to a client in an ASC must identify the referring physician. • Services provided to a client in a nursing facility (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) must identify the attending physician. • Laboratory and radiology services must identify the ordering physician. • Speech-language therapy must identify the ordering physician. • Physical therapy must identify the ordering physician. • Occupational therapy must identify the ordering physician. • In-home hyperalimentation services must identify the ordering physician. • THSteps-CCP services must identify the referring provider. • Do not use Medicare number for limited clients. For limited clients, use a nine-digit provider identifier in 17A. Electronic billers should use the Medicare six-digit code number or provider identifier. • The referring provider must be the primary care provider if the client is in a STAR or STAR+PLUS health plan. If there is not a referral from the primary care provider, a prior authorization number (PAN) must be on the claim. • Claims received without this information will be returned to the provider. **Physician Claims (Referring Physician)** A referring physician is required for consultation, laboratory, radiology, and radiation therapy procedures. The complete name and address or the provider identifier of the referring physician must be in Block 17 of the claim form. **Freestanding ASC Claims** The performing surgeon/referring physician name/number must be identified.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and Medicaid number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or nine-digit provider identifier of the facility that performed the service in Block 32. Medicaid regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

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Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available complete to five digits for each diagnosis observed. A pathologist is not required to supply a diagnosis except for: estrogen receptor assays, HLTVIII, plasmapheresis, and anatomical pathology specimens. Radiology groups are required to provide a diagnosis for inflammatory process localization using radioactive tracer (Gallium 67), graphic stress telethermometry, computerized axial tomography (CAT) scans, echography, arteriography, venography, and magnetic resonance imaging (MRI). The statement of medical necessity for abortions and the rationale for the decision must be included if it is not attached to the claim. **Ambulance** Ambulance providers must provide a concise description for each diagnosis observed or enter the ICD-9-CM diagnosis code to the highest level of specificity available complete to five-digits for each diagnosis observed. **Chiropractors** Chiropractors must indicate the exact level of subluxation (use of diagnosis codes 7390, 7391, 7392, 7393, 7394, 7395, 7398, 83900, 83901, 83902, 83903, 83904, 83905, 83906, 83907, 83908, 83920, 83921, and 83949 may be indicated in lieu of a written description) and the date of the X-ray that demonstrates the degree of subluxation. THSteps medical checkups—For paper and electronic billers, the diagnosis code is V202.
23	Prior authorization no. (PAN)	Enter the PAN issued by TMHP, if applicable.
24A	Date of service (DOS)	Enter the DOS for each procedure provided in a MM/DD/YYYY format. If more than one DOS is for a single procedure, each date must be given (such as "03/16, 17, 18/2001"). **Electronic Billers** Medicaid does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. "To" dates of service are not used on electronic claims.
24B	Place of service (POS)	Select the appropriate POS code for each service from the POS table under "Place of Service (POS) Coding" on page 5-19.If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The POS for all ambulance transfers will be the destination. THSteps medical checkups - For paper billers, the POS will always be "1" or "O." For electronic billers, the POS will always be "11."
24C	Type of service (TOS)	Enter the appropriate TOS code for each service performed (lab, X-ray, surgery, assistant surgeon, etc.). Physician and radiology facilities may only bill for the professional component of any service rendered to a hospital patient. For a listing of TOS codes, refer to "Type of Service (TOS)" on page 5-19. TOS "T" is used when billing for the technical component of laboratory and X-ray services; TOS "I" is used for the professional component; TOS "4" is used for the total (technical and professional) component for radiology, and TOS "5" is used for the total component for pathology. For THSteps medical checkups use TOS "S."

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Block No.	Description	Guidelines
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: • *Injections.* Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers under "Modifier Requirements for TOS Assignment" on page 5-11. • *Sutures.* Indicate number of sutures, length, and location of laceration. • *Laboratory.* Indicate the specific type of laboratory procedure. • *X-ray.* Indicate the number of views and type. • When unusual or extenuating circumstances occur, give a brief medical report. • *THSteps medical checkups.* Use a modifier to identify provider. • *Ambulance.* The pick-up point and destination must be indicated on the claim form. • *Anesthesiologists and CRNAs.* Enter the appropriate CPT anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. The procedure code must be preceded by TOS code "7." Enter the time in minutes. • Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," or "QK" (located under "Anesthesiology" in the Physician section); CRNAs use "QX" or "QZ." • Use modifiers (for example, acute, left, right) to describe services (refer to "Modifiers" on page 5-21). • *Eyewear.* When billing for eyewear, the prescription must be entered; the new prescription must be placed on Line five and the old prescription on Line 6.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24H	THSteps family planning	Indicate if the services were a result of a THSteps checkup or family planning referral.
24K	Other	Members of a group practice must identify the nine-digit provider identifier of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in Block 33 and must not be used to bill the Medicaid program. The space is also used to provide additional information such as pertinent comments that may explain unusual procedure. The CMS-1500 claim form is designed to list six line items in Block 24. If more than six line items are billed, a provider attaches additional forms with no more than 27 line items.
26	Patient's account number	Optional - Any alphanumeric characters (up to 15) in this block are referenced on the R&S report.
27	Accept assignment	Not optional - All providers of Medicaid services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

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Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.
30	Balance due	If appropriate, subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. **Refer to:** "Provider Signature on Claims" on page 5-23.
32	Name and address of facility where services rendered, if other than home or office	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the nine-digit provider identifier of the facility, such as hospital, birthing center, and nursing facility, where the service was provided. For ambulance transfers if the destination is a hospital or nursing facility, enter the name and address, and the nine-digit provider identifier of the facility. Independently practicing health care professionals must enter the name and number of the school district/cooperative where the child is enrolled. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the nine-digit provider identifier of the outside laboratory should be entered. The laboratory should bill the Texas Medicaid Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the nine-digit provider identifier, provider name, street, city, state, ZIP code, and telephone number.

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5.6 HCFA-1450 (UB-92) Claim Filing Instructions

The following provider types may bill electronically or use the HCFA-1450 (UB-92) claim form when requesting payment:

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

5.6.1 HCFA-1450 (UB-92) Electronic Billing

Electronic billers must submit HCFA-1450 (UB-92) claims with TDHconnect or approved vendor software that uses the ANSI ASC X12 837I 4010A format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638. Providers may request TDHconnect by contacting the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: “Electronic Billing” on page 3-2 for more information about electronic billing.

5.6.2 HCFA-1450 (UB-92) Claim Form (Paper) Billing

Providers obtain the HCFA-1450 (UB-92) claim forms from a vendor of their choice.

Note: *To avoid claim denial, only the provider’s Texas license number is preceded by “TX” and should be placed in form locators 82 and 83 of the HCFA-1450 (UB-92) claim form or in the referring provider license number field on the electronic claim unless the client is a limited client.*

Completed HCFA-1450 (UB-92) claims must contain the billing provider’s full name, address, and/or nine-digit provider identifier. A claim *without* a provider name, address, or provider identifier *cannot* be processed.

Refer to: “HCFA-1450 (UB-92) Claim Filing Instructions” on page 5-32.

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5.6.3 HCFA-1450 (UB-92) Blank Claim Form

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

a
b

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a
b
c
d

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23

50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

A
B
C

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

A
B
C

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

A
B
C

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE (A) | OTHER PROCEDURE CODE DATE (B) | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE (C) | OTHER PROCEDURE CODE DATE (D) | OTHER PROCEDURE CODE DATE (E)

83 OTHER PHYS. ID (A) a b

OTHER PHYS. ID (B) a b

84 REMARKS

a
b
c
d

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450 | OCR/ORIGINAL | I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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5.6.4 HCFA-1450 (UB-92) Instruction Table

The instructions describe what information must be entered in each of the block numbers of the HCFA-1450 (UB-92) claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

Block No.	Description	Guidelines
1	Provider name, address, and telephone number	Enter the hospital name, street, city, state, ZIP code, and telephone number.
3	Patient control number	Optional: any alphanumeric character (limit 16) entered in this Block will be referenced on the R&S report.
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 331 Home health agency* 711 RHCs 721 RDCs 731 FQHCs * Use TOB 331 only. All other TOBs are invalid and will deny.	Enter the three-digit TOB code First Digit—Type of Facility 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (RHC, FQHC, RDC) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities) 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care Second Digit—Bill Classification (clinics only) 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim—first claim 3 Interim—continuing claim 4 Interim—last claim 5 Late charges—only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	For inpatient and home health claims, enter the beginning and ending dates of service billed. For inpatient claims, this is usually the dates of admission and discharge.
7	Covered days	For inpatient claims, enter 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 will be equal to the number of covered accommodation days listed in Block 46.
8	Noncovered days	For inpatient claims, enter the total days represented on this claim that are not covered. The sum of Blocks 7 and 8 must equal the total days billed as reflected in Block 6.
12	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid Identification Form.
13	Patient address	Enter the patient's complete address as described (street, city, state, and ZIP code).

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Block No.	Description	Guidelines
14	Patient birth date	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born.
15	Patient sex	Indicate the patient's sex by entering an "M" or "F."
17	Admission date	Enter numerically the date (MM/DD/YYYY) of admission for inpatient claims; DOS for outpatient claims; start of care (SOC) for home health claims. ***Note:*** *Providers that receive a transfer patient from another hospital must enter the original admission date to identify the payor.*
18	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for nonpatients (TOB 141), home health claims (TOB 331), RHCs (TOB 711), RDCs (TOB 721), or FQHCs (TOB 731).
19	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 20.) 5 Trauma Center
20	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 1 Physician referral 2 Clinic referral 3 Health Maintenance Organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
21	Discharge hour (required field)	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.

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Block No.	Description	Guidelines
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provide 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired - place unknown (hospice use only) 43 Federal Hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Medicare-approved swing bed 62 Inpatient rehabilitation facility (IRF), including rehabilitation distinct part of a hospital 63 Long term care hospital (LTCH) 64 Medicaid-only nursing facility 65 Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)
23	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
24-30	Condition codes	Enter the two-digit condition code "05" and date the legal claim was filed for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient if this condition is applicable to the claim.
32ab-35ab	Occurrence codes and dates	Enter the appropriate code(s) and date(s). Medicaid-required codes are found under "Occurrence Codes" on page 5-41. Blocks 54, 61, 62, and 84 must also be completed as required.
36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39	Value codes	Accident Hour—For inpatient claims, if the patient was admitted as the result of an accident, enter the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.

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Block No.	Description	Guidelines
42 43	Revenue codes Revenue description	**Inpatient** For inpatient hospital services, enter the description and code for the total charges and each accommodation and ancillary provided. List accommodations first in order of occurrence, ancillaries in ascending order. Write the accommodation rate to the right of the dotted line. ***Note:*** *All claims for services submitted on a HCFA-1450 (UB-92) form based on procedure codes rather than revenue codes will be denied. Claims for services based on procedure codes, including drugs and other injections, must be billed using an CMS-1500 claim form.* a) Revenue code “001” is for the total charge and must be the last revenue code on the list. ***Exception:*** *Electronic billers must not use revenue code “001.” Using this code causes the claim billed amount to be doubled. Electronic billers should not put a code in this block.* b) *Laboratory.* If laboratory work is sent out, the name and address or nine-digit provider identifier of the laboratory where the work was forwarded must be entered. c) *Medical/Surgical Supplies.* Itemize these services provided in the inpatient facility (such as infusion pumps, traction setups, and crutches for inpatient use only). If provided to all admitted patients, admission kits should be billed using revenue code “270.” d) Charges for fetal monitoring must be billed using revenue code “732.”

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Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient** Enter the accommodation rate per day. **Home Health Services** Home health agencies must have the appropriate HCPCS procedure code preceded by TOS C and a description for all services billed. Do *not* use revenue codes for billing these services. Enter the DOS numerically (MM/DD/YY) for each service rendered along with the block number of the diagnoses listed in Blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary one. Each service and/or supply must be itemized on the claim form. The HCFA-1450 (UB-92) claim form is limited to 27 detail charges. **Outpatient** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. Enter the DOS numerically, and the block number of the diagnosis listed in Blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, identify the primary diagnosis. Each service except for medical/surgical and IV supplies and medication must be itemized on the claim by dates of service. For example: a) *Emergency Room.* Bill as “Emergency room” or “Emergency room charge per use.” If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. (Revenue code B-450, B-456, or B-459.) b) *Observation Room.* Bill as “observation room.” (Revenue code B-762.) c) *Operating Room.* Bill as “Operating Room.” (Revenue code B-360, B-361, or B-369.) d) *Recovery Room.* Bill as “Recovery Room” or “Cast Room” as appropriate. (Revenue code B-710 or B-719.) e) *Injections.* Must have “Inj. - name of drug; route of administration; the dosage and quantity” or the injection code. f) *Drugs and Supplies.* Take-home drugs and supplies are not a benefit of the Medicaid program. Take-home drugs must be billed with revenue code B-253. Take-home supplies must be billed with revenue code B-273. Self-administered drugs must be billed with revenue code B-637. The drug description must include the name, strength, and quantity. g) *Radiology.* The description should provide the location and the number of views. As an alternative, identify the HCPCS code. The physician must bill professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

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Block No.	Description	Guidelines
44	HCPCS/rates (continued)	h) *Laboratory.* Provide a complete description or use the procedure codes for the laboratory procedures. The physician must bill professional services by a physician separately. Block 83 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. i) *Nuclear Medicine.* Provide a complete description. j) *Day Surgery.* Day surgery should be billed as an inclusive charge (using TOS "F"). Do *not* bill services provided in conjunction with the surgery (lab, radiology, and anesthesia) separately. File claims for emergency, unscheduled outpatient surgical procedures with separate charges (lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's nine-digit provider identifier. ***Note:*** *The HCFA-1450 (UB-92) claim form is limited to 27 items per outpatient claim. If necessary, combine IV supplies and central supplies on the charge detail and considered as single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.*
45	Service date	Enter the corresponding procedure by dates of service numerically on outpatient claims. Multiple dates of service may not be combined on outpatient claims.
46	Units of service	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in Block 46 must represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
51	Medicaid No.	Enter the nine-digit provider identifier.
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 84 as required.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Medicaid identification number	Enter the patient's nine-digit Medicaid number from their Medicaid Identification.
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 PAN for home health services, freestanding psychiatric facilities, freestanding rehabilitation facilities, and for surgery if one was issued.
65	Employer name	Enter the name of the client's employer if health/care might be provided. Complete Block 66.
66	Employer location	Enter the complete address if an employer name is identified in Block 65.

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Block No.	Description	Guidelines
67	Principal diagnosis code	Enter the ICD-9-CM diagnosis code for the principal diagnosis to the highest level of specificity available.
68–75	Other diagnosis codes	Enter the ICD-9-CM diagnosis code to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB “141”). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alpha-fetoprotein.*
76	Admitting diagnosis	Enter the ICD-9-CM diagnosis code in Block E indicating the cause of admission or include narrative. ***Note:*** *The admitting diagnosis is only for inpatient claims.*
79	Procedure coding method	Enter code “5” for HCPCS or “9” for ICD-9-CM. Code “9” is used only on inpatient hospital billings.
80–81 a, b, c, d, e	Principal and other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date each was performed.
82	Attending physician ID	For inpatient claims, enter the physician’s license number or UPIN of the provider who performed the service/procedure and/or is responsible for the treatment and plan of care in the following format: 11233333 1 Two-digit state indicator (for example, TX for Texas) 2 Licensing board indicator examples B = Doctor of Medicine (MD) or Doctor of Osteopathy (DO) D = Dentist P = Podiatrist C = Chiropractor 3 License number. Example: TXBL1234 If the provider has a temporary license number, enter “TEMPO.” Example: TXBTEMPO Procedures are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures. For outpatient claims, enter the license number of the physician referring the patient to the hospital.
83 a, b	Other physician ID	For inpatient claims, enter the license number of the provider who performed the principle service/surgical procedure. If same as Block 83, enter that physician’s provider identifier number, license number, and name. For outpatient claims, enter the license number for the following: • The ordering physician for all laboratory and radiology services. (If a different physician ordered laboratory or radiology services enter his license number in Block 82 and enter the referring/attending physician’s license number or UPIN in this block.) • The designated physician for a limited client when the physician performed or authorized nonemergency care. • If the referring physician is a resident, Blocks 82 and 83 must identify the physician who is supervising the resident.

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Block No.	Description	Guidelines
84	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated and signed by the physician. • If services are the result of an accident the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the Medicaid provider identifier of the facility where the work was forwarded must be entered in this field. • If the patient is deceased, enter the date of death. • If services were rendered on the date of death, enter the time of death. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered. • Enter the date of onset for patients receiving dialysis services. • Request for 110-day rule for a third party insurance.
85	Provider representative signature	The hospital representative must sign their name. 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 a hospital representative authorizing this practice. **Refer to:** "Provider Signature on Claims" on page 5-23.
86	Date bill submitted	Enter the date the bill was signed.

5.6.5 Occurrence Codes

Code	Description	Guidelines
01	Auto accident/auto liability insurance involved	Enter the date of an auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.
02	Auto or other accident/ no fault involved	Enter the date of the accident including auto or other where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.
03	Accident/tort liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party other than no-fault liability. **Refer to:** "Tort Response Form" on page B-114.

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Code	Description	Guidelines
04	Accident/employment-related	Enter the date of an accident that allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with Workers' Compensation insurance or an employer. Only services not covered by Workers' Compensation may be considered for payment by Medicaid.
05	Other accident	Enter the date of an accident not described by the above codes. Use this code to report no other casualty related payers have been determined.
06	Crime victim	Enter the date on which a medical condition resulted from alleged criminal action.
10	Last menstrual period	Enter the date of the last menstrual period when the service is maternity-related.
11	Onset of symptoms	Indicate the date the patient first became aware of the symptoms or illness being treated.
16	Date of last therapy	Indicate the last day of therapy services for OT, PT, or speech therapy (ST).
17	Date outpatient OT plan established or last reviewed	Indicate the date a plan was established or last reviewed for occupation therapy.
24	Date other insurance denied	Enter the date of denial of coverage by a TPR.
25	Date benefits terminated by primary payer	Enter the last date for which benefits are being claimed.
27	Date home health plan of treatment was established	Enter the date the current plan of treatment was established.
29	Date outpatient PT plan established or last reviewed	Indicate the date a plan of treatment was established or last reviewed for physical therapy.
30	Date outpatient speech pathology plan established or last reviewed	Indicate the date a plan of treatment for speech pathology was established or last reviewed.
35	Date treatment started for PT	Indicate the date services were initiated for physical therapy.
44	Date treatment started for OT	Indicate when occupational therapy services were initiated.
45	Date treatment started for speech-language pathology (SLP)	Indicate when speech language pathology services were initiated.

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5.6.6 Filing Tips for Outpatient Claims

The following are outpatient claim filing tips:

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

Important: *Services and supplies that exceed the 28 items per claim limitation must be submitted on an additional HCFA-1450 (UB-92) claim form and will be assigned a different claim number by TMHP. Claims may have 71 detail lines for services and supplies plus one detail line for the total amount billed.*

- Combine central supplies and bill as one item. IV supplies may be combined and billed as one item. Include appropriate quantities and total charges for each combined procedure code used. Using combination procedure codes conserves space on the claim form.
- The 28-item limitation per claim: a HCFA-1450 (UB-92) claim form submitted with 28 or fewer items is given an internal claim number (ICN) by TMHP. Multipage claim forms are processed as one claim for that client *if all* pages contain 28 or fewer items.
- Itemized Statements: Itemized statements are not used for assignment of procedure codes. HCPCS codes or narrative descriptions of procedures *must* be reflected on the face of the HCFA-1450 (UB-92) claim form. Attachments will only be used for clarification purposes.
- Physical/occupational therapy (PT/OT) procedures are based on time (initial 30 minutes or additional 15 minutes). Use the quantity billed to reflect the number of additional 15-minute increments.

Line Item	Description	Quantity
Example: one hour of PT service should be billed as two line items.		
#1	Therapeutic exercise	1
#2	Additional 15 minutes	2

Refer to: "Procedure Coding" on page 5-20.

5.7 2002 ADA Dental Claim Filing Instructions

Providers billing for dental services and Intermediate Care Facility for the Mentally Retarded (ICF-MR) dental services may bill electronically or use the 2002 American Dental Association (ADA) claim form.

Note: *TMHP is responsible for reimbursing all THSteps dental services provided by dentists, including services rendered to STAR and STAR+PLUS clients.*

5.7.1 2002 ADA Dental Claim Electronic Billing

Electronic billers must submit THSteps dental claims using TDHconnect or in ANSI ASC X12 837D 4010A format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, 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. Providers may request TDHconnect by contacting the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information about electronic filing.

5.7.2 ADA Dental Claim Form (Paper) Billing

All participating THSteps dental providers are required to submit a 2002 ADA Dental claim form for paper claim submissions to Texas Medicaid. These forms may be obtained by contacting the ADA at 1-800-947-4746.

Important: *Claims must contain the billing provider's full name, address, and/or nine-digit provider identifier.*

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5.7.3 2002 ADA Dental Claim Form

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Other Insured (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

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J515 (Same as ADA Dental Claim Form – J516, J517, J518, J519)

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5.7.4 2002 ADA Dental Claim Form Instruction Table

The following table is an itemized description of the questions appearing on the form. Thoroughly complete the 2002 ADA Dental claim form according to the instructions in the table to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

ADA Block No.	ADA Description	Instructions
1	Type of transaction	For Texas Medicaid, check the Statement of Actual Services Box. The other two boxes are not applicable. Do *not* use the 2002 ADA claim form as a Texas Medicaid Prior Authorization form. **Refer to:** "THSteps Dental Mandatory Prior Authorization Request Form" on page B-109.
2	Predetermination/ preauthorization number	Enter Prior Authorization Number if assigned by Medicaid.
3	Name, address, city, state, ZIP code	Enter name and address of Texas Medicaid Program Contractor payer where the claim is to be sent.
4	Other dental or medical coverage?	Leave blank if no other Dental or Medical coverage (skip Blocks 5-11). Check yes if other Dental or Medical coverage is available. If not Medicaid, complete Blocks 5–11.
5	Subscriber name	Subscriber Name if non-Medicaid insurance PAN. This line refers to the insured and is not necessarily the patient. May be parent or legal guardian of client receiving treatment.
6	Date of birth (MM/DD/CCYY)	Enter insured's eight-digit date of birth (MM/DD/CCYY) if non-Medicaid insurance. This line refers to the insured and is not necessarily the patient. May be parent or legal guardian of client receiving treatment.
7	Gender	Check insured's correct gender if non-Medicaid insurance. This line refers to the insured and is not necessarily the patient. May be parent or legal guardian of client receiving treatment.
8	Subscriber identifier	Enter insured's subscriber identifier if non-Medicaid insurance. This line refers to the insured and is not necessarily the patient. May be parent or legal guardian of client receiving treatment.
9	Plan/group number	Enter insured's plan/group number if non-Medicaid insurance. This line refers to the insured and is not necessarily the patient. May be parent or legal guardian of client receiving treatment.
10	Relationship to primary subscriber	Enter insured's relationship to primary subscriber if non-Medicaid insurance. This line refers to the insured and is not necessarily the patient. May be parent or legal guardian of client receiving treatment.
11	Other carrier name, address, city, state, ZIP code	Information on other carrier, if applicable.
12	Name (last, first, middle initial, suffix), address, city, state, ZIP code	Enter client's last name, first name, and middle initial as exactly written on the Texas Medicaid Identification Form (Form 3087).
13	Date of Birth (MM/DD/CCYY)	Enter client's eight-digit date of birth (MM/DD/CCYY).
14	Gender	Check client's correct gender.
15	Subscriber identifier	Enter client's Medicaid number.
16	Plan/group number	Not applicable for Texas Medicaid.
17	Employer name	Not applicable for Texas Medicaid.
18	Relationship to primary subscriber	Not applicable for Texas Medicaid.

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ADA Block No.	ADA Description	Instructions
19	Student status	For exception to periodicity, check the full time student (FTS) box and provide a narrative explanation in the Remarks Block 35.
20	Name (last, first, middle initial, suffix), address, city, state, ZIP code	Not applicable to Texas Medicaid.
21	Date of birth (MM/DD/CCYY)	Not applicable to Texas Medicaid.
22	Gender	Not applicable to Texas Medicaid.
23	Patient ID/account number (assigned by dentist)	Used by dental office to identify internal patient account number. This field is optional. Not required to process claim.
24	Procedure date (MM/DD/CCYY)	Enter eight-digit DOS (MM/DD/CCYY).
25	Area of oral cavity	Not applicable for Texas Medicaid.
26	Tooth system	Not applicable for Texas Medicaid.
27	Tooth number(s) or letter(s)	Enter Tooth ID as required for procedure code. Refer to “Tooth Identification (TID) and Surface Identification (SID) Systems” on page 19-8.
28	Tooth surface	Enter Surface ID as required for procedure code. Refer to “Tooth Identification (TID) and Surface Identification (SID) Systems” on page 19-8.
29	Procedure code	Use appropriate Current Dental Terminology (CDT).
30	Description	Enter brief description from the CDT.
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 patients.
32	Other fee(s)	Enter other fees (e.g., other insurance payment).
33	Total fee	Total all fees in column under Block 31.
34	(Place an X on each missing tooth)	Place an “X” on each missing tooth as required for procedure code.
35	Remarks	Use the Remarks space for a narrative explanation for exception to periodicity (Block 19), a facility name and address if Place of Treatment (Block 38) is not a provider office, an emergency narrative (Block 45), or additional information such as reports for 999 codes, multiple supernumerary teeth, or remarks code.
36	Patient/guardian signature	Not applicable for Texas Medicaid.
37	Subscriber signature	Not applicable for Texas Medicaid.
38	Place of treatment	Check only Provider’s Office box or Hospital box. Use Hospital if a day surgery facility was used.
39	Number of enclosures	Texas Medicaid does not require enclosures to accompany a claim. *Do not* submit radiographs with claims.
40	Is treatment for orthodontics?	Check Yes or No as appropriate.
41	Date appliance placed	Not applicable for Texas Medicaid.
42	Months of treatment remaining	Not applicable for Texas Medicaid.
43	Replacement of prosthesis?	Not applicable for Texas Medicaid.
44	Date prior placement	Not applicable for Texas Medicaid.

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ADA Block No.	ADA Description	Instructions
45	Treatment resulting from (check applicable box)	Providers are required to check Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of accident (MM/DD/CCYY)	Not applicable for Texas Medicaid.
47	Auto Accident State	Not applicable for Texas Medicaid.
48	Name, address, city, state, ZIP code	Name and Address of Billing Group or Individual provider (*not* the name and address of a provider employed within a group).
49	Provider ID	Must enter *required* billing dentist's nine-digit provider identifier for a group or an individual (*not* a provider identifier for a provider employed within a group.)
50	License number	Not applicable for Texas Medicaid.
51	SSN or TIN	Not applicable for Texas Medicaid.
52	Telephone number	Enter area code and telephone number of billing group or individual (*not* the telephone number for the provider employed within a group).
53	Treating dentist signature	Required signature by treating dentist or authorized personnel must be in Block 53.
54	Provider ID	Must enter *required* performing dentist's nine-digit provider identifier treating the client.
55	License number	Not applicable for Texas Medicaid.
56	Address, city, state, ZIP code	Not applicable for Texas Medicaid.
57	Telephone number	Not applicable for Texas Medicaid.
58	Treating provider specialty	This field is optional.

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5.8 Family Planning 2017 Claim Form

Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐

1a. Title X Only: Full Pay ☐ Partial Pay ☐ No Pay ☐

2. Provider Number/TPI

3. Provider Name

4. Eligibility Date (V or XX) (MM/DD/CCYY)

5. Family Planning No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial)

7. Address (Street, City, State)

7a. ZIP code

8. County of Residence

9. Date of Birth (MM/DD/CCYY)

10. Sex F ☐ M ☐

11. Patient Status: New Patient ☐ Established Patient ☐

12. Patient's Social Security Number - -

13. Race (Code #) ☐
White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5) Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)

13a. Ethnicity ☐
Hispanic (5) Non-Hispanic (0)

14. Marital Status ☐
(1) Married (2) Never Married (3) Formerly Married

15. Family Income (All) $

15a. Family Size

16. Number Times Pregnant

17. Number Live Births

18. Number Living Children

19. Primary Birth Control Method Before Initial Visit ☐

20. Primary Birth Control Method at End of This Visit ☐

a=Oral Contraceptive
b=1-Month hormonal injection
c=3-Month hormonal injection
d=Cervical cap/diaphragm
e=Abstinence
f= Hormonal Implant
g=Male condom
h=Female condom
i=Hormonal/Contraceptive patch
j=Spermicide (used alone)
k=Intrauterine device (IUD)
l=Vaginal ring
m=Fertility awareness method (FAM)
n=Sterilization
o=Contraceptive sponge
p=Other method
q=Method unknown
r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r) ☐

a=Refused
b=Pregnant
c=Inconclusive Preg Test
d=Seeking Preg
e=Infertile
f=Rely on Partner
g=Medical

22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a

23. Other Insurance Name and Address

24. Insured's Policy/Group No.

25. Other Insurance Pd. Amt. $

25a. Date of Notification

26. Name of Referring Provider

27. ID No. of Referring Provider

28. Level of Practitioner: Physician ☐ Nurse ☐ Mid Level ☐ Other ☐

29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)
1. ________.______
2. ________.______
3. ________.______
4. ________.______

30. Authorization Number

31. Date of Occurrence (MM / DD / CCYY)

32. A						B	C	D		E	F	G	H
Dates of Service From MM	From DD	From CCYY	To MM	To DD	To CCYY	Place of Service	Type of Service	Procedures, Services, or Supplies CPT/HCPCS	Modifier	Dx. Ref. (29)	Units or Days (Quantity) No. of Participants (Teen Counseling)	$ Charges	Performing Provider #

33. Federal Tax ID Number/EIN

34. Patient's Account No. (optional)

35. Patient Co-Pay Assessed (V, X or XX) $

36. **Total Charges**

37. Signature of Physician or Supplier
Date:
Signed:

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.

Form Revised: January 2005

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5.8.1 Family Planning 2017 Claim Form Instructions

Block No.	Description	Guidelines	Required
1	Family planning program	Check the box for the specific entitlement funds to which these family planning services are billed. If the facility also receives Title X funds, the Level of Practitioner (28) must be indicated. ***Note:*** *Claims/Encounters will be cross-checked with Title XIX Medicaid eligibility before Title V, X, or XX processing.*	V, XIX, XX
1a	Title X only	If it is a "Title X Only" encounter, the level of payment must be indicated. If the facility also receives Title X funds, the level of practitioner (28) must be indicated.	X
2	Provider number/provider identifier	Enter the provider's nine-digit provider identifier.	V, X, XIX, XX
3	Provider name	Enter the provider's name as enrolled with TMHP.	V, X, XIX, XX
4	Eligibility date (V or XX)	Enter the date (MM/DD/CCYY) this client was originally designated eligible for Title V or XX services. If client has V or XX eligibility from a previous visit, enter that eligibility date. For a Title XX client, this information comes from the 2025 claim form. For a Title V client, this information comes from the Texas Eligibility Screening System (TESS).	V, XX
5	Family planning No. (Medicaid PCN if XIX)	If previous V, X, and/or XX claims or encounters have been submitted to TMHP, enter the client's nine-digit family planning number, which begins with "F." If the client has Title XIX Medicaid, enter the client's nine-digit client number from the Medicaid Identification form. If this is a new family planning client, without Medicaid, leave this field blank and TMHP will assign a family planning number for the client.	XIX
6	Patient's name (last name, first name, middle initial)	Enter the client's last name, first name, and middle initial as printed on the Medicaid Identification Form, if Title XIX, or as printed in the provider's records, if Title V, X, or XX.	V, X, XIX, XX
7	Address (street, city, state)	Enter the client's complete home address as described by the client (street, city, and state). This reflects the location where the client lives.	V, X, XIX, XX
7a	ZIP code	Enter the client's ZIP code.	V, X, XIX, XX
8	County of residence	Enter the county code that corresponds to the client's address. Please use the HHSC county codes.	V, X, XIX, XX
9	Date of birth	Enter numerically the month, day, and year (MM/DD/CCYY) the client was born.	V, X, XIX, XX
10	Sex	Indicate the client's sex by checking the appropriate box.	V, X, XIX, XX

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Block No.	Description	Guidelines	Required
11	Patient status	Indicate if this is the client's first visit to this family planning provider (new patient) or if this client has been to this family planning provider previously (established patient). If the provider's records have been purged and the client appears to be new to the provider, check "New Patient."	V, X, XIX, XX
12	Patient's Social Security number	Enter the client's nine-digit Social Security number (SSN). If the client does not have a SSN, or refuses to provide the number, enter 000-00-0001.	V, X, XIX, XX
13	Race (code #)	Indicate the client's race by entering the appropriate race code number in the box. Aggregate categories used here are consistent with reporting requirements of the Office of Management and Budget Statistical Direction. Race is independent of ethnicity and all clients should be self-categorized as White, Black or African American, American Indian or Native Alaskan, Asian, Native Hawaiian or other Pacific Islander, or Unknown or Not Reported. An "Hispanic" client must also have a race category selected.	V, X, XIX, XX
13a	Ethnicity	Indicate whether the client is of Hispanic descent by entering the appropriate code number in the box. Ethnicity is independent of race and all clients should be counted as either Hispanic or non-Hispanic. The Office of Management and Budget defines Hispanic as "a person of Mexican, Puerto Rican, Cuban, Central, or South American culture or origin, regardless of race."	V, X, XIX, XX
14	Marital status	Indicate the client's marital status by entering the appropriate marital code number in the box.	V, X, XIX, XX

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Block No.	Description	Guidelines	Required
15	Family income (all)	Titles V, XX, XX: Use the *gross monthly income* calculated and reported on the eligibility assessment tool. Title XIX providers: Enter the *gross monthly income* reported by the client. Be sure to include all sources of income. No documentation of income is required. For clients who are married (including common-law marriages) or who are 20 years of age or older, enter the gross monthly income of all family members. For unmarried clients age 19 years or younger, enter the gross monthly income of the client only, not the income of all family members. **To calculate gross monthly income for Title XIX:** If income is received in a lump sum, or if it is for a period of time greater than a month (e.g., for seasonal employment), divide the total income by the number of months included in the payment period. If income is paid weekly, multiply weekly income by 4.33. If paid every two weeks, multiply amount by 2.165. If paid twice a month, multiply by 2. Enter $1.00 for clients not wishing to reveal income information.	V, X, XIX, XX
15a	Family size	Titles V, X, XX: Use the family size reported on the eligibility assessment tool. Title XIX providers: Enter the number of family members supported by the income listed in Box 15. Must be at least "one."	V, X, XIX, XX
16	Number times pregnant	Enter the number of times this client has been pregnant. If male, enter zero.	V, X, XIX, XX
17	Number live births	Enter the number of live births for this client. If male, enter zero.	V, X, XIX, XX
18	Number living children	Enter the number of living children this client has. This also must be completed for male clients.	V, X, XIX, XX
19	Primary birth control method before initial visit	Enter the appropriate code letter (a through r) in the box.	V, X, XIX, XX
20	Primary birth control method at end of this visit	Enter the appropriate code letter (a through r) in the box.	V, X, XIX, XX
21	If no method used at end of this visit, give reason (required only if #20=r)	If the primary birth control method at the end of the visit was "no method" (r), you must complete this box with an appropriate code letter from Block 21 (a through g).	V, X, XIX, XX (only if #20=r)
22	Is there other insurance available?	Check the appropriate box.	
23	Other insurance name and address	Enter the name and address of the Health Insurance carrier.	
24	Insured's policy/group No.	Enter the Insurance Policy number or Group number.	
25	Other insurance paid amount	Enter the amount paid by the Other Insurance company. If payment was denied, enter "Denied" in this field.	

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Block No.	Description	Guidelines	Required
25a	Date of notification	Enter the date of the Other Insurance payment or denial in this field. This must be in the format of MM/DD/CCYY.	
26	Name of referring provider	If a nonfamily planning service is being billed, and the service requires a referring provider, enter the provider's name.	XIX
27	ID No. of referring provider	If a nonfamily planning service is being billed and the service requires a referring provider identifier, enter the referring provider identifier.	XIX
28	Level of practitioner	Enter the level of practitioner that performed the service. Primary care or generalist physicians and specialists are correctly classified as "Physicians." Certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants providing family planning encounters are correctly categorized as "Midlevel." Family planning encounters provided by a registered nurse or a licensed vocational nurse would be categorized as "Nurse." Encounters provided by staff not included in the preceding classifications would be correctly categorized as "Other." If a client has encounters with staff members of different categories during one visit, select the highest category of staff with whom the client interacted. Optional for agencies not receiving any Title X funding.	X
29	Diagnosis code (relate items 1, 2, 3, or 4 to item 32D by line # in 32E)	Enter the ICD-9-CM diagnosis code to the highest level of specificity available; complete to five digits for each diagnosis observed.	V, X, XIX, XX
30	Authorization number	Enter the authorization number for the client, if appropriate.	
31	Date of occurrence	Use this section when billing for complications related to sterilizations, contraceptive implants, or intrauterine devices (IUDs). This field should contain the date (MM/DD/CCYY) of the original sterilization, implant, or IUD procedure associated with the complications currently being billed.	V, X, XIX, XX, if billing complications
32A	Dates of service	Enter the dates of service for each procedure provided in a MM/DD/CCYY format. If more than one DOS is for a single procedure, each date must be given (such as 3/16, 17, 18/1998). **Electronic Billers** Medicaid does not accept multiple (to-from) dates on a single line detail. Bill only one date per line.	V, X, XIX, XX
32B	Place of service	Enter the appropriate POS code for each service from the POS table under "Place of Service (POS) Coding" on page 5-19. If the client is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.	V, X, XIX, XX

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Block No.	Description	Guidelines	Required
32C	Type of service	Enter the appropriate TOS code for each service performed (lab, X-ray, surgery, assistant surgeon). Physicians may only bill for the professional component of any service rendered to a hospital patient. For a listing of TOS codes, refer to "Type of Service (TOS)" on page 5-19. TOS "T" is used when billing for the technical component of laboratory and X-ray services; TOS "4" is used for the total component for radiology, and TOS "5" is used for the total component for pathology.	V, X, XIX, XX
32D	Procedures, services, or supplies CPT/HCPCS modifier	Enter the appropriate CPT or HCPCS procedure codes for all procedures/services billed using the family planning services listed in "Family Planning Services" on page 20-1.	V, X, XIX, XX
32E	Dx. ref. (29)	Enter the diagnosis line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in Block 29. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure.	V, X, XIX, XX
32F	Units or days (quantity)	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).	V, X, XIX, XX
	No. of participants (teen counseling)	For Teen Group Counseling, enter the total number of participants included in the teen group counseling session. Required for Title XX, Teen Group Counseling claims.	# of participants is required for Title XX teen group counseling
32G	$Charges	Indicate the charges for each service listed (quantity times reimbursement rate). Charges must not be higher than fees charged to private-pay clients. Approved rate tables can be found in "Family Planning Services" on page 20-1.	V, X, XIX, XX
32H	Performing provider # (XIX only)	Members of a group practice (except pathology and renal dialysis groups) must identify the nine-digit provider identifier of the doctor/clinic within the group who performed the service. ***Note:*** *We recommend that providers complete this field for Titles V, X, and XX when the procedure code that is entered would normally require a performing provider identifier, if it were billed under Title XIX. If a claim or encounter that was submitted for V, X, or XX is later determined as eligible to be paid from Title XIX and the performing provider identifier is missing, the claim will be denied with a request for this information. To avoid unnecessary claim or encounter denial, complete this information for all claims and encounters.*	XIX
33	Federal Tax ID Number/ EIN (Optional)	Enter the Federal Tax ID Number (TIN) (Employer Identification Number [EIN]) that is associated with the provider identifier enrolled with TMHP.	
34	Patient's account number (optional)	Enter the client's account number that is used in the provider's office for its payment records.	

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Block No.	Description	Guidelines	Required
35	Patient copay assessed	If the client was assessed a copayment (V, X, or XX), enter the dollar amount assessed. If no copay was assessed, enter $0.00. Copay cannot be assessed for Title XIX clients. Copayment must not exceed 25 percent of total charges for Title V or XX patients.	V, X, XX
36	Total charges	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.	V, X, XIX, XX
37	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on file" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. When providers enroll to be an electronic biller, the "Signature on file" requirement is satisfied during the enrollment process.	V, X, XIX, XX
38	Name and address of facility where services were rendered (if other than home or office)	If the services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP code, or the nine-digit provider identifier of the facility (such as the hospital or birthing center) where the service was provided. Independently practicing health care professionals must enter the name and number of the school district/cooperative where the child is enrolled (SHARS/ECI). For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the nine-digit provider identifier of the outside laboratory should be entered. The laboratory should bill the Texas Medicaid Program for the services performed.	XIX
39	Physician's, supplier's billing name, address, ZIP code, and telephone number	Enter the nine-digit provider identifier, provider name, street, city, state, ZIP code, and telephone number.	

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Block No.	Description	Guidelines	Required
	Teen group counseling	Providers billing Teen Group Counseling must complete the following fields: 1. Family planning program—should be Title XX 2. Provider number/provider identifier 3. Provider name 5. Family planning No.—Enter 999999999 (electronic billers, enter 999999999 in the Medicaid No. field) 6. Patient's name—Enter "teen group counseling" 12. Patient's Social Security number—should be 999-99-9999 29. Diagnosis code—use V2509 32A. Dates of service 32B. Place of service 32C. Type of service 32D. Procedures, services, or supplies; CPT/HCPCS modifier 32E. Dx. ref. (29) 32F. No. of participants 32G. $Charges 33. Federal Tax ID Number/EIN 36. Total charges 37. Signature of physician or supplier	XX – teen group counseling only

5.9 Vision Claim Form

All vision services must be billed on a CMS-1500 claim form or the appropriate electronic formats. The eyeglass prescription must be in Block 24D (line 5 for the new prescription and line 6 for the old prescription). The Patient Certification Form must be retained in the patient's file – *do not submit to TMHP.* Vision care services are benefits of the Texas Medicaid Program only for clients age 21 years of age and older. Vision claims submitted on other forms are denied with EOB 01145, "Claim form not allowed for this program." Providers have 120 days from the date of the R&S report to resubmit claims to TMHP on the CMS-1500, with the R&S report where the claim appears as denied attached.

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

Block Number	Description
1a	Medicaid identification number
2	Patient's name
3	Patient's date of birth
3	Patient's sex
5	Patient's address
9 and 9a–9d	Other insurance or government benefits
10	Was condition related to: Patient's employment Accident or injury
11	Medicare HIC number
12	Patient's or authorized person's signature
13*	Insured or authorized person's signature
17 (for name and/or address of provider) 17a (for provider identifier)	Name and address of prescribing medical doctor or doctor of optometry
21	Diagnosis or nature of illness or injury
24A	DOS

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Block Number	Description
24B	POS
24D	Describe procedures, medical services, or supplies furnished for each date given
24D, Line "5" for new prescription 24D, Line "6" for old prescription	Prescription/description of lenses and frames
24E	Diagnosis reference
24F	Charges
24K	Other
26*	The account number for the patient that is used in the provider's office for its billing records.
27 Check "YES" or "NO"	Accept assignment?
28	Total charges
29	Amount paid by other insurance
31	Signature of physician or supplier
32	Name and address of facility where services rendered
33	Telephone number
33	Physician's or supplier's name, address, city, state, and ZIP code
No longer used	Referral from screening program (THSteps)
Providers must have patients sign the Patient Certification Form and retain in their records. **Refer to:** "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" on page B-116. Do *not* submit to TMHP.	Selection of eyewear beyond program benefits/replacing lost or destroyed eyewear

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5.10 Remittance and Status (R&S) Report

The R&S report provides information on pending, paid, denied, and adjusted claims. TMHP provides weekly R&S reports to give providers detailed information about the status of claims submitted to TMHP. The R&S report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions. All claims for the same provider identifier and program processed for payment are paid at the end of the week, either by a single check or with Electric Funds Transfer (EFT). If no claim activity or outstanding account receivables exist during the cycle week, the provider does not receive an R&S report. Providers are responsible for reconciling their records to the R&S to determine payments and denials received.

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

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

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information.

5.10.1 R&S Report Delivery Options

TMHP offers three options for the delivery of the R&S report. Although providers have the choice of one of the following methods, the initial delivery method of a newly enrolled provider is set up with a *paper* R&S report delivery method.

- *Paper version*. Paper R&S reports are mailed to providers the following Friday after the weekly claims cycle. Reimbursement checks are mailed with the paper R&S report, if the provider has not elected EFT.

  Note: *Additional copies of paper R&S reports will be charged to the provider if requested more than 30 days after the original R&S report was issued. There is an initial charge of $9.75 for the request (additional hours = $9.75) with a charge of $0.32 per page and applicable taxes of 8.25 percent.*

- *Portable Document Format (PDF) version*. Using an Adobe Acrobat format, the PDF file is an exact replica of the paper R&S report. This online version allows a registered user to access the tmhp.com website to download the weekly R&S report. The report is available each Monday morning, immediately after the weekly claims cycle. Payments associated with the R&S report are not released until all provider payments are released the following Friday after the weekly claims cycle. Providers who elect to use the PDF version will not receive paper copies of the R&S report.

In addition to the paper or PDF version of the R&S report, a third, optional R&S report delivery method is also available. Using HIPAA-compliant EDI standards, the Electronic Remittance & Status (ER&S) report can be downloaded through the TMHP EDI Gateway using TDHconnect, the free Windows® -based software available from TMHP, or a third party software. The ER&S report is also available each Monday after the completion of the claims processing cycle. For more information about EDI formats and enrollment for the ER&S report, please refer to "TMHP Electronic Data Interchange (EDI)" on page 3-1.

5.10.2 Banner Pages

Banner pages serve two purposes. First, they print the provider's name and address in a location that appears in the window of the envelope. Second, they are used to inform providers of new policies and procedures. The title pages include the following information:

- TMHP address for submitting paper appeals
- Provider's name, address, and telephone number
- Unique R&S report number specific to each report
- Provider identifier
- Report sequence number (indicates the week number of the year)
- Date of the week being reported on the R&S report
- TIN
- Page number (R&S report begins with page 1)
- AIS provider identifier conversion (provider identifier converted for AIS use)
- AIS telephone number

5.10.3 R&S Report Field Explanation

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

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

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Program Type

PPP	Program
001	Long Term Care
100	Medicaid
200	Managed Care
300	Family Planning (Titles V, X, and XX)
400	CSHCN
999	Default/summary for all media regions

Claim Type (CT)

Claim Type	Description
020	Physician/supplier (Medicaid only) (genetics agencies, THSteps [medical only], FQHC, optometrist, optician)
021	THSteps (dental)
023	Outpatient hospital, home health, rural health clinic, FQHC
030	Physician crossovers
031	Hospital outpatient crossovers, home health crossovers, RHC crossovers
040	Inpatient hospital
050	Inpatient crossover
055	Family Planning Title V
056	Family Planning Title X
057	Family Planning Title XX
058	Family Planning Title XIX (Form 2017)

Media Source (MMM)

Region	Description
010	Paper
011	Paper adjustment
020	TDHconnect
021	TDHconnect adjustment
030	Electronic
031	Electronic adjustment
041	AIS adjustment
051	Mass adjustment
061	Crossover adjustment
071	Retroactive eligibility adjustment
080	Case Action Request Tracking System (CARTS)
081	CARTS adjustment
090	Phone
091	Referral Identification Monitoring System (RIMS)
100	Fax
110	Mail
120	Encounter
121	Encounter Adjustment

- *Medicaid #.* The client's Medicaid number.
- *Patient Account #.* If a patient account number is used on the provider's claim, it appears here.
- *Medical Record #.* If a medical record number is used on the provider's claim, it appears here.
- *Medicare #.* If the claim is a result of an automatic crossover from Medicare, the last ten digits of the Medicare claim number appears directly under the TMHP claim number.
- *Diagnosis.* Primary diagnosis listed on the provider's claim.
- *Service Dates.* Format MMDDYYYY (month, day, year) in "From" and "To" dates of service.
- *TOS/Proc.* Indicates by code the specific service provided to the client. The one-digit TOS appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code. For claims paid under prospective payment methodology, it is the code of the DRG.
- *Billed Quantity.* Indicates the quantity billed per claim detail.
- *Billed Charge.* Indicates the charge billed per claim detail.
- *Allowed Quantity.* Indicates the quantity TMHP has allowed per claim detail.
- *Allowed Charge.* Indicates the charges TMHP has allowed per claim detail. For inpatient hospital claims, the allowed amount for the DRG appears.
- *Place of Service (POS) Column.* The R&S report includes the POS to the left of the Paid Amount. A one-digit numeric code identifying the POS is indicated in this column. Refer to "Place of Service (POS) Coding" on page 5-19 for the appropriate cross-reference among the two-digit numeric POS codes (Medicare), alpha POS codes, and one-digit numeric code on the R&S report. Providers using electronic claims submission should continue using the same POS codes.
- *Paid Amt.* The final amount allowed for payment per claim detail. The total paid amount for the claim appears on the claim total line.
- *EOB (Explanation of Benefit) Codes and Explanation of Pending Status (EOPS) Codes.* These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to or directly below the claim. The EOPS appear only in "The Following Claims Are Being Processed" section of the R&S report. The codes explain the status of pending claims and are not an actual denial or final disposition. An explanation of all EOB and EOPS appearing on the R&S report are printed in the Appendix at the end of the R&S report. Up to five EOB codes are displayed.

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- *Modifier.* Modifiers have been developed to describe and qualify services provided. For THSteps dental services two modifiers are printed. The first modifier is the TID and the second is the SID.

Refer to: "Modifier Requirements for TOS Assignment" on page 5-11 for a list of the most commonly used modifiers.

5.10.4 R&S Report Section Explanation

5.10.4.1 Claims – Paid or Denied

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

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

- *Age.* Client's age according to TMHP records
- *Sex.* Client's sex according to TMHP records: M = Male, F = Female, U = Unknown
- *Pat-Stat.* Indicates the client's status at the time of discharge or the last DOS on the claim (refer to instructions for HCFA-1450 (UB-92) claim form, Block 22)
- *Proc.* ICD-9-CM code indicates the primary surgical procedure used in determining the DRG

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

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

Refer to: "Claims Information" on page 5-3 for a description of different claim types.

5.10.4.2 Adjustments to Claims

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

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

Refer to: "Modifier Requirements for TOS Assignment" on page 5-11 for a list of the most commonly used modifiers.

5.10.4.3 Financial Transactions

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

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Accounts Receivable

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

- *Control Number.* A number to reference when corresponding with TMHP.
- *Recoupment Rate.* The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
- *Maximum Periodic Recoupment Amount.* The amount to be withheld each week. This area is blank if the provider elects to have a percentage withheld each week.
- *Original Date.* The date the financial transaction was processed originally.
- *Original Amount.* The total amount owed TMHP.
- *Prior Date.* The date the last transaction on the A/R occurred.
- *Prior Balance.* The amount owed from a previous R&S report.
- *Applied Amount.* The amount subtracted from the current R&S report.
- *FYE.* The fiscal year end (FYE) for cost reports.
- *EOB.* The EOB code that corresponds to the reason code for the A/R.
- *Patient Name.* If the A/R is claim-specific, the name of the patient on the claim.
- *Claim Number.* If the A/R is claim-specific, the ICN of the original claim.
- *Backup Withholding Penalty Information.* A penalty assessed by the Internal Revenue Service (IRS) for noncompliance due to a B-Notice. Although the current

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payment amount is lowered by the amount of the backup withholding, the provider's 1099 earnings are not lowered.

- *Control Number.* TMHP control number to reference when corresponding with TMHP.
- *Original Date.* The date the backup withholding was set up originally.
- *Withheld Amount.* Amount withheld (31 percent) of the provider's checkwrite.

IRS Levies

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

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

Refunds

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

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

Payouts

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

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

Reissues

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

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

Voids and Stops

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

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

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5.10.4.4 Claims Payment Summary

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

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

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

- *Claims Paid.* Indicates the number of claims processed for the week and the year-to-date total.
- *System Payouts.* The total amount of system payouts made to the provider by TMHP.
- *Manual Payouts (Remitted by separate check or EFT).* The total amount of manual payouts made to the provider by TMHP.
- *Amount Paid to IRS for Levies.* The amount remitted to IRS and withheld from the provider's payment due to an IRS levy.
- *Amount Paid to IRS for Backup Withholding.* The amount paid to the IRS for backup withholding.
- *Accounts Receivable Recoupments.* The total amount withheld from the provider's payment due to accounts receivable.
- *Amounts Stopped/Voided.* The total amount of the payment that was voided or stopped with no reissuance of payment.
- *System Reissues.* The amount of the reissed payment.
- *Claim Related Refunds.* The total amount of claim-related refunds applied during the weekly cycle.
- *Nonclaim Related Refunds.* The total amount of nonclaim-related refunds applied during the weekly cycle.
- *Approved to Pay/Deny Amount.* The total amount of claim payments that were approved to pay/deny within the week. (This column will not be used at this time.)
- *Pending Claims.* The total amount billed for claims in process as of the cutoff date for the report.

5.10.4.5 The Following Claims are Being Processed

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

5.10.4.6 Explanation of Benefit Codes Messages

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

5.10.4.7 Explanation of Pending Status Codes Appendix

This section lists the description of all EOPs that appeared on the R&S report. EOPs appear in numerical order.

EOBs and EOPs may appear on the same pending claim because some details may have already finalized while others may have questions and are pending.

5.10.5 R&S Report Examples

See the following pages for examples of R&S reports.

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5.10.6 Banner Page R&S Report

```
                         Texas Medicaid & Healthcare Partnership
                          Medicaid Remittance and Status Report
                                   Date: 11/25/2004

              Mail original claim to:                          ROBERT SMITH MD
              Texas Medicaid & Healthcare Partnership          123 MAIN STREET
              P.O. Box 200555                                  ABC CLINIC
              Austin, TX 78720-0555                            AUSTIN, TX 78701
                                                               (512) 555-5555
              Mail all other correspondence to:
              Texas Medicaid & Healthcare Partnership          Provider ID:  0000000-11
              12357-A Riata Trace Parkway                      Report Seq. Number:  99
              Austin, TX 78727                                 R&S Number:    24600000

              (800) 925-9126
              (512) 514-3000
                                                                            Page 1 Of 8
______________________________________________________________________________________
                                     BANNER PAGE
______________________________________________________________________________________
(09/24/04 through 10/22/04) ***** Attention All Providers *****

The 2004 Texas Medicaid Provider Fee Schedules will be posted to the TMHP website at www.tmhp.com on
September 30, 2004. The schedules can be downloaded in an Excel format. Providers may request a copy of a
fee schedule free of charge by calling the TMHP Contact Center at 1-800-925-9126.



          ROBERT SMITH MD                              TAX ID NUMBER 750000000
          123 MAIN STREET                              YOUR MEDICAID AIS NUMBER IS 000000011
          ABC CLINIC                                   FOR AIS INQUIRY CALL TOLL FREE (800) 925-9126
          AUSTIN, TX 78701                             THE PROVIDER MANUAL PROVIDES DETAILS.
          (512) 555-5555                               PHYSICAL ADDRESS ON RECORD:
                                                       ROBERT SMITH MD
                                                       321 NORTH STREET
                                                       AUSTIN, TX 78751

                                                       (512) 555-6666
```


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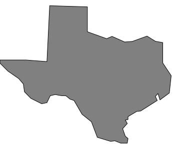
5.10.6.1 Paid or Denied Claims (Hospital) R&S Report



```
                               Texas Medicaid & Healthcare Partnership
                                Medicaid Remittance and Status Report
                                          Date: 11/25/2004

                 Mail original claim to:                                    TEXAS HOSPITAL
                 Texas Medicaid & Healthcare Partnership                    456 MAIN STREET
                 P.O. Box 200555                                            AUSTIN, TX 78701
                 Austin, TX 78720-0555                                      (512) 555-4321


                 Mail all other correspondence to:
                 Texas Medicaid & Healthcare Partnership                    Provider ID:  0000000-11
                 12357-A Riata Trace Parkway                                Report Seq. Number:  99
                 Austin, TX 78727                                           R&S Number:    24600000

                 (800) 925-9126
                 (512) 514-3000
                                                                                              Page 85 Of 100
 PATIENT NAME          CLAIM NUMBER        MEDICAID #   PATIENT ACCT #   MEDICAL RECORD #    MEDICARE #    EOB   EOB   EOB   EOB         DIAGNOSIS
---SERVICE DATES---                       -----BILLED-----      -----ALLOWED-----
   FROM         TO     TOS  PROC       QTY         CHARGE      QTY         CHARGE       POS        PAID AMT    EOB   EOB   EOB   EOB   EOB    MOD   MOD


GARCIA,LISA      10004003098765432140l236 258963258  33333333333       212345C                         01147                               64403
09/05/2003 09/07/2003 A   111        2.0       1,050.00     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   250       25.0         286.35     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   258       22.0         465.00     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   270       12.0          45.64     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   300       14.0         755.00     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   390        1.0          59.00     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   510        1.0         130.00     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   760       19.0         614.24     .0           .00       3             .00   00837
09/05/2003 09/07/2003 B   920        2.0         145.00     .0           .00       3             .00   00837
                                  PROC: 07534

                                          $3,550.23                   $.00                      $.00   CLAIM TOTAL

GONZALES,BEATRIZ 100040030258963147025896 147258369  33333333333       212345C                         00251 00164                         64881
10/24/2003 10/29/2003 A   111        4.0       2,100.00     .0           .00       3             .00   00837 00182
10/24/2003 10/29/2003 A   206        1.0       1,600.00     .0           .00       3             .00   00837 00182
10/24/2003 10/29/2003 B   250       27.0         177.00     .0           .00       3             .00   00837 00182
10/24/2003 10/29/2003 B   258       20.0         470.00     .0           .00       3             .00   00837 00182
10/24/2003 10/29/2003 B   270       33.0         199.07     .0           .00       3             .00   00837 00182

*****************************************************************************************************************************
  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 (800) 291-3734.
  CLAIMS WITH AN ALLOWED CHARGE OF $0.00 AND A PAID AMOUNT OF $0.00 MUST BE RESUBMITTED WITH A COMPLETED CLAIM AND A COPY OF
  THIS R&S PAGE TO THE FIRST ADDRESS LISTED ABOVE WITHIN 120 DAYS FROM THE DATE OF THE R&S.
```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5.10.6.2 Paid or Denied Claims (Physician) R&S Report

```
                                   Texas Medicaid & Healthcare Partnership
                                    Medicaid Remittance and Status Report
                                             Date: 11/25/2004

                     Mail original claim to:                                ROBERT SMITH MD
                     Texas Medicaid & Healthcare Partnership                123 MAIN STREET
                     P.O. Box 200555                                        ABC CLINIC
                     Austin, TX 78720-0555                                  AUSTIN, TX 78701
                                                                            (512) 555-5555

                     Mail all other correspondence to:
                     Texas Medicaid & Healthcare Partnership                Provider ID:  0000000-11
                     12357-A Riata Trace Parkway                            Report Seq. Number:  99
                     Austin, TX 78727                                       R&S Number:    24600000

                     (800) 925-9126
                     (512) 514-3000
                                                                                                      Page 5 Of 21
_________________________________________________________________________________________________________________________
 PATIENT NAME          CLAIM NUMBER       MEDICAID #   PATIENT ACCT #   MEDICAL RECORD #    MEDICARE #    EOB   EOB   EOB   EOB          DIAGNOSIS
---SERVICE DATES---                     -----BILLED-----     -----ALLOWED-----
   FROM        TO      TOS  PROC        QTY        CHARGE       QTY        CHARGE       POS        PAID AMT    EOB   EOB   EOB   EOB   EOB    MOD  MOD
_________________________________________________________________________________________________________________________

               ********************************************* CLAIMS - PAID OR DENIED ***************************************


DAVIS,EDNA    10003003012345678987654 3 123456789     01234567898765                           999999999A   01147                       74722
10/18/2003 10/18/2003 1   99232      1.0         57.52     .0           .00       3                  .00    00260
10/19/2003 10/19/2003 1   99238      1.0         70.55     .0           .00       3                  .00    00260

                                               $128.07                $.00                          $.00   CLAIM TOTAL

    00260    CLIENT IS COVERED BY OTHER INSURANCE WHICH MUST BE BILLED PRIOR TO THIS PROGRAM - SEE PRIVATE INSURANCE INFORMATION BELOW
             OR ON FOLLOWING PAGE.

PRIVATE INSURANCE INFORMATION:
                      ******************************** 0000010000 ********************************

                  0000010000                                           POLICY:         ABC888888888
                  P O BOX 555555                                       GROUP:
                  DALLAS, TX 75266                                     POLICY HOLDER:  DAVIS, EDNA
                  (800)555-1234                                        EMPLOYER:


SMITH,JOE    100030030123456789876543 123456789     01234567898765                             999999999A   01147                       74722
10/14/2003 10/14/2003 1   99232      1.0         57.52    1.0         11.50       3                11.50    00018

*************************************************************************************************************************************
  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 (800) 291-3734.
  CLAIMS WITH AN ALLOWED CHARGE OF $0.00 AND A PAID AMOUNT OF $0.00 MUST BE RESUBMITTED WITH A COMPLETED CLAIM AND A COPY OF
  THIS R&S PAGE TO THE FIRST ADDRESS LISTED ABOVE WITHIN 120 DAYS FROM THE DATE OF THE R&S.
```


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5.10.6.3 Adjustments R&S Report

```
                          Texas Medicaid & Healthcare Partnership
                            Medicaid Remittance and Status Report
                                     Date: 11/25/2004

             Mail original claim to:                               ROBERT SMITH MD
             Texas Medicaid & Healthcare Partnership               123 MAIN STREET
             P.O. Box 200555                                       ABC CLINIC
             Austin, TX 78720-0555                                 AUSTIN, TX 78701
                                                                   (512) 555-5555

             Mail all other correspondence to:
             Texas Medicaid & Healthcare Partnership               Provider ID:  0000000-11
             12357-A Riata Trace Parkway                           Report Seq. Number:  99
             Austin, TX 78727                                      R&S Number:    24000000

             (800) 925-9126
             (512) 514-3000
                                                                                          Page 9 Of 20
 PATIENT NAME         CLAIM NUMBER        MEDICAID #   PATIENT ACCT #   MEDICAL RECORD #   MEDICARE #    EOB   EOB   EOB   EOB          DIAGNOSIS
---SERVICE DATES---                    -----BILLED-----      -----ALLOWED-----
   FROM        TO      TOS  PROC      QTY        CHARGE     QTY        CHARGE       POS        PAID AMT    EOB   EOB   EOB   EOB   EOB    MOD  MOD

               ********************************************* ADJUSTMENTS - PAID OR DENIED ***************************************

ADJUSTMENT CLAIM:
HUDSON,MEL  1000200519876543210123455 222222222  555555555                                       01147                             V725
04/04/2003 04/04/2003 I   85060      1.0         26.32    .0          .00      3             .00   00488
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00   00127                                26
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00   00127                                26
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00   00127                                26
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00   00127                                26
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00   00127                                26

                                              $130.02                $.00                    $.00   ADJUSTMENT CLAIM TOTAL

    00123  THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 100020011200205240452000  WHICH APPEARS ON R&S DATED 08/27/2003

    00127    PAID ON CLAIM  ON 00/00/0000.

ORIGINAL CLAIM:
HUDSON,MEL  100020010987654321012345 222222222  555555555                                                                          V725
04/04/2003 04/04/2003 5   85060      1.0         26.32    .0          .00      3             .00
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00                                        26
04/06/2003 04/06/2003 I   88180      1.0         20.74    .0          .00      3             .00                                        26
*******************************************************************************************************************************************

  IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING.  OTHERWISE,
  COPY 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 (800) 291-3734.
```

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5.10.6.4 System Payouts R&S Report

```
                              Texas Medicaid & Healthcare Partnership
                                    Remittance and Status Report
                                         Date: 01/01/2005

              Mail original claim to:                                Robert Smith
              Texas Medicaid & Healthcare Partnership                123 Main Street
              P.O. Box 200555                                        ABC Clinic
              Austin, Texas 78720-0555                               Austin, Tx 78701
                                                                     (512) 555-5555
              Mail all other correspondence to:
              Texas Medicaid & Healthcare Partnership                Provider ID:  0000000-11
              12357-A Riata Trace Parkway                            Report Seq. Number:   99
              Austin, Texas 78727                                    R&S Number:    24600000

              (800) 925-9126
              (512) 514-3000

                                                                                        Page 6 Of
                                                      ------- REFUND CHECK -------
PAYOUT CONTROL NUMBER    PAYOUT AMOUNT    FYE    EOB      NUMBER        AMOUNT        PATIENT NAME      PCN        DOS

*********************************************************** FINANCIAL TRANSACTIONS ***********************************************************

SYSTEM PAYOUTS

YOUR PAYMENT AND 1099 LIABILITY HAVE BEEN INCREASED FOR THE REASON INDICATED BELOW.

    2001111111111       120.60                  06135     15589999      150.73          Del Valle, R.     555555555   05/01/2005

TOTAL FOR Program 100:    $120.60

YOUR PAYMENT AND 1099 LIABILITY HAVE BEEN INCREASED FOR THE REASON INDICATED BELOW.

    20010000000000       120.60                 06135     15589999      150.73          Del Valle, S.     444444444   05/01/2005

TOTAL FOR Program 200:  $120.60

*****************************************************************************************************************************************
```


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5.10.6.5 Manual Payouts R&S Report

```
                              Texas Medicaid & Healthcare Partnership
                                   Remittance and Status Report
                                        Date: 01/01/2005

                   Mail original claim to:                                     Robert Smith
                   Texas Medicaid & Healthcare Partnership                     123 Main Street
                   P.O. Box 200555                                             ABC Clinic
                   Austin, Texas 78720-0555                                    Austin, Tx. 78701
                                                                               (512) 555-5555
                   Mail all other correspondence to:
                   Texas Medicaid & Healthcare Partnership                     Provider ID:  0000000-11
                   12357-A Riata Trace Parkway                                  Report Seq. Number:   99
                   Austin, Texas 78727                                         R&S Number:    24600000

                   (800) 925-9126
                   (512) 514-3000
                                                                                                   Page 7 Of
______________________________________________________________________________________________________________________
                                                          ------- REFUND CHECK ------
PAYOUT CONTROL NUMBER     PAYOUT AMOUNT     FYE      EOB        NUMBER          AMOUNT       PATIENT NAME      PCN      DOS
______________________________________________________________________________________________________________________

*********************************************************** FINANCIAL TRANSACTIONS ************************************************************

MANUAL PAYOUTS

A CHECK FOR PROGRAM 200 HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.

   2001111111111         3.75                        00330          1312           52.82

TOTAL FOR MEDICAID:     $3.75

*********************************************************** FINANCIAL TRANSACTIONS ************************************************************

A CHECK FOR PROGRAM 200 HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW.

    200111000000         3.75                        00330          1312          52.82

TOTAL FOR MANAGED CARE:  $3.75

*****************************************************************************************************************************************
```


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5.10.6.6 Accounts Receivables, Void, and Stop Pay R&S Report

For purposes of example, accounts receivables, void, and stop pay appear together on the following R&S report example.

```
                              Texas Medicaid & Healthcare Partnership
                               Medicaid Remittance and Status Report
                                         Date: 11/25/2004

                   Mail original claim to:                              ROBERT SMITH MD
                   Texas Medicaid & Healthcare Partnership              123 MAIN STREET
                   P.O. Box 200555                                      ABC CLINIC
                   Austin, TX 78720-0555                                AUSTIN, TX 78701
                                                                        (512) 555-5555

                   Mail all other correspondence to:
                   Texas Medicaid & Healthcare Partnership              Provider ID:  0000000-11
                   12357-A Riata Trace Parkway                          Report Seq. Number:  99
                   Austin, TX 78727                                     R&S Number:    24600000

                   (800) 925-9126
                   (512) 514-3000
                                                                                                  Page 1 Of 8

CONTROL NUMBER   RECOUPMENT RATE     ORIGINAL DATE      PRIOR DATE                                 PATIENT NAME
                 MAXIMUM PERIODIC
                 RECOUPMENT AMOUNT   ORIGINAL AMOUNT    PRIOR BALANCE    APPLIED AMOUNT  FYE  EOB  CLAIM NUMBER

*********************************************************** FINANCIAL TRANSACTIONS ***********************************************************

ACCOUNTS RECEIVABLE

YOUR PAYMENT WAS REDUCED BY THE APPLIED AMOUNTS SHOWN BELOW FOR THE REASONS INDICATED.


1998177795139          100%          06/26/2000        11/25/2003                                  DREW, MARCY
                      40.85               40.85             40.85              .00       06065     1000200101234567898765 43

TOTAL ACCOUNTS RECEIVABLE                                                     $ .00

*********************************************************** FINANCIAL TRANSACTIONS ***********************************************************
VOIDS AND STOPS

CHECK NUMBER:  018173139           CHECK AMOUNT:         41.46          R&S NUMBER:         0         R&S DATE:  07/06/2003


TOTAL VOID/STOP CHECK AMOUNTS                          $ 41.46


**********************************************************************************************************************************************
```


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5.10.6.7 Refunds R&S Report

Texas Medicaid & Healthcare Partnership
Medicaid Remittance and Status Report
Date: 11/25/2004

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, TX 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-A Riata Trace Parkway
Austin, TX 78727

(800) 925-9126
(512) 514-3000

ROBERT SMITH MD
123 MAIN STREET
ABC CLINIC
AUSTIN, TX 78701
(512) 555-5555

Provider ID: 0000000-11
Report Seq. Number: 99
R&S Number: 24600000

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** FINANCIAL TRANSACTIONS **

REFUNDS

YOUR REFUND CHECK #000006830 DATED 10/12/2003 WAS RECEIVED BY TMHP AND APPLIED AS FOLLOWS:

CLAIM-SPECIFIC:

ICN	PATIENT NAME	MEDICAID NUMBER	DATE OF SERVICE	TOTAL BILLED	AMOUNT APPLIED THIS CYCLE	EOB
100030010123456789876543	DREW, SARA M.	123456789	07/01/2003	204.70	10.66	00124
Subtotal Claim Specific					$ 10.66	
TOTAL REFUNDS					$ 10.66	

****

5

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5.10.6.8 IRS Levy R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 01/01/2005

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, Texas 78727

(800) 925-9126
(512) 514-3000

Robert Smith
123 Main Street
ABC Clinic
Austin, ST 78701
(512) 555-5555

Provider ID: 0000000-11
Report Seq. Number: 99
R&S Number: 24600000

Page 9 Of

CONTROL NUMBER	-- MAXIMUM RECOUPMENT -- RATE	AMOUNT	ORIGINAL DATE	ORIGINAL AMOUNT	PRIOR BALANCE	PRIOR DATE	CURRENT AMOUNT	REMAINING BALANCE

** FINANCIAL TRANSACTIONS **

IRS LEVY INFORMATION FOR PROGRAM 100:

CONTROL NUMBER	RATE	AMOUNT	ORIGINAL DATE	ORIGINAL AMOUNT	PRIOR BALANCE	PRIOR DATE	CURRENT AMOUNT	REMAINING BALANCE
2587413698521	100%	95,652.01	05/01/2005	95,652.01	91,385.98	06/01/2005	167.00	91,128.98

IRS LEVY INFORMATION FOR PROGRAM 200:

CONTROL NUMBER	RATE	AMOUNT	ORIGINAL DATE	ORIGINAL AMOUNT	PRIOR BALANCE	PRIOR DATE	CURRENT AMOUNT	REMAINING BALANCE
2587413698521	100%	95,652.01	05/01/2005	95,652.01	91,385.98	06/01/2005	167.00	91,128.98

A PAYMENT IN THE AMOUNT OF $167.00 WAS REMITTED ON YOUR BEHALF TO THE INTERNAL REVENUE SERVICE DUE TO THE LEVY THAT IS DESCRIBED ABOVE.

****

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5.10.6.9 Backup Withholding Penalty Information R&S Report

Texas Medicaid & Healthcare Partnership
Remittance and Status Report
Date: 01/01/2005

Mail original claim to:
Texas Medicaid & Healthcare Partnership
P.O. Box 200555
Austin, Texas 78720-0555

Mail all other correspondence to:
Texas Medicaid & Healthcare Partnership
12357-A Riata Trace Parkway
Austin, Texas 78727

(800) 925-9126
(512) 514-3000

Robert Smith
123 Main Street
ABC Clinic
Austin, Tx 78701
(512) 555-5555

Provider ID: 0000000-11
Report Seq. Number: 99
R&S Number: 24600000

Page 8 Of

PROGRAM	CONTROL NUMBER	ORIGINAL DATE	WITHHELD AMOUNT

** FINANCIAL TRANSACTIONS **

BACKUP WITHHOLDING PENALTY INFORMATION:

OUR RECORDS INDICATE THAT YOU HAVE BEEN ASSESSED A PENALTY BY THE INTERNAL REVENUE SERVICE FOR NON-COMPLIANCE WITH BACKUP WITHHOLDING REQUIREMENTS. THEREFORE, YOUR PAYMENT HAS BEEN LOWERED AND THE PENALTY AMOUNT HAS BEEN REMITTED TO THE INTERNAL REVENUE SERVICE. 28% OF YOUR PAYMENT AMOUNT WILL BE WITHHELD WEEKLY UNTIL TMHP RECEIVES A W9 OR LETTER 147C AS REQUESTED IN A B-NOTICE PREVIOUSLY SENT TO YOUR FACILITY OR OFFICE.

Program 100	2002568752145	05/01/2005	49.01
Program 200	2002568752144	05/01/2005	49.01

Back up withholding

****

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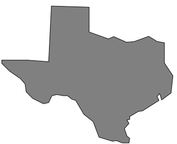
5.10.6.10 Reissues R&S Report



```
                         Texas Medicaid & Healthcare Partnership
                          Medicaid Remittance and Status Report
                                   Date: 11/25/2004

              Mail original claim to:                             ROBERT SMITH MD
              Texas Medicaid & Healthcare Partnership             123 MAIN STREET
              P.O. Box 200555                                     ABC CLINIC
              Austin, TX 78720-0555                               AUSTIN, TX 78701
                                                                  (512) 555-5555

              Mail all other correspondence to:
              Texas Medicaid & Healthcare Partnership             Provider ID:  0000000-11
              12357-A Riata Trace Parkway                         Report Seq. Number:  99
              Austin, TX 78727                                    R&S Number:    24600000

              (800) 925-9126
              (512) 514-3000
                                                                                   Page 1 Of 8
______________________________________________________________________________________________

************************************************************ FINANCIAL TRANSACTIONS ************************************************************

REISSUES

  YOUR PAYMENT HAS BEEN INCREASED BY THE AMOUNT INDICATED BELOW:

 CHECK NUMBER: 018111111         CHECK AMOUNT:          56.86        R&S NUMBER:    23550407         R&S DATE:  08/13/2003

TOTAL SYSTEM REISSUES                                 $ 56.86

********************************************************************************************************************************************
```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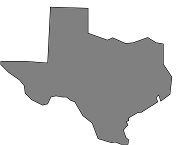
5.10.6.11 Claims in Process R&S Report



```
                                   Texas Medicaid & Healthcare Partnership
                                   Medicaid Remittance and Status Report
                                           Date: 11/25/2004

                Mail original claim to:                                ROBERT SMITH MD
                Texas Medicaid & Healthcare Partnership                123 MAIN STREET
                P.O. Box 200555                                        ABC CLINIC
                Austin, TX 78720-0555                                  AUSTIN, TX 78701
                                                                       (512) 555-5555

                Mail all other correspondence to:
                Texas Medicaid & Healthcare Partnership                Provider ID:  0000000-11
                12357-A Riata Trace Parkway                            Report Seq. Number:  99
                Austin, TX 78727                                       R&S Number:    24600000

                (800) 925-9126
                (512) 514-3000
                                                                                                    Page 61 Of 82
 PATIENT NAME         CLAIM NUMBER        MEDICAID #  PATIENT ACCT #   MEDICAL RECORD #    MEDICARE #     EOPS  EOPS  EOPS  EOPS          DIAGNOSIS
---SERVICE DATES---                     -----BILLED-----    -----ALLOWED-----
   FROM        TO     TOS  PROC         QTY        CHARGE      QTY        CHARGE      POS          PAID AMT     EOPS  EOPS  EOPS  EOPS  EOPS    MOD  MOD

***************************************************** THE FOLLOWING CLAIMS ARE BEING PROCESSED *************************************************

THE EXPLANATION OF PENDING STATUS (EOPS) CODES LISTED ARE NOT FINAL CLAIM DENIALS OR PAYMENT DISPOSITIONS.  THE EOPS CODES IDENTIFY THE REASONS
WHY A CLAIM IS IN PROCESS.  BECAUSE THESE CLAIMS ARE CURRENTLY IN PROCESS, NEW INFORMATION CANNOT BE ACCEPTED TO MODIFY THE CLAIM UNTIL THE CLAIM
FINALIZES AND APPEARS AS FINALIZED ON YOUR R&S REPORT. PLEASE REFER TO THE LAST SECTION OF THIS REPORT FOR THE TEXTUAL MESSAGES THAT CORRESPOND
TO THE EOPS CODES USED ON THIS REPORT.

ASTER,SISSY    9990200103001122556669988                                                                 00S03                             29532
06/22/2003 06/22/2003     90805      1.0         75.00

                                                $75.00

BOND,CHARLES  999020019988776655443322           BONCHOO581                                              00S03                             3128
07/16/2003 07/16/2003     1050X      1.0         53.86

                                                $53.86

CAMPELL,BILL  999020016655443322117788           CAMPBE0005                                              00S03                             78605
05/19/2003 05/19/2003     99253      1.0        213.20
05/20/2003 05/20/2003     99232      1.0        108.16
05/22/2003 05/22/2003     99232      1.0        108.16

                                               $429.52

*********************************************************************************************************************************************

  IF YOUR CLAIM HAS NOT APPEARED ON AN R&S REPORT AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO TMHP, PLEASE CALL CONTACT
  TELEPHONE INQUIRY AT (800) 925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.
```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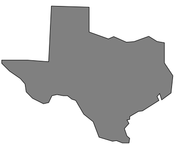
5.10.6.12 Summary R&S Report



Texas Medicaid & Healthcare Partnership
Medicaid Remittance and Status Report
Date: 11/25/2004

Mail original claim to: Texas Medicaid & Healthcare Partnership P.O. Box 200555 Austin, TX 78720-0555	ROBERT SMITH MD 123 MAIN STREET ABC CLINIC AUSTIN, TX 78701 (512) 555-5555
Mail all other correspondence to: Texas Medicaid & Healthcare Partnership 12357-A Riata Trace Parkway Austin, TX 78727	Provider ID: 0000000-11 Report Seq. Number: 99 R&S Number: 24600000
(800) 925-9126 (512) 514-3000	

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PAYMENT SUMMARY FOR DIRECT DEPOSIT BY EFT 000000098765432 IN THE AMOUNT OF 10,010.82.

	*** AFFECTING PAYMENT THIS CYCLE ***		*** AMOUNT AFFECTING 1099 EARNINGS ***	
	AMOUNT	COUNT	THIS CYCLE	YEAR TO DATE
CLAIMS PAID	10,010.82	252	10,010.82	104,306.86
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				
PAYMENT AMOUNT	10,010.82		10,010.82	104,306.86

APPROVED TO PAY/DENY CLAIMS	
PENDING CLAIMS	132.30

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5.10.6.13 Appendix R&S Report

```
                    Texas Medicaid & Healthcare Partnership
                     Medicaid Remittance and Status Report
                               Date: 11/25/2004

           Mail original claim to:                       ROBERT SMITH MD
           Texas Medicaid & Healthcare Partnership       123 MAIN STREET
           P.O. Box 200555                               ABC CLINIC
           Austin, TX 78720-0555                         AUSTIN, TX 78701
                                                         (512) 555-5555

           Mail all other correspondence to:
           Texas Medicaid & Healthcare Partnership       Provider ID:  0000000-11
           12357-A Riata Trace Parkway                   Report Seq. Number:  99
           Austin, TX 78727                              R&S Number:    24600000

           (800) 925-9126
           (512) 514-3000
                                                                          Page 1 Of 8
____________________________________________________________________________________

                        EXPLANATION OF BENEFITS CODES MESSAGES
____________________________________________________________________________________

THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

    00041    THESE CHARGES ARE INCLUDED IN THE GLOBAL AMBULATORY SURGICAL FACILITY PAYMENT.
    00058    PROCEDURE PAYMENT DETERMINED BY PROGRAM/BENEFIT PLAN, LOCALITY/SPECIALTY, DATE OF SERVICE AND BILLED AMOUNT.
    00095    ALLOWED AMT FOR THIS OUTPATIENT SERVICE IS INCREASED BY 5.2% FOR SFY 2000-2001 AND 2002-2003
    00100    A CHARGE WAS NOT NOTED FOR THIS SERVICE.
    00207    SERVICE NOT A BENEFIT.
    00274    MEDICAL NECESSITY OF THIS PROCEDURE MUST BE VERIFIED. PLEASE SUBMIT A SIGNED CLAIM, R&S COPY, HISTORY, PHYSICAL, PATHOLOGY
             AND/OR OPERATIVE REPORT.
    00356    TMHP MUST HAVE A VALID CONSENT FORM ON FILE FOR PAYMENT OF STERILIZATION PROCEDURES. REFER TO THE TEXAS MEDICAID PROVIDER
             PROCEDURES MANUAL FOR INFORMATION ON CONSENT FORMS.
    01147    PLEASE REFER TO OTHER EOB MESSAGES ASSIGNED TO THIS CLAIM FOR PAYMENT/DENIAL INFORMATION.


THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOP CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT

    00A02    THE CLIENT'S ELIGIBILITY IS BEING RESEARCHED.
    00F02    THE PROCEDURE IS NOT ON FILE FOR THIS PROVIDER SPECIALTY/TYPE.
```

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5.10.7 Provider Inquiries—Status of Claims

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

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

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

The provider allows TMHP 45 days to receive a Medicare-paid claim automatically transmitted for payment of deductible, coinsurance, or both. Claims that fail to cross over from Medicare may be filed to TMHP by submitting a copy of the Intermediary RA including the client's Medicaid number and the billing provider identifier.

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

- The provider utilizes claim status inquiry on the TMHP website (www.tmhp.com).
- A registered user of TDHconnect utilizes claim status inquiry within its software options.
- The provider calls AIS at 1-800-925-9126 to determine if the claim is pending, paid, denied, or if TMHP has no record of the claim.
- If any of three options above indicates TMHP has no record of the claim, the provider calls the TMHP Contact Center at 1-800-925-9126 to speak to a TMHP call center representative.
- If the TMHP Contact Center has no record of a claim that was submitted within the original filing deadline, the provider submits a copy of the original claim to TMHP for processing. Electronic billers may refile the claim electronically. For claims submitted by the hospital for inpatient services, the filing deadline is 95 days from the discharge date or the last DOS on the claim. For all other types of providers, the filing deadline is 95 days from each DOS on the claim.
- If the 95-day filing deadline has passed, the provider submits a signed copy of the claim and all documentation supporting the original claim submission to:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-A Riata Trace Parkway, Suite 100
Austin, TX 78727

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

Refer to: "Automated Inquiry System (AIS)" on page xiii for more information.

5.11 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500, Fields 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy number and group number
- Policyholder
- Effective date if available
- Date of disposition by other insurance resource (used to calculate filing deadline)
- Payment or specific denial information

5.11.1 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in the Medicaid program. When a TPR issues a payment or partial payment to a provider, the other insurance credit *must* be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR correctly in the appropriate block according to claim form instructions.

Refer to: The corresponding block number:

Claim Form	Reference
CMS-1500	Block 29 on page 5-31
HCFA-1450 (UB-92)	Block 54 on page 5-39
THSteps Dental	Block 31 on page 5-46

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5.11.1.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the clients deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

5.11.1.2 HMO Copayments

The following text contains important information about HMO copayments:

- TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare PPO copayments for clients who are eligible for reimbursement under Medicaid guidelines.
- TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.
- An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and the Texas Medicaid Program when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 - Office	Description
1-CP001	Private HMO copayment—professional
1-CP002	Private PPO copayment—professional
1-CP003	Medicare HMO copayment—professional
1-CP004	Medicare PPO copayment—professional
POS 5 - Outpatient	**Description**
1-CP005	Private HMO copayment—outpatient
1-CP006	Private PPO copayment—outpatient
1-CP007	Medicare HMO copayment—outpatient
1-CP008	Medicare PPO copayment—outpatient

Note: *Claims submissions for HMO copayments must be received by TMHP within 95 days of the DOS.*

5.11.1.3 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPR Customer Service at 1-800-846-7307. When calling TPR Customer Service line and when filing claims to TMHP, the provider must have the information below before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource
- Insurance company's name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client
- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

If providers have any questions about this information, they may contact the TMHP Contact Center at 1-800-925-9126.

5.11.1.4 110-Day Rule

If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. The following information is required:

- Name and address of the TPR
- Date the TPR was billed (used to calculate filing deadline)
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's R&S report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is *not* sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

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5.11.1.5 Filing Deadlines

Claims that involve filing to a TPR have apply the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appeal of claims originally denied with EOB 00260 indicating the provider files with a TPR must be received within 95 days of the date of disposition by the TPR or within 120 days of the date TMHP denied the claim.
- If more than 110 days have passed from the date a claim was filed to the TPR and no response has been received, the claim is submitted to TMHP for consideration of payment.
- In accordance with federal regulations, all claims must be initially filed with TMHP within 365 days of the DOS.

Refer to: "Third Party Resources" on page 4-13 for more information.

5.12 Filing Medicare Primary Paper Claims

Providers are allowed to file Medicare primary paper claims to TMHP for payment of coinsurance and/or deductible, for reasons given in the previous paragraph. Providers who bill on a HCFA-1450 (UB-92) paper claims form must submit the RA or Remittance Notice (RN) with a completed claim form. Providers who bill on the CMS-1500 paper claim form only require an RA or RN submission. Their claim form is optional; however, all of the required information must be included on the RA or RN for Medicaid processing. One RA or RN must be filed for each claim total and Medicare control number. Many providers receive their RAs or RNs electronically instead of on paper from their Medicare intermediary, and are allowed to create paper RAs or RNs to file with TMHP.

Depending on the billing type, the following information is required on the RA or RN for Medicaid processing:

Required Fields	Required on Claim Form?	Required on MRAN?	Must match from claim form to MRAN?
Billing Type: DRG Inpatient Facility HCFA-1450 (UB-92) RA or RN and Claim Form Required			
Client name	YES	YES	YES
Client other insurance information (including other insurance disposition of payment or denial)	YES	NO	NO
Coinsurance amount	NO	YES	NO
Date of service	YES	YES	YES
Deductible amount	NO	YES	NO
Diagnosis	YES	NO	NO
Diagnosis Related Grouper (DRG) code	NO	YES	NO
Health Insurance Claim (HIC) number—Client	YES	YES	YES
Internal Claim Number (ICN)—Medicare	NO	YES	NO
Medicaid client number	YES	NO	NO
Medicare allowed amount	NO	YES	NO
Total charges	YES	YES	NO
Medicare paid amount	NO	YES	NO
Medicare provider identifier	NO	YES	NO
*** Providers billing on a CMS-1500 can either bill these claims with an (MRAN) only or with an MRAN and a claim form.**			
**** The MRAN must have the required elements to process the claim.**			

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Required Fields	Required on Claim Form?	Required on MRAN?	Must match from claim form to MRAN?
Nine-digit Medicaid provider identifier	YES	NO	NO
Provider name	YES	YES	YES
Quantity billed	YES	NO	NO
Revenue code	YES	NO	NO
Type of bill code	YES	YES	NO
Medicare paid date	NO	YES	NO
Billing Type: Non-DRG Inpatient Facility HCFA-1450 (UB-92) RA or RN and Claim Form Required			
Client name	YES	YES	YES
Client other insurance information (including other insurance dispo-sition of payment or denial)	YES	NO	NO
Coinsurance amount	NO	YES	NO
Date of service	YES	YES	YES
Deductible amount	NO	YES	NO
Diagnosis	YES	NO	NO
HIC number—client	YES	YES	YES
ICN—Medicare	NO	YES	NO
Medicaid client number	YES	NO	NO
Medicare allowed amount	NO	YES	NO
Total charges	YES	YES	NO
Medicare paid amount	NO	YES	NO
Medicare paid date	NO	YES	NO
Medicare provider number	NO	YES	NO
Nine-digit provider identifier	YES	NO	NO
Procedure or Revenue code (applicable to provider type)	YES	NO	NO
Provider name	YES	YES	YES
Quantity billed	YES	NO	NO
Type of bill code	YES	YES	NO
Billing Type: Outpatient Facility HCFA-1450 (UB-92) RA or RN and Claim Form Required			
Client name	YES	YES	YES
Client other insurance information (including other insurance dispo-sition of payment or denial)	YES	NO	NO
Coinsurance amount	NO	YES	NO
Date of service	YES	YES	YES

*** Providers billing on a CMS-1500 can either bill these claims with an (MRAN) only or with an MRAN and a claim form.**
**** The MRAN must have the required elements to process the claim.**

5

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Required Fields	Required on Claim Form?	Required on MRAN?	Must match from claim form to MRAN?
Deductible amount	NO	YES	NO
Diagnosis	YES	NO	NO
HIC number—Client	YES	YES	YES
ICN—Medicare	NO	YES	NO
Medicaid client number	YES	NO	NO
Medicare allowed amount	NO	YES	NO
Total charges	YES	YES	NO
Medicare paid amount	NO	YES	NO
Medicare paid date	NO	YES	NO
Medicare provider number	NO	YES	NO
Modifier(s), if applicable	YES	NO	NO
Nine-digit provider identifier	YES	NO	NO
Procedure code	YES	NO	NO
Provider name	YES	YES	YES
Quantity billed	YES	NO	NO
Type of bill code	YES	NO	NO
Type of service code	YES	NO	NO
***Billing Type: Professional Billed with CMS-1500 Claim Form RA or RN Required, Claim Form Optional**			
Client name**	YES	YES	NO
Client other insurance information (including other insurance dispo-sition of payment of denial)**	YES	NO	NO
Coinsurance amount**	NO	YES	NO
Date of service**	YES	YES	NO
Deductible amount(s)**	NO	YES	NO
Diagnosis	OPTIONAL	OPTIONAL	OPTIONAL
HIC number—Client**	YES	YES	NO
ICN—Medicare**	NO	YES	NO
Medicaid client number**	YES	NO	NO
Medicare allowed amount**	NO	YES	NO
Total charges**	YES	YES	NO
Medicare paid amount**	NO	YES	NO
Medicare paid amount	NO	YES	NO
Medicare provider number	NO	YES	NO

*** Providers billing on a CMS-1500 can either bill these claims with an (MRAN) only or with an MRAN and a claim form.**

**** The MRAN must have the required elements to process the claim.**

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Required Fields	Required on Claim Form?	Required on MRAN?	Must match from claim form to MRAN?
Modifier(s), if applicable**	YES	YES	NO
Nine-digit Medicaid provider identifier (also include nine-digit performing provider identifier, if applicable)**	YES – Billing Prov. # YES – Perf. Prov. #	YES – Billing Prov. # YES – Perf. Prov. #	NO – Billing Prov. # NO – Perf. Prov. #
Place of service code**	YES	NO	NO
Procedure code**	YES	YES	NO
Provider name**	YES	YES	NO
Quantity billed** (If blank, TMHP will enter a quantity of 1)	YES	NO	NO
Type of service code**	YES	NO	NO
Medicare paid date	NO	YES	NO
*** Providers billing on a CMS-1500 can either bill these claims with an (MRAN) only or with an MRAN and a claim form.** **** The MRAN must have the required elements to process the claim.**			

If any of the required claim information is not provided, TMHP denies the claim.

5.12.1 Filing a Medicare Adjusted Claim

When submitting a Medicare-adjusted claim, providers should send only the adjusted Medicare RA or RN. Submission of the original RA or RN or the Medicaid R&S report is not required. The Medicare-adjusted claim is processed as a first time claim submission, which is referenced in the Claims - Paid or Denied section of providers' R&S reports.

Providers billing on a HCFA-1450 (UB-92) paper claim form must submit the RA or RN with a completed claim form. Providers who have received a letter requesting a claim form must also return the letter with their claim form submission.

Providers billing on a CMS-1500 paper claim form are only required to submit an RA or RN submission. The claim form is optional; however, all of the required information must be included on the RA or RN for Medicaid processing.

5.12.2 Medicare/Medicaid Filing Deadlines

Explanation of Medicare Benefits (EOMBs) must be received by TMHP within 95 days from the Medicare date of disposition in order to be considered for processing.

5.13 Medically Needy Claims Filing

TMHP must receive claims for unpaid bills not applied toward spend down within 95 days from the date eligibility was added to the TMHP client eligibility file (add date). These bills must be on the appropriate claim form (for example, CMS-1500 or HCFA-1450 [UB-92]). Providers are allowed to submit completed CMS claim forms directly to the Medically Needy Clearinghouse (MNC) or to applicants for the Medically Needy Program (MNP) to be used to meet spend down. The completed CMS claim forms used to meet spend down are held for ten calendar days by the MNC, then forwarded to TMHP claims processing. Claims for services provided after the spend down is met must be received within 95 days from the date eligibility is added. Inpatient hospital facility claims must be received within 95 days from the date of discharge or last DOS on the claim. This applies when eligibility is not retroactive.

The client's payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill.

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

When eligibility has been established, a TP 55 with spend down client can receive the same care and services available to all other Medicaid clients. If eligibility is established through TP 30 with spend down, the client's Medicaid eligibility is restricted to coverage for an emergency medical condition only. Emergency medical condition is defined under "Emergency Care" on page 4-7.

Refer to: "Medicare Crossover Reimbursement" on page 2-8.

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Section

6

Appeals

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6.1 Appeal Methods

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use three methods to appeal Medicaid claims to TMHP: electronic, Automated Inquiry System (AIS), or paper.

TMHP must receive all appeals of denied claims and requests for adjustments on paid claims within 120 days from the date of disposition of the Remittance and Status (R&S) report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline is extended to the next business day.

Standard administrative requests and medical appeals must be sent first to TMHP or the claims processing entity as a first-level appeal. After the provider has exhausted all aspects of the appeals process for the entire claim, the provider may submit a second-level appeal to HHSC.

1) A first-level appeal is a provider's initial standard administrative or medical appeal of a claim that has been denied or adjusted by TMHP. This appeal is submitted by the provider directly to TMHP for adjudication and must contain all required information to be considered.
2) A second-level appeal is a provider's final medical or standard administrative appeal of a claim to HHSC that:

   a.) Has been denied or adjusted by TMHP.

   b.) Has been appealed as a first-level appeal to TMHP, *and*

   c.) Has been denied again for the same reason(s) by TMHP.

This appeal is submitted by the provider to HHSC, which may subsequently require TMHP to gather information related to the original claim and the first-level appeal. HHSC is the sole adjudicator of this final appeal.

All providers must submit second-level administrative appeals and exceptions to the 95-day filing deadline appeals to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
PO BOX 204077
Austin, Texas 78720-4077

Note: *TMHP is not responsible for managing appeals as a result of utilization review (UR) decisions by the HHSC UR department. These must be submitted to the HHSC Medical & UR Appeals.*

Refer to: "Utilization Review Appeals" on page 6-7.

6.1.1 Electronic Appeal Submission

Electronic appeal submission is a method of submitting appeals using a personal computer. The electronic appeals feature can be accessed by a business organization (for example, billing organizations, vendors, and clearinghouses, etc.) interfacing directly with the TMHP Electronic Data Interchange (EDI) Gateway or through TDHconnect, the free Windows® -based software available from TMHP.

The Health Insurance Portability and Accountability Act (HIPAA) standard ANSI ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

6.1.1.1 Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow
- Maintained audit trails through print and download capabilities
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time

6.1.1.2 Allowed Electronic Appeals

Electronic appeal submission is available to business organizations (for example, billing organizations, vendors, and clearinghouses) interfacing directly with TMHP EDI or through TDHconnect.

The HIPAA standard ANSI ASC X12 837 format is accepted by TMHP EDI.

For other information, contact the TMHP EDI Help Desk at 1-888-863-3638.

6.1.1.3 Disallowed Electronic Appeals

The following claims may *not* be appealed electronically:

- Claims listed on the R&S report as *Incomplete Claims*. A new claim must be resubmitted with the corrected information, i.e., *a new day claim*
- Claims listed on the R&S report with $0 allowed and $0 paid. A new claim must be resubmitted with the corrected information, i.e., *a new day claim*
- Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays)
- Diagnosis-related group (DRG) assignment
- Medicare crossovers
- Claims listed as *pending* or *in process* with Explanation of Pending Status (EOPS) messages
- Claims denied as *past filing deadline* except when *retroactive* eligibility deadlines apply
- Claims denied as *past the payment deadline*

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed electronically if the requested form has been faxed according to the instructions under "Hysterectomy Services" on page 36-73.*

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6.1.2 Automated Inquiry System Appeals

The following appeals may be submitted using AIS:

- *Client Eligibility.* The client's correct Medicaid number, name, and date of birth are required.
- *Provider Information (Excluding Medicare Crossovers).* The correct provider identifier is required for the billing provider, performing provider, referring provider, and limited provider. The name and address of the provider are required for the facility and outside laboratory.
- *Claim Corrections.* Providers may correct the following:
  - Patient control number (PCN)
  - Date of birth
  - Date of onset
  - X-ray date
  - Place of service (POS)
  - Type of service (TOS)
  - Quantity billed
  - Prior authorization number (PAN)
  - Beginning date of service
  - Ending date of service
- The following appeals may *not* be appealed through AIS:
  - Claims listed on the R&S report as Incomplete Claims
  - Claims listed on the R&S report with $0 allowed and $0 paid
  - Claims requiring supporting documentation (for example, operative report, medical records, home health, hearing aid, and dental X-rays)
  - DRG assignment
  - Procedure code, modifier, or diagnosis code
  - Medicare crossovers
  - Claims listed as *pending* or *in process* with EOPS messages
  - Claims denied as *past filing deadline* except when retroactive eligibility deadlines apply
  - Claims denied as *past the payment deadline*
  - Inpatient Hospital claims requiring supporting documentation
  - Third party resource (TPR)/Other insurance

Providers may appeal these denials either electronically or on paper.

Refer to: "Disallowed Electronic Appeals" on page 6-2 to determine if these appeals can be billed electronically. If these appeals cannot be billed electronically, a paper claim must be submitted.

Exception: *Inpatient hospital claims denied for lack of a Hysterectomy Acknowledgment Statement or a Sterilization Consent Form may be appealed if the requested form has been faxed according to the instructions under "Hysterectomy Services" on page 36-73.*

6.1.3 Automated Inquiry System Automated Appeals Guide

To access the AIS automated appeals guide, providers can call 1-800-925-9126 (1-800-568-2413 for Children with Special Health Care Needs [CSHCN] Services Program). Providers may submit up to three fields per claim and 15 appeals per call. If during any step invalid information is entered three times, the call transfers to the TMHP Contact Center for assistance.

6.1.4 Paper Appeals

After determining a claim cannot be appealed electronically or by using AIS, appeal the claim on paper by completing the following steps:

1) Copy the R&S page where the claim is paid or denied or other official notification from TMHP.
2) Circle one claim per R&S page.
3) Identify the incorrect information and the corrected information that should be used to appeal the claim. Specify the reason for appealing the claim.
4) Attach a copy of supporting medical documentation that is necessary or requested by TMHP.
5) Attach a copy of the original claim if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues.

Reminder: *Do not copy supporting documentation on the opposite side of the R&S report.*

Note: *It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It also is recommended that paper documentation be sent via certified mail with a return receipt requested. This documentation, along with a detailed listing of the claims enclosed, provides proof that the claims were received by TMHP, which is particularly important if it is necessary to prove that the 120-day appeals deadline has been met. If providing proof via certified receipt, the certified receipt number must be indicated on the detailed listing. The provider may need to keep such proof regarding multiple claims submissions if the Medicaid provider identifier is pending.*

Medicare crossovers and inpatient hospital appeals related to medical necessity denials or DRG assignment/adjustment *must* be submitted on paper with the appropriate documentation.

Submit correspondence, adjustments, and appeals (including routine inpatient hospital claims) to the following address:

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

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Exception: *Hospitals appealing the HHSC Office of Inspector General (OIG) UR Department final technical denials, admission denials, DRG revisions, continued-stay denials, or cost/day outliers must appeal to HHSC at the following address:*

Texas Health and Human Services Commission
Medical & UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

6.1.4.1 DRG Adjustment Appeal

Hospital providers who are appealing for a DRG adjustment (higher weight DRG) must provide the original and revised HCFA-1450 (UB-92), the complete medical record, and a statement defining the reason for the requested change. Hospitals have 120 days from the date of the R&S report to request an addition of a diagnosis or procedure resulting in a DRG adjustment.

6.1.4.2 Medical Necessity Denial Appeals

Appeals of denials relating to medical necessity decisions made for all medical services with the exception of HHSC Inpatient Utilization Review cases may be submitted for further review if providers find denials are inappropriate. All necessary documentation must accompany the request for review. Incomplete appeals and adjustment requests are denied by TMHP with an explanation of benefits (EOB) code requesting additional information.

TMHP reviews each appeal (DRG adjustment and medical necessity) and forwards written notice of final action in the form of a letter or an adjustment transaction on the R&S report.

6.1.5 Appeals Submitted Incorrectly

If an incomplete appeal is received, it is returned to the sender with further appeal instructions and a request for more information. Documentation (either by letter or facsimile) that does not clearly indicate the reason for submission is returned to the sender for clarification. If an appeal is received that may be more appropriately addressed in another department, the appeal is forwarded to that department for them to respond.

If the TMHP Medical Director or designee identifies a pattern of ineffective use of the appeals process, the provider may be referred to a provider relations representative for assistance.

6.2 Refunds

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when overpayment, duplicate payment, payment to incorrect providers, and overpayments because of overlapping payments by Medicaid and another source occur. An overpayment must be refunded to Medicaid, but the amount refunded to TMHP does not exceed the Medicaid payment except in specific situations regarding other insurance payments as stated in "Refunds to TMHP Resulting from Other Insurance Payments and Conditions Surrounding Provider Billing of Third Party Insurers" on page 4-14.

Providers have the option of refunding by issuing a check to TMHP or requesting a recoupment through the paper appeal process. The paper appeal process does not require a provider to issue a check because the refund amount is reduced from the R&S report. To accurately process claim refunds, the TMHP Cash Reimbursement Unit requests that the refund check be accompanied by a Refund Information Form, found on page B-104, with the following information:

- Refunding provider's name and provider identifier
- Client's name and Medicaid ID number
- The date the medical service was rendered
- A copy of the R&S report showing the claim to which the refund is being applied
- The specific reason for the refund

If private insurance paid on the claim, the provider gives the exact amount paid and the insurance company's name, address, policy number, and group number.

To request the forms, contact the TMHP Contact Center at 1-800-925-9126, or write to the following address:

Texas Medicaid & Healthcare Partnership
Contact Center
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

6.3 Appeals to HHSC Fee-for-Service and PCCM

6.3.1 Administrative Claim Appeals

An administrative appeal is a request for review of (not a hearing on) claims denied by TMHP or claims processing entity for technical and non-medical reasons. There are *two types* of administrative appeals:

1) *Exception requests to the 95-day claim filing deadline.* A provider's formal written request for review of (not a hearing on) a claim that is denied or adjusted by TMHP for failure to meet the 95-day claim filing deadline. This exception should meet the qualifications for one of the five exceptions listed on page 6-5 and should be submitted directly to HHSC.
2) *Standard Administrative Appeal.* A provider's formal written request for review of (not a hearing on) a claim or prior-authorization that is denied by TMHP for technical and/or non-medical reasons.

An administrative claims appeal is a request for a review as defined in Title 1 *Texas Administrative Code* (TAC) §354.2201(2).

An administrative appeal must be:

- Submitted in writing to HHSC Claims Administrator Contract Management by the provider delivering the service or claiming reimbursement for the service.

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- Received by HHSC Claims Administrator Contract Management after the appeals process with TMHP or the claims processing entity has been exhausted, and must contain evidence of appeal dispositions from TMHP or the claims processing entity:
  - All correspondence and documentation from the provider to TMHP or the claims processing entity including copies of supporting documentation submitted during the appeal process.
  - All correspondence from TMHP or the claims processing entity to the provider including TMHP's final decision letter or such from the claims processing entity.
- Complete and contain all of the information necessary for consideration and determination by HHSC Claims Administrator Contract Management to include the following:
  - A written explanation specifying the reason/ request for appealing the claim.
  - Supporting documentation for the request.
  - All R&S reports identifying the claims/services in question.
  - Identification of the incorrect information and the corrected information that is to be used to appeal the claim.
  - A copy of the original claim, if available. Claim copies are helpful when the appeal involves medical policy or procedure coding issues. Also provide a corrected signed claim.
  - A copy of supporting medical documentation that is necessary or requested by TMHP.
  - Provider's internal notes and logs when pertinent (cannot be used as proof of timely filing).
  - Memos from the state, TMHP, or claims processing entity indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the appeal.
  - Other documents, such as receipts (i.e., certified mail along with a detailed listing of the claims enclosed), in-service notes, minutes from meetings, etc., if relevant to the appeals. Receipts can be helpful when the issue is late filing.
- Received by HHSC Claims Administrator Contract Management within 120 days from the date of disposition by TMHP or the claims processing entity as evidenced by the R&S sent to providers.

Providers that have submitted their claims electronically must identify the batch submission ID with the date on the electronic claims report. This report must indicate the TMHP assigned batch ID. In addition, this report must include the individual claim that is being appealed. This required information constitutes proof of timely filing.

Note: *Only reports accepted/rejected from TMHP or the claims processing entity to the vendor will be honored unless the provider is a direct submitter (TDHconnect). Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.*

HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date-of-service. All claims must be paid within 24 months from the date of service as outlined in 1 TAC §354.1003.

Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management. The filing and appeal deadlines are described in 1 TAC §354.1003.

Additional information requested by HHSC Claims Administrator Contract Management must be returned to HHSC Claims Administrator Contract Management within 21 calendar days from the date of the letter from HHSC Claims Administrator Contract Management. If the information is not received within 21 calendar days, the case is closed.

A determination made by HHSC Claims Administrator Contract Management is the final decision for claim appeals. No additional consideration is available. Therefore, ensure that all documents pertinent to the appeal are submitted. *New evidence* is required for an additional appeal to HHSC Claims Administrator Contract Management.

Providers mail appeal requests to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
PO Box 204077
Austin, Texas 78720-4077

6.3.1.1 Exceptions to the 95-Day Filing Deadline

HHSC Claims Administrator Contract Management is responsible for reviewing requests for exceptions to the 95-day filing deadline (fee-for-service and Primary Care Case Management [PCCM]). HHSC Claims Administrator Contract Management makes the final decision on whether claims fall within one of the exceptions to the 95-day filing deadline. Exception requests must be in writing and mailed directly to HHSC. Only providers can submit exception requests. Requests from billing companies, vendors, or clearinghouses are *not* accepted unless accompanied by a signed authorization from the provider (with each appeal). Without provider authorization, these requests are returned without further action.

Note: *HHSC will only consider exceptions to the 95-day filing deadline for claims that are submitted within the 365-day federal filing deadline from the date of service as outlined in 1 TAC §354.1003.*

Exceptions to the filing deadline are considered when one of the following situations exists:

- Catastrophic event that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business office or records by circum-

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stances that are clearly beyond the control of the provider, including but not limited to criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these people are presumed to be within the provider's control. The presumption can only be rebutted when the intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent.

- Delay or error in the eligibility determination of a client, or delay due to erroneous written information from HHSC, its designee, or another state agency.
- Delay due to electronic claim or system implementation problems.
- Submission of claims occurred within the 365-day federal filing deadline (when services are authorized retroactively), but the claim was not filed within 95 days from the date of service because the service was determined to be a benefit of the Medicaid program, and a retroactive effective date for the new benefit was applied.
- Client eligibility is determined retroactively and the provider is not notified of retroactive coverage.

Under the conditions and circumstances listed above, providers must submit the following documentation, if appropriate, and any additional requested information to substantiate approval of an exception. All claims that are to be considered for an exception must accompany the request. HHSC considers only the claims that are attached to the request.

All exception requests must include an affidavit or statement from the provider stating the details of the cause for the delay, the exception being requested, and verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.

- Exception requests for catastrophic events must include evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.
- Exception requests for the delay or error in the eligibility determination of a recipient must include the written document from HHSC or its designee that contains the erroneous information or explanation of the delayed information.
- Exception requests for the delay due to electronic claim or system implementation problems must include the written repair statement, invoice, computer or modem generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.
- Exception requests for service authorized retroactively must include a written, detailed explanation of the facts and documentation to demonstrate the 365-day federal filing deadline for the benefit was met.
- Exception requests for client eligibility determined retroactively and the provider is not notified of retroactive coverage must include a written, detailed explanation of the facts and activities illustrating the provider's efforts in requesting eligibility information for the client. The explanation must contain dates, contact information, and any responses from the client.

Refer to: "Exceptions to the 95-Day Filing Deadline" on page 5-5 for more detailed information.

6.3.1.2 Exceptions to the 120-day Appeal Deadline

HHSC shall consider exceptions to the 120-day appeal deadline. HHSC Claims Administrator Contract Management decides whether a claim falls within one of the exceptions. All claims that are to be considered for an exception must accompany the request. HHSC considers only the claims that are attached to the request.

- An exception request must be received by HHSC within 18 months from the date of service to be considered.
- The following exceptions to the 120-day appeal deadline are considered if the criteria in the previous bullet is met and there is evidence to support one of the bullets below:
  - Errors made by a third party payor that were outside the control of the provider. The provider must submit an affidavit or statement from the third party payer stating the details of the cause for the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.
  - Errors made by the reimbursement entity that were outside the control of the provider. The provider must submit an affidavit or statement from the original payor stating the details of the cause of the error, the exception being requested, and verification that the error was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent. This affidavit or statement must be made by the person with personal knowledge of the facts.
  - Claims were adjudicated, but an error in the claim's processing was identified after the 120-day appeal deadline.

Adequate back-up documentation *must* also accompany the exception request. Failure to provide adequate documentation results in the case being closed. Providers

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are notified of the reason for denial. HHSC may request additional information which must be received within 21 calendar days from the date of the letter from HHSC. If the information is not received within 21 calendar days, the case will remain closed.

HHSC must receive a written exception request within 120 days of TMHP's final action. *Multiple requests submitted simultaneously must be sorted by provider identifier first, and then alphabetically by client name.* The orderly submission of exception requests facilitates the review process. Exception requests are returned to the provider if not submitted in the required format.

Additional claims cannot be added to an exception request after the exception request has been completed by HHSC. Additional claims require completed exception request information and will be considered as an exception request separate from the original request. Information from a previous request is not linked together by HHSC to complete or understand additional claims.

6.3.1.3 Exceptions to the 24-Month Payment Deadline

HHSC shall consider exceptions to the 24-month claims payment deadline for the situations listed below. The final decision about whether a claim falls within one of the exceptions will be made by HHSC.

- *Refugee Eligible Status*: The payable period for all Refugee Medicaid/Medicare eligible recipient claims is the federal fiscal year in which each date of service occurs plus one additional Federal Fiscal year. The date of service for inpatient claims is the discharge date.
- *Medicare/Medicaid Eligible Status*: The payable period for Medicaid/Medicare eligible recipient claims filed electronically is 24 months from the date the file is received from Medicare by TMHP or the claims processing entity. The payable period for Medicaid/Medicare eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice.
- *Retroactive Supplemental Security Income Eligible*: The payable period for Supplemental Security Income (SSI) Medicaid eligible recipients when the Medicaid eligibility is determined retroactively is 24 months from the date the Medicaid eligibility is added to the eligibility file. The date is referred to as the "add date."

Mail exception requests to HHSC at the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
PO Box 204077
Austin, Texas 78720-4077

Note: *Medicaid health maintenance organization (HMO) providers must communicate with their respective HMOs regarding appeals related to the filing deadline or any exception request policy. HHSC Claims Administrator Contract Management does not have the authority to manage these appeals.*

6.3.2 Medical Necessity Appeals

Medical necessity appeals are defined as disputes regarding medical necessity of services. Providers must appeal to TMHP and exhaust the appeal/grievance process before submitting an appeal to HHSC.

Medical necessity appeals related to UR decisions made by HHSC's UR Department *must* be appealed to HHSC *not* TMHP.

When filing appeals to HHSC, providers must submit copies of all supporting documentation, including information sent to TMHP.

6.3.3 Utilization Review Appeals

Hospitals may appeal adverse UR decisions made by the HHSC's OIG UR department to the HHSC Medical & UR Appeals Unit. The written appeal request must be received by the Medical and UR Appeals Unit within 120 days from the date of the original HHSC OIG UR decision letter. If the request is not received within 120 days, the appeal is not conducted, and the HHSC OIG UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request, submission of the complete medical record, or the original properly completed notarized affidavit in the format approved by HHSC. Procedures and specific requirements for appealing these decisions can be found in the sections below.

Hospitals may appeal adverse UR determinations to the following address:

Texas Health and Human Services Commission
Medical & UR Appeals, H-230
PO Box 85200
Austin, TX 78708-5200

Note: *UR Admission Denials, Continued Stay Denials, DRG Revisions, Cost/Day Outlier Denials or Technical Denials issued by Medicaid managed care organizations (MCOs) must be appealed to the appropriate health plan. HHSC's Medical and UR Appeals Unit does not have the authority to manage these appeals.*

6.3.3.1 Admission Denials, Continued Stay Denials, DRG Revisions, and Cost/Day Outlier Denials

If a hospital is dissatisfied with the original HHSC OIG UR decision, it submits a written request for an appeal to HHSC's Medical & UR Appeals Unit. The request *must* include a copy of the complete medical record, a letter explaining the reasons why the HHSC's OIG UR decision is incorrect, a copy of the HHSC OIG UR decision letter, and an original properly completed notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. If the complete medical record or a properly completed notarized affidavit is not submitted initially with the appeal request, the provider has 21 calendar days to do so. If the required documentation is not received within

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this time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered the final decision.

- Complete medical records must be provided to HHSC at no charge. A complete medical record must include, but is not limited to, history and physical examinations, discharge summary, physicians' progress notes, physicians' orders, laboratory reports, X-ray reports, operative reports, pathology reports, nurses' notes, medication sheets, vital signs sheets, therapy notes, specialty consultation reports, emergency room record and special diagnostic and treatment records.
- The HHSC Medical & UR Appeals Unit is responsible for conducting an independent review in response to the provider's appeal. Medical & UR Appeals staff professionals use all documentation in the medical record to determine if an inpatient admission was appropriate and that the diagnoses and procedures are correct. HHSC OIG UR screening criteria as described in 1 TAC §371.204 are not used by this unit to determine the appropriateness of an inpatient admission. The HHSC Medical & UR Appeals Associate Medical Director for Medicaid/CHIP performs a complete review for the medical necessity of the admission, DRG validation, quality of care, continued stay medical necessity and ancillary charges (*Tax Equity and Fiscal Responsibility Act of 1982* [TEFRA] cases) using the medical record documentation submitted on appeal. After completion of the review, the physician renders a final decision on the case. The final decision may include determinations regarding multiple aspects of the admission. The hospital is notified in writing of the final decision. Inpatient admission denials cannot be rebilled as outpatient claims except as noted in "Hospital Outpatient Observation Room Services" on page 25-25.
- If the hospital is dissatisfied with the appeal decision, the attending physician or medical director of the hospital may request an educational conference with the HHSC Associate Medical Director for Medicaid/CHIP. The educational conference is held by telephone and is between the HHSC Associate Medical Director for Medicaid/CHIP and the hospital medical director or attending physician involved with the case. It is an opportunity for the physicians to discuss the deciding factors in the case as well as the hospital's claims billing processes that may have affected the adjudication of the case. This conference will not alter the previous appeal decision.

The Medicaid program recognizes hospital staff may use guidelines, such as the American Hospital Association's *Coding Clinic*, to assist them in identifying diagnoses and/or procedures for statistical and billing purposes. However, the HHSC Medical & UR Appeals Unit determines the appropriate diagnoses and/or procedures for reimbursement purposes using the documentation in the *medical record* (submitted on appeal) and the following guidelines:

- *Principal diagnosis assignment*. The diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during the admission to the hospital.
- *Secondary diagnoses assignment*. Conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care or monitoring, or, in the case of a newborn (up to 28 days of life), which the physician deems to have clinically significant implications for future health care needs. Normal newborn conditions or routine procedures should not be considered as complications or comorbidities for DRG assignment.

If the principal diagnosis, secondary diagnoses, or procedures are not substantiated in the medical record, not sequenced correctly, or have been omitted, the codes may be changed, added, or deleted by the HHSC Associate Medical Director for Medicaid/CHIP. When it is determined the diagnoses or procedures are substantiated and sequenced correctly, a final DRG assignment is made.

6.3.3.2 Final Technical Denials

Hospitals may submit a request for a written appeal to the HHSC's Medical & UR Appeals only if the hospital has evidence the HHSC's UR department issued a final technical denial in error or did not provide proper notification of the final technical denial. The request must include a letter explaining the reasons why the HHSC's decision is incorrect and a copy of the HHSC's UR decision letter.

The written appeal request must be received by HHSC within 120 days from the date of the original HHSC UR decision letter. If the request is not received within the 120 days, the appeal is not conducted and the HHSC's UR decision is considered final. Any claim the facility may have to the Medicaid funds at issue are barred. Extensions of time are not granted for filing the written appeal request.

If the appeal time frame is met, HHSC's Medical & UR Appeals Unit reviews all the documentation and renders a final decision on the case. If it is determined the technical denial was issued correctly by the HHSC's UR department, the HHSC's decision is upheld. The hospital is notified in writing of the decision. This decision is the final decision of HHSC.

If it is determined the final technical denial decision should be overturned, HHSC's Medical and UR Appeals Unit will request a copy of the complete medical record and an original properly completed notarized affidavit in the format approved by HHSC. The affidavit allows the hospital to certify the record as a business and legal document. The Associate Medical Director for Medicaid/CHIP performs a complete review for the medical necessity of the admission, DRG validation, quality of care or continued stay, and ancillary charges (for TEFRA cases) using the medical record documentation. After completion on the review, the physician renders a final decision on

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the case. The final decision may include multiple aspects of the admission. The hospital is notified in writing of the final decision.

If the documentation requested above is not received within the required time frame, the case is closed without further opportunity for review and the original HHSC OIG UR decision is considered final.

6.3.4 Complaints to HHSC—Fee-for-Service and PCCM

Fee-for-service and PCCM providers may file complaints to the HHSC Claims Administrator Contract Management if they find they did not receive full due process from TMHP in the management of their appeal. Fee-for-service and PCCM providers must exhaust the appeals/grievance process with TMHP before filing a complaint with the HHSC Claims Administrator Contract Management.

Refer to: "Appeals to HHSC Fee-for-Service and PCCM" on page 6-4 for information about submission of an appeal to HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning the Medicaid program. The term *complaint* does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction and does not include a provider's oral or written dissatisfaction with an adverse determination.

Under the complaint process, the HHSC Claims Administrator Contract Management works with TMHP and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program and contract issues, as applicable.

Complaints must be in writing and received by the HHSC Claims Administrator Contract Management within 60 calendar days from TMHP's written notification of the final appeal decision.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by TMHP is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to TMHP, including copies of supporting documentation submitted during the appeal process.
- All correspondence from TMHP to the provider, including TMHP's final decision letter.
- All R&S reports of the claims/services in question, if applicable.
- Provider's original claim/billing record, electronic or manual, if applicable.
- Provider's internal notes and logs when pertinent.
- Memos from the state or TMHP indicating any problems, policy changes, or claims' processing discrepancies that may be relevant to the complaint.
- Other documents, such as receipts (i.e. certified mail), original date-stamped envelopes, in-service notes, minutes from meetings, etc., if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
PO Box 204077
Austin, TX 78720-4077

6.3.5 Complaints to HHSC—HMO Services

Medicaid Managed Care providers (HMOs) may file complaints to HHSC Health Plan Operations if they find they did not receive full due process from the HMOs. HHSC is only responsible for the management of complaints from managed care providers. Appeals/grievances, hearings, or dispute resolutions are the responsibility of the health plans. Providers must exhaust their appeals/grievance process with their health plan before filing a complaint with HHSC.

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the Medicaid program. The term complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.

Under the complaint process, HHSC works with the health plans and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues, as applicable.

Complaints *must* be in writing and received by HHSC within 60 calendar days from the health plan's written notification of the final action.

When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the health plan is incorrect and copies of the following documentation:

- All correspondence and documentation from the provider to the health plan, including copies of supporting documentation submitted during the appeals process.
- All correspondence from the health plan to the provider. Correspondence includes the initial determination letter; all appeal determination letters, and the final decision letter.
- All R&S reports of the claims/services in question, if applicable.
- Provider's original claim/billing record, electronic or manual, if applicable.
- Provider's internal notes and logs when pertinent.

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- Memos from the state or the health plan indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the complaint.
- Other documents such as receipts (i.e., certified mail), original date-stamped envelopes, in-service notes, minutes from meetings, etc., if relevant to the complaint. Receipts can be helpful when the issue is late filing.

Complaint requests for HMO's may be mailed to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

6.4 Cost Report Settlement Appeal Process

A provider who is dissatisfied with the determination contained in the Notice of Amount of Program Reimbursement (NPR) from TMHP Medicaid Audit may request an appeal as follows:

- The request for appeal must be in writing.
- The request for appeal must be filed within 120 calendar days from the date of receipt of the NPR.
- If the amount in controversy is at least $1,000, the request for the appeal must be filed with TMHP Medicaid Audit.
- If the NPR shows that the provider is indebted to the Medicaid program, TMHP must take the necessary action to recover the overpayment, including a suspension of interim payments. This process will take place even if an appeal has been requested.

6.4.1 Appeals to TMHP Medicaid Audit

A provider's request to appeal his or her NPR must do the following:

- Identify specific individual items in TMHP Medicaid Audit's determination with which the provider disagrees.
- Give the reasons the provider believes these are incorrect.
- Identify the amount in controversy for each item and provide a calculation of that amount.

The appeal may include any materials the provider believes will support its position.

TMHP Medicaid Audit completes a desk review of the appeal within six months of the date of receipt of complete documentation supporting the appeal. TMHP does the following:

- Review the materials submitted by the provider.
- Inform the provider if it appears that the request for an appeal was not timely or the amount of controversy is not at least $1,000.
- Review the record that formed the basis for the determination of the total payment due to the provider.
- Attempt to resolve as many points in controversy as possible with the provider and inform him or her in writing the issues that have been resolved and those that the provider may appeal to HHSC.
- Ensure all available documentation in support of the provider or TMHP Medicaid Audit is part of the record.

To appeal to TMHP Medicaid Audit, send the written notice to the following address within 120 days of receipt of the NPR letter to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit Operations Director
PO Box 200345
Austin, TX 78720-0345

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Section

7

Managed Care

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7.1 Medicaid Managed Care

The Texas Medicaid Program, administered by HHSC, operates the Medicaid Managed Care program under the authority of federal waivers and state plan amendments approved by the Centers for Medicare & Medicaid Services (CMS).

7.1.1 Overview

Originally, the Texas Medicaid Managed Care Program was called the State of Texas Access Reform (STAR) Program. The STAR Program was established to explore different methods of building a framework of managed care around segments of the Texas Medicaid Program. In 1995, the Texas Legislature adopted Senate Bill 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of the Texas Medicaid Program to incorporate managed care delivery systems statewide.

Currently, the Medicaid Managed Care Program consists of two types of health care delivery systems: Health Maintenance Organizations (HMOs) and Primary Care Case Management (PCCM). HMOs provide services in the metropolitan areas, including Nueces. PCCM provides services in the remaining 202 rural counties. (See page 7-21 for a listing of PCCM counties and page 7-19 for a listing of HMO service areas.)

The principal objectives of Medicaid Managed Care are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Clients enrolled in any of the Medicaid Managed Care programs may reside in metropolitan or rural areas. These programs include:

- *The State of Texas Access Reform (STAR) Program* operates under a 1915(b) waiver and provides acute care medical assistance in a Medicaid Managed Care environment for clients who reside in the Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis metropolitan service areas (SAs) (see "STAR Program" on page 7-11)
- *The STAR+PLUS Program* operates under a 1915(b) waiver and 1915(c) waiver and provides integrated acute and long term care in a Medicaid Managed Care environment for clients who reside in the Bexar, Travis, Nueces, and Harris Service Areas (see "STAR+PLUS Program" on page 7-16)
- *The NorthSTAR Program*, administered by the Department of State Health Services (DSHS), operates under a 1915 (b) waiver and provides integrated behavioral health services under contract with a behavioral health organization (BHO) for clients who reside in the Dallas SA (see "NorthSTAR Program" on page 7-18)
- *The PCCM Program*, administered by TMHP, operates under a state plan amendment for clients who reside in the 202 rural Texas counties (see "PCCM Expansion" on page 7-21)

The goals of Medicaid Managed Care are to:

- Improve the access to care for clients enrolled in the programs
- Increase quality and continuity of care for clients
- Decrease inappropriate usage of the health care delivery system, such as emergency rooms for non-emergencies
- Achieve cost-effectiveness and efficiency for the state
- Promote provider and client satisfaction

Additional goals for the STAR+PLUS Program include:

- Integrating acute and long term care services
- Coordinating Medicare services for clients who are dual eligible

Higher use of medical services by traditional Medicaid clients occurs when clients obtain care through emergency rooms or access duplicative services for the same medical condition. In Medicaid Managed Care, clients assume a responsible role in achieving their personal health care by choosing a primary care provider, then actively participating with their primary care provider to access preventive, primary care services. This collaborative approach to health care delivery usually achieves Medicaid cost savings by reducing duplicative services and unnecessary emergency and inpatient care.

Although many of the Medicaid Managed Care requirements are similar, each program has established specific objectives, eligibility and enrollment requirements, and claims filing processes, which are detailed in this section.

7.1.2 Client Eligibility and Effective Date

HHSC has targeted specific client groups within the Texas Medicaid population for managed care enrollment. Refer to each program in this section for eligibility requirements.

In most cases, Medicaid eligibility is not retroactive. For exceptions, see "Enrollment of Pregnant Women (Type Program 40)" on page 7-12.

7.1.2.1 Managed Care Eligibility and Effective Date

Benefits under the STAR, STAR+PLUS, NorthSTAR, and PCCM Programs usually begin on the first day of the next month following selection of a primary care provider and plan. For example, a client who has become eligible for Medicaid benefits for the first time, may be certified and begin to receive benefits under the Texas Medicaid Program on the same day. If the client is also determined to be eligible for managed care, a second and separate enrollment process takes place.

The client does not begin to receive services under Medicaid Managed Care until the first day of the following month (providing enrollment takes place before the *cut-off*

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date for the following month). Enrollments and disenrollments become effective on the first day of the month (refer to example 1).

Example 1	
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and primary care provider	January 1
Managed Care benefits begin	February 1

If a client selects a primary care provider or, if applicable, a health plan after the *cut-off* date (approximately the 15th of the month) they will not be enrolled in managed care nor appear on a primary care provider's patient list until the second month after their enrollment effective date (refer to example 2).

Example 2	
Client certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Client selects health plan and primary care provider	January 20
Managed Care benefits begin	March 1

Clients may receive services under the traditional Medicaid program from the first date of eligibility. Claims for these services are billed to TMHP. Once managed care eligibility is in effect, the provider must bill the client's managed care organization for all capitated services. Providers continue to bill non-capitated services to TMHP.

7.1.2.2 PCCM Expansion

When a client in the PCCM expansion area is determined Medicaid-eligible and is a mandatory enrollee, the client is automatically enrolled in PCCM. Enrollment into PCCM is prospective.

Exception: *Newborn enrollments are retroactive to the date of birth.*

Example	
Client certified for Texas Medicaid	January 2
Medicaid benefits begin	January 1
Managed Care benefits begin	February 1

Refer to: "Client Medicaid Identification (Form H3087) (18 Pages)" on page B-16 for examples of the STAR, STAR+PLUS, NorthSTAR and PCCM Programs' Medicaid Identification Form (Form H3087).

"PCCM Expansion" on page 7-21

7.1.3 Primary Care Provider Changes

7.1.3.1 Client-Initiated Primary Care Provider Changes

A client may change primary care providers *without cause* or for the following reasons:

- The client is dissatisfied with the care or treatment they have received.
- The client's condition or illness would be better treated by another provider type.
- The client's new address is no longer convenient to the primary care provider's location.
- The provider leaves the program (i.e., moves, no longer accepts Medicaid, is removed from Medicaid enrollment, is no longer affiliated with the Medicaid Managed Care Program, or is deceased).
- The client/primary care provider relationship is not mutually agreeable.

7.1.3.2 Provider-Initiated Primary Care Provider Changes

A provider may request a client be reassigned to another primary care provider for any of the following reasons:

- The client is not included in the primary care provider's scope of practice.
- The client is non-compliant with medical advice.
- The client consistently displays unacceptable office decorum.
- The client/primary care provider relationship is not mutually agreeable.

Any request by a provider to reassign a client to another primary care provider must be processed through the applicable managed care program. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling by health plan or PCCM staff. The health plan or PCCM will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers should also notify the client about the reassignment in writing and send a copy of the notification to the health plan.

If the client indicates that they have made a primary care provider change, follow the process below:

- Access the daily Primary Care Provider Change List located on the Panel Report webpage to confirm selection as the newly requested primary care provider. If the list verifies the primary care provider change with a future effective date, proceed with scheduling an appointment.
- If the Primary Care Provider Change List does not reflect the newly requested primary care provider, direct the client to call 1-888-302-6688 to request a primary care provider change. Once the provider has ensured that

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the primary care provider change request appears on the daily Primary Care Provider Change List, the appointment may be scheduled.

Client requests for primary care provider changes received prior to the middle of the month usually become effective on the first day of the following month. If a client's request for a primary care provider change is received after the middle of the month, the change may become effective on the first day of the second month following the request, as shown in the example below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

7.1.3.3 Medicaid Managed Care-Initiated Primary Care Provider Changes

In addition, a client may be reassigned to another primary care provider for any of the following reasons:

- The primary care provider is sanctioned by HHSC.
- The primary care provider exhibits a documented pattern of unacceptable quality of care.
- The primary care provider inappropriately reduces client's right to access specialty services covered under Medicaid Managed Care.

7.1.4 Health Plan Changes

7.1.4.1 Client-Initiated HMO Plan Changes

Clients have the right to change plans once a month.

Exception: *For clients in the PCCM expansion counties, the only Medicaid Managed Care model available is PCCM along with traditional fee-for-service. HMO health plans do not exist in PCCM expansion counties.*

Clients must call the enrollment broker to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

Example	
Request received on or before	Mid-May
Change effective	June 1
Request received after	Mid-May
Change effective	July 1

Note: *All plan change requests must be processed by the enrollment broker.*

7.1.4.2 Health Plan Managed Care Administrator-Initiated Changes

Each health plan has a limited right to request that a client be disenrolled without the client's consent. HHSC must approve any request for such disenrollment.

A health plan may request that a client be disenrolled for the following reasons:

- The client loans his Medicaid Identification Form (Form H3087) to another person to obtain services.
- The client continually disregards the advice of his primary care provider.
- The client repeatedly uses the emergency room inappropriately.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client's behavior. Reasonable measures may include education or counseling conducted by health plan staff. HHSC will notify the client of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client of the availability of appeal procedures and the HHSC fair hearing process.

Neither the health plan nor a provider may request a disenrollment based on an adverse change in the client's health or the utilization of services which are medically necessary for the treatment of a client's condition.

7.1.5 Client Rights and Responsibilities

7.1.5.1 Client Rights

In Texas, Medicaid Managed Care clients have defined rights and responsibilities. Each health plan and primary care provider share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

Note: *Please refer to PCCM Expansion, "Client Rights and Responsibilities" on page 7-23 for information about client rights and responsibilities related to PCCM.*

Medicaid Managed Care clients have the right to:

- Be treated fairly and with dignity and respect
- Know that their medical records and discussions with their providers will be kept private and confidential
- A reasonable opportunity to choose a health care plan and primary care provider (the doctor or health care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
    - Be informed of available health plans and primary care providers in their areas
    - Be informed of how to choose and change health plans and primary care providers
    - Choose any health plan that is available in their area and choose a primary care provider
    - Change their primary care provider

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- Change health plans without penalty
- Be educated about how to change health plans or primary care providers

- Ask questions and get answers about anything they don't understand, and that includes the right to:
  - Have their provider explain their health care needs to them and talk to them about the different ways their health care problems can be treated
  - Be told why care or services were denied and not given
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  - Work as part of a team with their provider in deciding what health care is best for them
  - Say yes or no to the care recommended by their provider
- Utilize each available complaint and appeal process through the managed care organization and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  - Make a complaint to their health plan or to the state Medicaid program about their health care, provider, or health plan
  - Get a timely answer to their complaint
  - Access the health plan appeal process and the procedures for doing so
  - Request a fair hearing from the state Medicaid program and request information about the process for doing so
- Timely access to care that does not have any communication or physical access barriers. That the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care
  - Get medical care in a timely manner
  - Be able to get in and out of a health care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*
  - Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information
  - Be given an explanation they can understand about their health plan rules, including the health care services they can get and how to get them
- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they do not want to do, or to punish them.

7.1.5.2 Client Responsibilities

Medicaid Managed Care health plans and primary care providers should help clients understand their responsibilities. These include the responsibility to:

- Learn and understand each right they have under the Medicaid program. That includes the responsibility to:
  - Learn and understand their rights under the Medicaid program
  - Ask questions if they do not understand their rights
  - Learn what choice of health plan is available in their area
- Abide by the health plan and Medicaid Managed Care policies and procedures. That includes the responsibility to:
  - Learn and follow their health plan rules and Medicaid rules
  - Choose their health plan and a primary care provider
  - Make any changes in their health plan and primary care provider in the ways established by Medicaid Managed Care and by the health plan
  - Keep their scheduled appointments
  - Cancel appointments in advance when they cannot keep them
  - Always contact their primary care provider first for nonemergency medical needs
  - Be sure they have approval from their primary care provider before going to a specialist (except for self-referred services)
  - Understand when they should and should not go to the emergency room
- Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  - Tell their primary care provider about their health
  - Talk to their providers about their health care needs and ask questions about the different ways their health care problems can be treated
  - Help their providers get their medical records
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  - Work as a team with their provider in deciding what health care is best for them
  - Understand how the things they do can affect their health
  - Do the best they can to stay healthy
  - Treat providers and staff with respect

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7.1.5.3 Advance Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult clients 18 years of age and older about their rights under state and federal law, in advance of their receiving care (*Social Security Act* §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client's right to refuse, withhold, or withdraw medical treatment advance directives. These policies and procedures must comply with provisions contained in 42 Code of Federal Regulations (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:

- A client's right to self-determination in making health care decisions
- The *Advance Directives Act*, Chapter 166, Texas Health and Safety Code, which includes:
    - A client's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition
    - A client's right to make written and non-written Out-of-Hospital Do-Not-Resuscitate Orders
    - A client's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the client's behalf if the client becomes incompetent

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client's advance directive. A statement of limitation on implementing a client's advance directive should include at least the following information:

- A clarification of the provider's conscience objections
- Identification of the state legal authority permitting a provider's conscience objections to carrying out an advance directive
- A description of the range of medical conditions or procedures affected by the conscience objection

A provider cannot require a client to execute or issue an advance directive as a condition for receiving health care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider's policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

7.1.6 Primary Care Provider Requirements and Information

Under Medicaid Managed Care HMOs, eligible Medicaid clients must select a health plan and a primary care provider. Under Medicaid Managed Care PCCM, eligible Medicaid clients do not have to select a health plan. PCCM eligible Medicaid clients select a primary care provider. The primary care provider furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week (see "Continuous Access" on page 7-9). Primary care includes ongoing responsibility for preventive health care, health maintenance, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services.

Primary care providers can choose to contract with PCCM and HMO health plans simultaneously.

Effective December 1, 2006, PCCM Medicaid clients (except SSI-related clients) living in the STAR program service areas of Bexar, Dallas, El Paso, Harris, Harris Expansion, and Lubbock will no longer have PCCM as an option for Medicaid covered health care services. The Health and Human Services Commission mailed out initial notification letters and enrollment kits to affected clients in July 2006.

Although PCCM clients in these service areas will be moving to an HMO, PCCM still needs primary care providers. By remaining enrolled in PCCM, providers ensure continuity of care for each PCCM client in those STAR metropolitan areas as they transition to an HMO. Providers should remember that choosing an HMO does not require that providers terminate their contracts with PCCM. Providers may contract simultaneously with an HMO(s) as well as with PCCM.

PCCM providers in the STAR metropolitan areas are encouraged to continue to provide ongoing health care services to PCCM clients who live in contiguous areas not affected by the changes. There may be instances where PCCM clients may choose a PCCM primary care provider in a metropolitan (STAR) service area.

Provider types who are eligible to serve as a primary care provider include:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Nurse practitioners or clinical nurse specialists (family practice, women's health, or pediatrics)
- Certified nurse-midwives
- Physician assistants
- Rural health clinics (RHCs)
- Federally qualified health centers (FQHCs)
- Specialists willing to provide medical homes to clients who have special needs

The primary care provider either furnishes or arranges for all the client's health care needs, including well check-ups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services.

Texas Health Steps (THSteps) providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps services are self-referred. Medicaid

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HMOs determine how their clients will access THSteps services. The HMO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the HMO's network. Clients in PCCM are encouraged to access their primary care provider for THSteps services, but may self-refer to any Medicaid THSteps provider. Providers who perform THSteps must work in collaboration with the client's primary care provider to ensure continuity of care.

Female clients may access obstetrical and gynecological providers directly. Although primary care providers are encouraged to assist clients in accessing these services, Medicaid Managed Care enrollees may self-refer for the following services:

- Emergency services
- Family planning
- THSteps services
- Early Childhood Intervention (ECI) case management
- Case Management for Children and Pregnant Women (CPW)
- Obstetric or gynecological services
- School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative (DARS) case management
- DSHS case management
- Department of Aging and Disability Services (DADS) case management
- Behavioral health services (contact client's health plan for specific requirements)

Behavioral health providers must enroll with each HMO to be reimbursed for services provided to clients. Although Medicaid Managed Care clients may self-refer for behavioral health services, HMO health plan providers should contact the client's health plan for specific in-network requirements. If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO.

Refer to: "NorthSTAR Program" on page 7-18.

PCCM operates an open-specialty network. Therefore, behavioral health providers do not have to enroll with PCCM. PCCM clients may access behavioral health services from any Medicaid-enrolled behavioral health provider.

Providers cannot enroll Medicaid clients; however, educating clients is encouraged. Medicaid clients must enroll through the official state enrollment form or by calling the STAR Help Line at 1-800-964-2777.

Providers should follow these rules when educating patients:

- Generally, providers may not influence patients to choose one HMO health plan over another or one PCCM provider over another.
- Under Medicaid Managed Care, HMO providers must inform patients of all Medicaid Managed Care health plans in which the providers participate.
- HMO providers participating in a Medicaid Managed Care HMO may display state-approved, health-related marketing materials in their offices, provided it is done equally for all HMOs in which they participate. HMO providers cannot give out or display plan-specific marketing items or giveaways to patients.
- Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
- HMO providers may inform patients of special services offered by all Medicaid Managed Care health plans in which the providers participate.
- HMO providers may inform patients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.
- HMO providers may assist a patient by contacting a plan (or plans) to determine if a particular specialist or service is available, if the patient requests this information.
- HMO providers may not influence patients based on reimbursement rates or methodology used by a particular plan.
- HMO providers can provide the necessary information for the patient to contact a particular plan but cannot promote any plan over another.
- In no instances can HMO providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined above, and patients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the patient, not by the HMO provider or the provider's agent.
- PCCM providers may stock primary care provider selection forms and/or provide a blank primary care provider selection form to the client. They may assist the client in filling out the selection forms. However, they may not in any way influence or coerce the client in making a primary care provider selection. Each client must personally complete and mail their individual form. Providers are prohibited from supplying provider-identified stationary and/or envelopes to the client for this purpose.
- HMO providers may display stickers indicating they participate in a particular Medicaid Managed Care health plan as long as they do not indicate anything more than "(health plan) is accepted or welcomed here."

7.1.6.1 Continuous Access

Continuous access is an important feature of Medicaid Managed Care. Twenty-four-hour primary care provider availability enables clients to access and use services appropriately, instead of relying on emergency rooms for after-hours care.

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Continuous access can be provided through direct access to a primary care provider's office and/or through on-call arrangements with another office or service. Clients should be informed of the primary care provider's normal office hours and should be instructed how to access urgent medical care after normal office hours.

After-Hours Guidelines

Primary care providers are required to have *at least one* of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- An office phone answered after hours by a medical exchange or a professional answering service. If an answering service is used, the following must be met:
  - The answering exchange or service must be able to contact the primary care provider or a designated back-up provider for immediate assistance
  - The primary care provider, or designated back-up provider, must be notified of all calls
  - All calls must be returned in a timely manner by the primary care provider or designated back-up
  - The answering service must meet the language requirements of the major Medicaid population groups in the primary care provider's area
- An office phone answered after office hours by an answering machine that instructs the client (in the language of the major Medicaid population groups) to do one of the following:
  - Call the name and phone number of a medical facility where the client can request to speak with a medical professional to determine whether emergency treatment is appropriate
  - Call another number where the primary care provider can be reached
  - Call the name and phone number of a medical professional serving as designated back-up. In this situation, the client must be able to speak with the back-up provider or a clinician who can offer immediate assistance
- An office phone transferred after hours to another location where someone will answer and be able to contact the primary care provider or designated back-up provider

Unacceptable Phone Arrangements

The telephone answering procedures listed below are *not* acceptable:

- An office phone that is answered only during office hours
- An office phone that is answered by a recording or an answering service that directs clients to go to the emergency room
- An office phone answered after hours by an answering machine recording that tells clients to leave a message
- An office phone answering machine recording that informs clients of regular office hours and requests that they call back during those hours
- PCCM providers may not direct clients to call the PCCM nurse helpline in order to meet the primary care provider 24-hour continuous coverage requirements

7.1.6.2 Cultural Competency and Sensitivity

HHSC values the diversity of the Texas Medicaid population and requires TMHP to provide programs to support clients from diverse cultural backgrounds:

- Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.
- Articles in the *Texas Medicaid Bulletin* and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in primary care provider offices.

Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

Limited English Proficiency

Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the *Civil Rights Act* of 1964 states that "no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the primary care provider to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients
- Have access to proficient interpreters during hours of operation
- Develop written policies and procedures regarding interpreter services
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency

In order to meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff
- Hire staff interpreters
- Use qualified volunteer staff interpreters
- Arrange for the services of volunteer community interpreters (excluding the client's family or friends)
- Contract with an outside interpreter service

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- Use a telephone interpreter service such as Language Line Services
- Develop a notification and outreach plan for beneficiaries with limited English proficiency

Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR).

Additional information, including the complete guidance memorandum on prohibition of discrimination against persons with limited English proficiency issued by the OCR, can be found on the Internet at www.hhs.gov/ocr/lep/guide.html.

7.1.6.3 Primary Care Provider-to-Client Ratio and Capacity

HHSC oversees all Medicaid Managed Care providers for accessibility and quality of care. If HHSC determines that providers do not have, or fail to maintain, the capacity or capability of providing quality, accessible care, their clients will be reduced through a freeze on new enrollments to the provider's panel. HHSC may disenroll current clients if required accessibility and quality of care to clients is jeopardized.

7.1.7 Medicaid Managed Care Complaints and Fair Hearings

Medicaid Managed Care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals/grievances or dispute resolution is the responsibility of each managed care health plan or PCCM. Providers must exhaust the complaints/grievance process with their managed care health plan or PCCM before filing a complaint with HHSC.

Please refer to the respective health plan or PCCM for information about specific complaint policies and procedures. For PCCM, please see "Provider Complaints and Appeals" on page 7-39. For NorthSTAR, see "Complaints and Appeals" on page 7-20. For HMOs, refer to the respective health plan's policies and procedures.

7.2 STAR Program

7.2.1 Overview

The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Currently, the STAR Program consists of only one type of health care delivery system (HMO) in select Texas counties. The selected grouping of counties is known as a Service Area (SA).

7.2.1.1 STAR HMO Model

In the HMO model, each STAR health plan is responsible for contracting with providers and/or delegated network to create a health care provider delivery network. Clients who reside in one of the SA counties where this model is an option, and who have selected an HMO, are required to select a primary care provider from the HMO provider directory.

7.2.2 Client Eligibility

HHSC has targeted these client groups within the Texas Medicaid population for STAR Program enrollment:

Type	Program	Enrollment Code
1	Regular Temporary Assistance for Needy Families (TANF)	M
3	MAO RSDI Increases - No Medicare	M*
7	12 months Medicaid denied due to earnings	M
12	Supplemental Security Income (SSI) Manually Certified - No Medicare	M*
13	SSI Recipient - No Medicare	M*
18	Disabled Adult Children denied SSI due to increase in SS benefits - No Medicare	M*
19	Transitional SSI - No Medicare	V
20	04 months Medicaid - TANF	M
22	Early Age Widows/Widowers - No Medicare	M*
29	12 months transitional Medicaid - limited TANF	M
37	12 months transitional Medicaid denied due to earned income; disregards ending	M
40	Pregnant women	M
43	Children under 1 year of age with income below 185% FPIL	M

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Type	Program	Enrollment Code
44	Children aged 6-19 yrs. with income below 100% FPIL	M
45	Children up to age 1 year, born to Medicaid eligible mothers	M
47	Medicaid for deprived children with step-grandparent income	M
48	Children aged 1-5 yrs. with income below 133% FPIL	M
61	TANF State Program	M
M = Mandatory V = Voluntary M* = Mandatory adults aged 21 and older		

7.2.3 Client Enrollment

A STAR Program client is free to choose a STAR health plan and primary care provider. To maximize enrollment, the STAR Program offers four alternative ways that clients can enroll:

- *Telephone Enrollment*. A client can enroll in the STAR Program by calling 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.
- *Mail-in Enrollment*. If calling is not convenient, a client may enroll by completing the STAR Program enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider directories for each plan.
- *Onsite Enrollment*. In addition to telephone and mail-in enrollment, clients can enroll by talking with a STAR Program customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.
- *Default Enrollment*. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a STAR health plan and primary care provider, the client will be assigned to a plan and primary care provider. The following factors are considered when processing a default enrollment:
    - Client's past claims history, taking into account an established relationship with a STAR or participating primary care provider
    - Client's age
    - Client's sex
    - Client's geographic proximity to the primary care provider

7.2.3.1 STAR Help Line (STAR Enrollment Broker)

Hours	8 a.m. to 8 p.m., Central Time, Monday through Friday
Telephone	1-800-964-2777
Telecommunications device for the deaf (TDD)	1-800-267-5008

7.2.3.2 Automatic Re-enrollment

If a client loses Medicaid eligibility and then regains eligibility within six months, the client is automatically reassigned to his previous health plan and primary care provider.

7.2.3.3 Enrollment of Pregnant Women (Type Program 40)

Women who are on Medicaid type program 40 may be retroactively enrolled in STAR. Women who are certified for Medicaid type program 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Those who are certified after the 10th of the month will be on fee-for-service the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification. There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

It is important that providers call the number listed on the Medicaid Identification Form (Form H3087) for plan and provider information.

***Example 1**: Woman Certified in Her 6th Month*

Client certified for Texas Medicaid	August 1
Medicaid benefits begin	August 1
STAR Program benefits begin	August 1

***Example 2**: Woman Certified in Her 6th Month*

Client certified for Texas Medicaid	August 12
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

***Example 3**: Woman Certified in Her 9th Month*

Client certified for Texas Medicaid	August 5
Medicaid benefits begin	August 1
STAR Program benefits begin	September 1

A pregnant woman who is on type program 40 has 16 days from the date of application to choose a STAR health plan. If she does not choose a STAR health plan, one will be chosen for her.

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Expedited Medicaid Managed Care Enrollment for Pregnant Women

The enrollment broker contacts the client to begin the enrollment process and assists the client in selecting an HMO. The client may also contact the enrollment broker directly at 1-800-964-2777 (STAR Help Line). To protect continuity of care and client choice, the enrollment broker will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Until coverage begins in a Medicaid Managed Care Program, clients will be covered under traditional Medicaid fee-for-service. Clients may initially receive a Medicaid Identification Form (Form H3087) that shows them to be a client of a STAR health plan but does not list the plan name. To ensure proper billing, providers should call the enrollment broker at 1-800-964-2777 (STAR Help Line) to obtain the name of the client's health plan. The health plan name should appear on the Medicaid Identification Form (Form H3087) the following month. However, client eligibility should always be verified.

Within 14 days of enrolling in a new health plan, a plan representative will contact the new client to help arrange the first prenatal appointment. Physicians should also expect contact from the health plans to facilitate prenatal appointments for new clients. Physicians and other prenatal care providers are encouraged to make prenatal appointments within two weeks or as soon as possible.

Enrollment of Newborns

STAR health plans are responsible for all covered services provided to newborn clients. In the STAR Program, newborns are automatically assigned to the mother's STAR health plan. In the STAR+PLUS Program, newborns are enrolled in the STAR plan offered by the mother's STAR+PLUS plan, if available. If the STAR+PLUS plan does not also provide STAR services in the service area, the newborn is automatically enrolled in traditional Medicaid until the mother selects a STAR plan for the newborn.

To ensure reimbursement, it is essential that all health care providers verify eligibility before medical care is provided to STAR Program clients, except in cases of emergency. In situations where emergency care must be provided, the client's STAR health plan and primary care provider should be determined as soon as possible.

STAR Program clients' Medicaid Identification Forms (Form H3087) will indicate their participation in the STAR Program. Additionally, some STAR health plans offer their clients a STAR identification card. If applicable, both forms of identification should be requested when determining whether or not the client is a STAR Program client.

Refer to: "Client Medicaid Identification (Form H3087) (18 Pages)" on page B-16 for examples of the STAR, STAR+PLUS, NorthSTAR, and PCCM Programs' Medicaid Identification Form (Form H3087).

As with the traditional Medicaid program, there may be a delay of up to several months from the date of birth (DOB) for a newborn to receive a Medicaid client number. Providers should check with each STAR health plan for claim filing requirements.

If the newborn has not yet been assigned a primary care provider, the Medicaid Identification Form (Form H3087) will indicate that the client is "Newborn" and instruct the provider to "Call Plan" to inquire about filing a claim.

Refer to: "Newborn Claims Submission" on page 7-16 and "STAR+PLUS Program" on page 7-16.

Timely Notification and Assignment of Medicaid ID for Newborns

Hospitals that submit their birth certificate information utilizing the DSHS, Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the HHSC Form 7484, receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care.

Call 1-512-458-7367 for further questions or comments about this new process.

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7.2.4 Service Areas

Service Area (SA)	Counties	STAR Health Plans Available	STAR Health Plan Provider Services
Bexar	Bexar, Kendall, Comal, Guadalupe, Wilson, Atascosa, and Medina	Community First Superior Health Plan Aetna	1-800-434-2347 option 4 1-877-391-5921 option 3 1-800-248-7767
Dallas	Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall	AMERIGROUP Texas, Inc. Parkland HEALTH*first* UNICARE Health Plan of Texas	1-800-454-3730 1-888-672-2277 option 2 1-866-480-4830
El Paso	El Paso	El Paso First Premier Plan Superior Health Plan	1-915-532-3778 Ext. 1067 1-877-391-5921 option 3
Harris	Harris, Montgomery, Waller, Fort Bend, Galveston, and Brazoria	AMERIGROUP Texas, Inc. Community Health Choice Texas Children's Molina Health Plans of Texas	1-800-454-3730 1-888-760-2600 option 3 1-832-824-2600 1-866-449-6849 option 1
Lubbock	Lubbock, Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lynn, and Terry	FIRSTCARE Superior Health Plan	1-800-264-4111 Ext. 4380 1-877-391-5921
Nueces	Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Victoria	AMERIGROUP, Texas, Inc. Driscol Children's Health Plan Superior Health Plan	1-800-454-3730 1-877-324-3627 option 2 1-877-391-5921 option 3
Tarrant	Tarrant, Wise, Denton, Parker, Hood, and Johnson	AMERIGROUP Texas, Inc. Aetna Health Inc. Cooks Children	1-800-454-3730 1-800-306-8612 1-800-964-2247
Travis	Travis, Williamson, Lee, Bastrop, Caldwell, Hays, and Burnet	Superior Health Plan AMERIGROUP Texas, Inc.	1-877-391-5921 option 3 1-800-454-3730

Refer to: "PCCM Expansion" on page 7-21 for details relating to PCCM expansion areas.

7.2.5 STAR Program Benefits

STAR Program clients receive all the benefits of the traditional Texas Medicaid Program and the following additional benefits:

- Adult well-checks
- Removal of the inpatient spell of illness limitation
- Unlimited medically necessary prescription drugs for adults

7.2.5.1 Adult Well-Check

An annual adult physical exam performed by the client's primary care provider is an additional benefit of the STAR Program for clients 21 years of age and older. The annual physical exam is performed in addition to family planning services. This service is provided to healthy individuals for the purpose of promoting health and preventing injury or illness.

The annual examination should be age and health risk appropriate and should include all the clinically indicated elements of history, physical examination, laboratory/diagnostic examination, and patient counseling that are consistent with good medical practice. Providers are encouraged to adopt a nationally recognized, evidence-based standard for the elements of the annual exam, such as the guidelines published by the American Academy of Family Physicians at www.aafp.org.

This service is only reimbursable when performed by the current designated primary care provider on the date of service and is allowed once per state fiscal year (September 1 through August 31), per client.

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The following appropriate codes may be billed:

- 99385 and 99386 for a new patient
- 99395 and 99396 for an established patient

7.2.5.2 Spell of Illness

STAR clients are entitled to medically necessary care without a time frame limitation. Members younger than 21 years of age already have this benefit under the Comprehensive Care Program (CCP).

7.2.5.3 Prescriptions

STAR Program members who are age 21 years or older are permitted to receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client's health care needs. Prescription reimbursement continues to be processed through the HHSC Vendor Drug Program. All Medicaid clients who are younger than 21 years of age receive unlimited medically necessary prescription drugs.

7.2.6 Claims Filing Information

All claims for Medicaid Managed Care clients enrolled in a STAR HMO must be submitted to the STAR health plan in which the client is enrolled at the time of service (or date of admission for inpatient hospital claims), except as noted below. The STAR HMO, as a secondary payor, does not determine payment based on the primary payor's authorization of services and/or approval of hospital stays.

TMHP processes claims for the following clients/programs:

- All SSI clients who are in the STAR Program
- The following non-capitated services to STAR clients enrolled in an HMO:
  - ECI targeted case management
  - DSHS case management (except for the Dallas SA where clients are enrolled in NorthSTAR)
  - DADS services (except for the Dallas SA where clients are enrolled in NorthSTAR)
  - CPW Case Management
  - SHARS
  - DARS
  - THSteps Dental (dentist services only)
  - Tuberculosis services provided by DSHS-approved providers
  - Vendor Drug Program (out-of-office drugs)
  - Audiology services and hearing aids for children under the age of 21 (hearing screening services are provided through the THSteps Program and are capitated) through PACT (Program for Amplification for Children of Texas).

A claim must be submitted to TMHP for processing for a patient who was classified as SSI on the date of admission to a hospital. However, if the patient was an HMO client as of the date of admission to the hospital and was admitted as TANF- (i.e., not SSI) certified, but changed to SSI during the same hospital stay, the claim must be submitted to the client's HMO for payment of the entire hospital stay. All PCCM claims are submitted to TMHP, whether TANF or SSI.

If the provider of services is not the client's assigned primary care provider, the primary care provider's name and provider identifier must be entered in the Referring Provider field (boxes 17 and 17a) on the CMS-1500, indicating a referral from the primary care provider. If this information is missing or if the treating provider is not the assigned primary care provider on the dates of service, the claim will be denied.

Providers submitting claims for SSI voluntary clients must follow the client's individual plan requirements for referrals, authorization, admission notification, and concurrent review. The plan is responsible for notifying TMHP of the services that they have approved so those claims can be processed accordingly. Claims for SSI clients who are voluntarily enrolled in PCCM or an HMO will be paid at traditional Medicaid rates.

All traditional Medicaid processing guidelines are followed in processing these claims including the 95-day filing deadline. Send claims through regular mail to the following address:

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

Claims delivered by UPS or other courier methods are to be addressed to the following:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

TMHP Electronic Claims Submission

Electronic claims submission is available to providers filing claims for PCCM clients and all SSI voluntary clients in STAR HMOs. Providers must use their provider identifier when billing. For assistance with enrolling to file electronic claims, contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638, or a provider representative. Contact individual plans for information on electronic claims submissions to STAR HMOs (refer to chart, STAR Program SAs).

Refer to: "TMHP Electronic Data Interchange (EDI)" on page 3-1 for more information about electronic claims submission.

7.2.6.1 Pregnant Women (TP40)

Claims for pregnant women who are on type program 40 should be directed to the plan administrator listed on the Medicaid Identification Form (Form H3087). In some instances, a primary care provider will not be assigned for the first month of eligibility. These claims should be filed with the following temporary primary care provider number

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as the referring provider: PCCTP4001. For clients who do not yet have a primary care provider assigned, call the client's plan administrator for more information. If a health plan name does not appear on a STAR client's Medicaid Identification Form (Form H3087), call the STAR Help Line at 1-800-964-2777. For PCCM clients, call the PCCM Client Helpline at 1-888-302-6688.

7.2.6.2 Newborn Claims Submission

Newborns are automatically enrolled in the mother's STAR health plan. Claims for services provided to newborns should be filed with the mother's STAR health plan. Providers filing claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which in most cases is within 95 days of each date of service.

HMO Newborn Claims Filing

Claims for newborns who are clients of an HMO should be filed directly with the client's HMO.

Health care providers should file newborn claims using the newborn's Medicaid identification number as soon as it is made available to them.

HMOs must pay providers for inpatient and professional services related to neonatal care for up to 48 hours after vaginal delivery and 96 hours after Caesarian delivery. (Prior authorizations and primary care provider assignment cannot be a reason for denial of claims.)

HMOs may require prior authorizations for hospital and professional services beyond the 48/96 hour time limits.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the STAR health plan in which the client is enrolled.

Note: *Telephone numbers and addresses for claims submission and appeals for STAR HMOs can be found in the appropriate HMO policies and procedures manual for the appropriate SA.*

Refer to: "Claims Filing Information" on page 7-18 for information about claims filing for STAR+PLUS.

"Claims Filing Information" on page 7-19 for information about claims filing for NorthSTAR.

7.3 STAR+PLUS Program

7.3.1 Overview

In 1995, the Texas Legislature adopted Senate Bill 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of the Texas Medicaid Program to incorporate Medicaid Managed Care delivery systems statewide. STAR+PLUS is the result of Texas Senate Concurrent Resolution 55 of the 74th Legislature (1997), which directed HHSC to develop and implement a long term care integrated model demonstration program.

The STAR+PLUS Program consists of two types of health care delivery systems: an HMO delivery system and a PCCM model.

Clients eligible for Medicaid under the SSI Programs residing in Harris County began enrolling in STAR+PLUS. STAR+PLUS integrates acute care and long term care into a Medicaid Managed Care delivery system for eligible Medicaid clients under the SSI Program. HHSC is the operating agency for STAR+PLUS. It is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs.

7.3.1.1 HMO Model

In the HMO model, the STAR+PLUS health plan is responsible for contracting with providers and/or delegated network to create a health care provider delivery network. SSI clients who reside in one of the SA counties where this model is an option, and who have selected an HMO, are required to select a primary care provider from the HMO provider directory if they are not covered by Medicare. SSI clients who are also covered by Medicare (Dual Eligibles) must select a STAR+PLUS HMO to receive Medicaid community based long term care services.

Children born to STAR+PLUS clients will be enrolled with the STAR plan operated by the same HMO if available. If the STAR+PLUS plan does not also operate a STAR plan, the newborn is automatically enrolled into traditional Medicaid until the mother chooses a STAR health plan for the newborn.

7.3.1.2 Service Area

The STAR+PLUS Program is only available to eligible Medicaid clients under SSI programs who reside in Harris County.

The following STAR+PLUS health plans are available:

- AMERIGROUP Texas, Inc. (1-800-600-4441)
- Evercare of Texas, Inc. (1-888-887-9003)
- PCCM (1-888-834-7226)

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7.3.1.3 Client Eligibility

HHSC has targeted these client groups within the Texas Medicaid population for STAR+PLUS Program enrollment:

- Enrollment for category 01, 03, 04 (SSI aged, blind and disabled clients) and the following program types are *mandatory* for STAR+PLUS:

Type Program	Description
03	Denied SSI clients who are Medicaid-eligible under Pickle provisions.
12	SSI client.
13	SSI client.
14	***Note:*** *Only those client that have been determined eligible for the 1915 (b) Nursing Facility Waiver (CBA) will be enrolled in STAR+PLUS. All other clients in TP 14 are excluded from participation.*
18	Disabled adult children denied SSI dues to increase in Social Security benefits.
22	Denied SSI clients who receive widow/widower Social Security benefits.
51	Medicaid and community-based nursing care services.

- Enrollment for category 03 and 04, SSI Blind and Disabled children, and type program 19, Medicaid and community-based waiver program for children younger than age 21 years, may enroll in a STAR+PLUS HMO.

Refer to: "Client Eligibility and Effective Date" on page 7-4 for more information on eligibility effective dates.

7.3.1.4 Dual Eligible Clients

Many STAR+PLUS clients are eligible for Medicaid and Medicare. STAR+PLUS HMOs are not at risk for the delivery of acute care services needed by these clients.

All STAR+PLUS clients with Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). MQMBs receive Medicare benefits through a Medicare Risk Product (HMO) or Medicare fee-for-service insurance program. To reduce confusion, HHSC has mandated that STAR+PLUS MQMBs continue to receive all their acute care services as they do today, with Medicare being the primary payor and traditional Medicaid, through TMHP, the secondary payor. Providers are to continue billing for Medicare acute care services through the client's Medicare HMO or fee-for-service insurer following the rules of the Medicare insurer. If the client is in both a Medicare and Medicaid HMO, the client uses the Medicare primary care provider, and providers follow the Medicare HMO's medical management rules for authorization, concurrent review, etc. MQMBs choose a Medicaid HMO but do not choose a Medicaid primary care provider.

Refer to: Sections on MQMBs in this manual for further instructions.

"Claims Filing Information" on page 7-18 for MQMB reimbursement requirements.

Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare HMO also offered by their STAR+PLUS plan. With the implementation of the Medicare prescription benefit in January 2006, dual eligibles no longer receive any prescription benefit through Medicaid.

Medicare Advantage Plans

The two STAR+PLUS plans operating in Harris County also offer a Medicare Advantage plan for Medicare recipients. Dual eligibles who are in STAR+PLUS may join the Medicare Advantage plan offered by their STAR+PLUS HMO or they may join any other Medicare Advantage plan or choose to not join a Medicare Advantage plan.

For those STAR+PLUS members that have joined the Medicare Advantage plan offered by their STAR+PLUS plan, the state pays a capitated payment to cover all Medicaid liabilities that may result from a Medicare covered service being delivered through the Medicare Advantage plan. Payment to Medicare providers for copays and deductibles must be paid by the STAR+PLUS/ Medicare Advantage plan HMO, and providers should not have to bill Medicaid. TMHP will *only* pay Medicaid-only services for these clients (refer to section 7.2.6, in addition to those services that are not a benefit of Medicare). TMHP will deny or recuperate claims submitted and/or paid for Medicare co-insurance, deductibles and co-pays for STAR+PLUS members who have also joined the Medicare Advantage plan offered by their STAR+PLUS HMO. For further information, refer to the appropriate plan's guidelines on benefits and claims submissions.

7.3.1.5 Ineligible Clients

Clients not eligible for STAR+PLUS who will remain in the traditional Medicaid program include clients who are:

- Participating in a Home and Community-Based Waiver other than the Nursing Facility Waiver:
  - Community Living Assistance and Support Services (CLASS) Waiver Program
  - Medically Dependent Children's (MDCP) Waiver Program
  - Home and Community Services (HCS) Waiver Program
  - Mental Retardation Local Authority (MRLA) Waiver Program
  - Deaf/Blind Multiple Disabled Waiver Program
- Residents in a nursing facility
- Residents in intermediate care facilities for the mentally retarded (ICF-MR)

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- Residents of state hospitals or institutions for mental diseases
- Frail Elderly (or 1929B) Program recipients
- Recipients of In-Home and Family Support Program Services
- Qualified Medicare Beneficiaries (QMBs)
- Undocumented aliens
- Clients who receive limited Medicaid benefits and do not qualify for participation in the Vendor Drug Program

7.3.2 STAR+PLUS Program Benefits

STAR+PLUS Program clients receive all the benefits of the traditional Texas Medicaid Program and the following additional benefits:

- Adult well-checks
- Spell of Illness policy defined in "Spell of Illness" on page 7-15
- Prescriptions policy defined in "Prescriptions" on page 7-15 (for STAR+PLUS members that are not dual eligibles)

7.3.3 Claims Filing Information

The claims filing guidelines found in "Claims Filing Information" on page 7-15, also apply to STAR+PLUS.

In addition to the claim types found on page 7-18, TMHP processes claims for the following STAR+PLUS clients/ programs:

- All PCCM claims for the PCCM model
- All crossovers for deductibles and coinsurance on STAR+PLUS MQMBs
- All claims for Medicaid-only services (refractions, hearing exams, etc.) provided to STAR+PLUS MQMBs

STAR+PLUS MQMBs receive services and have their acute care claims processed as though they are not in a Medicaid Managed Care program. TMHP is responsible for reimbursing all Medicare coinsurance and deductibles that meet Medicaid payment criteria, as well as for all services that are a benefit of the Medicaid program (refractions, hearing exams, etc.) that are not covered under the Medicare program.

STAR+PLUS clients can be enrolled in PCCM as noted above. These clients are mostly children and adolescents with Severe and Persistent Mental Illness (SPMI) and/or Serious Emotional Disturbance (SED). PCCM clients receive all acute care through PCCM and choose a PCCM primary care provider.

7.4 NorthSTAR Program

7.4.1 Overview

NorthSTAR, in the Dallas SA, provides behavioral health services (mental health, chemical dependency, and substance abuse treatment) for Medicaid enrollees through a behavioral health organization (BHO). NorthSTAR is known as a *behavioral health carve-out* of the STAR Program in the Dallas SA. Medicaid provides access to physical health care while NorthSTAR provides mental health and chemical dependency (behavioral health) services.

NorthSTAR provides easier access to a comprehensive array of behavioral health services and providers. The program's goal is to provide clinically necessary covered behavioral health services to enrollees, through a network of qualified and credentialed providers.

In the NorthSTAR Program, ValueOptions is the sole BHO and is responsible for contracting with providers and maintaining a behavioral health care provider delivery network. The BHO also:

- Offers education and support to the provider network
- Performs utilization management through authorization of services, concurrent review, and special studies
- Performs quality assurance monitoring and activities
- Provides client services including education and outreach
- Processes claims

7.4.2 Provider Requirements and Information

In the STAR Program, clients select a primary care provider from among the providers who have contracted with a STAR HMO or PCCM. In the NorthSTAR Program, a client may have several different providers for different specialty behavioral health services. The BHO will arrange behavioral health services and make referrals to specific providers within the BHO network.

Providers are encouraged to coordinate care with physical health providers in the Medicaid Managed Care and traditional Medicaid programs. Behavioral health providers may do this by notifying the Medicaid Managed Care or traditional Medicaid provider. Behavioral health providers may also notify the BHO that the client is receiving services.

Providers interested in becoming a ValueOptions network provider can obtain additional information by contacting ValueOptions at 1-888-800-6799.

Note: *If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO (ValueOptions) to provide services to NorthSTAR enrollees. Providers who serve NorthSTAR*

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enrollees without being in the provider network or without prior authorization in nonemergency situations risk non-payment of claims.

7.4.3 Service Area

The NorthSTAR Program is available in the Dallas SA. The following counties are included: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

The ValueOptions Provider Services contact telephone number is 1-888-800-6799.

7.4.3.1 Client Eligibility

Most Medicaid clients residing in the Dallas SA must enroll in NorthSTAR. All STAR Program enrollees are subject to mandatory enrollment in NorthSTAR. Once enrolled in NorthSTAR, ValueOptions will coordinate enrollee behavioral health services.

Refer to: "Medicaid Identification Form H3087" on page 4-18 for a sample of the Medicaid Identification Form (Form H3087).

Note: *NorthSTAR Program enrollment information is not reflected on the Medicaid Identification Form (Form H3087), but enrollment can be confirmed by the BHO or the enrollment broker.*

Medicaid clients residing in the Dallas SA that are not eligible to enroll in a NorthSTAR BHO are:

- Medicaid clients living in a nursing facility
- Medicaid clients living in an ICF-MR
- Medicaid clients living in state hospitals' Institutions for Mental Disease Over Age 65 Program
- Children who are in the custody of the Department of Family and Protective Services (DFPS) (in foster care)
- Certain Medicaid clients that are ineligible for NorthSTAR such as type program 55

Refer to: "Client Enrollment" on page 7-12 for further information on STAR Program eligible client program types and for further information on STAR Program eligibility effective dates.

7.4.4 Client Enrollment

When a Medicaid enrollee requests services, the provider should contact ValueOptions or the enrollment broker to verify enrollment in NorthSTAR. If the client is not currently enrolled in NorthSTAR, the provider may give the client the telephone number of the enrollment broker so the client may become enrolled in NorthSTAR.

The enrollment broker staff is trained to assist potential clients in their understanding of both the STAR and NorthSTAR programs.

Medicaid clients can enroll in the following ways:

- Telephone enrollment with ValueOptions or the enrollment broker
- Mail-in enrollment using the NorthSTAR enrollment form
- Onsite enrollment at a designated NorthSTAR enrollment site (contact the enrollment broker for a list of enrollment sites)

7.4.4.1 NorthSTAR Enrollment Broker

Hours	8 a.m. to 8 p.m., Central Time, Monday through Friday
Telephone	1-800-964-2777
Telephone TDD	1-800-267-5008

7.4.4.2 Guidelines for Working with NorthSTAR Clients

Clients enrolled in NorthSTAR, like any other clients, have these rights:

- To be treated with respect, dignity, privacy and confidentiality, and without discrimination
- To consent to or refuse treatment and actively participate in treatment decisions
- To use each available complaint process and to receive a timely response to complaints
- To receive timely access to care that does not have any communication or physical access barriers

7.4.5 Claims Filing Information

All behavioral health claims for NorthSTAR enrollees in the Dallas SA must be filed to the NorthSTAR BHO, ValueOptions. Behavioral health specialists and hospitals are not to bill TMHP for behavioral health services provided to clients who are enrolled in or eligible for enrollment in the NorthSTAR Program.

Exception: *Claims with a primary diagnosis of developmental disability (mental retardation, autism, pervasive developmental disorder) are submitted to TMHP.*

If a behavioral health claim is submitted to TMHP for any diagnosis other than a developmental disabilty, it is denied. If it is paid erroneously, TMHP recoups it later.

7.4.5.1 Hospital Billing

In the Dallas SA, SSI clients are subject to mandatory enrollment in Medicaid Managed Care through the NorthSTAR Program. In some instances, general acute care hospitals treat a NorthSTAR client with a primary behavioral health diagnosis. In that instance, the general acute care hospital needs to seek authorization and reimbursement from ValueOptions using the CMS-1500 form for outpatient services and HCFA-1450 (UB-92) for inpatient services.

7.4.5.2 Behavioral Health Billing

Services provided under the STAR Program are billed to the STAR HMO in which the patient is enrolled. PCCM providers submit claims to TMHP. The STAR Program in

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the Dallas SA covers medically necessary physical health care services and behavioral health services that are delivered by medical providers, such as primary care physicians, FQHCs, and RHCs. STAR also covers ambulatory laboratory and ancillary services required to diagnose or treat behavioral health conditions and psychological testing for certain non-behavioral health diagnoses.

The program-related forms are the CMS-1500 and HCFA-1450 (UB-92).

PCCM providers refer to "Behavioral Health Services" on page 7-30.

7.4.5.3 Prior Authorization Requirements

To receive payment for services to ValueOptions clients, providers must be enrolled with ValueOptions. (Exceptions include emergency care and medically necessary treatment episodes that began before the client joined a NorthSTAR plan.) ValueOptions requires that the provider obtain prior authorization for most nonemergency services. If the provider does not obtain prior authorization, they may not get payment for services. These rules apply whether the provider's practice or facility is located in or out of the Dallas SA.

7.4.6 Complaints and Appeals

A *complaint* is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the health plan. The term *complaint* does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction.

Appeals/grievances, hearings, or dispute resolution is the responsibility of ValueOptions. Providers must exhaust the appeals/grievance process with ValueOptions before filing a complaint with NorthSTAR Provider Relations. Under the complaint process, NorthSTAR Provider Relations works with ValueOptions and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues, as applicable. When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the NorthSTAR health plan is incorrect and copies of the following documentation:

- All R&S reports of the claims/services in question, if applicable
- Provider's claims/billing records (electronic or manual) related to the complaint
- Provider's internal notes and logs when pertinent
- Memos from the state or the health plan indicating any problems, policy changes, or claims processing
- Discrepancies that may be relevant to the complaint
- Other documents such as receipts (i.e., certified mail)
- Original date-stamped envelopes, in-service notes
- Minutes from meetings, etc., if relevant to the complaint

All NorthSTAR providers must exhaust the ValueOptions complaint and appeals process first. After this process is exhausted and if the outcome is unsatisfactory, NorthSTAR providers may file complaints/appeals with NorthSTAR Provider Relations at the following address:

NorthSTAR Provider Relations
DSHS
909 W. 45th Street
PO Box 12668
Austin, TX 78711-2668

Quality Improvement Monitoring

Direct quality of care concerns to ValueOptions or NorthSTAR Provider Relations at the following address:

NorthSTAR Provider Relations
DSHS
909 W. 45th Street
PO Box 12668
Austin, TX 78711-2668

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7.5 PCCM Expansion

7.5.1 Overview

Primary Care Case Management (PCCM), administered by TMHP, is a service delivery model under the Texas Medicaid Managed Care Program. It is not an HMO. PCCM is a network of primary care providers and hospitals under contract with HHSC. PCCM primary care providers and hospitals contract directly with HHSC. PCCM clients select or are assigned a primary care provider from among those who have contracted with HHSC. PCCM was originally implemented as one of the health care delivery options available under the STAR Program, but is no longer part of the STAR Program.

Effective September 1, 2005, PCCM was implemented in the following counties:.

PCCM Counties					
Anderson	Andrews	Angelina	Archer	Armstrong	Austin
Bailey	Bandera	Baylor	Bell	Blanco	Borden
Bosque	Bowie	Brazos	Brewster	Briscoe	Brooks
Brown	Burleson	Callahan	Cameron	Camp	Carson
Cass	Castro	Chambers	Cherokee	Childress	Clay
Cochran	Coke	Coleman	Collingsworth	Colorado	Comanche
Concho	Cooke	Coryell	Cottle	Crane	Crockett
Culberson	Dallam	Dawson	Deaf Smith	Delta	DeWitt
Dickens	Dimmit	Donley	Duval	Eastland	Ector
Edwards	Erath	Falls	Fannin	Fayette	Fisher
Foard	Franklin	Freestone	Frio	Gaines	Gillespie
Glasscock	Goliad	Gonzales	Gray	Grayson	Gregg
Grimes	Hall	Hamilton	Hansford	Hardeman	Hardin
Harrison	Hartley	Haskell	Hemphill	Henderson	Hidalgo
Hill	Hopkins	Houston	Howard	Hudspeth	Hutchinson
Irion	Jack	Jackson	Jasper	Jeff Davis	Jefferson
Jim Hogg	Jones	Karnes	Kenedy	Kent	Kerr
Kimble	King	Kinney	Knox	Lamar	Lampasas
LaSalle	Lavaca	Leon	Liberty	Limestone	Lipscomb
Live Oak	Llano	Loving	Madison	Marion	Martin
Mason	Matagorda	Maverick	McCulloch	McLennan	McMullen
Menard	Midland	Milam	Mills	Mitchell	Montague
Moore	Morris	Motley	Nacogdoches	Newton	Nolan
Ochiltree	Oldham	Orange	Palo Pinto	Panola	Parmer
Pecos	Polk	Potter	Presidio	Rains	Randall
Reagan	Real	Red River	Reeves	Roberts	Robertson
Runnels	Rusk	Sabine	San Augustine	San Jacinto	San Saba
Schleicher	Scurry	Shackelford	Shelby	Sherman	Smith
Somervell	Starr	Stephens	Sterling	Stonewall	Sutton
Swisher	Taylor	Terrell	Throckmorton	Titus	Tom Green
Trinity	Tyler	Upshur	Upton	Uvalde	Val Verde
Van Zandt	Walker	Ward	Washington	Webb	Wharton
Wheeler	Wichita	Wilbarger	Willacy	Winkler	Wood
Yoakum	Young	Zapata	Zavala		

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The Southeast Region (Chambers, Hardin, Jefferson, Liberty, and Orange Counties) previously was part of the STAR Program. Culberson, Hudspeth, and Blanco Counties, previously STAR HMO counties, changed to PCCM-only counties on September 1, 2005.

7.5.2 Contact Numbers

Provider Helpline

Monday through Friday, 7 a.m. to 7 p.m., Central Time
1-888-834-7226, option 5, then option 1, then option 5
Fax: 1-512-506-7002

Client Helpline

Monday through Friday, 7 a.m. to 7 p.m., Central Time
1-888-302-6688

PCCM Inpatient/Outpatient Prior Authorization Line

Outpatient and Prior Authorization, Notifications, Prior Authorizations and Updates to Existing Authorizations
Monday through Friday, 7 a.m. to 7 p.m., Central Time
1-888-302-6167
Fax: 1-512-302-5039

Community Health Services Helpline

Case Management and Health and Program Benefit Education
Monday through Friday, 8 a.m. to 5 p.m., Central Time
1-888-276-0702

The Nurse Helpline

24 hours a day, 7 days a week
1-800-304-5468

7.5.3 Client Eligibility

HHSC has targeted the following client groups for PCCM expansion enrollment:

Type	Program	Enrollment Code
1	Regular TANF	M
3	MAO RSDI Increases - No Medicare	M*
7	12 months Medicaid denied due to earnings	M
12	SSI Manually Certified - No Medicare	M*
13	SSI Recipient - No Medicare	M*
18	Disabled Adult Children denied SSI due to increase in SS benefits - No Medicare	M*
19	Transitional SSI - No Medicare	V
20	04 months Medicaid - TANF	M
29	12 months transitional Medicaid - limited TANF	M
22	Early Age Widows/Widowers - No Medicare	M*
37	12 months transitional Medicaid denied due to earned income; disregards ending	M
40	Pregnant women	M
43	Children under 1 year of age with income below 185% FPIL	M
44	Children 6-19 yrs. with income below 100% FPIL	M
45	Children up to 1 year of age born to Medicaid eligible mother	M
47	Medicaid for deprived children with step-grandparent income	M
48	Children 1-5 years of age with income below 133% FPIL	M
61	TANF State Program	M
M = Mandatory V = Voluntary M* = Mandatory adults ages 21 yrs. and older		

To verify a client's eligibility and primary care provider, access one of the following eligibility resources:

- Medicaid Identification Form (Form H3087)
- Monthly panel report
- TMHP website at www.tmhp.com
- TDHconnect or other vendor software
- AIS at 1-800-925-9126, option 1
- Contact Center at 1-800-925-9126, option 5

In some situations, an eligibility response may indicate that the provider should contact PCCM to verify the primary care provider information. For more information, please call the TMHP Contact Center at 1-800-925-9126, or the PCCM Provider Helpline at 1-888-834-7226.

7.5.4 Client Enrollment

Enrollment into PCCM is mandatory for Medicaid clients residing in one of the expansion counties and who meet the following criteria:

- Low-income families (primarily women and children)
- Blind and disabled individuals who receive Supplemental Security Income (SSI) and are age 21 years and older.

Children under the age of 21 who receive SSI may enroll on a voluntary basis. Elderly and disabled Medicaid clients who live in a nursing home or who are enrolled in community based long-term care will remain in traditional Medicaid.

- *Telephone Enrollment*. A client can enroll in the PCCM Program by calling 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.

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- *Mail-in Enrollment*. If calling is not convenient, a client may enroll by completing the PCCM Program enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider directories for each plan.
- *Onsite Enrollment*. In addition to telephone and mail-in enrollment, clients can enroll by talking with a PCCM Program customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.
- *Default Enrollment*. The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a PCCM health plan and primary care provider, the client will be assigned to a plan and primary care provider. The following factors are considered when processing a default enrollment:
    - Client's past claims history, taking into account an established relationship with a PCCM or participating primary care provider
    - Client's age
    - Client's sex
    - Client's geographic proximity to the primary care provider

Clients on Medicare and individuals enrolled in the Medically Needy Program are not eligible for PCCM enrollment.

7.5.5 Client Rights and Responsibilities

7.5.5.1 Client Rights

PCCM clients have defined rights and responsibilities. PCCM and primary care providers share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

PCCM clients have the right to:

- Be treated fairly and with dignity and respect
- Know that their medical records and discussions with their providers will be kept private and confidential
- A reasonable opportunity to choose a primary care provider (the doctor or health care provider they will see most of the time and who will coordinate their care) and to change to another provider in a reasonably easy manner. These opportunities include the right to:
    - Be informed of available primary care providers in their areas
    - Be informed of how to choose and change primary care providers
    - Change their primary care provider
- Ask questions and get answers about anything they don't understand, and that includes the right to:
    - Have their provider explain their health care needs to them and talk to them about the different ways their health care problems can be treated
    - Be told why care or services were denied and not given
- Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
    - Work as part of a team with their provider in deciding what health care is best for them
    - Say yes or no to the care recommended by their provider
- Utilize each available complaint and appeal process through PCCM and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
    - Make a complaint to PCCM or to the state Medicaid program about their health care, provider, or PCCM
    - Get a timely answer to their complaint
    - Access the PCCM appeal process and the procedures for doing so
    - Request a fair hearing from the state Medicaid program and request information about the process for doing so
- Timely access to care that does not have any communication or physical access barriers. That includes the right to:
    - Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care
    - Get medical care in a timely manner
    - Be able to get in and out of a health care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the *Americans with Disabilities Act*
    - Have interpreters, if needed, during appointments with their providers and when talking to PCCM. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information
    - Be given an explanation they can understand about PCCM rules, including the health care services they can get and how to get them
- Not be restrained or secluded when doing so is for someone else's convenience, or is meant to force them to do something they do not want to do, or to punish them.

7.5.5.2 Client Responsibilities

PCCM and primary care providers should help clients understand their responsibilities. These include the responsibility to:

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- Learn and understand each right they have under the Medicaid program. That includes the responsibility to:
    - Learn and understand their rights under the Medicaid program
    - Ask questions if they do not understand their rights
- Abide by PCCM and Medicaid Managed Care policies and procedures. That includes the responsibility to:
    - Learn and follow PCCM rules and Medicaid rules
    - Choose a primary care provider
    - Make any changes in their primary care provider in the ways established by Medicaid Managed Care
    - Keep their scheduled appointments
    - Cancel appointments in advance when they cannot keep them
    - Always contact their primary care provider first for nonemergency medical needs
    - Be sure they have approval from their primary care provider before going to a specialist (except for self-referred services)
    - Understand when they should and should not go to the emergency room
- Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
    - Tell their primary care provider about their health
    - Talk to their providers about their health care needs and ask questions about the different ways their health care problems can be treated
    - Help their providers get their medical records
- Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
    - Work as a team with their provider in deciding what health care is best for them
    - Understand how the things they do can affect their health
    - Do the best they can to stay healthy
    - Treat providers and staff with respect

7.5.6 Primary Care Provider Changes

7.5.6.1 Client Initiated Primary Care Provider Changes

The enrollment broker assigns a primary care provider to clients for the first month. This primary care provider assignment will be based on several factors, including existing provider or physician relationships and geographical location. The client's Medicaid Identification Form (Form H3087) will list the primary care provider name.

PCCM clients may change their primary care provider by calling the PCCM Client Helpline at 1-888-302-6688.

Client requests for primary care provider changes received before the middle of the month usually become effective on the first day of the following month. Client requests for primary care provider changes received after the middle of the month usually become effective on the first day of the second month following the request. A primary care provider change could take up to 45 days to take effect.

7.5.6.2 Provider Initiated Primary Care Provider Changes

Occasionally, the relationship between a client and their primary care provider may become unsatisfactory to one or both parties. A provider may request a client be reassigned to another primary care provider for any of the following reasons:

- The client is not included in the primary care provider's scope of practice.
- The client is non-compliant with medical advice.
- The client consistently displays unacceptable office decorum.
- The client/primary care provider relationship is not mutually agreeable.

If the relationship with the client is unsatisfactory due to behavioral issues on the client's part, the primary care provider should contact PCCM Community Health Services at 1-888-276-0702 to request assistance in resolving the problem. A community health coordinator can intervene and help providers with non-adherent and disruptive patients in most instances. The referral can also be made by submitting the PCCM Community Health Services Referral Request Form via fax to PCCM Community Health Services at 1-512-302-0318. A copy of the PCCM Community Health Services Referral Request Form can be found on page B-66.

If the relationship with the client cannot be improved, the provider must notify TMHP in writing to request reassignment of a client to another primary care provider before the request can be processed. The primary care provider must also notify the client in writing stating the reason for the reassignment. A copy of the letter to the client may serve as notification to TMHP.

TMHP will notify the client of the reassignment in writing and request that the client choose another primary care provider. Primary care provider requests to reassign a client usually take 60 days before the change is made. During this time, the primary care provider is responsible for providing primary care to the client or referring the client to another provider for medically necessary care.

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7.5.7 Provider Enrollment

Primary care providers can choose to contract with PCCM and HMO health plans simultaneously. A PCCM primary care provider's contractual obligations are identified in the contract between HHSC and each primary care provider. *These obligations are in addition to those required for Medicaid program participation* and are intended to ensure clients have access to quality health care from trained and credentialed providers.

Refer to: "Primary Care Provider Requirements and Information" on page 7-8.

7.5.7.1 Additional Criteria for Primary Care Providers

All primary care providers must meet credentialing/recredentialing criteria. Primary care providers are also required to meet the following criteria:

- *Ability to Perform or Directly Supervise the Ambulatory Primary Care Services of Clients*. Provider performance is monitored on an ongoing basis. The PCCM Administrator follows up on evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to clients.
- *Admitting Privileges*. The primary care provider must maintain admitting privileges with a hospital which is a participating provider in PCCM, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a contracted PCCM hospital.
- *Education Sessions*. PCCM disseminates utilization management (UM) and case management policies and procedures to each PCCM primary care provider. PCCM also provides a series of educational sessions regarding all aspects of UM and case management. Primary care providers are encouraged to attend at least one educational session on UM and case management policies and procedures each year.

When a primary care provider's PCCM credentialing file is complete, the TMHP Medical Director and Credentialing Committee verify all credentials and present their findings to the HHSC Medical Director for Medicaid and CHIP Programs (HHSC Medical Director), at the Credentialing Committee meeting. The HHSC Medical Director reviews the credentials and determines whether the applicant meets HHSC credentialing criteria. The decision to accept a provider as a PCCM primary care provider is made by HHSC in accordance with basic credentialing standards.

7.5.7.2 Credentialing Committee

The Credentialing Committee is charged with the responsibility of reviewing each provider applicant's file to ensure that enrolling physicians and other health care professionals are qualified to perform services as PCCM providers.

The committee reviews each provider applicant's file and decides whether the provider should be recommended to the HHSC Medical Director as a primary care provider in the PCCM provider network. If HHSC approves the recommendation, the provider is accepted as a participating provider for three years.

The Credentialing Committee is also charged with the responsibility of recredentialing PCCM providers, which occurs every three years after initial credentialing.

The Credentialing Committee also reviews and approves credentialing policies and procedures for PCCM.

7.5.7.3 Members of the Credentialing Committee

The Credentialing Committee is comprised of the following members:

- Chair: Medical Director, HHSC Medicaid and Children's Health Insurance Program (CHIP) Programs
- Co-Chair: Associate Medical Director, HHSC Medicaid and CHIP Programs
- Co-Chair: Medical Director, TMHP
- Associate Medical Director, TMHP
- Contracting and Credentialing Manager, TMHP
- Quality Services Officer, TMHP

If a committee member is unable to attend a meeting, the member may appoint a designee.

7.5.7.4 Credentialing Committee Frequency/ Logistics

The Credentialing Committee meets monthly, or as required, to review new applications for credentialing/ recredentialing. The PCCM Contracting and Credentialing staff will have previously completed the initial screening for each provider in accordance with the standards of the National Committee for Quality Assurance (NCQA).

7.5.7.5 Credentialing Committee Action

The TMHP Medical Director, as the Co-Chair, is charged with implementing the credentialing and recredentialing standards for participating providers in PCCM. The HHSC Medical Director also reviews submitted documentation and recommends acceptance or rejection of each provider.

Based on this action, the HHSC executes the contract of approved providers. PCCM then notifies each approved applicant in writing of the application's status. For approved providers, the notification includes:

- A fully executed provider contract
- The date upon which the contract is effective
- Conditions of participation in PCCM
- Recredentialing requirements

Applicants who are not approved are notified by certified mail of the denial, the reason for the denial, and the process for reconsideration. Applicants may request reconsideration by submitting evidence that the deficiency(ies) for which the original application was denied has/have been corrected.

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A provider has 30 days to request a reconsideration of a recredentialing denial to the Credentialing Grievance Committee. Such requests must be in writing and submitted to the following address:

Primary Care Case Management (PCCM)
Credentialing Grievance Committee
Credentialing Mail Code MC-B05
PO Box 204270
Austin, TX 78720-4270

7.5.7.6 Credentialing Grievance Committee

The Credentialing Grievance Committee reviews providers' requests for reconsideration of credentialing decisions.

Members of the Credentialing Grievance Committee

The Credentialing Grievance Committee is composed of the following members:

- Medical Director, HHSC Medicaid and CHIP Programs, or designee
- Medical Director, TMHP
- Contracting and Credentialing Manager, TMHP
- Provider Services Director, TMHP
- Staff person from HHSC Medicaid/CHIP Primary Care Case Management Program

Credentialing Grievance Committee Frequency/ Logistics

The Credentialing Grievance Committee convenes within 60 days after receipt of a grievance or request for reconsideration. The provider is notified of the date, time, and location of the grievance hearing before the Credentialing Grievance Committee. The provider may attend the grievance hearing.

Notification of the Credentialing Grievance Committee's Decision

The provider is notified in writing of the decision of the Credentialing Grievance Committee within 45 days after adjournment of the hearing. The Credentialing Grievance Committee forwards its recommendations to HHSC following the hearing.

A decision of the Credentialing Grievance Committee may be submitted for reconsideration to:

Texas Health and Human Services Commission
Office of General Counsel
4900 N. Lamar, 4th Floor
Austin, TX 78751

7.5.7.7 Primary Care Provider Termination/ Disenrollment

Primary care providers may terminate the PCCM agreement by providing 90 days prior written notice. Ninety days prior notice is requested to allow sufficient time to complete the reassignment process of clients in a primary care provider's panel to new primary care providers.

Individual provider agreements will terminate automatically upon a provider's death, the sale of the provider's practice, or termination as a participant in the Texas Medicaid Program.

Clinics shall notify PCCM within 30 days when a provider employee leaves the employ of or terminates his contract with the clinic, or is no longer willing to function as a primary care provider.

HHSC may terminate an agreement by providing 30 days prior written notice.

Termination or disenrollment notification should be sent to the following address:

Primary Care Case Management (PCCM)
Contracting and Credentialing Department MC-B05
PO Box 204270
Austin, TX 78720-4270

All correspondence must include the primary care provider's contracted provider identifier on signed letterhead. Providers may also contact the Provider Enrollment/Contracting and Credentialing Department at 1-800-925-9126, option 2, to request a Provider Information Change (PIC) form.

Refer to: "Provider Information Change Form" on page B-73.

7.5.7.8 Miscellaneous Provisions

Several other provisions apply to primary care provider participation in PCCM:

- A primary care provider agreement may be modified only by written agreement signed by all parties.
- A primary care provider agreement is not assignable by a primary care provider, either in whole or in part, without the prior written consent of the HHSC.
- primary care provider agreements shall be governed and construed in accordance with the laws of the State of Texas.
- A primary care provider shall be required to bring all legal proceedings against HHSC in the Texas state courts.
- An agreement shall become effective only upon the primary care provider's completion of the provider credentialing process and a determination by the HHSC or its designee that the primary care provider meets all of the requirements for participation in PCCM.

7.5.8 Support Services

7.5.8.1 Provider Support Services

PCCM core support services to primary care providers include:

- *Provider Helpline.* The PCCM Provider Helpline at 1-888-834-7226 is available to assist PCCM providers with a broad range of Medicaid and PCCM issues. Toll-

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free customer service lines are available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, and are answered directly by call center representatives.

- *Provider Relations Representatives.* Provider relations representatives conduct informational and educational workshops, group meetings, and training sessions for office practices and groups when requested, and can assist in enrolling new primary care providers in PCCM. To contact the provider relations representative serving your area, call the TMHP Contact Center at 1-800-925-9126 or visit the TMHP website at www.tmhp.com.
- *Medical Director Services.* The TMHP Medical Director maintains overall responsibility for utilization management procedures, quality improvement activities and reporting, health education for both clients and providers, authorization requirements, and claim appeals related to the appropriateness of specific medical procedures or services. To contact the Medical Director, call 1-512-506-7000, and press "0" for the operator.
- *Primary Care Provider and Hospital List.* PCCM prepares and distributes to clients a listing of all providers. This listing identifies those providers who are accepting new patients, those whose panels are closed, and those who provide THSteps services. This listing is updated on a quarterly basis. To request a copy of the listing, contact the PCCM Provider Helpline at 1-888-834-7226 or visit the TMHP website at www.tmhp.com.
- *Monthly Panel Report.* PCCM provides to primary care providers a list of clients who have selected or who have been assigned to the primary care provider for management and coordination of their health care. This list is available online at www.tmhp.com, or in hard copy by calling the PCCM Provider Helpline at 1-888-834-7226. Clients on this list are eligible for PCCM services throughout the entire month.

7.5.8.2 Client Support and Education

PCCM provides educational services to its clients. The most significant of these are three helplines:

- *Client Helpline.* The non-clinical Client Helpline at 1-888-302-6688 is the primary resource for clients seeking information or answers to questions. Clients may call the helpline to discuss concerns and file complaints regarding the operation and management of PCCM. The helpline operates from 7 a.m. to 7 p.m., Central Time, Monday through Friday. After hours, a recorded message instructs clients who need assistance with clinical, urgent, or emergent situations to contact the PCCM nurse helpline at 1-800-304-5468.
- *Community Health Services*. PCCM clients are eligible to receive services provided by Community Health Services (CHS). CHS staff includes registered nurses, social workers, nutritionists, and health educators from all over Texas who can educate PCCM clients about the role of a primary care provider, the referral process, or the Medicaid change from fee-for-service to managed care. CHS staff can also provide information about disease prevention, care coordination, and location of resources. CHS staff is available to meet with clients in a provider's office. Providers can refer clients for CHS services by calling the CHS toll-free number at 1-888-276-0702, Monday through Friday, 8 a.m. to 5 p.m., Central Time, or by faxing a PCCM Community Health Services Referral Request Form to 1-512-302-0318. Providers can refer up to four clients on a request form.
- *The Nurse Helpline.* PCCM provides a toll-free clinical nurse helpline at 1-800-304-5468 for its clients. The nurse helpline is staffed (nationally) by registered nurses who use physician-developed, symptom-based algorithms and 1,200 sets of self-care instructions to provide information, triage, and clinical assessment services for health plan clients 24 hours a day, 7 days a week. The nurse helpline nurses do not diagnose; they assess the client's symptoms and guide the client to the most appropriate care setting. The nurse helpline number is widely publicized to PCCM clients. The nurse helpline can:
    - Provide triage, assistance, and reassurance to clients
    - Direct clients to the most appropriate care setting

If a nurse determines that a client needs emergency care, the nurse will direct the client to the nearest emergency facility or contact 9-1-1 on the client's behalf.

In addition, PCCM publishes a semi-annual newsletter in both English and Spanish for client heads of household. The focus of the newsletter is health-related (such as the importance of well-child care, and the significance of early entry into prenatal care), but it also provides useful information about services to improve clients' access to health care, such as nonemergent medical transportation, community child care resources, and clinical services offered during nontraditional hours of operation.

Linguistic Services

It is the provider's responsibility to ensure that interpretive services are available to his practice. Interpretive services include language interpreters, American Sign Language (ASL) interpreters, and RELAY TEXAS (TDD) access. When interpretive services are necessary to ensure effective communications regarding treatment, medical history, or health education, PCCM providers may contact the PCCM nurse helpline at 1-800-304-5468. For assistance to clients who are hearing impaired, call RELAY TEXAS (TDD) at 1-800-735-2988. If the provider's staff is in need of translation services to meet requirements on Limited English Proficiency (LEP), call 1-800-752-0093.

Refer to: "Provider Responsibilities" on page 7-30.

"Cultural Competency and Sensitivity" on page 7-10.

7.5.8.3 Monthly Client Panel Report

Primary care providers can obtain their monthly panel report containing a list of clients assigned to them by accessing the TMHP website at www.tmhp.com. Providers

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who prefer to receive a monthly panel report by mail may call the PCCM Provider Helpline at 1-888-834-7226 to request a monthly paper report. This report verifies client assignments for the current month and identifies those who have been defaulted to a provider's practice and those that may be eligible for THSteps services.

Clients appearing on the monthly panel report are eligible for services for the entire calendar month.

Based on the number of clients appearing on the monthly panel report, the primary care provider receives a monthly case management fee. This check is issued by TMHP.

Refer to: "Claims Filing Information" on page 7-40.

Panel Closings

PCCM primary care providers may choose to close their panel to new assignments. To close a panel, primary care providers should contact the PCCM Provider Enrollment, Contracting/Credentialing Department in writing (by mail or fax) to request a suspension of new enrollments or assignments to his practice. All correspondence must include the provider's contracted provider identifier on signed letterhead. Should the provider choose to re-open his panel, contact the PCCM Contracting/Credentialing Department in writing (by mail or fax) to request the panel be re-opened to new assignments. Providers should notify PCCM at least 30 days before re-opening their panel. Providers may contact the Provider Enrollment, Contracting/Credentialing Department for a Provider Information Change Form to close and re-open a panel.

Refer to: "Provider Information Change Form" on page B-73.

7.5.9 Covered Services

PCCM clients are entitled to all medically necessary services currently covered under the Texas Medicaid Program. Except as specified below, primary care providers shall provide (directly or through referrals) all Medicaid-covered services.

Refer to: "Referrals" on page 7-33.

Spell of Illness

Reimbursement to hospitals for adult inpatient services is limited to the patient "spell of illness." The spell of illness is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively." After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the patient has been out of an acute care facility for 60 consecutive days.

Prescriptions

As in fee-for-service Medicaid, adult PCCM clients 21 years of age and older are limited to three medicine prescriptions each month. When more than three prescriptions per month are needed, providers may prescribe maintenance medication(s) to cover more than a one month supply.

Annual Adult Physical Exams

Annual well visit exams are excluded for PCCM adult clients age 21 years of age and older except for well-woman annual exams provided as part of family planning or OB/GYN medical visits.

7.5.9.1 Self-Referred Services

PCCM clients may select any Medicaid-enrolled provider to access the following services *without a referral*:

- *Emergency Services.* In case of a medical emergency, clients may seek emergency medical services from the nearest facility. To ensure continuity of care, the emergency facility is asked to contact the client's primary care provider within 24 hours or the next business day after providing services. Primary care providers or a primary care provider's designee must be available to respond to an emergency room (ER) call promptly. If the emergency visit results in an admission, the facility also must notify PCCM prior to claims submission.

Refer to: "PCCM Inpatient Authorization Process" on page 7-34.

- *OB/GYN Services.* PCCM clients may select a PCCM-contracted OB/GYN as their primary care provider. As a primary care provider, the OB/GYN is responsible for providing or arranging for all medically necessary services. PCCM clients may also seek direct services of any Medicaid-enrolled OB/GYN who is not their primary care provider for the following services:
  - One well-woman examination per year
  - Care related to pregnancy
  - Care for all active gynecological conditions
  - Diagnosis, treatment, and referral to a Medicaid-enrolled specialist for any disease or condition within the scope of the designated professional practice of a licensed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts
- *Family Planning Services.* Family planning services include preventive health, medical counseling, and educational services that assist individuals in planning and/or preventing pregnancy and achieving optimal reproductive and general health. Primary care providers are encouraged to provide these services if requested by a client. Clients are not required to obtain family planning services through their primary care provider. Family planning is a service that does not require a primary care provider referral. Clients may go to a DSHS Family Planning state-contracted Medicaid facility for family planning services. Inpatient services must be delivered in a PCCM-contracted hospital/facility.

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- *THSteps.* PCCM clients are free to select any THSteps-enrolled Texas Medicaid provider to perform THSteps services. If a THSteps screening is performed by a provider who is not the client's primary care provider, this information should be forwarded to the client's primary care provider so that the client's medical record can be updated.

Refer to: "Texas Health Steps (THSteps)" on page 43-1.

- *Vision Services.* Clients do not need a referral to access necessary covered vision services for refractive errors. However, any diagnosed condition or abnormality of the eye that requires treatment or additional services beyond the scope of an exam for refractive errors must be referred back to the client's primary care provider. Vision care providers who furnish additional services must have a referral from the client's primary care provider. Covered vision services are:
    - One eye exam each state fiscal year (September 1 through August 31) for clients under age 21 unless there is a diopter change of 0.5 or more
    - Replacement of lost or damaged eyeglasses for clients under age 21
    - One eye exam every 24 months for assessing the need for eyeglasses for adults
    - Unlimited medically necessary eye exams for a diagnosis of illness or injury
- *Behavioral Health Services.* Behavioral health services do not require a primary care provider referral. These services include mental health and substance abuse services by a Medicaid-enrolled psychiatrist, psychologist, licensed professional counselor (LPC), licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), and Texas Commission on Alcohol and Drug Abuse (TCADA) licensed facility.

Refer to: "Behavioral Health Services" on page 7-30.

"Psychiatric Services" on page 36-261.

"Psychologist" on page 38-1.

"Licensed Professional Counselor (LPC)" on page 30-1.

"Licensed Clinical Social Worker (LCSW)" on page 28-1.

"Licensed Marriage and Family Therapist (LMFT)" on page 29-1.

- *ECI.* Case management for Early Childhood Intervention. See "Case Management for Early Childhood Intervention (ECI)" on page 13-1.
- *CPW*. Case Management for Children and Pregnant Women. See "Case Management for Children and Pregnant Women (CPW)" on page 12-1.
- *School Health and Related Services (SHARS).* Clients may select any qualified provider to access medically necessary and reasonable services to ensure that Medicaid-eligible children with disabilities receive the benefits mandated by federal and state legislation that guarantees a free and appropriate public education. See "School Health and Related Services (SHARS)" on page 42-1.
- *School-Based Clinic Services.* Clients may receive services from school-based clinics without a referral from their primary care provider. See "School Health and Related Services (SHARS)" on page 42-1.

7.5.9.2 Community Health Services

The goal of the PCCM Community Health Services program is to facilitate the coordination of health related services required by PCCM clients. This means collaborating with providers, clients, and their families in identifying problems and resources, and removing barriers in accessing treatment and services. PCCM community health coordinators are located in all PCCM service areas. Examples of services offered by staff include:

- The management of high-risk pregnancies in conjunction with the client's physician
- Pediatric care coordination and education services for acute and chronically ill children
- Case management for all chronic and/or complex cases identified and eligible for community health services
- Assistance in accessing state and community resources
- Assistance in improving healthy behaviors and treatment compliance
- Provide health education on a variety of health-related topics

By offering the above services, PCCM assists both providers and clients with early, expedited access and intervention, increasing the likelihood of improved health outcomes.

Clients can be referred for care management and/or education on the following subjects:

- A newly diagnosed condition
- Asthma management
- Coronary artery disease
- Chronic obstructive pulmonary disease
- Dental health
- Diabetes management
- Effective use of benefits
- Hypertension
- Nutrition
- Otitis media
- Prenatal education
- Parenting and child development
- Puberty education
- Safety
- Smoking cessation

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Community health coordinators can assist clients in obtaining food, clothing, and other resources by linking them with public and/or private community organizations.

Providers interested in scheduling a community health education program in their office or referring a PCCM client for community health services can do so by:

- Completing the "Primary Care Case Management (PCCM) Community Health Services Referral Request Form" on page B-65 and faxing to 1-512-302-0318; or
- Calling the Community Health Services Intake staff at 1-888-276-0702, Monday through Friday, 8 a.m. to 5 p.m., Central Time.

7.5.9.3 Behavioral Health Services

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Behavioral health services do not require a primary care provider referral. PCCM clients may self-refer to any Medicaid-enrolled behavioral health provider for treatment. A referral from the client's primary care provider is not required. A primary care provider may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A primary care provider may also provide behavioral health services within the scope of his practice.

PCCM clients may receive any behavioral health service that is medically necessary, currently covered by the Texas Medicaid Program, and provided by a Medicaid-enrolled behavioral health provider. Behavioral health providers include psychiatrists, psychologists, LCSWs, LPCs, LMFTs, and TCADA licensed facilities. See each individual aforementioned section for benefits and limitations.

In addition, many services are offered through DADS and DSHS that do not require a referral. These include case management for mental health and mental retardation, mental health rehabilitative services, and mental retardation diagnosis and assessment.

Behavioral health providers are encouraged to contact a client's primary care provider to discuss the patient's general health. Primary care providers are encouraged to maintain contact with the behavioral health provider to document behavioral health assessments and treatments and to inform the behavioral health provider of any condition the client may have that could impact the behavioral health service delivery. However, client approval for any exchange of information between the primary care provider and behavioral health provider is required. Please use the "Primary Care Case Management (PCCM) Behavioral Health Consent Form" on page B-63.

Primary care providers are responsible for documenting referrals to behavioral health providers and any known self-referrals for behavioral health services in each client's medical record.

Outpatient Services

Outpatient Behavioral health services that exceed 30 visits per client, per calendar year must be prior authorized by TMHP. Fax the completed form, "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-81 to TMHP/Special Medical Prior Authorizations at 1-512-514-4213 for prior authorization. Refer to individual provider sections of this manual for additional information on extension requirements ("Psychologist" on page 38-1, "Psychiatric Services" on page 36-261, "Licensed Clinical Social Worker (LCSW)" on page 28-1, "Licensed Marriage and Family Therapist (LMFT)" on page 29-1, "Licensed Professional Counselor (LPC)" on page 30-1) or contact TMHP at 1-800-925-9126.

Inpatient Services

PCCM requires notification for urgent or emergent inpatient psychiatric care in an acute care facility prior to claims submission for in-network facilities. Scheduled admissions for psychiatric care require prior authorization. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility. Fax the completed PCCM Inpatient/Outpatient Authorization Form to the PCCM Inpatient Prior Authorization Department at 1-512-302-5039 or call 1-888-302-6167.

Prior authorization is required for psychiatric admissions of patients under 21 years of age to a freestanding psychiatric facility. Fax the completed "Psychiatric Hospital Inpatient Admission Form" on page B-74 to 1-512-514-4211 to obtain authorization. Inpatient psychiatric admissions to freestanding facilities for clients 21 years of age and older are not covered under the Medicaid Program.

Refer to "Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-71 for additional information concerning the requirements of freestanding psychiatric admissions, or contact the TMHP Comprehensive Care Inpatient Psychiatric (CCIP) Unit at 1-800-213-8877.

7.5.10 Provider Responsibilities

In addition to the requirements listed in "Provider Requirements and Information" on page 7-18, PCCM primary care providers have clearly defined roles, responsibilities, and contractual requirements.

Verifying Primary Care Provider Assignment

At the time that an appointment is made, the provider should ask the client for the name of the primary care provider on the client's Medicaid Identification Form (Form H3087). If a different primary care provider is listed, direct the client to go to the provider listed on their Medicaid Identification Form H3087 or to request a change.

Note: *Providers may not request primary care provider changes for their clients. Federal guidelines prohibit influence by providers on a patient's choice of their primary care provider.*

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Primary Care Provider Services

PCCM defines the services to be provided and the responsibilities to be assumed by a PCCM primary care provider as follows:

- The primary care provider agrees to provide primary care services to PCCM clients. Primary care services are all medical services required by a client for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under the Texas Medicaid Program. The primary care provider must ensure that clients under the age of 21 receive all services required by the THSteps program. All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.
- Provide or arrange for medically necessary care within the following guidelines:
    - *Urgent Care.* Within 24 hours after the request
    - *Routine Care*. Within two weeks after the request
    - *Physical/Wellness Exams*. Within four to eight weeks after the request
    - *Prenatal Care.* Initial visit within 14 calendar days of the request or by the 12th week of gestation
- Refer clients to an approved Texas Medicaid provider or PCCM-contracted facility when the needed services are not available through the primary care provider's office or clinic. Specialists to whom primary care providers refer clients also should schedule appointments within the timeframes described above. Primary care providers may contact the PCCM Provider Helpline (1-888-834-7226) for a list of contracted facilities.
- Coordinate, monitor, and document medical treatment and covered services delivered by all providers to each client, including treatment during inpatient stays.
- Comply with all authorization and notification requirements of PCCM.
- Verify the eligibility of each client prior to providing covered services to determine whether the client is eligible for services under PCCM on the date of service.
- Coordinate care for children receiving services from or who have been placed in the conservatorship of DFPS. Primary care providers are responsible for furnishing or arranging for all medically necessary services while the child is under the conservatorship of DFPS and until the child is placed in foster care and is no longer eligible for PCCM enrollment.
- Cooperate with and participate in PCCM UM programs.
- Maintain hospital admitting privileges at a PCCM-contracted facility as applicable or maintain a referral relationship with a provider with admitting privileges.
- Provide preventive services using clinically accepted guidelines and standards.

7.5.10.1 Office and Medical Records Standards

To ensure that each onsite office or facility used to deliver health care to PCCM clients is safe, sanitary, and accessible, PCCM has defined standards for offices and other facilities:

- A site visit is conducted for each location as part of the evaluation process.
- An office compliance audit ensures that the facility meets defined standards.
- Evaluators use the visit as an opportunity to interact with the provider and office staff.
- Evaluators are prepared to explain the program and promote a strong network relationship.

For a provider to be considered for PCCM participation, all office sites must be in compliance with the "conditions of participation" stipulated in the provider contract. PCCM staff conducts an office onsite review at each primary care site prior to the acceptance of the provider into PCCM. Subsequently, Provider Relations staff performs routine audits at primary care office sites every two years.

The "Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation" on page B-68 is used to evaluate a provider's office:

- Offices that are found to be marginally acceptable receive a follow-up visit within 90 days.
- PCCM may recommend that HHSC cancel a provider's contract if office conditions do not meet defined standards after notice of required corrective action has been provided, and time to make changes has been made available.

7.5.10.2 Medical Records Standards

A PCCM provider is required to maintain comprehensive and accurate medical records to ensure quality and continuity of care. Each provider must maintain and make available medical records in accordance with the applicable provider agreement.

Content of Medical Record

Each patient's medical record must include patient identification information, progress notes, and laboratory, referral, and consultation notes. Data to be maintained includes:

- Patient identification information:
    - Patient's full name, address, and phone number
    - Patient's history, including: past and present medical condition of patient and family, past illnesses and surgeries, X-ray and lab tests, immunizations, documentation of discussion of Advance Directives (patients 21 years of age and older)
- Present physiological condition:
    - Drug or allergy sensitivities
    - Current medications

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- Progress notes:
  - Patient's complaint or reason for visit
  - Results of physical examinations
  - Tests, procedures, and medications ordered by physician
  - Diagnoses and problems identified
  - Health education/preventive services performed
- Laboratory, referral, and consultation notes:
  - Laboratory and X-ray reports
  - Consultation and referral consultation reports
- Copies of reports concerning hospital admissions including:
  - Authorizations
  - Surgical reports
  - Discharge summaries

Refer to: "General Medical Record Documentation Requirements" on page 1-10.

In addition, PCCM providers performing THSteps comprehensive medical checkups must document all components of the checkup. These documentation requirements are detailed in "Documentation of Completed Checkups" on page 43-14.

Important: *Upon request, a provider will give PCCM copies of client medical records, as outlined in the provider agreement, so that PCCM staff can implement utilization management, quality improvement, and grievance programs.*

Confidentiality of Medical Records

The relationship and all communication between physician and patient are privileged. Accordingly, the medical record containing information about the relationship is confidential.

A physician's code of ethics, as well as Texas and federal laws, protect against the disclosure of the contents of medical records to persons or agencies that are not properly authorized to receive such information.

For a provider to release the contents of a patient's medical record to a third party, the patient must first authorize the disclosure by signing and dating an authorization form. If the record is for a deceased individual, the executor of the estate must authorize the release.

PCCM's policy is to allow only medical personnel and health professionals who are directly involved in the delivery or evaluation of a patient's records to access the medical record. All requests for medical record information must be handled according to policy and law.

An authorization from the patient for release of medical information is not required when the release is requested by and made to PCCM, TMHP, HHSC, the external quality review organization, or the Texas Attorney General's Medicaid Fraud Control Unit.

Medical Records Audits

PCCM Provider Relations staff performs a general medical record review of the primary care provider's practice as part of the credentialing and recredentialing process and as part of the quality improvement program. The "Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation" on page B-68 is used to evaluate provider medical records as part of the credentialing and recredentialing process.

Medical record audit results are submitted to the Medical Director and, if necessary, to the Credentialing Committee for review. Depending upon review findings, the Credentialing Committee will assist the Medical Director in concluding the audit in one of three ways:

- Recommending that HHSC accept the provider
- Recommending that HHSC reject the provider on the basis of poor medical record documentation and procedures
- Recommending that HHSC accept the provider conditionally with the provision that certain changes must be made and standards must be met within a specified timeframe

These recommendations apply to audits of an initial review of a provider as well as those of subsequent reviews.

If a provider has been found to be marginally in compliance with requirements, he will be given training and education directed at correcting the deficiency. PCCM will establish a system to audit this provider every 60 days for a maximum of three follow-up audits:

- Each audit must show substantial improvement over the previous audit.
- Following the third follow-up audit, if no improvement has been noted, PCCM will work with HHSC to apply sanctions and monitor performance closely.
- Subsequent to these measures, if the provider is still not in full compliance, PCCM will recommend to HHSC that the provider be terminated from the plan.

Medical records may also be reviewed in conjunction with provider profiling to identify opportunities to improve care and services.

Access and Availability Standards

PCCM staff routinely evaluates and monitors provider compliance with scheduling requirements. These scheduling requirements are designed to enhance access to health services and to provide assurance of service availability based on the urgency of need.

Refer to: "Provider Responsibilities" on page 7-30.

"Primary Care Provider Requirements and Information" on page 7-8.

7.5.11 Monitoring Provider Performance

PCCM is responsible for monitoring quality of care and, if necessary, recommending that HHSC disenroll providers who do not meet plan requirements.

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Among the indicators used to monitor PCCM providers' performance are:

- *Client Comments and Complaints.* The PCCM Complaints Department closely monitors the activities associated with client complaints as they relate to quality assurance and utilization management reviews for specific provider performances. The reports of these activities are used to trigger separate actions and inquiries about performance.
- *Office Site Reviews.* PCCM staff undertakes a variety of assessments as part of quality improvement activities and provider service activities. The results of these reviews are made part of the file of performance factors and indicators assessed during the recredentialing process.
- *Compliance With 24-Hour Access Standards.* PCCM staff conducts audits to assess the degree of compliance with Medicaid Managed Care access standards. Client comments and complaints may trigger reviews of specific providers. The results of these reviews are considered in the recredentialing process.
- *Ability to Perform or Directly Supervise Ambulatory Primary Care Services for Clients.* Provider performance is monitored on an ongoing basis. PCCM staff follows up evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to plan clients.
- *Admitting Privileges.* PCCM staff verifies that each provider maintains membership on the medical staff with admitting privileges at a minimum of one accredited contracted hospital or has an acceptable (timely and complete transfer of patients and records) arrangement with a primary care provider who has such admitting privileges.
- *Continuing Medical Education Credits.* Provider Enrollment/Contracting and Credentialing staff monitors each provider's activities in the area of continuing medical education credits.
- *Education Sessions.* PCCM provides a series of educational sessions that include aspects of UM and case management. Provider contracts require that each primary care provider attend at least one educational session each year.
- *Valid DEA Certification.* Proof of Drug Enforcement Administration (DEA) certification must be submitted as part of the application process and will be maintained by PCCM in its credentialing files.
- *Performance Within Scope of Individual Licensure and PCCM Credentialing.* PCCM staff provider applications include a statement providing assurance that a certified registered nurse practitioner, nurse midwife, or physician assistant will perform services only within the scope of his licensure, and that the individual will be disciplined immediately if this agreement is violated.
- *Compliance with Fraud and Abuse Policy.* PCCM will recommend to HHSC that a network provider be suspended immediately upon notification from any source that the provider:
    - Has been terminated or suspended from participation in the Medicaid or Medicare Program.
    - Has lost his license.
    - Has been convicted of a criminal act.

PCCM employs the above indicators as part of its oversight function. Findings are cataloged and analyzed for patterns of performance that require special attention. Where warranted, the results are made part of the recredentialing process. Failure to adhere to the above standards of performance will be grounds for suspension or termination.

7.5.12 Referrals

Referrals are an integral component of PCCM's health care delivery program. Referrals ensure that clients gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting.

Referral procedures are designed to capture the information needed to support and manage the utilization of services by the provider network. Proper documentation of referrals is necessary for accurate medical record keeping.

PCCM primary care providers function as the *medical home* for PCCM clients. Primary care providers are responsible for arranging and coordinating appropriate referrals to other providers, including specialists, and for managing, monitoring, and documenting the services of other providers.

Primary care providers are responsible for the appropriate coordination and referral of PCCM clients for the following services:

- CPW case management services
- DARS case management services
- ECI case management services
- Mental retardation (MR) targeted case management
- SHARS
- Texas Commission for the Blind case management services
- THSteps medical case management
- THSteps dental (including orthodontics)
- Tuberculosis services
- Vendor drugs

7.5.12.1 Open Specialty Referral Network

PCCM operates an open specialty referral network. Primary care providers may refer patients to any Texas Medicaid-approved specialist within the State of Texas that accepts PCCM clients for covered health services. Medically necessary referrals to specialists do not require authorization from PCCM.

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For all referrals, primary care providers should furnish their provider identifier and complete information on treatment procedures and diagnostic tests performed prior to the referral. The referral should specify the following:

- Initial diagnosis/diagnoses
- Reason for the referral
- Services requested from the referral specialist
- Number of authorized visits (optional)

Primary care providers may make a referral to another primary care provider or a specialist during periods of absence or unavailability. Primary care providers may also make a referral if a client requests a second medical opinion.

After receiving a referral specialist's report, if ongoing treatment for an illness is required, primary care providers have the discretion to specify the period of time or number of visits authorized for ongoing treatments to be given by the specialist.

The referring primary care provider's identifier must be entered on all claims submitted by the treating provider, indicating the primary care provider authorized the services. It is the responsibility of the treating specialist to ensure that the patient continues to be an eligible PCCM client throughout the period of treatment.

7.5.12.2 Referral Form

No form for a referral to a specialist is required. However, primary care providers are encouraged to use the PCCM Referral Form. This form reflects accepted practices in the Texas medical community.

The use of this form will simplify:

- Dissemination of necessary information to the specialist
- Documentation for the client's medical record of the specialist's diagnosis and treatment

Refer to: "Primary Care Case Management (PCCM) Referral Form" on page B-67.

One copy of the referral form should be given to the specialist. One copy should be maintained in the client's medical record.

7.5.13 Specialist Responsibilities

Specialists are responsible for furnishing medically necessary services to PCCM clients who have been referred by their primary care provider for specified treatment or diagnosis. While the specialist does not contract with PCCM, all facility services should be delivered in a contracted PCCM facility.

Specialists are responsible for verifying the eligibility of the referred client prior to providing treatment.

To ensure continuity of care for clients, the specialist must maintain communication with the client's primary care provider. This communication should ensure that the primary care provider's medical records adequately document the specialist services provided, all results or findings, and all recommendations. The specialist may use the lower half of the PCCM Referral Form for this purpose.

When a primary care provider refers a client to a specialist, the specialist should review the case with the primary care provider to fully understand the services being requested. Services requiring more than one visit should be coordinated with the primary care provider for approval of additional visits. Referrals from a primary care provider must be documented in both the primary care provider's and the specialist's records.

If a specialist determines that a client's condition warrants attention (i.e., hospitalization or diagnostic procedures), the specialist should seek authorization from the PCCM Inpatient/Outpatient Prior Authorization Department by telephone at 1-888-302-6167 or by fax at 1-512-302-5039.

Emergency treatment does not require authorization.

Refer to: "Facility/Hospital Services" on page 7-35.

7.5.13.1 Specialist-to-Specialist Referrals

Referrals from one specialist to another for a medically necessary service must be authorized by the client's primary care provider or, if the client does not have a primary care provider, the specialist can call the PCCM Client Helpline to obtain a one-time appointment approval.

7.5.13.2 Claims for Specialist Services

Specialists may bill for health care services provided to PCCM clients if the patient was referred by the client's primary care provider. To indicate a referral from the client's primary care provider, the primary care provider's name and provider identifier must be included in the Referring Physician field (boxes 17 and 17A) on the CMS-1500 claim form. A referral is not required if a specialist is providing a service that does not require a referral from a primary care provider.

Reimbursement for specialists is based on the current Medicaid fee-for-service rates.

Refer to: "Referrals" on page 7-33 and "Self-Referred Services" on page 7-28.

7.5.14 PCCM Inpatient Authorization Process

7.5.14.1 Definitions

Authorization. The process of obtaining approval for the delivery of services.

Routine/Non-Emergent Condition. A symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

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Urgent Condition. A symptom or condition that is not an emergency, but requires further diagnostic work-up and/or treatment within 24 hours to avoid a subsequent emergent situation.

Emergent/Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

Emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title
- Needed to evaluate or stabilize an emergency medical condition

Poststabilization Services. Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.

Observation Services. Services received within a hospital setting, which are "reasonable and necessary" to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient.

Notification. The process by which a facility informs PCCM that a client has been admitted as an inpatient to their facility on an urgent or emergent basis.

7.5.14.2 Professional Services

Emergency Room Services

Primary care providers should become actively involved in educating PCCM clients regarding the appropriate use of the emergency room and other emergency services. Providers should notify PCCM of any client who may need further education by calling the Client Helpline at 1-888-302-6688, or by using the PCCM Community Health Services Referral Request Form.

Refer to: "Primary Care Case Management (PCCM) Community Health Services Referral Request Form" on page B-65.

7.5.14.3 Facility/Hospital Services

All providers requesting prior authorization or notification of admission for a PCCM client must complete the PCCM Inpatient/Outpatient Authorization Form and include the following information:

- Facility name and provider identifier
- Client name, Medicaid number (PCN), and date of birth
- Requesting (admitting) physician's name and provider identifier
- Name of person completing form
- Date completed
- Telephone number
- Fax number
- Admit date
- Diagnosis codes (primary, secondary, etc.)
- Diagnosis Related Groups (DRG) code (for DRG facilities)
- Procedure codes
- Discharge date
- Clinical information to support medical necessity if required

If the provider's request is determined to be incomplete, the Inpatient Prior Authorization Department contacts the provider requesting the specific information needed to make the authorization determination and places the request in pending status. If the requested information is not received by the second business day, the information is requested again. If the information is not received by the fourth business day from the date the request was placed in pending status, the request is denied. A denial letter is sent to the facility and/or the requesting physician. When the requested information is received within four business days from the original pend date, the authorization is processed.

For most admissions, a letter of notification/authorization is faxed to the requesting facility or the requesting physician once the determination is complete. For scheduled inpatient admissions, both the facility and the physician will receive faxed notification.

Authorization is a condition of reimbursement. It is not a guarantee of payment.

Claims are processed based on the authorization completed at the time of claim submission. If there is a change in an existing authorization (i.e., discharge date, change in diagnosis, DRG, or change in procedure), the facility is required to submit an updated PCCM Inpatient/Outpatient Authorization Form or contact the Inpatient Prior Authorization Department with the update prior to claim submission to avoid denial of the claim.

When the billed and authorized DRG are not the same, the lower DRG will be paid. For non-DRG facilities, the claim will pay at the lower number of inpatient days when the length of stay billed and authorized are different.

7.5.14.4 Emergency Room Services

Emergency room (ER) providers are authorized by PCCM to furnish the medically necessary appropriate treatment of PCCM clients. The ER provider must perform the medical screening examination; i.e, assess the medical needs of a PCCM client who appears in the ER to determine the medical necessity of services and the appropriate setting for rendering services.

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ER providers must determine a patient's status based on the urgent, emergent, and non-emergent definitions noted in "Definitions" on page 7-34. In some cases, medically necessary services are needed to determine the patient's condition. The necessity of these services must be documented in the medical record. ER providers are paid for medically necessary services required to determine and stabilize the patient's condition.

If a determination is made that the client has a *routine/non-emergent* condition, the client's primary care provider should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged by the primary care provider as appropriate.

If a determination is made that the client has an *urgent* condition, the client's primary care provider should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged within 24 hours.

If the client has an *emergent* condition, the ER must treat the client until the condition is stabilized or until the client can be admitted or transferred. Once the client is stabilized, the ER staff must notify the client's primary care provider to arrange for medically necessary hospital admission or follow-up care. If the ER staff is unable to contact the primary care provider (or designated on-call provider) within one hour, the ER staff should treat the client and report the primary care provider's unavailability by contacting the PCCM Provider Helpline at 1-888-834-7226.

Hospitals are eligible to bill for any services required in the medical screening examination and stabilization of a PCCM client. All services must be supported by the clinical record.

When treatment is provided to a PCCM client, *professional* and *facility* services must be billed separately.

Reimbursement of emergency facility and ancillary charges for diagnostic tests, monitoring, and treatment is based on the actual services rendered. The hospital is paid at its current Medicaid reimbursement rate.

7.5.14.5 Observation Services

Observation services are those received within a hospital setting, which are "reasonable and necessary" to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient. Some patients, while not requiring hospital admission, may require a period of observation in the hospital environment as an outpatient. Observation services may be provided in any part of the hospital where a patient placed in observation can be assessed, examined, monitored, and/or treated in the course of the customary handling of patients by the facility. Observation services after the 23rd hour are *not* payable by Medicaid. If the patient is going to be admitted, the patient's status must be changed from observation to inpatient prior to the 24th hour.

If an inpatient admission occurs from an observation status, the Inpatient Prior Authorization Department must be notified. Notification of admission is the responsibility of the admitting facility. If necessary, notification of admission is accepted from the physician's office. The payment for the inpatient admission includes the observation stay. Notification of admission is required prior to claim submission to avoid claim denial.

7.5.14.6 Urgent and Emergent Admissions

Notification of admission is required prior to claim submission to avoid claim denial. Notification of admission is the responsibility of the admitting facility. However, if necessary, notification of admission is accepted from the physician.

Notification is not required for 23-hour observation stays, unless the stay is converted to an inpatient status. The following information should be included on the notification:

- Facility name and provider identifier
- Client name, Medicaid number (PCN), and date of birth
- Requesting (admitting) physician's name and provider identifier
- Name of person completing form
- Date completed
- Phone number
- Fax number
- Admit date
- Diagnosis codes (primary, secondary etc.)
- DRG code (for DRG facilities)
- Procedure codes
- Discharge date
- Clinical information to support medical necessity if required

If the provider's request is determined to be incomplete, the Inpatient Prior Authorization Department contacts the provider requesting the specific information needed to make the authorization determination and places the request in pending status. If the requested information is not received by the second business day, the information is requested again. If the information is not received by the fourth business day from the date the request was placed in pending status, the request is denied. A denial letter is sent to the facility and/or the requesting physician. When the requested information is received within four business days from the original pend date, the authorization is processed.

If an emergent admission is necessary, the hospital must notify PCCM prior to claim submission. Failure to notify the PCCM Inpatient Prior Authorization Department prior to claim submission will result in denial of the claim.

Notification of emergency admissions can be provided by calling the PCCM Inpatient Prior Authorization Department at 1-888-302-6167, or faxing to 1-512-302-5039.

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7.5.14.7 OB/Newborn Notification

Routine

Authorization is not required for routine obstetrical and newborn care within the routine length of stay (48 hours for vaginal deliveries and 96 hours for C-section deliveries).

Non-Routine

All obstetrical and newborn admissions with non-routine clinical status (complicated condition or DRG) or non-routine length of stay (over 48 hours for vaginal deliveries and 96 hours for C-section deliveries) require notification of admission and clinical documentation prior to claim submission. Notification of admission is the responsibility of the admitting facility. However, if necessary, notification of admission is accepted from the physician. Notification of admission is required prior to claim submission to avoid claim denial.

7.5.14.8 Scheduled Inpatient Admissions

Prior authorization is required for all scheduled inpatient admissions. Prior authorization of admission is a shared responsibility of the admitting facility and physician, but only one provider (admitting facility or physician) is required to submit an authorization request.

7.5.14.9 Appeals of Denied Requests for Authorization

If an authorization request for admission or service is denied, the requesting provider will receive a denial letter from the PCCM Prior Authorization Department. Where appropriate, the hospital or facility involved is also notified of the denial.

Refer to: "Appeals" on page 6-1 and "Authorization Appeals" on page 7-40.

7.5.14.10 Out-of-Network Inpatient Services

Out-of-network hospitals are reimbursed only for inpatient services provided to PCCM clients as the result of an emergency admission. Out-of-network facilities must notify the Inpatient Prior Authorization Department of a client admission within the next business day following the admission. Medical documentation must be submitted with notification to determine appropriateness for transfer to a contracted facility. Scheduled medical and surgical admissions or any non-emergent admission must be precertified indicating the reason why the patient must be admitted or transferred to an out-of-network facility (i.e., the services needed are not provided in a network facility, the patient had an emergent condition requiring admission while away from the service area).

After a patient in an out-of-network hospital is stabilized, additional services are considered non-covered benefits. The out-of-network hospital may, however, request an exception to the stabilization policy by contacting the PCCM Inpatient Prior Authorization Department at 1-888-302-6167:

- The hospital must state the circumstances surrounding the emergency admission and provide an estimate of the additional number of days required until the patient is discharged.
- PCCM grants exceptions based on the information provided by the non-contracted hospital and issues a authorization for billing purposes if an exception is granted.
- Although in some cases the PCCM Inpatient Prior Authorization Department may require additional time to review the circumstances of the request for exception, it normally reviews the request and contacts the out-of-network hospital within 36 hours of its request. The Inpatient Prior Authorization Department will either provide the non-contracted hospital with a authorization or deny the exception request.
- Should a stabilization exception be denied, any inpatient services provided to the PCCM client at the out-of-network hospital will cease to be a covered benefit 24 hours after the hospital is notified.

Nonemergency inpatient admissions are not a covered benefit at out-of-network hospitals and are considered for reimbursement only if authorization has been received from the PCCM Inpatient Prior Authorization Department or the client would experience an undue burden traveling to a network hospital. In this case, a *hardship exemption* may be granted. This exemption permits reimbursement of a nonemergency admission at an out-of-network hospital.

To obtain a hardship exemption, the attending physician or designee must contact the PCCM Inpatient Prior Authorization Department at 1-888-302-6167 before any nonemergency admission to an out-of-network hospital and provide details to substantiate why the client would experience an undue burden traveling to a network hospital.

If the details substantiate undue burden, the PCCM Inpatient Prior Authorization Department will grant the exemption and issue a authorization. The physician can then admit the patient to the out-of-network hospital.

Note: *Under no circumstances will authorization for an undue travel burden be granted after a patient has been admitted for a nonemergency condition to an out-of-network hospital.*

Primary care providers referring clients to specialists should make the specialist aware of the PCCM non-contracted hospital admission policy.

7.5.15 Outpatient Prior Authorization Process

The following outpatient procedures require prior authorization:

- Computed Tomography Imaging (CT)
- Computed Tomography Angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)

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- All laser surgeries
- Some endoscopic procedures
- Some podiatry procedures
- pH probe tests
- Sleep studies
- Some surgical procedures

Refer to: "Prior Authorization for Radiology Services" on page 39-5 for more information about MRI/MRA and CT/CTA authorizations

The following outpatient procedures do not require prior authorization:

- Anesthesia services (type of service 7)
- Surgeries performed on an outpatient emergent basis (retrospective authorization must occur for claims payment)
- Application/removal of casts, splints, or strapping (excluding podiatry office procedures and services)
- Burns — local treatment (does not include skin grafts or long-term wound care)
- Catheterization of blood vessels (excluding heart catheterizations) for diagnosis or therapy (includes venous access, puncture of shunt, etc.)
- Circumcision, newborn and for phimosis (up to 21 years of age)
- Fractures/dislocations (closed or open treatment)
- Incision and drainage of abscesses
- Injection procedures for radiology or in conjunction with surgical procedures
- Intubation/tracheostomy tube changes
- Removal of foreign bodies
- Removal of pressure equalization (PE) tubes with or without grafts
- Repair of lacerations/wounds (includes the eye)
- Replacement of gastrostomy tubes
- Replantation of digits
- Sterilization procedures (male and female)
- Urodynamics
- Esophageal manometry
- Ultrasounds
- Holter monitors
- Tympanostomy
- Tonsillectomy for client's under 12 years of age
- Adenoidectomy for client's under 12 years of age
- Bronchoscopy
- Sigmoidoscopy
- Proctosigmoidoscopy
- Permanent removal of nail/nail matrix
- Colonoscopy (except with endoscopic ultrasound exam or fine needle biopsy)
- Esophageal Endoscopy (except for ablation procedures)
- Appendectomy for ruptured appendix or incidental removal
- Hernia repair (except initial repair under 5 years of age with strangulation or incarceration)
- Upper GI Endoscopy (except for drainage of psuedocyst or placement of gastrostomy tube)

Requests for prior authorization of outpatient services must be faxed to the Outpatient Prior Authorization Department at 1-512-302-5039 on the PCCM Inpatient/Outpatient Authorization Form, or by calling 1-888-302-6167. Other forms will not be accepted for outpatient prior authorizations or updates.

The request must include the following information:

- Facility name and provider identifier
- Client name, Medicaid number (PCN), and date of birth
- Requesting (admitting) physician's name and provider identifier
- Name of person completing form
- Date completed
- Telephone and fax number
- Admit date
- Diagnosis codes (primary, secondary, etc.)
- Procedure codes
- Clinical information to support medical necessity is required

If the prior authorization request is determined to be incomplete, the Outpatient Prior Authorization Department faxes the provider a letter requesting the specific information needed to make the prior authorization determination and places the request in pending status. At least two additional attempts to call and/or fax the provider to obtain this information will be made during the next four business days. If the requested information is not received by the fourth business day, a letter is sent to the client stating that the prior authorization request cannot be processed until the provider responds with the specific information necessary to complete the prior authorization request. This client letter is sent along with a copy of the initial letter to the provider that lists the specific information necessary to make the prior authorization determination. If the provider does not submit the information necessary to complete the prior authorization request within seven calendar days from the date of the letter sent to the client, a letter is sent to the provider and the client notifying them of the denial of service due to incomplete or missing information.

A letter of authorization determination is faxed to the requesting provider once the request is completed.

If there is a change in an existing authorization (i.e., change in diagnosis or change in procedure), the facility/provider is required to submit an updated PCCM Inpatient/Outpatient Authorization Form with clinical

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documentation supporting the change or contact the Outpatient Prior Authorization Department with the update prior to claim submission to avoid claim denial.

Providers performing urgent or emergent outpatient procedures that require authorization must contact the PCCM Outpatient Prior Authorization Department within 7 calendar days to obtain the authorization.

7.5.16 Transportation Services

7.5.16.1 Nonemergency Transportation

Nonemergency transportation services are available to eligible Medicaid clients who have no other means of transportation. This service is known as the Medical Transportation Program (MTP) and is detailed in "Medical Transportation" on page I-1.

For information on emergency transportation, see "Ambulance" on page 8-1.

7.5.17 Provider Complaints and Appeals

7.5.17.1 Conflict Resolution

The relationship between client and primary care provider may become unsatisfactory to one or both parties. The primary care provider should contact the PCCM Provider Helpline or write to request assistance in resolving the situation.

PCCM will initiate one or more of the following steps:

- Contact the client and the provider to assess the situation and provide educational information that may clarify the situation, if applicable
- Reassign the client to another primary care provider
- Refer the situation to the Complaint Resolution Team, if applicable
- Begin complaint/grievance resolution
- Refer the situation to the Community Health Services staff for education or to help clarify the situation

7.5.17.2 Provider Complaints

PCCM provides for due process in resolving provider complaints. Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. The majority of complaints are resolved within 30 business days.

Complaints must be submitted in writing to:

Primary Care Case Management (PCCM)
Complaints Unit MC-C04
PO Box 204270
Austin, TX 78720-4270
Or faxed to: 1-888-235-8399

Question regarding the status of a complaint or the complaint process should be directed to the PCCM Provider Helpline at 1-888-834-7226.

Provider Complaint Policy

PCCM takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, PCCM works with the provider to resolve the issue or directs the complaint to the appropriate PCCM department.

- *Complaints Unit.* Complaints that concern the relationship between a provider or provider's staff and a client.
- *Medical Affairs Division.* Complaints that relate to utilization of services (including emergency room use), denial of continued stay, and all clinical and access issues. This includes provider's appeal of an adverse authorization decision.
- *PCCM Administration.* Complaints that concern the relationship between a provider and any PCCM staff person or complaints about the overall plan management.

If the complaint relates to a medical issue, the Medical Affairs staff may assist in the resolution of the complaint.

The provider complaints process applies only to the resolution of disputes within the control of PCCM, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other participating providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC staff with support from PCCM staff.

Provider Complaint Procedures

The PCCM Complaints Unit handles all provider complaints. The processing of provider complaints is described below:

- Providers must submit their complaint in writing to the PCCM Complaints Unit.
- Providers will receive a written acknowledgement letter from PCCM within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Services or Medical Affairs, are made as appropriate.
- Complaints dealing with the quality of, access to, or continuity of care are referred to the PCCM Primary Care Provider Contract Compliance Department for follow-up and inclusion in the provider file.
- If the complaint cannot be resolved within 30 business days, the provider is notified in writing or by phone of the status of the complaint.

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If the provider believes he did not receive due process from PCCM, the provider may file a complaint with HHSC. However, providers must exhaust the appeals/grievance process with PCCM before filing a complaint with HHSC.

Refer to: "Medicaid Managed Care Complaints and Fair Hearings" on page 7-11.

"Complaints to HHSC—Fee-for-Service and PCCM" on page 6-9.

7.5.17.3 Authorization Appeals

A denial is issued when an authorization or update to an existing request by a physician or a facility is not approved by the TMHP Medical Director or designee.

A medical necessity denial is issued when the documentation provided fails to support the need for requested service or the client's condition/service requested does not warrant the level or location of care the provider requested.

A denial is also issued when the provider has failed to comply with PCCM policies and procedures. These include failure to:

- Notify of an inpatient stay
- Obtain authorization for an elective/scheduled service prior to the delivery of service

A denial may also be issued if:

- The provider or the location of service is not within the network
- The patient is no longer eligible for coverage
- Texas Medicaid does not cover the service

The appeals or authorization reconsideration process affords the provider the opportunity to dispute a denial and explain or justify the original request.

Refer to: "Appeals" on page 6-1.

Appeal Procedures for Denials Other Than Medical Necessity

Level I: Review by PCCM

The provider may request a reconsideration of a denial if the provider has evidence that he complied with policy. The provider can appeal by resubmitting the authorization request with additional information to support the reconsideration and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the denial prior to submitting the claim.

Level II: Review by HHSC

If a provider believes he did not receive full consideration under the appeals process, he may file an appeal with HHSC. Providers must exhaust the appeals process with PCCM before filing an appeal with the HHSC.

Refer to: "Appeals to HHSC Fee-for-Service and PCCM" on page 6-4.

If it is determined that the provider did not receive full consideration, HHSC will work with the provider and PCCM to ensure that a proper review of the appeal is conducted.

Appeal Procedures for Medical Necessity Denials

Level I: Review by PCCM

Providers can appeal medical necessity denials by resubmitting the authorization request with additional clinical information to support the appeal and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the denial prior to submitting the claim.

Upon receipt of the request:

- The Medical Director or designee reviews the information and makes a determination.
- After the determination is made, the Medical Affairs nurse sends the resolution letter to the appealing provider.

If dissatisfied with the reconsideration decision, a provider can request another reconsideration by resubmitting the authorization request with additional clinical information not previously submitted to support the requested services and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the decision prior to submitting the claim for the services.

Once a provider has submitted a claim for services, reconsiderations for medical necessity cannot be performed by the PCCM Prior Authorizations Departments. The provider will need to follow the process for administrative claims appeals.

Refer to: "Appeals to HHSC Fee-for-Service and PCCM" on page 6-4

Level II: Review by HHSC

If a provider believes he did not receive full consideration under the appeals process, he may file a complaint with HHSC. Providers must exhaust the appeals process with PCCM before filing a complaint with HHSC.

Refer to: "Complaints to HHSC—Fee-for-Service and PCCM" on page 6-9.

"Medicaid Managed Care Complaints and Fair Hearings" on page 7-11.

7.5.18 Claims Filing Information

In addition to fee-for-service payments, providers enrolled as PCCM primary care providers receive a case management fee of $2.93 per client, per month. The fee-for-service reimbursement for PCCM is based on the Texas Medicaid Reimbursement Methodology (TMRM) structure.

7.5.18.1 Case Management Fee

The case management fee is compensation for managing the medical care of PCCM clients who have either selected or who have been assigned to the primary care provider's practice as their *medical home*. The fee:

- Is paid to the primary care provider whether or not the client is seen that month.

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- Is paid to the primary care provider in a separate check no later than the 10th state business day of each month.

Two reports are made available to primary care providers on a monthly basis. The client panel report lists the PCCM clients who have selected or who have been assigned to each primary care provider's practice. This report is available electronically at www.tmhp.com, or in hard copy by calling the PCCM Provider Helpline at 1-888-834-7226. The second report, a case management summary, is produced by TMHP and accompanies the case management check.

If there are any discrepancies in either report, providers are to contact their TMHP provider relations representative. Providers are to call the Provider Helpline (1-888-834-7226) prior to returning a check. This allows PCCM to provide necessary research and assistance.

Refer to: "Monthly Client Panel Report" on page 7-27.

7.5.18.2 PCCM Newborn Claims Filing

Newborns of PCCM mothers are automatically enrolled in PCCM.Claims filing procedures for PCCM newborns will continue to be handled under the traditional Medicaid billing guidelines through TMHP.

Health care providers should file newborn claims using the newborn's Medicaid Identification number as soon as it is made available to them. Claims submitted for newborns that have not yet been assigned a primary care provider should show PCCNEWB01 as the referring provider identifier. While the provider is listed as PCCNEWB01, any Medicaid provider can see the newborn. Claims submitted for newborns will be accepted even if a primary care provider has not been identified. Depending on when the Medicaid certification date falls within the default cycle, parents of a newborn may have up to 45 days to select a primary care provider for their baby. If parents do not select a primary care provider by the next default date, a primary care provider is selected for the newborn on the basis of geographic criteria.

Once the baby is assigned a primary care provider and a Medicaid number, normal billing and referral procedures will be in effect.

7.5.18.3 Network Hospitals

A network hospital is one that is contracted to provide services to PCCM clients. Individual reimbursement arrangements are negotiated for the HHSC by PCCM Hospital Contracting.

For all service areas, all inpatient services to PCCM clients, including services provided to PCCM clients receiving SSI benefits, are reimbursed at the PCCM rate.

7.5.18.4 Out-of-Network Hospitals

An out-of-network hospital is one that is not contracted to provide services to PCCM clients:

- Out-of-network hospitals are reimbursed only for inpatient services provided to PCCM clients as the result of an emergency admission. Inpatient services are reimbursed at the rate paid by the traditional Medicaid program.
- Reimbursement for emergency treatment will be made at the current Medicaid rates.

Hospitals that are not contracted with PCCM are reimbursed according to traditional Medicaid rates.

7.5.18.5 Emergency Outpatient Services

If the client presents at a hospital emergency outpatient facility, the physician should provide the medically necessary medical screening examination and stabilization services immediately, and the client should be referred back to the primary care provider for follow-up care. Reimbursement for emergency outpatient services requires that the medical record document the medically necessary services.

The hospital should contact the client's primary care provider within 24 hours or the next business day to advise that emergency treatment has been provided. In addition, if a procedure requiring authorization was performed while in the emergency department, the hospital should contact the PCCM Outpatient Prior Authorization Department within 7 calendar days to obtain the authorization. If the condition results in an inpatient admission, the hospital must notify the PCCM Inpatient Prior Authorization Department prior to claim submission. Reimbursement in cases of emergency treatment will be based on the actual services rendered. The hospital will be reimbursed at its current Medicaid reimbursement rate.

Refer to: "PCCM Inpatient Authorization Process" on page 7-34.

"Outpatient Prior Authorization Process" on page 7-37.

7.5.18.6 Nonemergency Outpatient Clinic Services

All hospitals are reimbursed for outpatient clinic services at their current Medicaid outpatient reimbursement rate.

7.5.18.7 PCCM Claims Details

If the provider of the services billed is not the client's assigned primary care provider, the primary care provider's name and provider identifier must be entered in the referring provider field of the claim form (boxes 17 and 17A on the CMS-1500) indicating a referral from the primary care provider.

If this information is missing or if the treating provider is not the assigned primary care provider on the date of service, the claim will be denied.

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For services requiring authorization, enter the authorization number in the prior authorization field. It is not necessary to send the PCCM Authorization Request Form with the claims submission.

Refer to: "PCCM Inpatient Authorization Process" on page 7-34.

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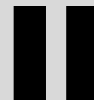

Texas Medicaid Services

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Section 10 Birthing Center
Section 11 Blind Children's Vocational Discovery and Development Program
Section 12 Case Management for Children and Pregnant Women (CPW)
Section 13 Case Management for Early Childhood Intervention (ECI)
Section 14 Certified Nurse-Midwife (CNM)
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Section

8

Ambulance

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8.1 Enrollment

To enroll in the Texas Medicaid Program, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; acquire a license from the Texas Department of State Health Services (DSHS), approving equipment and training levels of the crew; and enroll in Medicare.

A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier (see “Medicare/Medicaid Coverage” on page 8-7).

Note: *Air ambulance providers are not required to enroll with Medicare.*

Reminder: *When ambulance providers enroll in Medicaid, they accept Medicaid payment as payment in full. They cannot bill clients for Texas Medicaid-covered benefits.*

Refer to: “Provider Enrollment” on page 1-2 for more information about enrollment procedures.

8.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Note: *Services for STAR+PLUS Program Medicaid Qualified Medicare Beneficiaries (MQMBs) must be prior authorized and processed by TMHP.*

Refer to: “Managed Care” on page 7-1 for more information.

8.2 Reimbursement

Ground ambulance emergency and nonemergency transports and mileage are reimbursed in accordance with the reasonable charge methodology in Title 1 *Texas Administrative Code* (TAC) §355.8600. Air ambulance transports and mileage, as well as other ambulance procedure codes, are reimbursed at the lesser of the provider's billed charges or the published Medicaid fee. See also “Ambulance Procedure Codes” on page 8-8 for ambulance procedure codes and fees.

Ambulance providers are reimbursed for the transport plus mileage. Medicaid payments for ambulance services are subject to the 2.5 percent Medicaid payment reduction discussed in “Reimbursement Methodology” on page 2-2.

Refer to: “Reimbursement” on page 2-2 for more information about reimbursement methodologies.

“Medicaid Program Limitations and Exclusions” on page 1-17 for information on Medicaid exclusions.

8.3 Benefits and Limitations

Medicaid reimburses for emergency and nonemergency (for the severely disabled) transports.

For ground transportation, providers must bill procedure codes 9-A0428 and 9-A0425 or 9-A0429 and 9-A0425 with modifier ET. Providers must bill the appropriate mileage with the appropriate base rate procedure code.

For air transportation, providers must bill either with procedure codes 9-A0430 and 9-A0435 or 9-A0431 and 9-A0436. Providers must bill the appropriate mileage with the appropriate base rate procedure code.

When submitting a claim for water transport services, providers are to use procedure code 9-A0999. The claim suspends for manual review and pricing.

Night calls are no longer paid separately.

The payment rates represent a global payment. It is inappropriate to bill for any supplies or other services related to the transport, unless otherwise specified in this section.

The integrity of the information about a client’s condition which requires the transport and the medical necessity of the transport are the responsibility of the ambulance provider. The ambulance provider may be sanctioned, including exclusion from the Medicaid Title XIX programs, for completing or signing a claim form that includes false or misleading representations of the client’s condition or the medical necessity of the transport.

8.3.1 Emergency Ambulance Services

According to 1 TAC §354.1111, an emergency transport is a service provided by a Medicaid-enrolled ambulance provider for a Medicaid client whose condition meets the definition of an emergency medical condition. Conditions requiring cardio pulmonary resuscitation (CPR) in transit or the use of above routine restraints for the safety of the client or crew are also considered emergencies. Facility-to-facility transfers are appropriate as emergencies if the required emergency treatment is not available at the first facility.

8.3.1.1 Prior Authorization for Emergency Out-of-State Transport

All out-of-state (air and ground) transports require authorization before the transport is considered for payment.

To initiate the prior authorization process, providers must call 1-800-540-0694 (7 a.m. to 7 p.m., Monday through Friday, Central Time) *before* the transfer or on the first workday following transfers that occur after hours, on weekends, or on holidays.

TMHP is responsible for processing prior authorization requests for all Medicaid clients, Primary Care Case Management (PCCM) clients, and all STAR+PLUS MQMBs.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness,

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semiconsciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria.

Emergency transports do not require prior authorization.

8.3.1.2 Emergency Transport Billing

When billing emergency transports electronically, a minimum of one diagnosis description or the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code must be written on the claim form or in the diagnosis code field for electronic billers. A claim that has "see attached" as the only information in the diagnosis block is not processed for payment consideration.

Important: *Transports may be appealed as emergency claims only. Emergency transports that are denied cannot be accepted on appeal as nonemergency transports. Emergency transports billed as nonemergency services are denied.*

Note: *Emergency and nonemergency claims may be billed electronically to Medicaid. For electronic billers, the hospital's provider identifier must be entered in the Facility ID field. Providers should consult their software vendor for the location of this field on the electronic claim form.*

All emergency claims submitted on paper are required to have the following documentation:

- Distance of transport traffic patterns
- Time of transport
- Acuity of client

Place of Service Codes

National place of service (POS) codes 41 and 42 are accepted by the Texas Medicaid Program.

Condition Codes

Electronic billers should use as many condition codes as needed to fully describe the patient's condition.

The following condition codes are accepted by the Texas Medicaid Program:

Condition Codes				
01	02	03	04	05
06	07	08	09	60

Condition code 60 is used to notify TMHP that the patient was taken to the nearest facility.

Origin and Destination Codes

All claims submitted on paper or electronically must include the two-digit origin and destination codes. The origin is the first digit, and the destination is the second digit. The following are the origin and destination codes accepted by the Texas Medicaid Program:

Origin and Destination Codes					
D	E	G	H	I	J
N	P	R	S	X	

8.3.2 Nonemergency Ambulance Services

According to 1 TAC §354.1111, *nonemergency transport* is defined as a transport to or from a medical appointment for a Medicaid client who requires treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transport.

Severely disabled is defined as the physical condition of a Medicaid client that limits mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or intravenous infusion).

A round-trip transport from the client's home to a scheduled medical appointment (e.g., an outpatient or freestanding dialysis or radiation facility) is a covered service when the client meets the definition of severely disabled. All nonemergency ambulance transfers to a scheduled doctor's appointment require the doctor's name and address, and information that describes the client's condition which requires transport by ambulance.

Nonemergency transports of clients with conditions that do not meet the severely disabled criteria and are not prior authorized are not a covered Medicaid service. Providers may call the TMHP Contact Center at 1-800-925-9126 or their provider relations representative with questions about the nonemergency ambulance transport policy.

Refer to: "Medical Transportation" on page I-1 for more information about nonemergency transportation.

8.3.2.1 Nonemergency Ambulance Transport Prior Authorization

According to *Human Resource Code* (HRC) §32.024 (t), Medicaid enrolled physician, nursing facility, health care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

Providers must request and obtain prior authorization *before* contacting the ambulance provider for the transport of their severely disabled Medicaid clients. In addition, the HRC states that a provider who is denied payment for nonemergency ambulance transport may be entitled to payment from the nursing facility, health care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the provider submits a copy of the bill for which payment was denied.

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TMHP responds to nonemergency transport prior authorization requests within 48 hours of receipt of the request. It is recommended that all requests for a prior authorization number (PAN) be submitted in sufficient time to allow TMHP to issue the PAN before the date of the requested transport. Documentation of a client's condition that meets the severely disabled definition must be provided at the time of request. If the client does not meet the severely disabled criteria, nonemergency ambulance services are not covered. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as eligibility and filing deadlines.

These prior authorization requirements also apply to Medicaid providers who participate in PCCM. Medicaid providers who participate in one of the Medicaid Managed Care health maintenance organization (HMO) plans must follow the requirements of their plan.

Prior authorizations for nonemergency transports require supporting documentation. The TMHP Ambulance Unit reviews the documentation to determine whether the client meets the definition of severely disabled. Incomplete information may cause the request to be denied.

The following information assists TMHP in determining the appropriateness of the transport:

- A detailed explanation of the severity of the client's physical condition that establishes the medical necessity for transport. If the client is bed-confined, documentation must clearly state the reasons for the confinement
- The necessary equipment, treatment, or personnel used during the transport
- The origination and destination points of the client's transport

Important: *TMHP requires prior authorization for all out-of-state ambulance transports.*

8.3.2.2 Nonemergency Prior Authorization Process

Medicaid providers and TMHP use the following prior authorization process:

1) The client's physician, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF-MR), health care provider, or other responsible party faxes a copy of the "Ambulance Fax Cover Sheet" found on page B-6 to the TMHP Ambulance Unit at 1-512-514-4205. Information and documentation listed on the form must be sent with the request before the transport to the initial or next medical appointment. Documentation requirements are outlined in this section under "Supporting Documentation" on page 8-5.
2) TMHP reviews all of the documentation it receives, and a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the severely disabled criteria or that the client is not eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406.
3) The requester contacts the transporting ambulance provider and supplies the provider with the PAN and the dates of service that were approved.
4) Hospitals may call TMHP at 1-800-540-0694 or fax to 1-512-514-4205 to request a PAN when discharging a client or transporting the client to another facility.

Important: *Ambulance provider claims submitted without a PAN are denied. A provider who is denied payment for nonemergency ambulance transport because of failure to obtain prior authorization or because a request for prior authorization was denied can appeal to TMHP. If the review shows that prior authorization was not obtained before transport, the denial of reimbursement will be upheld. If the review shows that prior authorization was obtained before transport or that the request for prior authorization was improperly denied based on the documentation of medical necessity submitted initially, the denial of reimbursement may be overturned.*

8.3.2.3 Nonemergency Prior Authorization and Retroactive Eligibility

Prior authorization is issued to clients who are Medicaid-eligible and who meet the severely disabled criteria. If a request for a PAN is received and the client's Medicaid coverage is pending, the request will be denied. The client's eligibility may be granted retroactively. The requestor has 95 days from the date that the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be reconsidered.

To inquire about Medicaid eligibility, providers can contact the Automated Inquiry System (AIS) at 1-800-925-9126.

8.3.2.4 Prior Authorization Types, Definitions

Short Term

Short-term prior authorizations are issued to a client whose condition meets the severely disabled criteria for a short period of time. The length of the prior authorization is determined based on the treating physician's or surgeon's prognosis of recovery. If a recovery period cannot be determined at the time the prior authorization is requested, the TMHP Ambulance Unit defaults the authorization to 60 days with the option for an extension based on updated documentation received before the 60 days have lapsed. Hospital-to-hospital and hospital-to-outpatient medical facility transports are issued a PAN for that transport only. If the client already has a short-term or annual PAN, the PAN may be used for the ambulance transport. The hospital is responsible for obtaining the prior authorization.

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180-Day

180-day prior authorizations are issued to a client and are granted within 24 hours of the time received, excluding weekends and holidays, for the authorization of nonemergency ambulance services. The request will be effective for a period of 180 days from the date of issuance if the request includes a written statement from a physician. Requests can be submitted up to 60 days before the date of service. The provider who requests this authorization is required to complete the "Physician's Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)" on page B-70 (certification form) in its entirety. Incomplete forms are not considered as a valid authorization request and are returned with a denial letter. The certification form is not considered documentation after the service is rendered and should not be sent with a claim or an appeal. Texas Medicaid no longer approves authorizations for a year.

8.3.2.5 Supporting Documentation

Providers must submit supporting documentation with all prior authorization requests.Examples include:

- Admit and discharge records with prognosis, including emergency room records
- A history and physical completed within six months or a care plan detailing daily activities from a facility or home health agency
- A letter on the health care provider's letterhead including the patient's primary mode of mobility and diagnosis history

In hospital-to-hospital transports or hospital-to-outpatient medical facility transports, the TMHP Ambulance Unit considers information by telephone from the hospital. Beginning June 1, 2005, providers are no longer required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request the hospital fax the supporting documentation.

8.3.3 Claim Denials and Appeals

Ambulance provider claims submitted for nonemergency transports without the PAN are denied and must be appealed on paper by the provider. The appeal must be accompanied by supporting documentation. Clients may appeal PAN request denials by contacting TMHP Client Notification at 1-800-414-3406.

Important: *All ambulance denials (air or ground) must be appealed on paper. Telephone and electronic appeals are not accepted.*

For claims or appeals related to prior authorization denials for the 180-day authorization request, the certification form is not considered as documentation after the service is rendered.

On appeal, supporting documentation is critical for determining the client's condition. Ambulance providers who file paper claims must include all information that supports the reason for the transport and attach a copy of the run sheet to the claim. The emergency medical technician (EMT) who transported the client must sign the documentation.

Refer to: "Supporting Documentation" on page 8-5.

8.3.4 Ambulance Disposable Supplies

Reimbursement for disposable supplies is separate from the established global fee for ambulance transports. Providers should use one procedure code, 9-A0382, to combine all payable disposable supplies used (e.g., gauze, bandages, tape, suction catheter, gloves, and mask) during emergency and nonemergency ambulance transports. Reimbursement for this procedure code is limited to a maximum of $20.30 per transport (one-way) and $40.60 round trip. A maximum of two supply procedure codes are allowed per round trip. In situations involving multiple transports on the same date of service, the provider may appeal claims denied because they exceed two supply procedure codes per claim. When billing for nonpayable supplies, providers must bill the appropriate national code. Providers must provide medically necessary supplies for the client's safe transport.

8.3.5 Oxygen

Reimbursement for oxygen is the lesser of the provider's customary profile, the prevailing profile, or the provider's actual charge in accordance with 1 TAC §355.8600. A maximum of two oxygen procedure codes are allowed per round trip. In situations involving multiple transports on the same date of service, the provider may appeal claims that have denied for this two-code limit. Providers must bill the appropriate national code.

8.3.6 Waiting Time

Procedure code 9-A0420 may be billed when it is the general billing practice of local ambulance companies to charge for unusual waiting time (longer than 30 minutes). Providers must use the following procedures:

- Separate charges must be billed for all clients, Medicaid and non-Medicaid, for unusual waiting time.
- The circumstances requiring waiting time and the exact time involved must be documented in Block 24 of the CMS-1500 claim form.
- The amount charged for waiting time must not exceed the charge for a one-way transfer.

Important: *Waiting time is reimbursed up to one hour.*

8.3.7 Extra Attendant or Registered Nurse

Charges for an extra attendant or registered nurse (in addition to the two-person crew) for an ambulance transfer are reimbursed when the claim documents the medical necessity of advanced life-support services (e.g., procedure code 9-A0424). Without documentation of the medical need of the third attendant, the third attendant's

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services are not reimbursable. Medicaid does not reimburse based on each ambulance provider's internal policy.

8.3.8 Night Call

The Texas Medicaid Program does not reimburse an extra charge for a night call.

8.4 Membership Fees

The *Texas Insurance Code* does *not* apply to ambulance providers who finance, in part or in whole, the ambulance service by subscription. HHSC's Bureau of Emergency Management and Bureau of Policy and Operations have specific guidelines about these subscription plans. For more information, providers may contact their regional Emergency Medical Services (EMS) program administrator or the HHSC EMS Division at 1-512-834-6700.

8.5 Types of Transport

8.5.1 Multiple Client Transports

Multiple client transports occur when more than one client with Medicaid coverage is transported in the same vehicle simultaneously. A claim for each client *must* be completed and must reference *multiple transfers* with the names and Medicaid numbers of other clients sharing the transfer in Block 19 of the CMS-1500 claim form. Providers must enter charges on a separate claim for each client. TMHP adjusts the payment to 80 percent of the allowable base rate for each claim and divides mileage equally among the clients who share the ambulance.

Important: *Mileage determinations are based on the Official State Mileage Guide.*

Refer to: "Claims Filing Instructions" on page 5-23.

8.5.2 Out-of-Locality Transports

Transports to out-of-locality providers are covered if a local facility is not adequately equipped to treat the condition. *Out-of-locality* refers to one-way transfers of *50 or more* miles from point of pickup to point of destination.

Important: *Transports may be cut back to the closest appropriate facility.*

8.5.3 Air or Boat Transports

Air ambulance transport services, by means of either fixed or rotary wing aircraft, may be covered only if one of the following conditions exists:

- The client's medical condition requires immediate and rapid ambulance transportation that could not have been provided by ground ambulance.
- The point of client pick-up is inaccessible by ground vehicle.
- Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility.

Important: *Air transport claims may be submitted on paper with supporting documentation. Claims may be submitted electronically with a short description of the client's physical condition in the comment field. If the client's condition cannot be documented, providers must file a paper claim.*

8.5.4 Pregnancy Transports

Transporting a pregnant woman may be covered as an emergency transfer if the client's condition is documented as an emergency situation at the time of transfer.

Claims documenting a home delivery or delivery en route are considered emergency transfers. Premature labor and early onset of delivery (less than 37 weeks gestation) also may be considered an emergency. Active labor without more documentation of an emergency situation is not payable as an emergency transport.

Important: *First day of last menstrual period (LMP) or estimated due date (EDD) must be in Block 14 of the claim form and on the documentation.*

If the pregnant client is transported in an ambulance on a nonemergency basis, all criteria for nonemergency prior authorization must be met.

8.5.5 Transports to or From State Institutions

Ambulance transports to or from a state-funded hospital for admission or following discharge are covered when nonemergency transfer criteria are met. Ambulance transfers of clients while they are inpatients of the institution are not covered. The institution is responsible for routine nonemergency transportation.

8.5.6 Transports for Nursing Facility Residents

Transports from a nursing facility to a hospital are covered if the client's condition meets emergency criteria. Nonemergency transfers for the purpose of required diagnostic or treatment procedures not available in the nursing facility (such as dialysis treatments at a freestanding facility) are also allowable *only* for clients meeting the definition of severely disabled.

The nursing facility is responsible for providing routine nonemergency transportation for services not provided in the nursing facility. The cost of such transportation is included in the nursing facility vendor rate. This nonemergency transport requires the nursing facility to request and obtain a prior authorization number from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

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Transports of nursing facility residents for rehabilitative treatment (for example, physical therapy) to outpatient departments or physicians' offices for recertification examinations for nursing facility care are *not* reimbursable ambulance services.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (for example, admission or X-ray).

If a client is returned by ambulance to a nursing facility following hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form. This transport is considered for payment only if the client meets the severely disabled criteria. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for nonemergency ambulance transports. Ambulance providers may assist nursing facilities in obtaining prior authorizations.

Ambulance providers may bill a nursing facility or client for a nonemergency ambulance transport only under the following circumstances:

- *Providers may bill the nursing facility* when the nursing facility requests the nonemergency ambulance transport without a prior authorization number.
- *Providers may bill the client* only when the client requests transport that is not an emergency and the client does not meet the severely disabled criteria. The provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Providers are encouraged to have the client sign the *Private Pay Agreement.*

Providers may refer questions about a nursing facility's responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representatives.

8.5.7 No-Transport

The Texas Medicaid Program does not reimburse providers for services that do not result in a transport to a facility, regardless of any medical care rendered. If a client contacts an ambulance provider, but the call does not result in a transport, the provider should have the client sign an acknowledgment statement and bill the client for services rendered.

8.6 Medicare/Medicaid Coverage

Medicaid is the secondary payor to other health insurance sources including Medicare. Ambulance claims for Medicaid and Medicare Part B claims must be filed with Medicare first.

MQMBs are eligible for Medicaid benefits such as ambulance transports. Qualified Medicare Beneficiaries (QMBs) are not eligible for Medicaid benefits. The Medicaid program is only required to pay for coinsurance and/or deductibles for QMBs. Therefore, providers should not request prior authorization for ambulance services for these clients.

Important: *Providers must use national procedure codes when billing Medicaid.*

Refer to: "Medicare/Medicaid Clients" on page 4-12.

8.6.1 Medicare Paid

Assigned claims filed with and paid by Medicare should automatically transfer to TMHP for payment of the deductible and coinsurance liability.

Providers must submit Medicare-paid claims that do not cross over to TMHP for the coinsurance and deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.

8.6.2 Medicare Denied

All claims denied by Medicare for administrative reasons must be appealed to Medicare before they are sent to Medicaid.

An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to TMHP for consideration.

Providers must send claims to TMHP on a CMS-1500 claim form with the ambulance provider identifier, unless they are a hospital-based provider. Hospital-based ambulance providers must send Medicare denied claims to TMHP on a HCFA-1500 claim form with the ambulance provider identifier and a copy of the MRAN.

Note: *All claims for STAR+PLUS clients with Medicare and Medicaid should follow the same requirements used for obtaining prior authorization for Medicaid-only services from TMHP. The STAR+PLUS HMO is not responsible for reimbursement of these services.*

8.7 Relation of Service to Time of Death

Medicaid benefits cease at the time of the client's death. However, if the client dies in the ambulance while en route to the destination, Medicaid covers the transport. If a physician pronounces the client dead after the ambulance is called, Medicaid covers the ambulance service (base rate plus mileage) to the point of pickup. Providers must

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Indicate the date and time the client died in Block nine of the CMS-1500 claim form. If a physician or coroner pronounces the client dead *before* the ambulance is called, the service is not covered.

Important: *Equipment and supplies are included in the base rate. They are not separately reimburseable, and are considered part of another procedure. Therefore, equipment and supplies cannot be billed to the client.*

8.8 Ambulance Procedure Codes

Use the following procedure codes when billing for ambulance services provided to Medicaid-eligible clients:

Emergency Code	Limitations	Maximum Fee
9-A0382	Maximum allowable fee of $20.30 is per transport, not to exceed $40.60 round trip.	$20.30
9-A0420		*
9-A0422		*
9-A0424		*
9-A0425 with modifier ET	Use modifier ET to denote emergency services. A0425-ET is denied if it is billed without A0429.	*
9-A0429		*
9-A0430		$1,140.08
9-A0431		$609.00
9-A0435		$16.24
9-A0436		$16.24
9-A0999	Use for water ambulance services.	MP
***Reimbursed at reasonable charge, which is the lesser of the provider's customary profile, the prevailing profile, or the provider's actual charge in accordance with 1 TAC §355.8600.**		

Nonemergency Code	Limitations	Maximum Fee
9-A0382	Maximum allowable fee of $20.30 is per transport, not to exceed $40.60 round trip.	$20.30
9-A0420		*
9-A0422		*
9-A0424		*
9-A0425	A0425 is denied if it is billed without A0428	*
9-A0428		*
9-A0430		$1,140.08
9-A0431		$609.00
9-A0435		$16.24
9-A0436		$16.24
***Reimbursed at reasonable charge, which is the lesser of the provider's customary profile, the prevailing profile, or the provider's actual charge in accordance with 1 TAC §355.8600.**		

8.9 Claims Information

Providers must submit ambulance services to TMHP on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from a vendor of their choice. TMHP does not supply them. Providers may file emergency and nonemergency ambulance services claims to TMHP in an approved electronic format. Nonemergency claims filed electronically must include the PAN in the appropriate field.

Reminder: *Providers must submit multiple transports for the same client on the same date of service through one claim submission.*

Refer to: "Reimbursement" on page 2-2.

8.9.1 Modifiers on Ambulance Claims

Ambulance providers may see the HH modifier on their Remittance and Status (R&S) reports, which indicates the transfer is from a noncontracted to a contracted hospital. It does not affect claim payment or processing.

Modifier TG may be used to indicate advanced life support (ALS) services were provided when billing basic life support (BLS) procedure codes.

8.9.2 Claim Filing Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP EDI General Information	3-1
CMS-1500 Claim Filing Instructions	5-24
Communication Guide	A-1
Ambulance Claim Example 1	D-3
Ambulance Claim Example 2	D-3
Ambulance Claim Example 3	D-4
Acronym Dictionary	F-1

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Section

9

Ambulatory Surgical Center (ASC)

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9.3 Benefits and Limitations 9-2
9.4 Claims Information 9-2
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9.1 Enrollment

To enroll in the Texas Medicaid Program, ambulatory surgical centers (ASCs) must do the following:

- Meet and comply with applicable state and federal laws, rules, regulations, and provisions of the state plan under Title XIX of the *Social Security Act*
- Be enrolled in Medicare
- Meet and comply with state licensure requirements for ASCs
- If Medicare doesn't issue a hospital a part B ambulance provider number, the hospital must submit a letter from Medicare denying issuance, and a Medicaid-only number will be issued.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Out-of-state ASCs that are Medicare-certified as an ASC in the state where they are located and provide services to a Texas Medicaid client may be entitled to participate in the Texas Medicaid Program.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Only providers complying with CLIA will be reimbursed for laboratory services.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Hospital Ambulatory Surgical Center" on page 25-16 for more information about HASCs.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

9.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

9.2 Reimbursement

The Medicaid rates for ASCs are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8121. The current ASC/HASC fee schedule and ASC/HASC fee schedule insert are available on the TMHP website at www.tmhp.com. To request a hard copy of the fee schedule and insert, call the TMHP Contact Center at 1-800-925-9126.

Note: *If billing for a surgical procedure not listed in the fee schedule, providers must bill with an unlisted procedure code.*

Physician and certified registered nurse anesthetist (CRNA) services performed in an ASC must be billed under the physician or CRNA provider identifier and are reimbursed separately.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

"Hospital Ambulatory Surgical Center" on page 25-16 for more information.

9.3 Benefits and Limitations

Refer to: "Family Planning Services" on page 20-1 for implantable contraceptive capsules reimbursement and code information.

"Benefits and Limitations" on page 25-24.

9.4 Claims Information

Freestanding ASC claims must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them. Information on the performing surgeon must be supplied in Block 17 of the CMS-1500 claim form for the claim to be processed. Hospital-based ASCs file a HCFA-1450 (UB-92).

ASCs who wish to bill for nurse anesthetists' services must enroll as a nurse anesthetist group provider and indicate the CRNA performing provider identifier on claims for those services. For specific billing instructions for CRNA services, see "Certified Registered Nurse Anesthetist (CRNA)" on page 15-1.

9.5 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
HCFA-1450 Claim Filing Instructions	5-32
Communication Guide	A-1
Ambulatory Surgical Center Claim Example	D-4
Hospital-Based ASC Claim Example	D-17
Acronym Dictionary	F-1

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Section

10

Birthing Center

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10.1 Enrollment

A birthing center must be licensed as a birthing center by the Department of State Health Services (DSHS) and meet the minimum standards as required by *Health and Safety Code*, Chapter 244.010. To enroll in the Texas Medicaid Program, a birthing center must be licensed to provide a level of service commensurate with the professional services of a Doctor of Medicine (MD), Doctor of Osteopathy (DO), or certified nurse-midwife (CNM) who acts as birth attendant. Texas Medicaid only reimburses birthing centers for services determined by the attending physician or CNM to be reasonable and necessary for the care of the mother or newborn child.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

A birthing center is a place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. This term does not include a hospital, ambulatory surgical center, or residence of the woman giving birth.

Birthing centers are *encouraged* to refer clients for THSteps services.

Refer to: “Texas Health Steps (THSteps)” on page 43-1.

“Provider Enrollment” on page 1-2.

“Medicaid Program Administration” on page vii.

Set up referral procedures for family planning services described in “Family Planning Services” on page 20-1.

DSHS website, www.dshs.state.tx.us/famplan/ for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from DSHS.

10.1.1 Medicaid Managed Care Enrollment

Birthing centers may be eligible to enroll in the Medicaid Managed Care Program as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: “Managed Care” on page 7-1 for more information.

10.2 Reimbursement

The Medicaid rates for birthing centers are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8181.

Refer to: “Reimbursement” on page 2-2 for more information about reimbursement.

10.2.1 Laboratory Services

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: “Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2.

10.3 Benefits and Limitations

Birthing centers, using their nine-digit provider identifier, can only submit claims for their facility services (e.g., labor and delivery services). The maternity clinic, physician, CNM, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) performing services must submit separate claims for their services because the services they provide (e.g., prenatal, family planning) are not approved birthing center services.

The Medicaid program reimburses procedure codes 1-99431 and 1-99432 when performed in the birthing center and billed by a physician or CNM.

Procedure code 1-99433 is not payable when performed in the birthing center.

Important: *Childbirth education classes and the use of a documented midwife as the birth attendant are not benefits of the Texas Medicaid Program.*

The following table lists the allowable procedure codes for birthing center services with the corresponding maximum fees:

Service	Procedure Code	Maximum Fee
Admission	P-99221	$69.60
Delivery	P-59409	$546.19
Admission and Labor	P-S4005 ***Note:*** *S4005 may not be billed in conjunction with 99221 and/or 59409*	$152.03

Health and Safety Code, Chapter 47, requires birthing centers located in a county with a population of more than 50,000 and that has 100 or more births per year to offer all newborns a hearing screening as a part of the obstetrical care at delivery. For more information regarding newborn hearing screening contact:

DSHS
Program for Amplification for Children of Texas (PACT)
1100 West 49th Street
Austin, TX 78756
1-512-458-7724

Refer all newborns who have abnormal screening results to a local PACT provider for follow-up care. PACT provides services and hearing aids for children ages birth through 20 years of age who have permanent hearing loss and are Medicaid-eligible.

Traditional Medicaid providers are reimbursed for the diagnosis and treatment of abnormal hearing screen follow-up when a local PACT provider is not available.

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Providers must use procedure codes 5-92585, 5/I/T-92587, and 5/I/T-92588 when billing for follow-up diagnosis of abnormal hearing screens.

Refer to: "Certified Nurse-Midwife (CNM)" on page 14-1.

10.3.1 Newborn Eligibility Process

To provide a Medicaid number to a child born to a mother eligible for Medicaid, birthing centers must complete the "Birthing Center Report (Newborn Child or Children) Form 7484" on page B-11. Use the following guidelines when completing the Form 7484:

- Enter the newborn's name on the form (if known).
- Do not complete the form for stillbirths.
- Submit the form to DSHS within five days of the child's birth. The five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child's eligibility.
- Duplicate Birthing Center Report (Newborn Child or Children) Form 7484 as needed. DSHS and TMHP do not supply this form.

Important: *The use of "Baby Boy" or "Baby Girl" delays the assignment of a Medicaid number.*

Reminder: *Birthing centers are encouraged to refer clients for THSteps services and set up referral procedures for family planning services (refer to "Family Planning Services" on page 20-1).*

Upon receipt of a completed 7484 form, DSHS verifies the mother's eligibility, and within 10 days sends notification letters to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid number and the effective date of coverage. After the child has been added to the eligibility file, DSHS issues a Medicaid Identification Form (Form H3087) to the client.

The attending physician's notification letter is sent to the address on file (by license number) at the Texas Medical Board. This address must be kept current to ensure timely notification. Physicians must submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Note: *When billing for a Medicaid Managed Care client, providers must follow the client's health plan guidelines for newborn billing.*

10.4 Claims Information

Claims for birthing center services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

10.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Instructions	5-23
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Birthing Center Claim Example	D-1
Acronym Dictionary	F-1

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Section

11

Blind Children's Vocational Discovery and Development Program

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11.4.1 Claim Filing Resources 11-2

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11.1 Enrollment

The Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS), is the Medicaid provider of case management for children younger than 16 years of age who are blind and visually impaired.

Providers must meet educational and work experience requirements that are commensurate with their job responsibilities and must be trained in DBS case management activities.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

11.1.1 Medicaid Managed Care Enrollment

DARS DBS providers do not need to enroll with Medicaid Managed Care. All claims for service provided by DARS DBS are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients.

11.2 Reimbursement

Case management services for the Blind Children's Vocational Discovery and Development Program (BCVDDP) are reimbursed according to a fixed rate as established by HHSC. DARS DBS providers should bill procedure code G9012.

Refer to: Title 1 *Texas Administrative Code* (TAC) §355.8381 for more information on reimbursement and "Federal Financial Participation (FFP) Rate" on page 2-8 for federal matching percentage.

11.3 Benefits and Limitations

Procedure code G9012 is limited to one per month, per client, regardless of the number of contacts during the month.

Reminder: *A contact is defined as "an activity performed by a Blind Children's Specialist with the client or with another person or organization on behalf of the client to locate, coordinate, and monitor necessary services."*

Refer to: "Department of Assistive and Rehabilitative Services (DARS), Blind Services" on page A-18 of this manual for local addresses of DARS DBS.

Providers must *not* bill a claim when or after the client turns 16 years of age.

Any child with a suspected or diagnosed visual impairment may be referred to BCVDDP. DARS DBS assesses the impact the visual impairment has on the child's development and provides blindness-specific services to increase the child's skill level in the areas of independent living, communication, mobility, social, recreational, and vocational discovery and development. For more information, visit the DARS website at www.dars.state.tx.us.

11.4 Claims Information

Providers must submit case management services to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

11.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP Website	5-10
Communication Guide	A-1
Blind Children's Vocational Discovery and Development Program (BCVDDP) Claim Form	D-6
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Section

12

Case Management for Children and Pregnant Women (CPW)

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12.1 Overview

Case management services are provided to assist eligible clients in gaining access to necessary medical, social, educational, and other services; encourage cost-effective health and health-related care; discourage over utilization or duplication of services; and make appropriate referrals to providers. Case managers provide the necessary coordination to providers of services when these services are needed by a client.

12.1.1 Eligibility

To be eligible for services, a person must:

- Be eligible for Medicaid.
- Be a pregnant woman with a high-risk condition, or a child (birth through 20 years of age) with a health condition or health risk.
- Be in need of services to prevent illnesses or medical conditions, to maintain function, or to slow further deterioration.
- Want to receive case management services.

Pregnant women with a high-risk condition are defined as women who are pregnant and have one or more high-risk medical and/or personal/psychosocial conditions during pregnancy. Children with a health condition are defined as children with a health condition/health risk or children who have, or are at risk for, a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

12.1.2 Referral Process

To refer a Medicaid client for Children and Pregnant Women (CPW) services, call 1-877-847-8377 or consult the CPW provider list at www.dshs.state.tx.us/caseman/providerRegion.shtm. A referral for CPW services can be received from any source. A case management provider will contact the family to offer a choice of providers and to obtain information necessary to request prior authorization for case management services.

12.2 Enrollment

Enrollment for CPW providers is a two-step process.

Step 1: Potential providers must submit a Department of State Health Services (DSHS) Case Management for Children and Pregnant Women provider application to the DSHS Health Screening and Case Management Unit.

Eligible case managers include registered nurses with a diploma, associate's, bachelor's, or advanced degree or social workers with a bachelor's or advanced degree who are currently licensed by their respective Texas licensure board and whose license is not temporary in nature. Eligible case managers must also have at least two years of cumulative, paid, full-time work experience or two years of supervised full-time, educational, internship/practicum experience in the past ten years. The experience must be with children who are up to 21 years of age and/or pregnant women. The experience must include assessing psychosocial and health needs and making community referrals for these populations.

For more information about provider qualifications and enrollment, contact DSHS at 1-512-458-7111, Ext. 2168, visit the case management website at www.dshs.state.tx.us/caseman/default.shtm, or write to the following address:

Case Management
Health Screening and Case Management Unit
1100 West 49th Street, MC-1938
Austin, TX 78756-3199

***Note:** Before providing services, each case manager must attend DSHS case manager training. Training is conducted by DSHS regional staff.*

Step 2: Upon approval by DSHS, potential providers must enroll as a Medicaid provider for CPW and submit a copy of their DSHS approval letter. Facility providers must enroll as a CPW group, and each eligible case manager must enroll as a performing provider for the group. Federally qualified health center (FQHC) facilities that provide CPW services use their FQHC number and will not apply for an additional provider number for CPW.

Refer to: "Provider Enrollment" on page 1-2 for more information about procedures for enrolling as a Medicaid provider.

12.2.1 Medicaid Managed Care Enrollment

CPW providers are not required to enroll with Medicaid Managed Care. All claims for services provided by CPW providers are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients. Medicaid Managed Care health plans are not responsible for reimbursing CPW case management program services.

12.3 Benefits and Limitations

CPW services are limited to one contact per day per client. Additional provider contacts on the same day are denied as part of another service rendered on the same day.

Providers must adhere to CPW case management program rules, policies, and procedures.

All services must be prior authorized. One comprehensive visit is approved for all eligible clients. Follow-up visits are authorized based on contributing factors. Additional visits can be requested and may be authorized based on a continuing need for services. A prior authorization number is required on all claims for CPW services.

***Note:** Prior authorization is a condition of reimbursement, not a guarantee of payment.*

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Approved case management providers may request prior authorization from DSHS by fax (1-512-458-7574) or on the website at www.dshs.state.tx.us/caseman /subpaweb.shtm.

Note: *CPW providers are not required to file claims with other health insurance before filing with Medicaid.*

Reminder: *Billable services are defined in program rule 25 Texas Administrative Code (TAC) §27.5.*

CPW services are not billable when a client is an inpatient at a hospital or other treatment facility.

Reimbursement for services rendered by providers not approved by the DSHS Health Screening and Case Management Unit will be denied.

Providers must document all services in accordance with program rule, program policy, and Medicaid policy.

12.4 Reimbursement

CPW providers are reimbursed in accordance with Title 1 TAC §355.8401. The procedure code to be used for all CPW services is G9012. Modifiers are used to identify which service component is provided.

Service	Contact Code	Maximum Fee
Comprehensive visit	1-G9012 *with* modifier U5 *and* modifier U2	$54.58
Follow-up face-to-face	1-G9012 *with* modifier U5 *and* modifier TS	$54.58
Follow-up telephone	1-G9012 *with* modifier TS	$18.00

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Medicaid payments for CPW services are subject to the 2.5 percent Medicaid payment reduction discussed in "Fee Schedules" on page 2-3.

12.5 Reporting Child Abuse or Neglect

All CPW providers are required to report suspected child abuse or neglect as outlined in "Reporting Child Abuse or Neglect" on page 1-5 and "Training" on page 1-6.

12.6 Technical Assistance

Providers may contact DSHS program staff as needed for assistance with program concerns. Providers should contact TMHP provider relations staff as needed for assistance with claims problems or concerns.

12.6.1 Assistance with Program Concerns

Providers who have questions, concerns, or problems with program rule, policy, or procedure contact DSHS program staff. Contact names and numbers can be obtained from the case management website at www.dshs.state.tx.us /caseman/default.shtm, or by calling 1-512-458-7111, Ext. 2168.

Regional staff make routine contact with providers to ensure providers are delivering services as required.

12.6.2 Assistance with Claims Concerns

Providers should review all Medicaid bulletins for any changes to claim filing requirements. Providers that have questions, concerns, or problems about claims should contact the TMHP provider relations representative in their region. Call the TMHP Contact Center at 1-800-925-9126 for more information about provider relations representatives.

12.7 Claims Information

Claims for CPW services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

12.7.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP Website	5-10
Communication Guide	A-1
Case Management for Children and Pregnant Women (CPW) Claim Example	D-7
Acronym Dictionary	F-1

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Section

13

Case Management for Early Childhood Intervention (ECI)

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13.1 Enrollment

To be a qualified provider, the provider must contact the Texas Early Childhood Intervention (ECI) Program at 1-512-424-6754. ECI providers are eligible to enroll as Texas Medicaid Targeted Case Management providers rendering service to children younger than 3 years of age with a disability and/or developmental delay as defined by ECI criteria. After meeting the case management criteria of the Texas ECI Program, providers must request a Medicaid application from TMHP Provider Enrollment.

To participate in the Texas Medicaid Program, an ECI provider must comply with all applicable federal, state, local laws, and regulations about the services provided. Additionally, facilities must be certified by the Texas ECI Program and must submit a copy of the current contract award with the Texas ECI Program.

Refer to: “Provider Enrollment” on page 1-2 for more information about enrollment procedures.

13.1.1 Medicaid Managed Care Enrollment

ECI case management providers do not need to enroll with Medicaid Managed Care. File all claims for ECI services to TMHP, including those for Medicaid Managed Care clients. Medicaid Managed Care health plans are not responsible for reimbursing ECI case management services.

13.2 Reimbursement

ECI case management services are reimbursed according to a maximum allowable fee established by HHSC. The maximum allowable fee for procedure code 1-G9012 is $141.83 per month. Payment for procedure code 1-G9012 was excluded from the 2.5 percent Medicaid payment reduction effective September 1, 2003.

Refer to: “Reimbursement” on page 2-2 for more information on reimbursement.

Reimbursement for public providers is limited to the federal matching percentage of the maximum allowable fee and is subject to adjustment on October 1 of each year, or as otherwise directed by the Centers for Medicare & Medicaid Services (CMS). Reimbursement for private providers is up to the maximum allowable fee.

The Texas Medicaid Program reimburses covered ECI services when provided in natural environments. Natural environments are defined as settings that individual families identify as natural or normal for their family, including the home, neighborhood, and community settings in which children without disabilities participate. ECI case management services may be provided in the following places of service (POS): office/facility (POS 1), home (POS 2), and other locations (POS 9). POS for ECI case management is determined by the case manager’s location at the time the service is rendered.

13.3 Benefits and Limitations

ECI providers are reimbursed for case management services rendered to children younger than 3 years of age with a disability and/or developmental delay as defined by ECI criteria.

Case management services must be stated in the child’s Individualized Family Service Plan (IFSP).

Important: *ECI services end on the child’s third birthday.*

Reminder: *A contact is defined as an activity performed by the assigned case manager with the client or with another person or organization on behalf of the client to locate, coordinate, and facilitate access to necessary services.*

13.4 Referral Requirements for Children with Disabilities or Developmental Delays

ECI is a statewide system of services available to families of children from birth to 3 years of age with disabilities or developmental delays. The state agency responsible for ECI services is the Department of Assistive and Rehabilitative Services (DARS). DARS contracts with local ECI programs to provide services in every Texas county.

All health care professionals are required under federal and state regulations to refer children younger than 3 years of age to ECI within two business days of identification of a disability or suspected delay in development.

Referrals may be based on professional judgment or a family’s concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

ECI programs determine eligibility on referrals based on no-cost evaluations and assessments. Children are eligible if they meet one or more of the following criteria:

- A delay in one or more areas of development
- Atypical development (children who perform within their appropriate age range on test instruments, but whose patterns of development are different from their peers)
- A medically diagnosed condition (children who have a medically diagnosed condition with a high probability of resulting in developmental delay)

Families and professionals work together to develop an IFSP for appropriate services based on the unique needs of the child and the child’s family.

ECI case management services are provided at no cost to families. Other services may include physical, occupational, speech, and language therapy; service coordination; vision services; auditory services; developmental services; nutrition services; family counseling and education; and assistive technology services and devices.

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To refer families for services, call the local ECI Program or the DARS Inquiries Line at 1-800-628-5115. For brochures or more information, call the DARS Inquiries Line or visit the DARS website at www.dars.state.tx.us/ecis.

Refer to: "Early Childhood Intervention (ECI) (THSteps-CCP Only)" on page 43-53 for additional services.

13.5 Claims Information

Services by an ECI provider must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

13.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP Website	5-10
Communication Guide	A-1
Case Management for Early Childhood Intervention (ECI) Claim Example	D-6
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Certified Nurse-Midwife (CNM)

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14.1 Enrollment

To enroll in the Texas Medicaid Program, a certified nurse-midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners for the State of Texas as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives. A current copy of the provider's American College of Nurse-Midwives Certificate must be submitted with the Medicaid provider enrollment application. A CNM must also be enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

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

Effective September 1, 2005, CNMs must use their individual provider identifier to bill for services they provide to Medicaid clients.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendment's (CLIA) rules and regulations. Providers not complying with CLIA are not reimbursed for laboratory services.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. The collaborating physician does not have to be a participating provider in the Texas Medicaid Program. If the arrangement is changed or canceled, the CNM must notify TMHP Provider Enrollment in writing within two weeks after the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

CNMs may enroll as providers of Texas Health Steps (THSteps) medical checkups for newborns younger than two months of age and adolescent females. Specific information may be found in the THSteps section of this manual.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Provider Enrollment" on page 43-5 for more information about enrollment in the THSteps Program.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

"Family Planning Services" on page 20-1.

14.1.1 Medicaid Managed Care Enrollment

CNMs are eligible to enroll in Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

14.2 Reimbursement

According to Title 1 *Texas Administrative Code* (TAC) §355.8281, the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current CNM fee schedule is available on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

14.3 Benefits and Limitations

CNMs may be reimbursed for primary care services including family planning, gynecology services, treatment of acute minor illnesses, chronic stable conditions provided to women throughout their lives, and to newborns for the first two months of life in addition to the maternity cycle care (antepartum, intrapartum, and postpartum).

CNM-performed services are covered by the Texas Medicaid Program if the services are within the scope of practice for CNMs as defined by state law, consistent with rules and regulations made by the Texas Board of Nurse Examiners or other appropriate state licensing authority, and provided by a licensed physician (MD or DO).

Important: *Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and received within 95 days from the date of service.*

14.3.1 Deliveries

Procedure code 2-59410 must be performed in a participating Medicaid Title XIX general or acute care hospital or special hospital or facility licensed and approved for the operation of maternity and newborn services. Home deliveries by a CNM are reimbursable when the CNM has received prior authorization from TMHP for a home delivery. The CNM must submit a written request for prior authorization during the client's third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

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Home deliveries performed by a CNM without prior authorization are denied.

Important: *Childbirth education classes are not a benefit of the Texas Medicaid Program.*

Reminder: *CNMs must bill procedure code 59410 with type of service (TOS) 2.*

14.3.2 Newborn Exams

CNMs must bill procedure code 1-99431 or 1-99432 if all minimum requirements of an initial newborn examination are performed. If the provider chooses to perform a brief examination (that does not include all the components listed), the provider bills the procedure code 1-99431 or 1-99432 with modifier 52, which does not count as a THSteps checkup. One code may be billed once in a lifetime for each newborn.

A THSteps newborn screening exam includes family and neonatal history:

- Physical exam, including length, weight, and head circumference
- Vision and hearing screening
- Health education
- State-required newborn hereditary/metabolic laboratory testing
- Hepatitis B immunization

A $5 fee is paid for each vaccine administered.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for information about THSteps-CCP Program.

Bill antepartum/postpartum services using the following codes and modifier TH:

Procedure Code/Modifier	
1-99201-TH	1-99202-TH
1-99203-TH	1-99204-TH
1-99205-TH	1-99211-TH
1-99212-TH	1-99213-TH
1-99214-TH	1-99215-TH
1-99341-TH	1-99342-TH
1-99344-TH	1-99345-TH

Refer to: "Maternity Service Clinic (MSC)" on page 31-1 for more information about antepartum care, risk assessment, document requirements, postpartum care, and frequency of services.

"Family Planning Services" on page 20-1 for more information.

14.4 Claims Information

Submit claims for CNM services to TMHP in an approved electronic format or on a CMS-1500 claim form.

All services must be filed using the nine-character CNM provider identifier regardless of the employment arrangements (e.g., physician-, hospital-, or birthing center-employed).

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

Refer to: "General Medicaid Eligibility" on page 4-3 for information about crossover payments.

14.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP Website	5-10
Communication Guide	A-1
Certified Nurse-Midwife (CNM) Claim Example	D-7
Acronym Dictionary	F-1

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Section

15

Certified Registered Nurse Anesthetist (CRNA)

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15.1 Enrollment

To enroll in the Texas Medicaid Program, a certified registered nurse anesthetist (CRNA) must be a registered nurse (RN) approved as an advance practice nurse (APN) by the state where he practices and is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider's Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Refer to: “Provider Enrollment” on page 1-2 for more information about enrollment procedures.

15.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: “Managed Care” on page 7-1 for more information.

15.2 Reimbursement

A CRNA is reimbursed the lesser of either the CRNA's billed charges or 92 percent of the reimbursement for the same sevice paid a physician (MD or DO) anesthesiologist in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8221. The current CRNA fee schedule is available on the TMHP website at www.tmhp.com. To request a copy, call the TMHP Contact Center at 1-800-925-9126.

CRNAs are eligible for high-volume provider payments as specialists in accordance with “Additional Payments to High-Volume Providers” on page 2-6. Medicaid payments to CRNAs are subject to the 2.5 percent Medicaid payment reduction discussed in “Professional Providers and Outpatient Facilities Reimbursement Reduction” on page 2-6.

The following is an example of Texas Medicaid Reimbursement Methodology for CRNA services:

CRNA Reimbursement Methodology	
Time = 120 min, modifier = QX(15)	120/15 = 8 (quantity billed)
Date of service	06/01/02
Procedure code	7-00851 with 6.00 base units + 8 = 14.00
Conversion factor	14.00 x $18.21 = $254.94 (physician reimbursement before 2.5 percent Medicaid payment reduction)
$254.94 x 92%	$234.54 (CRNA reimbursement before 2.5 percent Medicaid payment reduction)

Refer to: “Reimbursement” on page 2-2 for more information about reimbursement.

15.2.1 Base Units

Base units are the RVUs assigned by Texas Medicaid to each anesthesia service billed. The Texas Medicaid Program uses the uniform relative value guide generated by the Texas Medicare Program.

Refer to: Base units assigned to each Current Procedural Terminology (CPT) anesthesia code can be found in the *Texas Medicaid Fee Schedule* posted on the TMHP website.

Important: *For correct processing, providers must bill anesthesia services (type of service [TOS] 7) as the first line item. Any other service billed on the same day must be billed as a subsequent line item.*

15.2.2 Time Units

Time Units are based on the time in minutes indicated on the claim by the provider, divided by 15-minute increments.

Refer to: “Anesthesia for Labor and Delivery” on page 36-24

For continuous epidural analgesia, the Texas Medicaid Program reimburses for the time when the anesthesia provider is physically present and monitoring the continuous epidural. Reimbursable time refers to the time period between the catheter insertion and the commencement of delivery. Claims for procedure codes 7-01967, 7-01968, and 7-01969 must indicate the time spent administering the epidural and the actual time spent with the client. Insertion and injection of the epidural are not reimbursed separately.

An anesthesia provider who administers epidural anesthesiology and remains with the client throughout labor and delivery or Cesarean section should combine all charges with the appropriate CPT anesthesia code (7-01967 for vaginal delivery or 7-01968 for Cesarean section). The claim must reflect the actual time spent administering the

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epidural and the actual time spent with the client in the delivery and/or operating room. If the anesthesiologist administers the epidural and leaves the client to return at a later time for the delivery or Cesarean section, the time not spent with the client is not reimbursable.

Note: *The anesthesia provider must be physically present in the room to bill for actual time spent with the client.*

15.2.3 Interpreting the R&S Report

The Billed Qty field on the Remittance and Status (R&S) report reflects only the number of units TMHP processed for time. The RVUs assigned for the procedure code are not shown in the Billed Qty field.

15.3 Benefits and Limitations

Reasonable and medically necessary services performed by a CRNA are covered if the services are within the scope of the CRNA's practice, as defined by state law; prescribed and supervised by and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice; or provided under one of the following conditions:

- No physician anesthesiologist is on the medical staff of the facility where the services are provided (e.g., rural settings).
- No physician anesthesiologist is available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician performing the procedure requiring the services specifically requests the services of a CRNA.
- The eligible client requiring the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

The Texas Medicaid Program does not reimburse the CRNA for equipment, drugs, or supplies—they are the responsibility of the facility where the CRNA services are provided. If the equipment, drugs, and supplies are covered and reimbursable by the Texas Medicaid Program, payment is considered for the Medicaid-enrolled facility. The basis and amount of reimbursement depends on the reimbursement methodology used by the Texas Medicaid Program for the services and providers involved.

15.3.1 Claims Management Modifiers

CRNAs bill using CPT anesthesia procedure codes and either the QX or QZ modifier.

Refer to: "Anesthesia" on page 36-24 for more information on the reimbursement of anesthesia services.

15.3.2 Epidurals, Blood Patch

Procedure code 2-62273 is payable to provider types 04 (independent CRNA) and 05 (independent CRNA group).

15.4 Claims Information

All CRNA services *must* be billed with a CRNA individual provider identifier or a CRNA group provider identifier. *No* payment for CRNA services will be made under a hospital or physician provider identifier.

Providers are to submit CRNA services to TMHP in an approved electronic format or on a CMS-1500 claim form.

Refer to: "Client Eligibility" on page 4-1 for information on crossover payments.

15.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP Website	5-10
Communication Guide	A-1
Certified Registered Nurse Anesthetist (CRNA) Claim Example	D-8
Acronym Dictionary	F-1

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Section

16

Certified Respiratory Care Practitioner (CRCP) Services

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16.1 Enrollment

To enroll in the Texas Medicaid Program, a certified respiratory care practitioner (CRCP) must be certified by the Department of State Health Services (DSHS) to practice under *Texas Occupation Code*, Chapter 604. Medicare certification is not a prerequisite for Medicaid enrollment.

A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted.

CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

16.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

16.2 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider's billed charges or the rate calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8089, which is $66.68 per daily visit for procedure code 1-99503.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

16.3 Benefits and Limitations

TMHP must prior authorize all in-home respiratory therapy services.

Respiratory therapy services provided by a Medicaid provider enrolled as a CRCP may be reimbursed when services are reasonable, medically necessary, and prescribed by the client's physician. These services are for all age groups and do not require the client to be homebound.

Medicaid coverage of CRCP services is available to clients who meet the following criteria:

- Are ventilator-dependent for life support at least six hours per day
- Are ventilator-dependent for at least 30 consecutive days as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF)
- Require respiratory care as an inpatient in a hospital, SNF, or ICF and would be eligible to have payment made for such inpatient care
- Have adequate social support services available for care at home
- Prefer care at home

16.3.1 Procedure Codes

Procedure code 1-99503 is allowable for CRCP services.

The recommended frequency for procedure code 1-99503 is as follows: one visit daily for the initial seven days of home ventilation therapy; one visit every fourth day through the initial 30 days of home ventilation therapy; and one visit every four weeks thereafter.

Procedure code 1-99503 includes, but is not limited to, the following:

- Respiratory therapy services and treatments prescribed by the client's physician
- Education of the client and/or appropriate family members/support people about the in-home respiratory care (must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation)

Important: *Procedure code 1-99503 may be reimbursed once per day, up to 24 visits per year.*

16.3.2 Prior Authorization

The CRCP must request and receive prior authorization from TMHP for in-home respiratory therapy services. Prior authorization requests must include the dated physician's order, all pertinent medical records, and other information to justify the medical necessity/dependency of ventilator support and/or requested therapy services. Authorization may be given for up to 12 months and may be extended based on an interim report from the physician that documents the medical necessity and appropriateness of continued in-home respiratory therapy services.

All supporting documentation must be included with the request for authorization. Providers should send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-A Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

16.4 Claims Information

CRCP services must be submitted to TMHP in an approved electronic claims format or on an CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

Important: *Electronic billers must submit the Prior Authorization Number (PAN) on the electronic claim form. Providers should consult the software vendor for the location of this field in the software.*

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16.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP website	5-10
Communication Guide	A-1
Certified Respiratory Care Practitioner (CRCP) Claim Example	D-8
Acronym Dictionary	F-1

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Section

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Chemical Dependency Treatment Facility (CDTF)

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17.2 Reimbursement 17-2
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17.4 Claims Information 17-2
  17.4.1 Claim Filing Resources 17-3

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17.1 Enrollment

Only chemical dependency treatment facilities (CDTFs) licensed by the Department of State Health Services (DSHS) are eligible to enroll and participate in the Texas Medicaid Program. Each facility must submit a copy of its DSHS license with the enrollment packet. State and federally-owned facilities are exempt from the licensing requirement.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

17.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll in Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. A CDTF that provides behavioral health services to clients in NorthSTAR must be a network provider of the NorthSTAR behavioral health organization.

Refer to: "Managed Care" on page 7-1

17.2 Reimbursement

Chemical dependency treatment facilities are reimbursed the lesser of the billed amount or the established maximum allowable fee.

The Texas Medicaid Program covers outpatient counseling services for chemically dependent children and adolescents. The Texas Medicaid Program provides reimbursement for the following outpatient counseling services with modifier HF, Substance abuse program:

Procedure Code	Maximum Fee
9-H0004	$11.75
9-H0005	$16.00

Reimbursable procedure codes that are available to the CDTF/DSHS provider type include 9-H0004 with modifier HF and 9-H0005 with modifier HF. Procedure code 9-H0004 is billed in 15-minute intervals. Procedure code 9-H0005 is billed in 1-hour increments.

Refer to: "Reimbursement" on page 2-2 for more information.

17.3 Benefits and Limitations

17.3.1 Outpatient Counseling

CDTF services must be rendered in accordance with the DSHS Chemical Dependency Treatment Facility Licensure Standards. Eligibility for services and the specific services to be provided must be determined by a qualified credentialed counselor (QCC), as defined by DSHS. To be eligible for admission to a chemical dependency treatment program, an individual must meet the criteria for substance abuse or substance dependence as defined in the latest edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Sufficient documentation must be maintained in the client record to support the diagnosis and justify the placement decision into the program.

The Texas Medicaid Program covers outpatient counseling services for chemically dependent children and adolescents who are 13 through 17 years of age.

Children who are 10 through 12 years of age and young adults who are 18 through 20 years of age may receive chemical dependency outpatient counseling services only when the assessment indicates that the individual's needs, experiences, and behavior are similar to those of adolescent clients. Every age exception must be clinically justified, documented, and approved in writing by a QCC. Supporting documentation, including written approval by the QCC, must be maintained by the facility in the client record.

Outpatient group counseling is limited to 135 hours per client, per calendar year (January 1 through December 31). Outpatient individual counseling is limited to 26 hours per client, per calendar year. Outpatient group and individual counseling is only payable in the outpatient setting, and place of service (POS) code 5 should be indicated on the paper claim. Clients in an inpatient status, such as residing in a DSHS facility, are *not* eligible for these outpatient services.

Modifier HF is required on all procedures billed by CDTF/DSHS.

17.4 Claims Information

Chemical dependency treatment services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

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17.4.1 Claim Filing Resources

Important: *Electronic billers must bill POS code 22 in the appropriate field and must submit their own nine-character provider identifier in the facility ID field. Providers should consult with their software vendor for the location of this field in the software.*

Refer to the following sections and/or forms when filing claims:

Resource	Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Chemical Dependency Treatment Facility Claim Example	D-9
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Section

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Chiropractic Services

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18.4 Claims Information 18-3
18.4.1 Claim Filing Resources 18-3

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18.1 Enrollment

To enroll in the Texas Medicaid Program, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled, if their license is due to expire within 30 days; a current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

18.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

18.2 Reimbursement

The Medicaid rates for chiropractic services are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8085.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

18.3 Benefits and Limitations

Medicaid reimburses the treatment of a spinal subluxation by manual manipulation of the spine. The exact level of subluxation must be indicated by the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code listed in the following table or narrative. Chiropractors are not required to certify that an X-ray is available to demonstrate the existence of a subluxation. However, chiropractors may choose to use an X-ray for this purpose.

Providers who choose to document a subluxation by X-ray may refer to the following guidelines:

- An acute condition is documented by an X-ray taken no more than three months before the date treatment is initiated.
- A chronic condition is documented by an X-ray taken no more than 12 months before the initiation of treatment.
- An older X-ray may be used if the subluxation has existed for more than 12 months and is considered a chronic and permanent condition.

The following diagnoses are accepted in lieu of written documentation to indicate treatment of subluxation and the level:

Diagnosis Code	Description
7390	Nonallopathic lesions of head region, not elsewhere classified
7391	Nonallopathic lesions of cervical region, not elsewhere classified
7392	Nonallopathic lesions of thoracic region, not elsewhere classified
7393	Nonallopathic lesions of lumbar region, not elsewhere classified
7394	Nonallopathic lesions of sacral region, not elsewhere classified
7395	Nonallopathic lesions of pelvic region, not elsewhere classified
7398	Nonallopathic lesions of rib cage, not elsewhere classified
83900	Closed dislocation, cervical vertebra, unspecified
83901	Closed dislocation, first cervical vertebra
83902	Closed dislocation, second cervical vertebra
83903	Closed dislocation, third cervical vertebra
83904	Closed dislocation, fourth cervical vertebra
83905	Closed dislocation, fifth cervical vertebra
83906	Closed dislocation, sixth cervical vertebra
83907	Closed dislocation, seventh cervical vertebra
83908	Closed dislocation, multiple cervical vertebra
83920	Closed dislocation, lumbar vertebra
83921	Closed dislocation, thoracic vertebra
83949	Closed dislocation, other vertebra

Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions.

Coverage includes up to 12 treatments per benefit period. For chiropractic services, *a benefit period* is defined as "12 consecutive months, beginning with the date the client receives the first Medicaid-covered chiropractic treatment." Benefits cannot exceed one treatment per day.

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Coverage is limited to the following procedure codes:

Procedure Code	Place of Service	Maximum Fee
1-98940	1, 2	$20.46
1-98941	1, 2	$25.91
1-98942	1, 2	$31.91

The AT modifier is *required* to identify acute CMT services.

Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients are excluded from chiropractic limitations. When chiropractic services are billed for these clients, the service is denied with instructions to bill Medicare first.

18.4 Claims Information

Chiropractic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

18.4.1 Claim Filing Resources

Providers may refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Chiropractic Services Claim Example	D-9
Acronym Dictionary	F-1

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Section

19

Dental

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19.1 Communication with TMHP

For assistance with claims or client eligibility questions, dental providers may contact a TMHP call center representative on the Dental Inquiry Line or access the Automated Inquiry System (AIS).

19.1.1 Dental Inquiry Line

The Dental Inquiry Line (1-800-568-2460) is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about dental services and appeals.

Any dental service claim denial may be appealed by telephone if it was *not* denied as an incomplete claim and does not require one of the following items or conditions:

- Narratives
- Radiographs
- Models
- Other tangible documentation
- Review by the TMHP Dental Director

19.1.2 AIS

AIS (1-800-925-9126, Option 1) is available 7 days a week, 23 hours a day, with scheduled downtime between 3 a.m. and 4 a.m., and is the main point of contact for client eligibility.

Refer to: "Automated Inquiry System (AIS)" on page xiii for more information. AIS requires a touch-tone telephone.

19.1.3 TMHP Website

Additional information about Medicaid enrollment, general customer service, and provider education/training is available on the TMHP website at www.tmhp.com.

19.1.4 Texas Health Steps (THSteps) and Intermediate Care Facility for the Mentally Retarded (ICF–MR) Dental Prior Authorization

Submit claims, dental correspondence, and THSteps and ICF-MR prior authorization requests to the appropriate address listed in the table below:

Correspondence	Address
American Dental Association (ADA) dental claim forms	Texas Medicaid & Healthcare Partnership PO Box 200555 Austin, TX 78720-0555
All dental correspondence Prior authorization requests	Texas Medicaid & Healthcare Partnership THSteps and ICF-MR Dental Authorization PO Box 202917 Austin, TX 78720-2917

19.2 General Information

Medicaid dental services rules are described under Title 25 *Texas Administrative Code* (TAC) Part 1, Chapter 33, Subchapter G, §§33.301–33.311, §§33.314–33.315, §§33.317–33.320, Subchapter H, §33.331, §33.334, and §§33.351–33.358. The online version of TAC is available at the Secretary of State's website at www.sos.state.tx.us/tac/index.shtml.

19.2.1 THSteps

A broad range of dental services is available to THSteps-eligible clients, including emergency, diagnostic, preventive, therapeutic, and orthodontic services.

Refer to: "THSteps Dental Services" on page 19-5.

19.2.2 Client Rights

Dental providers enrolled in the Texas Medicaid Program enter into a written contract with the HHSC to uphold the following rights of the Medicaid client:

- To receive dental services that meet or exceed the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the Texas State Board of Dental Examiners (TSBDE).
- To receive information following a dental examination regarding the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need for administration of sedation or anesthesia, including risks.
- To have full participation in the development of the treatment plan and the process of giving informed consent.
- To have freedom from physical, mental, emotional, sexual, or verbal abuse or harm from the provider or staff.
- To have freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

Important: *A provider's failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.*

19.2.3 Reporting Child Abuse or Neglect

All THSteps providers are required to report suspected child abuse or neglect as outlined in "Reporting Child Abuse or Neglect" on page 1-5 through "Training" on page 1-6.

19.2.4 Complaint Management System

The program receives and documents complaints from any source and refers them to the appropriate entity for

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investigation. Examples of complaints from clients regarding providers include:

- The provider did not consult with the client, explain what services were necessary, or obtain parent/guardian informed consent.
- The treating provider refused to make the child's record available to the new provider.
- The provider did not give the child enough/any local anesthesia or pain medication.
- The provider did not use sterile procedures; the facility and/or equipment were not clean.
- The provider and/or his staff was verbally abusive.
- The client did not receive a service, but the provider billed Medicaid.
- The provider charged a Medicaid client for covered benefits.

19.2.5 ICF-MR

A broad range of preventive and therapeutic dental services is available to Medicaid-eligible residents of ICF-MR facilities who are 21 years of age or older.

Refer to: "ICF-MR Dental Services" on page 19-7.

19.2.6 Emergency Services

A limited range of services is available, with prior authorization, for Medicaid eligibles of *any age* who have a dental-related problem that is secondary to a life-threatening medical problem.

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 36-335 for complete description and details.

19.2.7 Long Term Care (LTC) Emergency Dental Services

The Department of Aging and Disability Services (DADS) provides a limited range of dental services for Medicaid-eligible residents of LTC facilities. For information, providers should contact the appropriate LTC facility or DADS at 1-512-438-2633.

19.3 Provider Enrollment

To become a provider of THSteps or ICF-MR dental services, a dentist must:

- Currently be licensed by the TSBDE or currently be licensed in the state where the service was performed
- Practice within the scope of his professional licensure
- Complete the Dental Provider Enrollment Application and return it to TMHP

Call the TMHP Contact Center at 1-800-925-9126 to request application forms, or download them from the TMHP website at www.tmhp.com. Out-of-state providers should refer to Section 2.5 "Medicaid Service Provided Outside Texas".

A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted. Dental licensure for owners of a dental practice is a requirement of the Occupations Code, *Vernon's Texas Codes Annotated (VTCA),* Subtitle D, Chapters 251-267 (the *Dental Practice Act*).

A dentist must complete the Dental Provider Enrollment Application for each separate practice location and will receive a unique provider identifier if the application is approved.

The application form includes a written agreement with HHSC.

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 19-50 for information on Doctor of Dentistry enrollment.

19.3.1 Provider Enrollment Requirements

Providers interested in enrolling in the Texas Medicaid Program must be actively licensed with the TSBDE or other state where services are provided. Dental licensure for owners of a dental practice is a requirement of the *Dental Practice Act*. All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Medicaid. Any change in ownership or licensure must be reported in writing to TMHP Provider Enrollment.

Dental providers may enroll in the THSteps Dental and ICF-MR Dental Programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. The enrollment requirements are different with respect to the category of enrollment.

Dentists must specify a category of practice by choosing one of the specialties listed in "Categories of Practice" on page 19-5 of this manual.

Changes of licensure status or category of practice must be reported immediately and will affect reimbursement by the Medicaid program.

Refer to: "Maintenance of Provider Information" on page 1-6.

"Provider Enrollment" on page 1-2.

19.3.1.1 THSteps Dental Checkup/Treatment Facilities

All THSteps dental checkup/treatment policies apply to examinations and treatment completed in a dentist's office, a health department, clinic setting, or in a mobile/satellite unit. *Enrollment of a mobile/satellite unit must be under a dentist or clinic name*. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities. The physical setting must be appropriate so that all elements of the checkup/treatment can be completed. The checkup must meet the requirements detailed in

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"Parental Accompaniment" on page 19-39. The provider with a mobile unit must obtain a permit from the TSBDE for the unit.

19.3.1.2 THSteps Dental and ICF-MR

Providers may enroll as a group practice or as an individual dentist.

The individual dentist must designate that primary services will be provided within a specific category of practice.

Regardless of the category of practice type designation under THSteps Dental, providers can only bill for THSteps/ICF-MR services.

Refer to: "Categories of Practice" on page 19-5.

"THSteps" on page 19-3 for more information on the services that are reimbursable.

19.3.1.3 Doctor of Dentistry Practicing as a Limited Physician

Providers may enroll as a dental group or as an individual dentist.To enroll as a Doctor of Dentistry Practicing as a Limited Physician, a dentist must:

- Currently be licensed by the TSBDE or currently be licensed in the state where the service was performed at that time
- Have a *Medicare* provider identification number before applying for and receiving a *Medicaid* provider identifer
- Enroll as a Medicaid provider with a limited physician provider identifier

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 36-335 for a complete description and details.

19.3.1.4 Categories of Practice

All dental providers must declare one of the following categories:

- General practice
- Pediatric dentist
- Periodontist
- Endodontist
- Oral and maxillofacial surgeon
- Orthodontist
- Other (prosthodontist, public health, and others)

19.3.2 THSteps and ICF-MR Provision of Services

All THSteps and ICF-MR dental services shall be performed by the enrolled provider except for permissible work done by a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices, or in a commercial laboratory registered with the TSBDE. The *Texas Dental Practice Act* and the rules and regulations of the TSBDE (22 TAC, Part 5) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

***Note:** According to federal Medicaid guidelines, dental services that are not covered under the THSteps Dental Program that are medically necessary, and for which Federal Financial Participation (FFP) is available, may be considered for THSteps-eligible clients through the Comprehensive Care Program (CCP).*

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

19.4 Medicaid Managed Care Enrollment

THSteps, ICF-MR, and emergency dental service providers do not need to enroll in Medicaid Managed Care.

All claims for services provided by a dentist for THSteps and ICF-MR clients are submitted to TMHP.

All claims for emergency dental services provided to LTC residents are submitted to DADS.

If the client is enrolled in Medicaid Managed Care, the dentist *must request precertification* or approval from the client's Managed Care Organization (MCO) for anesthesia, facility use, and charges. *The dentist must use the MCO's contracted facility and anesthesia provider.* These services are included in the capitation rates paid to health maintenance organizations (HMOs), and the facility/ anesthesiologist risks nonpayment from the HMO without such prior approval. Coordination of all specialty care is the responsibility of the client's primary care provider. The primary care provider must be notified by the dentist and/ or the MCO of the planned services.

19.5 THSteps Dental Services

THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients younger than 21 years of age. THSteps dental service standards were designed to meet federal regulations and incorporate the recommendations of representatives of dental professional organizations in the state.

The *Omnibus Budget Reconciliation Act* (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available, regardless of the limitations of the Texas Medicaid Program. This expansion is referred to as CCP.

Refer to: "THSteps Medical and Dental Administrative Information" on page 43-5 for more information.

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19.5.1 How the Program Works

THSteps' designated staff (Texas Department of State Health Services [DSHS], DADS, or contractor), through outreach and information, encourage eligible children to use THSteps dental checkups and prophylactic care when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

A message (THSteps Dental Checkup Due) will appear on the client Medicaid Identification Form (Form H3087) under the child's name when a child is eligible for a THSteps Dental checkup but has not been seen within the last 6 months. This message is intended as a reminder to the parent, not the provider, that the child is due for a periodic dental checkup. The absence of such a message means that a dental provider has provided the child a periodic dental checkup within the last 6 months.

Important: *The provider may provide other covered services to a client as long as the client's Medicaid eligibility is current for that month.*

Children within regular Medicaid have free choice of Medicaid-enrolled providers and are given names of enrolled providers. Call 1-877-847-8377 for a list of THSteps dental providers in a specific area.

Upon request, DSHS (or its contractor) will assist eligible children with scheduling and free transportation to their dental appointment. For transportation arrangements, clients can call the Medical Transportation Program at 1-800-633-8747.

Note: *Children younger than 15 years of age must be accompanied by the child's parent, legal guardian, or other family member, at all dental visits. For additional information and exceptions, see "Parental Accompaniment" on page K-2.*

19.5.2 Dental Referrals

Routine Dental Referrals

Children may receive THSteps dental periodic checkups beginning at 12 months of age, and every 6 months thereafter through 20 years of age. Children younger than 12 months of age are not eligible for *routine* dental examinations; however, they may be referred when a medical checkup identifies the medical necessity for dental services. Children younger than 12 months of age also can be seen for emergency dental services by the dentist at any time for trauma, baby bottle tooth decay, or other oral health problems, such as early childhood caries (cavities).

If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnosis or treatment, the provider performing the dental checkup should assist the client in planning follow-up care or in making a referral to the qualified provider. This manual provides information regarding covered benefits, getting assistance to identify qualified providers, and how to code and bill for services covered by the THSteps, THSteps-CCP, or traditional Medicaid programs.

If the client is enrolled in a Medicaid Managed Care HMO, the dental care will be provided by fee-for-service providers; however, other providers, such as the facility and anesthesiology care, must be HMO network providers or pre-approved by the HMO.

Note: *Clients up to 21 years of age also may self-refer for dental services.*

19.5.3 THSteps Dental Eligibility

The client must be Medicaid- and THSteps-eligible (younger than 21 years of age) at the time of the service request and service delivery. However, orthodontic services already in progress may be continued even after the client loses Medicaid eligibility if treatment is begun before the 21st birthday and is completed within 36 months. The client is *not* eligible for THSteps dental preventive or therapeutic benefits if the client's Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027 A-C) states *any* of the following:

- Emergency care only
- Presumptive eligibility (PE)
- Qualified Medicare beneficiary (QMB)

A client is eligible for oral evaluations and preventive dental services beginning at 12 months of age and once every 6 months thereafter. A message appears below the client's name on the monthly client Medicaid Identification Form (Form H3087) stating the client is due for a dental checkup, which is a reminder to parents.

Emergency and orthodontic services can be provided within the guidelines specified for each area.

Clients are not eligible for CCP services on or after their 21st birthday, but are eligible for non-CCP THSteps dental services (see fee schedule for CCP and non-CCP reimbursed services) through the end of the month of their 21st birthday.

Note: *If a client has a birthday on any day except the first day during the month, the new eligibility period is considered to begin on the first day of the following month.*

Refer to: "Medicaid Identification Form H3087" on page 4-18.

"Emergency Services" on page 19-4 and "Doctor of Dentistry Practicing as a Limited Physician" on page 36-335.

"Orthodontic Procedure Codes and Fee Schedule" on page 19-43.

"Medicaid Dental Fee Schedule" on page 19-9.

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19.6 ICF-MR Dental Services

ICF-MR dental services are mandated by Medicaid, and reimbursement is provided for treatment of dental problems for Medicaid-eligible residents of ICF-MR facilities who are 21 years of age or older. Residents of ICF-MR facilities who are younger than 21 years of age receive services through the regular THSteps Program. Eligibility for ICF-MR services is determined by DADS.

Procedure codes without a CCP designation in the *Limitations* column of the dental fee schedule may be billed in a routine manner for ICF-MR clients.

These procedures must be documented as medically necessary and appropriate. ICF-MR clients are *not* subject to periodicity for preventive care.

Important: *For procedure codes with a CCP designation, a provider may request authorization with documentation or provide documentation on the submitted claim.*

Refer to: "Texas Health Steps (THSteps) and Intermediate Care Facility for the Mentally Retarded (ICF–MR) Dental Prior Authorization" on page 19-3 for questions about ICF-MR services.

"Medicaid Dental Fee Schedule" on page 19-9.

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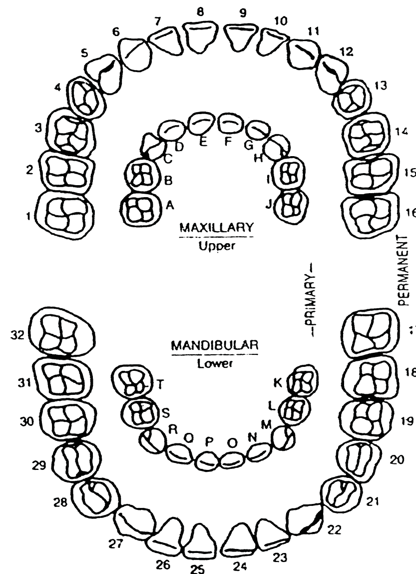
19.7 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID and/or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. 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	

19.7.1 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the *Current Dental Terminology* (CDT) published by the ADA.

The TID for each identified supernumerary tooth will be used for paper and electronic claims and can only be billed with the following procedure codes:

- For primary teeth only: D7111
- For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510

Permanent Teeth Upper Arch																
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Super #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Permanent Teeth Lower Arch																
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Super #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Primary Teeth Upper Arch										
Tooth #	A	B	C	D	E	F	G	H	I	J
Super #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Primary Teeth Lower Arch										
Tooth #	T	S	R	Q	P	O	N	M	L	K
Super #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

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19.8 Benefits and Limitations

All dental providers must comply with the rules and regulations of the TSBDE, including standards for documentation and record maintenance as stated in the TSBDE Rules 22 TAC §108.7, *Minimum Standard of Care, General*, and §108.8, *Records of the Dentist*.

19.8.1 Medicaid Dental Fee Schedule

For THSteps clients, procedure limitations may be waived when *all* the following have been met:

- Medically necessary and for which FFP is available
- Prior authorized by the TMHP Dental Director
- Properly documented in the client's record (refer to "Documentation Requirements" on page 19-39)

Important: *For ICF-MR clients, services designated as CCP-type are available.*

In the *Limitations* column of the fee schedule, abbreviations indicate the age range limitations and documentation requirements.

The following abbreviations also appear in a table at the bottom of each page of the fee schedule:

Acronym	Description
A	Age range limitations
CCP	Payable under CCP for clients younger than 21 years of age when THSteps benefits or limits are exceeded
FMX	Intraoral radiographs—complete series
FQHC	Federally qualified health center
MTID	Missing tooth ID(s)
N	Narrative of medical necessity of procedure is required to be retained in the client's record
NC	No charge to Medicaid and may not bill the client
PATH	Pathology report to accompany claims and required to be retained in the client's record
PC	Periodontal charting is required to be retained in the client's record
PHO	Pre- and post-operative photographs required
PPXR	Pre- and post-operative radiographs are required and are to be retained in the client's record; do not send with initial claims
PXR	Preoperative radiographs are required and are to be retained in the client's record; do not send with initial claims

19.8.2 Diagnostic

Procedure Code	Limitations	Maximum Fee
	Clinical Oral Evaluations	
All evaluations are subject to a six-month periodicity, per provider.		
D0120*	Exam performed subsequent to the initial exam with a recall prophylaxis or periodic six-month examination. A 1-20	$14.72
D0140*	An evaluation for a specific oral health problem. When used for emergency claims, the appropriate block must be checked. ET modifier required for electronic claims. A 1-20, N	$19.16
D0150*	May be billed *once* in client's lifetime per provider. A 1-20	$18.02

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
D0160*	Problem-focused detailed and extensive, by report. Not payable for routine post-op follow-up. A 1-20, N, CCP	$15.25
D0170*	A 1-20	$16.88
D0180*	Limited to once per lifetime per provider; may not be paid on the same day as procedure codes D0120, D0140, D0150, D0160, or D0170. A 13-20	$8.02
	Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Number of films required is dependent on age of client—in no case are less than eight films required. Adults and children over 12 years of age require 12-20 films, as is appropriate. The Panorex (D0330) with four bitewing radiographs (D0274) may be considered equivalent to the complete or full-mouth series (D0210), and the billed amount for either combination is equivalent to the maximum fee of $36.04. Allowable once every three years by the same dentist. Not allowed as an emergency service. A 2-20	$36.04
D0220	A 1-20	$6.41
D0230	The total cost of periapicals and/or other radiographs cannot exceed the payment for a complete intraoral series. A 1-20	$5.87
D0240	May be billed once per arch. Periapical films taken at an occlusal angle should be billed as periapical radiograph, code D0230. May be billed as an emergency service. A 7-20	$10.00
D0250	A 1-20, N, CCP	$18.75
D0260	A 1-20, N, CCP	$12.50
D0270	A 2-20	$5.00
D0272	A 2-20	$11.93
D0274	A 2-20	$17.66
D0277	Not to be billed within 36 months of D0210 or D0330. A 1-20	$31.75
D0290	A 1-20, N, CCP	$33.75
D0310	A 1-20, N, CCP	$45.00
D0320	A 1-20, N, CCP	$75.00
D0321	A 1-20, N, CCP	$35.00
D0322	A 1-20, N, CCP	$33.75
D0330*	Limited to one panoramic film during 3-9 years of age and one film during 10-20 years of age, by the same dentist or a group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. Supplemental bitewings are payable in addition to a panoramic with reimbursement not to exceed the total reimbursement for a full mouth radiograph ($36.04 each). Under 3 years of age, must document the necessity of a panoramic film. The Panorex (D0330) with four bitewing radiographs (D0274) may be considered equivalent to the complete or full-mouth series (D0210), and the billed amount for either combination is equivalent to the maximum fee of $36.04. A 3-20	$32.54
D0340*	Not reimbursable separately when diagnostic work-up or crossbite therapy work-up performed. A 1-20, N, CCP	$33.75

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
D0350	For all images taken. Not reimbursable separately when diagnostic work-up or crossbite therapy work-up performed. A 1-20	$18.75
***Note:** Radiograph codes do not include the exam. If an exam is also performed, providers must bill the appropriate ADA procedure code.*		
Tests and Examinations		
D0415	A 1-20, N, CCP	$25.00
D0425	Not reimbursable separately, considered part of all other dental procedures.	NC
D0460	Not reimbursable separately when any endodontic procedure code performed. A 1-20, N, CCP	$12.50
D0470*	Not reimbursable separately when crown, fixed prosth-odontics, diagnostic work-up, or crossbite therapy work-up performed. A 1-20, N, CCP	$22.50
Oral Pathology Laboratory		
D0472	By pathology laboratories only. (refer to CPT codes)	NC
D0473	By pathology laboratories only. (refer to CPT codes)	NC
D0474	By pathology laboratories only. (refer to CPT codes)	NC
D0480	By pathology laboratories only. (refer to CPT codes)	NC
D0502	A 1-20, N, CCP	$57.50
D0999	A 1-20, N, CCP	Manually priced
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

19.8.3 Preventive

Procedure codes D1110, D1120, D1201, D1203, D1204, D1205, and D1351 are not a benefit when billed on the same date of service as any D4000 series periodontal procedure code.

Procedure Code	Limitations	Maximum Fee
Dental Prophylaxis		
D1110*	Limited to one prophylaxis per client per six-month period (includes oral health instructions). If billed on emergency claim, procedure code will be denied. A 13-20	$28.00
D1120*	Limited to one prophylaxis per client per six-month period (includes oral health instructions). If billed on emergency claim, procedure code will be denied. A 1-12	$18.75
Topical Fluoride Treatment (Office Procedure)		
D1201*	A 1-12 (includes oral health instructions)	$28.68
D1203*	This code (D1203) is payable with codes D4210, D4240, D4260, D4341, or D4355 when billed on the same date of service (includes oral health instructions). A 1-12, N, CCP	$7.50
D1204*	This code (D1204) is payable with codes D4260, D4341, or D4355 when billed on the same date of service (includes oral health instructions). A 13-20, N, CCP	$7.50
D1205*	A 13-20 (includes oral health instructions)	$35.47
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

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Procedure Code	Limitations	Maximum Fee
	Other Preventive Services	
D1320	A client requiring tobacco counseling may be referred to a THSteps primary care provider.	NC
D1330	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure is payable *only* for medically necessary situations that are *non-routine.* May be considered for reimbursement with D4355, D4341, and other periodontal procedures. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the client's care. Oral hygiene instruction is denied when billed on the same day as dental prophylaxis (D1110, D1120) and/or topical fluoride treatments with prophylaxis (D1201, D1205) by the same provider. Procedure code D1330 is limited to once per client, per year by *any* provider. A 1-20, N, CCP	$12.50
D1351*	Sealants may be applied at any age to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per-tooth basis, regardless of the number of surfaces sealed. A 1-20	$14.41
	Space Maintenance (Passive Appliances)	
When a client needs a space maintainer and exceeds the listed age limitation, the service can be covered under CCP. The provider must justify medical necessity with radiograph(s) and/or a narrative on the authorization request and receive authorization for payment of the service. Limitation for space maintainers is to hold the space for the loss of one of the *first or second primary molars* (#A, #B, #I, #J, #K, #L, #S, and #T) or the loss of a *permanent first molar* (#3, #14, #19, and #30). There is no payment for replacement if it was previously paid for by Medicaid/THSteps. Fees for space maintainers include maintenance and repair. One space maintainer is reimbursed per TID, per client, per lifetime.		
D1510*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$80.00
D1515*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$118.75
D1520*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$75.00
D1525*	A 1-20 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$106.25
D1550*	A 3-12 (#A, #B, #I, #J, #K, #L, #S, #T), MTID A 3-20 (#3, #14, #19, #30), MTID	$18.75

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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19.8.4 Therapeutic

19.8.4.1 Medicaid Reimbursement Limitations

Medicaid reimbursement is contingent on compliance with the following limitations:

- For documentation requirements, refer to "Documentation Requirements" on page 19-39.
- Restorations on permanent posterior teeth, except codes D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, and D2664, are paid on the basis of the surface or surfaces restored. The maximum amount payable is $90.27.
- Total restorative fee per tooth on primary teeth cannot exceed $78.03, the fee for a stainless steel crown. (Exceptions: D2933 and D2335)
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- More than one restoration on a single surface is considered a single restoration.
- Multiple surface restoration must show definite crossing of the plane of each surface listed for each primary and permanent tooth completed.
- A multiple surface restoration cannot be billed as two or more separate one-surface restorations.
- Restorations and therapeutic care are provided as a Medicaid service based on medical necessity and reimbursed only for therapeutic reasons and not preventive purposes (refer to CDT).

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the date of service. If the client did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the client's chart in lieu of a post-op radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the client returns to the office after the claim has been filed, the dentist is obligated to attempt to seat the restoration or appliance at no cost to the client or the Texas Medicaid Program. For records retention requirements, refer to "Documentation Requirements" on page 19-39.

19.8.5 Restorative

Procedure Code	Limitations	Maximum Fee
	Amalgam Restorations (Including Polishing)	
D2140*	This procedure code has been changed to include primary and permanent teeth. Reimburse primary TIDs A-T at $30.99; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $32.86. A 1-20, PXR	$32.86
D2150*	This procedure code has been changed to include primary and permanent teeth. Reimburse primary TIDs A-T at $41.45; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $43.73. A 1-20, PXR	$43.73
D2160*	This procedure code has been changed to include primary and permanent teeth. Reimburse primary TIDs A-T at $45.00; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $55.71. A 1-20, PXR	$55.71
D2161*	This procedure code has been changed to include primary and permanent teeth. Reimburse primary TIDs A-T at $52.69; reimburse permanent TIDs 1-5, 12-21, and 28-32 at $60.04. A 1-20, PXR	$60.04

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Procedure Code	Limitations	Maximum Fee
Resin-Based Composite Restorations—Direct		
All fees for resin restorations on primary teeth are limited to $78.03, which is the fee for a stainless steel crown (exceptions D2335 and D2933). All fees for resin restorations on permanent teeth are limited to a total of $90.27 for posterior teeth and $150 for anterior teeth. Resin restoration includes composites or glass ionomer.		
D2330*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$39.67
D2331*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$52.57
D2332*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$68.64
D2335*	TID C-H, M-R, #6-11, #22-27. A 1-20, PXR	$85.19
D2390*	TID for primary anterior TIDs C-H, M-R; permanent anterior TIDs 6-11, 22-27. A 1-20, PXR	$68.75 primary; $150.00 permanent
D2391*	TID for primary posterior; TIDs A, B, I, J, K, L, S, T; permanent posterior TIDs 1-5, 12-21, 28-32. A 1-20, PXR	$38.49 primary; $42.04 permanent
D2392*	TID for primary posterior; TIDs A, B, I, J, K, L, S, T; permanent posterior TIDs 1-5, 12-21, 28-32. A 1-20, PXR	$49.49 primary; $55.10 permanent
D2393*	TID for primary posterior; TIDs A, B, I, J, K, L, S, T; permanent posterior TIDs 1-5, 12-21, 28-32. A 1-20, PXR	$58.07 primary; $67.45 permanent
D2394*	TID for primary posterior; TIDs A, B, I, J, K, L, S, T; permanent posterior TIDs 1-5, 12-21, 28-32. A 1-20, PXR	$64.62 primary; $75.06 permanent
Gold Foil Restorations (Permanent Teeth only)		
D2410	A 4-20, N, PPXR, CCP	$75.00
D2420	A 4-20, N, PPXR, CCP	$125.00
D2430	A 4-20, N, PPXR, CCP	$125.00
Inlay/Onlay Restorations (Permanent Teeth only)		
For procedure codes D2510 through D2664 inlay/onlay (permanent teeth only), porcelain is allowed on all teeth, no longer limited to anterior teeth only. Prior authorization is required for any combination of inlays/onlays or permanent crowns that exceed the limit of four inlays/onlays or permanent crowns.		
D2510*	A 4-20, N, PPXR, CCP	$181.25
D2520*	A 13-20, N, PPXR, CCP	$264.00
D2530*	A 13-20, N, PPXR, CCP	$264.00
D2542	Same as D2520. A 13-20, N, PPXR, CCP	$264.00
D2543	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2544	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2610	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2620	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2630	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2642	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2643	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2644	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2650	All materials accepted. A 13-20, N, PPXR, CCP	$264.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
D2651	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2652	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2662	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2663	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2664	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
Crowns—Single Restorations Only		
For procedure codes D2710 through D2799, single crown restorations (permanent teeth only) the following limitations apply: • Porcelain is allowed on all teeth, and is no longer limited to anterior teeth only. • Prior authorization is required for any combination of onlays or permanent crowns that exceed the limit of four onlays or permanent crowns. • Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior (6–11, 22–27) permanent teeth.		
D2710	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2720	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2721	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2722	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2740	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2750*	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2751*	All materials accepted. A 13-20, N, PPXR	$264.00
D2752	All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2780	A 13-20, N, PPXR, CCP	$264.00
D2781	A 13-20, N, PPXR, CCP	$264.00
D2782	A 13-20, N, PPXR, CCP	$264.00
D2783	Anterior teeth only (#6-11 and #22-27). A 13-20, N, PPXR, CCP	$264.00
D2790	Posterior teeth only (#1-5; #12-21; and #28-32). All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2791*	Posterior teeth only (#1-5; #12-21; and #28-32). All materials accepted. A 13-20, N, PPXR	$264.00
D2792*	Posterior teeth only (#1-5; #12-21; and #28-32). All materials accepted. A 13-20, N, PPXR, CCP	$264.00
D2794	Prior authorization required for any combination of four or more permanent cast crown, inlays or onlays. A 13-20, N, PPXR, CCP	$264.00
D2799	Denied as global fee to any crown placed.	NC
D2915	A 4-20	$18.75
Other Restorative Services		
D2910	A 4-20, PXR	$18.75
D2920	A 1-20, PXR	$20.00
D2930*	A 1-20, PXR	$78.03
D2931*	A 1-20, PXR	$81.25
D2932*	A 1-20, PXR ($68.75 per primary tooth)	$68.75
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

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Procedure Code	Limitations	Maximum Fee
D2933*	Limited to anterior primary teeth only (TID C-H, M-R). A 1-20, N, CCP, PXR	$85.51
D2940*	Not allowed on the same date as permanent restoration. A 1-20, PXR	$20.90
D2950*	Provider payments received in excess of $45.00 for restorative work performed within six months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4-20, N, CCP, PXR	$45.00
D2951	Not payable with crowns or D2950. Not allowed on primary teeth. A 4-20, PXR	$12.50
D2952	Not payable with D2950. Not allowed on primary teeth. A 4-20, PXR	$87.50
D2953	Must be used with D2952. Not allowed on primary teeth. A 13-20	$43.75
D2954*	Not payable with codes D2952 or D3950 on the same TID by the same provider. Not allowed on primary teeth. A 4-20, N, CCP, PXR	$75.00
D2955	For removal of posts (for example, fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4-20, CCP, PXR	$75.00
D2957	Must be used with D2954. Not allowed on primary teeth. A 13-20, PXR, CCP	$37.50
D2960	A 4-20, N, PPXR, CCP	$112.50
D2961	A 4-20, N, PPXR, CCP	$181.25
D2962	A 4-20, N, PPXR, CCP	$212.50
D2980	A 4-20, PXR (permanent teeth only)	$50.00
D2999	A 1-20, N, CCP, PXR	Manually priced
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

19.8.6 Endodontics

Root canal fillings cannot be billed in addition to apexification procedures that have been initiated. Codes W-D3351, W-D3352, and W-D3353 include the final root canal filling.

Root canal payments are limited to four permanent teeth for each client. Additional medically necessary root canals can be reimbursed under CCP when documented in the Remarks field of the ADA dental claim form.

If the client is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

Procedure Code	Limitations	Maximum Fee
	Pulp Capping	
D3110	A 1-20, N, PXR, CCP	$16.25
D3120	A 1-20, N, PXR, CCP	$15.00
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

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Procedure Code	Limitations	Maximum Fee
	Pulpotomy	
D3220*	Will include all definitions given. A 1-20, PXR	$43.98
D3221	Denied as global fee to any endodontic procedure.	NC
	Endodontic Therapy on Primary Teeth	
D3230*	Anterior primary incisors and cuspids (C-H; M-R). A 1-20, PXR	$38.75
D3240*	Posterior first and second molars (A, B, I, J, K, L, S, T). A 1-20, PXR	$43.98
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)	
	Complete root canal therapy—Pulpectomy is part of root canal therapy and includes all appointments necessary to complete treatment.	
	Root canal therapy that has only been initiated—or taken to some degree of completion, but not carried to completion with a final filling—may not be billed as a root canal therapy code. It must be billed using code D3999 with a narrative description of what procedures were completed in the root canal therapy.	
D3310*	A 4-20, PPXR	$177.99
D3320*	A 4-20, PPXR	$206.25
D3330*	A 4-20, PPXR	$312.13
D3331	Not payable, use retreatment codes.	NC
D3332	Not payable, use retreatment codes.	NC
D3333	Not payable, use retreatment codes.	NC
	Endodontic Retreatment	
D3346*	A 4-20, PPXR	$156.25
D3347*	A 4-20, PPXR	$206.25
D3348*	A 4-20, PPXR	$275.00
	Apexification/Recalcification Procedures	
D3351*	A 4-20, N, PXR, CCP	$75.00
D3352*	A 4-20, N, PXR, CCP	$50.00
D3353*	A 4-20, PPXR, CCP	$100.00
	Apicoectomy/Periradicular Services	
D3410	A 4-20, N, PPXR, CCP	$131.25
D3421	A 4-20, N, PPXR, CCP	$162.50
D3425	A 4-20, N, PPXR, CCP	$162.50
D3426	A 4-20, N, PPXR, CCP	$75.00
D3430	A 4-20, N, PPXR, CCP	$50.00
D3450	A 4-20, N, PXR, CCP	$75.00
D3460	Prior authorization required. Submit request with periapical radiographs, for each tooth involved. A 16-20, N, PPXR, CCP	$212.50
D3470	A 4-20, N, PXR, CCP	$125.00
	Other Endodontic Procedures	
D3910	A 1-20, N, CCP	$18.75
D3920	A 4-20, N, PXR, CCP	$81.25
D9974*	Must include documentation of medical necessity. A 13-20 CCP	$56.25

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
D3950	Not payable with codes D2952 or D2954 on the same TID by the same provider. A 4-20, N, PXR, CCP	$50.00
D3999	A 1-20, N, PXR, CCP	Manually priced
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

19.8.7 Periodontics

Procedure Code	Limitations	Maximum Fee
Surgical Services (Including Usual Postoperative Care)		
D4210	A 13-20, N, PXR, CCP	$162.50
D4211	A 13-20, N, PXR, CCP	$50.00
D4240	A 13-20, N, FMX, PXR, PC, CCP	$181.25
D4241	Limited to once per year. A 13-20, N, FMX, PXR, PC	$55.00
D4245	Per quadrant. A 13-20, N, PXR, CCP	$181.25
D4249	A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for billing of this code. A 13-20, N, PPXR, CCP	$162.50
D4260	A 13-20, N, FMX, PXR, PC, CCP	$225.00
D4261	Limited to once per year. A 13-20, N, FMX, PXR, PC	$67.00
D4265	Deny as global to other services.	NC
D4266	Considered upon submission of an appeal with the following documentation: medical and dental history indicating a co-morbid condition; pre-operative radiographs that show evidence of the bony defect; post-operative radiographs that show evidence of the procedure being performed; intra-oral photographs, if the bony defect is not evident on radiographs (this documentation may also be requested by HHSC and/or its agent as deemed necessary); periodontal probing depths documenting bony defect; final restoration treatment plan for edentulous site(s). A 13-20, N, PXR, CCP	$275.00
D4267	Considered upon submission of an appeal with the following documentation: medical and dental history indicating a co-morbid condition; pre-operative radiographs that show evidence of the bony defect; post-operative radiographs that show evidence of the procedure being performed; intra-oral photographs, if the bony defect is not evident on radiographs (this documentation may also be requested by HHSC and/or its agent as deemed necessary); periodontal probing depths documenting bony defect; final restoration treatment plan for edentulous site(s). A 13-20, N, PXR, CCP	$325.00
D4270	A 13-20, N, PXR, CCP	$193.75
D4271	A 13-20, N, PXR, CCP	$206.25
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

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Procedure Code	Limitations	Maximum Fee
D4273	This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13-20, N, PXR, CCP	$225.00
D4274	This procedure is performed in an edentulos area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13-20, N, PXR, CCP	$125.00
D4275	Limited to once per day. A 13-20	$225.00
D4276	Prior authorization is required; Not payable in addition to D4273 or D4275 on the same date of service. A 13-20	$225.00
Nonsurgical Periodontal Services		
D4320	A 1-20, PXR	$62.50
D4321	A 1-20, PXR	$100.00
D4341	D4341 is not payable if provided within 90 days of D4355. A 13-20, FMX, PC, PXR, CCP	$56.25
D4342	May not be paid in addition to procedure codes D4210, D4211, D4240, D4241, D4245, D4249, D4260, D4261, D4266, D4267, D4270, D4271, D4273, D4274, D4275, D4276, D4320, D4321, D4341, D4355, D4381, D4910, D4920, and D4999 on the same day. A 13-20, PC, FMX	$7.00
D4355*	D4355 is not payable if provided within 90 days of D4341. A 13-20, N, PXR, CCP	$75.00
D4381	This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13-20, N, PXR, CCP	$30.00
Other Periodontal Services		
D4910	A 6-20, N, PXR, CCP (not payable with or after D4355)	$37.50
D4920	A 6-20, N, PXR, CCP	$25.00
D4999	A 13-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.8.8 Prosthodontics (Removable)

Local anesthesia is considered to be part of removable prosthodontic procedures.

Procedure Code	Limitations	Maximum Fee
Complete Dentures (Including Routine Post Delivery Care)		
D5110	A 3-20, PXR	$375.00
D5120	A 3-20, PXR	$375.00
D5130	A 3-20, N, PXR, CCP	$387.50
D5140	A 3-20, N, PXR, CCP	$387.50

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
Partial Dentures (Including Routine Post Delivery Care)		
D5211*	A 6-20, PXR, MTID	$275.00
D5212*	A 6-20, PXR, MTID	$275.00
D5213	A 9-20, N, PXR, MTID, CCP	$400.00
D5214	A 9-20, N, PXR, MTID, CCP	$400.00
D5281*	A 9-20, N, PXR, MTID, CCP	$250.00
Adjustments to Dentures		
D5410	A 3-20, PXR	$18.75
D5411	A 3-20, PXR	$18.75
D5421	A 6-20, PXR	$18.75
D5422	A 6-20, PXR	$18.75
Repairs to Complete Dentures		
D5510	Cost of repairs cannot exceed replacement costs. A 3-20, PXR	$50.00
D5520	Cost of repairs cannot exceed replacement costs. A 3-20, PXR	$43.75
Repairs to Partial Dentures		
Cost of repairs cannot exceed replacement costs. A bill for the laboratory portion not to exceed $137.50 must be submitted.		
D5610*	A 3-20, PXR	$115.00
D5620	A 6-20, PXR	$56.25
D5630*	A 6-20, PXR	$50.00
D5640*	A 6-20, PXR	$43.75
D5650*	A 6-20, PXR	$50.00
D5660*	A 6-20, PXR	$62.50
D5670*	May not be paid in addition to procedure codes D5211, D5212, D5213, D5214, D5281. and D5640. A 6-20	$175.00
D5671*	May not be paid in addition to procedure codes D5211, D5212, D5213, D5214, D5281, and D5640. A 6-20	$175.00
Denture Rebase Procedures		
D5710	A 4-20, PXR	$137.50
D5711	A 4-20, PXR	$137.50
D5720*	A 7-20, PXR	$137.50
D5721*	A 7-20, PXR	$137.50
Denture Reline Procedures		
Allowed whether or not the denture was obtained through THSteps or ICF-MR dental services if the reline makes the denture serviceable.		
D5730	A 4-20, N, PXR, CCP	$81.25
D5731	A 4-20, N, PXR, CCP	$81.25
D5740*	A 7-20, N, PXR, CCP	$75.00
D5741*	A 7-20, N, PXR, CCP	$75.00
D5750	A 4-20, PXR	$118.75
D5751	A 4-20, PXR	$118.75
D5760*	A 7-20, PXR	$118.75
D5761*	A 7-20, PXR	$118.75

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
	Interim Prosthesis	
D5810	A 3-20, N, PXR, CCP	$200.00
D5811	A 3-20, N, PXR, CCP	$200.00
D5820	A 3-20, N, PXR, CCP	$162.50
D5821	A 3-20, N, PXR, CCP	$162.50
	Other Removable Prosthetic Services	
D5850	A 3-20, N, PXR, CCP	$37.50
D5851	A 3-20, N, PXR, CCP	$37.50
D5860	A 4-20, N, PXR, CCP	$387.50
D5861	A 4-20, N, PXR, CCP	$387.50
D5862	A 4-20, N, PXR, CCP	$162.50
D5867	Denied as part of any repair or modification of any removable prosthetic.	NC
D5875	Denied as part of any repair or modification of any removable prosthetic.	NC
D5899	A 1-20, N, PXR, CCP	Manually priced
	Maxillofacial Prosthetics	
D5911	A 1-20, N, PXR, CCP	$50.00
D5912	A 1-20, N, PXR, CCP	$90.00
D5913	A 1-20, N, PXR, CCP	$875.00
D5914	A 1-20, N, PXR, CCP	$875.00
D5915	A 1-20, N, PXR, CCP	$875.00
D5916	A 1-20, N, PXR, CCP	$562.50
D5919	A 1-20, N, PXR, CCP	$1,125.00
D5922	A 1-20, N, PXR, CCP	$140.00
D5923	A 1-20, N, PXR, CCP	$337.50
D5924	A 1-20, N, PXR, CCP	$437.50
D5925	A 1-20, N, PXR, CCP	$375.00
D5926	A 1-20, N, PXR, CCP	$450.00
D5927	A 1-20, N, PXR, CCP	$450.00
D5928	A 1-20, N, PXR, CCP	$450.00
D5929	A 1-20, N, PXR, CCP	$900.00
D5931	A 1-20, N, PXR, CCP	$375.00
D5932	A 1-20, N, PXR, CCP	$1,300.00
D5933	A 1-20, N, PXR, CCP	$281.25
D5934	A 1-20, N, PXR, CCP	$562.50
D5935	A 1-20, N, PXR, CCP	$562.50
D5936	A 1-20, N, PXR, CCP	$625.00
D5937	Not for temporo mandibular dysfunction (TMD) treatment. A 1-20, N, PXR, CCP	$262.50
D5951	Ortho only—requires prior authorization. A 0-20, N, PXR	$140.00
D5952	Ortho only—requires prior authorization. A 0-20, N, PXR	$843.75

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
D5953	Ortho only—requires prior authorization. A 13-20, N, PXR	$843.75
D5954	Ortho only—requires prior authorization. A 0-20, N, PXR	$443.75
D5955	Ortho only—requires prior authorization. A 0-20, N, PXR	$225.00
D5958	Ortho only—requires prior authorization. A 0-20, N, PXR	$225.00
D5959	Ortho only—requires prior authorization. A 0-20, N, PXR	$100.00
D5960	Ortho only—requires prior authorization. A 0-20, N, PXR	$100.00
D5982	A 1-20, N, PXR, CCP	$112.50
D5983	A 1-20, N, PXR, CCP	$162.50
D5984	A 1-20, N, PXR, CCP	$162.50
D5985	A 1-20, N, PXR, CCP	$162.50
D5986	A 1-20, N, PXR, CCP	$50.00
D5987	A 1-20, N, PXR, CCP	$131.25
D5988	A 1-20, N, PXR	$112.50
D5999	A 1-20, N, PXR, CCP	Manually priced
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC= No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

19.8.9 Implant Services

All the following implant services codes require mandatory prior authorization.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
- Space cannot be filled with removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).

Procedure Code	Limitations	Maximum Fee
D6010	Includes second stage surgery and placement of healing cap. A 16-20, N, PPXR, CCP	$1,125.00
D6040	A 16-20, N, PPXR, CCP	$2,000.00
D6050	A 16-20, N, PPXR, CCP	Manually priced
Implant Supported Prosthetics		
D6053	Deny as global to other services.	NC
D6054	Deny as global to other services.	NC
D6055	A 16-20, N, PXR, CCP	$300.00
D6056*	A connection to an implant that is a manufactured component, made of machined high noble metal, titanium, titanium alloy, or ceramic. Placement included. May include the removal of a temporary healing cap or replacement with an abutment of alternate design. Mandatory prior authorization. A 16-20, N, PPXR, CCP	$350.00
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

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Procedure Code	Limitations	Maximum Fee
D6057	A connection to an implant that is a fabricated component, usually by a laboratory, specific for an individual application. A custom abutment is typically fabricated using a casting process and usually is made of noble or high noble metal. Placement included. May include the removal of a temporary healing cap or replacement with an abutment of alternate design. Mandatory prior authorization. A 16-20, N, PPXR, CCP	$350.00
D6058	Not considered medically necessary.	NC
D6059	Not considered medically necessary.	NC
D6060	Not considered medically necessary.	NC
D6061	Not considered medically necessary.	NC
D6062	Not considered medically necessary.	NC
D6063	Not considered medically necessary.	NC
D6064	Not considered medically necessary.	NC
D6065	Not considered medically necessary.	NC
D6066	Not considered medically necessary.	NC
D6067	Not considered medically necessary.	NC
D6068	Not considered medically necessary.	NC
D6069	Not considered medically necessary.	NC
D6070	Not considered medically necessary.	NC
D6071	Not considered medically necessary.	NC
D6072	Not considered medically necessary.	NC
D6073	Not considered medically necessary.	NC
D6074	Not considered medically necessary.	NC
D6075	Not considered medically necessary.	NC
D6076	Not considered medically necessary.	NC
D6077	Not considered medically necessary.	NC
D6078	Not considered medically necessary.	NC
D6079	Not considered medically necessary.	NC
D6080	May include: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis. A 16-20, N, PXR, CCP	$43.75
D6090	A 16-20, N, PXR, CCP	$137.50
D6095	Involves the surgical removal of an implant. A 16-20, N, PPXR, CCP	$175.00
D6100	A 16-20, N, PXR, CCP	$225.00
D6199	A 16-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.8.10 Prosthodontics (Fixed)

All the following prosthodontic codes require mandatory prior authorization.

Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by the TMHP Dental Director are:

- At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).

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- The space cannot be filled with a removable partial denture.
- The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
- Each abutment or each pontic constitutes a unit in a bridge.
- Porcelain is allowed on all teeth and is no longer limited to anterior teeth only.

Procedure Code	Limitations	Max Fee
	Fixed Partial Dental Pontics	
D6210	A 16-20, PPXR, MTID, CCP	$264.00
D6211	A 16-20, PPXR, MTID, CCP	$264.00
D6212	A 16-20, PPXR, MTID, CCP	$264.00
D6240	A 16-20, PPXR, MTID, CCP	$264.00
D6241	A 16-20, PPXR, MTID, CCP	$264.00
D6242	A 16-20, PPXR, MTID, CCP	$264.00
D6245	A 16-20, PPXR, MTID, CCP	$264.00
D6250	A 16-20, PPXR, MTID, CCP	$264.00
D6251	A 16-20, PPXR, MTID, CCP	$264.00
D6252	A 16-20, PPXR, MTID, CCP	$264.00
D6253	Deny as global to other services.	NC
	Fixed Partial Dental Retainers—Inlays/Onlays	
D6545	A 16-20, PPXR, CCP	$264.00
D6548	A 16-20, PPXR, CCP	$264.00
D6600	Deny as global to other services.	NC
D6601	Deny as global to other services.	NC
D6602	Deny as global to other services.	NC
D6603	Deny as global to other services.	NC
D6604	Deny as global to other services.	NC
D6605	Deny as global to other services.	NC
D6606	Deny as global to other services.	NC
D6607	Deny as global to other services.	NC
D6608	Deny as global to other services.	NC
D6609	Deny as global to other services.	NC
D6610	Deny as global to other services.	NC
D6611	Deny as global to other services.	NC
D6612	Deny as global to other services.	NC
D6613	Deny as global to other services.	NC
D6614	Deny as global to other services.	NC
D6615	Deny as global to other services.	NC
	Fixed Partial Dental Retainers—Crowns	
D6720	A 16-20, PPXR, CCP	$264.00
D6721	A 16-20, PPXR, CCP	$264.00
D6722	A 16-20, PPXR, CCP	$264.00
D6740	A 16-20, PPXR, CCP	$264.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Max Fee
D6750	A 16-20, PPXR, CCP	$264.00
D6751	A 16-20, PPXR, CCP	$264.00
D6752	A 16-20, PPXR, CCP	$264.00
D6780	A 16-20, PPXR, CCP	$264.00
D6781	A 16-20, PPXR, CCP	$264.00
D6782	A 16-20, PPXR, CCP	$264.00
D6783	A 16-20, PPXR, CCP	$264.00
D6790	Permanent posterior teeth only. A 16-20, PPXR, CCP	$264.00
D6791	Permanent posterior teeth only. A 16-20, PPXR, CCP	$264.00
D6792	Permanent posterior teeth only. A 16-20, PPXR, CCP	$264.00
Other Fixed Partial Dental		
D6920	A 16-20, PXR, CCP	$135.00
D6930	A 16-20, PXR, CCP	$37.50
D6940	A 16-20, N, PXR, CCP	$87.50
D6950	A 16-20, N, PXR, CCP	$137.50
D6970	A 16-20, N, PXR, CCP	$100.00
D6971	A 16-20, N, PXR, CCP	$87.50
D6972	A 16-20, N, PXR, CCP	$81.25
D6973	A 16-20, N, PXR, CCP	$56.25
D6975	A 16-20, N, PXR, CCP	$125.00
D6976	Prior authorization required; must be used with D6970 or D6971. A 16-20, PXR, CCP	$50.00
D6977	Prior authorization required; must be used with D6972. A 16-20, PXR, CCP	$40.63
D6980	A 16-20, N, PXR, CCP	$68.75
D6999	A 16-20, N, PXR, CCP	Manually priced
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

19.8.11 Oral and Maxillofacial Surgery

All oral surgery procedures include local anesthesia and visits for routine postoperative care.

Procedure Code	Limitations	Maximum Fee
Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)		
D7111	TIDs A-T and AS-TS. A 1-20	$8.00
D7140*	Replaces procedure codes D7110, D7120, and D7130. A 1-20, PXR	$33.52
Surgical Extractions (Includes Local Anesthesia, Suturing, if Needed, and Routine Postoperative Care)		
D7210*	Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1-20, PXR	$58.75
A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter		

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Procedure Code	Limitations	Maximum Fee
D7220*	Impaction requiring incision of overlying soft tissue and removal of tooth. A 1-20, PXR	$90.00
D7230*	Impaction requiring incision of overlying soft tissue, elevation of flap, removal of bone or sectioning of tooth for surgical removal. A 1-20, PXR	$120.00
D7240	Impaction requiring incision of overlying soft tissue, elevation of flap, removal of bone and sectioning of tooth for surgical removal. A 1-20, PXR	$150.00
D7241	Document unusual circumstance. A 1-20, PXR	$156.25
D7250*	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft and/or hard tissue healing has occurred. A 1-20, N, PXR	$92.50
Other Surgical Procedures		
D7260	A 1-20, N, PXR	$137.50
D7261	May not be paid on the same day as D7260; TIDs 1-16 only. A 1-20	$137.50
D7270*	A 1-20, N, PXR, CCP	$110.00
D7272	Requires prior authorization. A 1-20, N, PXR, CCP	$150.00
D7280	Requires prior authorization. A 1-20, N, PXR	$87.50
D7282	Permanent TIDs 1-32 only; may not be paid on the same day as D7280. A 4-20	$62.50
D7285	A 1-20, PXR, PATH, CCP	$75.00
D7286*	A 1-20, PXR, PATH	$62.50
D7287	Deny as global to other services. A 1-20	NC
D7290	A 1-20, N, PXR, CCP	$137.50
D7291	A 4-20, N, PXR, CCP	$50.00
Alveoloplasty—Surgical Preparation of Ridge for Dentures		
D7310	A 1-20, N, PXR, CCP	$56.25
D7320	A 1-20, N, PXR, CCP	$75.00
Vestibuloplasty		
D7340	A 1-20, N, PXR, CCP	$125.00
D7350	A 1-20, N, PXR, CCP	$250.00
Surgical Excision of Soft Tissue Lesions		
D7410	A 1-20, PXR, PATH	$100.00
D7411	A 1-20, PXR, PATH	$150.00
D7412		NC
D7413	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$100.00
D7414	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$150.00
D7415	Deny as global to other services.	NC

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
	Surgical Excision of Intraosseous Lesions	
D7440	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$181.25
D7441	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$237.50
D7450	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$118.75
D7451	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$162.50
D7460	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 0-20, N, PXR, PATH, CCP	$118.75
D7461	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 0-20, N, PXR, PATH, CCP	$162.50
D7465	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20, N, PXR, PATH, CCP	$68.75
	Excision of Bone Tissue	
D7471	Denied as global to all extractions	NC
D7472	Prior authorization is required. A 1-20	$160.00
D7473	Deny as global to other services. A 1-20	NC
D7485	Deny as global to other services. A 1-20	NC
D7490	Refer to CPT codes.	NC
	Surgical Incision	
D7510*	TID required. A 1-20, PXR	$37.50
D7520	A 1-20, N, PXR, CCP	$125.00
D7530	A 1-20, N, PXR	$50.00
D7540	A 1-20, N, PXR	$100.00
D7550*	A 1-20, N, PXR	$106.25
D7560	A 1-20, N, PXR, CCP	$125.00
D7670	A 1-20, N, PXR, CCP	$81.25
D7671	A 1-20, N, PXR, CCP	NC
D7771	A 1-20, N, PXR, CCP	NC
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	
D7820	A 1-20, N, PXR	$81.25
D7830	Refer to CPT codes.	NC
D7880	Narrative required on claim form. A 1-20, N, PXR, CCP	$140.00
D7899	Narrative required on claim form. A 1-20, N, PXR, CCP	Manually priced
	Repair of Traumatic Wounds	
D7910*	Narrative required on claim form. A 1-20, N, PXR, CCP	$75.00

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

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Procedure Code	Limitations	Maximum Fee
Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)		
Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.		
D7911	A 1-20, N, PXR, CCP	$81.25
D7912	A 1-20, N, PXR, CCP	$162.50
Other Repair Procedures		
D7960	Narrative required on claim form. A 1-20, N, PXR, CCP	$105.00
D7970*	A 1-20, N, PXR, CCP	$112.50
D7971*	A 1-20, N, PXR, CCP	$43.75
D7972	TIDs 1, 16, 17, and 32 only; may not be paid in addition to D7971 on the same day. A 13-20	$43.75
D7980	A 1-20, N, PXR, CCP	$193.75
D7983	A 1-20, N, PXR, CCP	$162.50
D7997*	Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. Prior authorization is required. A 1-20, N, PXR, CCP	$50.00
D7999*	A 1-20, N, PXR, CCP	Manually priced

A=Age range limitations, N=Narrative required, FMX=Full-mouth radiographs (nonpanoramic), MTID=Missing tooth ID(s), PPXR=Pre- and post-op radiographs required, PXR=Pre-op radiographs required, PHO=pre- and post-operative photographs required, PC=Periodontal charting required, PATH=Pathology report required, CCP=Comprehensive Care Program, NC=No charge to Medicaid and may not bill the client, and *= Services payable to an FQHC for a client encounter

19.8.12 Adjunctive General Services

Procedure Code	Limitations	Maximum Fee
Unclassified Treatment		
D9110*	Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. A 1-20, N	$18.75
Anesthesia		
Providers must comply with TSBDE Rules, 22 TAC §§108.30–108.35. Any anesthesia type services are paid only to the provider. Criteria for dental therapy under general anesthesia must be used (see page 19-32). A local anesthesia fee is *not* paid in addition to other restorative, operative, or surgical procedure fees. Prior authorization is available for exceptions to periodicity.		
D9210	Claim form narrative should describe the situation if used as a diagnostic tool. A 1-20, N, CCP	$12.50
D9211*	A 1-20, N, CCP	$18.75
D9212*	A 1-20, N, CCP	$31.25
D9215*	Claim form narrative should explain how the doctor initiated a procedure, but could not complete it, and needs to claim the rendered anesthesia. A 1-20, N, CCP	$12.50
D9220	May not be billed with codes D9230 or D9610. Can only be billed with D9221. May be billed twice within a 12-month period. A 1-20	$87.50

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Procedure Code	Limitations	Maximum Fee
D9221	May not be billed with codes D9230 or D9610. Can only be billed with D9220. A 1-20	$31.25
D9230*	May not be billed with code D9920, D9610, D9220, or D9221. May not be billed more than one per client, per day. A 1-20.	$28.38
D9241	May not be billed with code D9220 or D9221. May not be billed on the same date of service as D9920. A 1-20	$81.25
D9242	Not considered to be medically necessary.	NC
D9248*	May be billed twice within a 12-month period. 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. A 1-20	$125.00
	Professional Consultation	
D9310	An oral evaluation by a specialist of any type who is also providing restorative or surgical services should be billed as D0160. A 1-20, N, CCP	$15.25
	Professional Visits	
D9410	Narrative required on claim form. A 1-20	$25.00
D9420	One charge per hospital or ambulatory surgical center (ASC) case; one case per client in a 12-month period. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the client's record and may be subject to retrospective review and recoupment. A 1-20, N	$38.00
D9430	Narrative required on claim form. During regularly scheduled hours, no other services performed. Visits for routine post-operative care are included in all therapeutic and oral surgery fees. A 1-20, N	$15.00
D9440	Narrative required on claim form. Visits for routine post-operative care are included in all therapeutic and oral surgery fees. A 1-20, N	$31.25
D9450	Deny as global to other services.	NC
	Drugs	
D9610	Providers must comply with TSBDE *Rules and Regulations*, Chapter 109.175. May not be billed with code D9220, D9221, or D9920. A 1-20, N	$18.75
D9630	Other drugs and/or medicaments by report includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be billed with codes D9220, D9221, D9230, D9241, D9248, D9610, and D9920. A 1-20, N	$9.00
	Miscellaneous Services	
D9910	Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. A 1-20, N, CCP	$12.50
D9911	Denied as part of D9910.	NC
D9920	The provider must indicate on the claim the client's medical diagnosis of mental retardation or that the client is ICF-MR eligible. A 1-20	$50.00
D9930*	A 1-20, N	$25.00

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Procedure Code	Limitations	Maximum Fee
D9940	A 1-20, N, CCP	$118.75
D9950	A 1-20, N, CCP	$56.25
D9951	Full mouth procedure. Limited to once per year, per client, any provider. A 1-20, N, CCP	$37.50
D9952	Full mouth procedure. Payable once per lifetime, any provider. A 1-20, N, CCP	$150.00
D9970	The removal of discolored surface enamel defects resulting from altered mineralization or decalcification of the superficial enamel layer. Not a separate reimbursed service. A 1-20	NC
D9971	Not payable; bill as extractions.	NC
D9972	Not medically necessary.	NC
D9973	Not medically necessary.	NC
D9974*	Same as old code D3960. A 13-20	$56.25
D9999*	A 1-20, N, CCP, PPXR	Manually priced

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19.9 THSteps and ICF-MR Types of Services

The following categories of dental services are available: emergency and trauma-related, diagnostic, preventive, and therapeutic.

19.9.1 Emergency and Trauma-Related Services

Prior authorization is not required for emergency or trauma-related dental services. Claims for these dental services must be filed *separately* from nonemergency dental services. Only one such claim per client, per day may be submitted. Routine therapeutic procedures are *not* considered emergency or trauma-related procedures.

When billing for emergency or trauma-related dental services, the provider must:

- Enter the word “Emergency” or “Trauma” in the description field of the claim form (also enter a brief description of the CDT procedure code used)
- Check the appropriate box in Block 45, *Treatment Resulting From*, of the claim form (the options to check are *Occupational Illness/Injury, Auto Accident*, or *Other Accident*)
- If checking the *Other Accident* box, briefly describe in the *Remarks* field, Block 35 of the ADA claim form, what caused the emergency or trauma

Documentation to support the diagnosis and treatment of trauma must be retained in the client’s record.

Note: *Indicating Trauma in the description field allows the provider to be reimbursed for treatment on an emergency, continuing, and long-term basis without regard to periodicity, subject to the client’s eligibility and program limitations. An exception to periodicity for THSteps dental services is granted automatically for immediate treatment and any future follow-up treatment, as long as each claim submitted for payment is marked “Trauma” in the Description field, Block 30, and the original date of treatment or incident is referenced in the Remarks field, Block 35.*

Refer to: “2002 ADA Dental Claim Filing Instructions” on page 5-43.

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19.10 Services for Children Younger Than 12 Months of Age

Bill initial visits for children *younger than 12 months of age* as *Emergency* with documentation of need. Bill subsequent visits necessary to complete the case as an exception to periodicity by describing the reason for the exception in the *Remarks* field, Block 35.

19.10.1 Change of Provider

A provider may refer a client to another provider when appropriate.

A provider may discontinue treatment for any of the following reasons:

- Treatment by a dental specialist such as a pediatric dentist, periodontist, oral surgeon, endodontist, or orthodontist is indicated.
- The services needed are outside the skills or scope of practice of the initial provider.
- There is documented failure to keep appointments by the client or parent/guardian, noncompliance with the treatment plan, or conflicts with the client or other family members.

In any such action to discontinue treatment, providers must comply with 22 TAC §108.5, *Patient Abandonment*.

The client may select another provider, if desired.

HHSC may refer the client to another provider as a result of adverse information obtained during a utilization review or resolution of a complaint from either provider or client.

If the client does not return for the completion of services and there is documented failure to keep appointments by the client or parent/guardian, the dental provider who initiated the services may submit a claim for reimbursement to be received by TMHP within the 95-day filing deadline from the last date of service.

19.10.2 Interrupted, Incomplete Treatment Plans

Authorizations for treatment plans that have been issued to a provider are *not* transferable to another provider. If a client's treatment plan is interrupted and the services are not completed, the new provider must request authorization to complete the interrupted, incomplete, and authorized treatment plan initiated by the original provider.

To complete the treatment plan, the client must be eligible for Medicaid with a current client Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Form H1027).

19.10.3 Periodicity for Scheduled Preventive Dental Services

The dental provider may perform any medically necessary dental service that is within the Texas Medicaid Program's guidelines and limitations.

A narrative explaining the reason for the exception to periodicity limitations must be included on the claim to TMHP, whether electronic or paper. The exception must be indicated in the appropriate block whether filing paper claims or electronically. Documentation must be in the client's file.

19.10.4 Exceptions to Periodicity

For THSteps clients, exceptions to the periodicity schedule for dental services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients younger than 12 months of age)
- Required to meet federal/state exam requirements for Head Start, daycare, foster care, or preadoption
- Clients' choice to change service providers (not applicable to referrals)
- Subsequent therapeutic services necessary to complete a case for clients younger than 12 months of age when initiated as emergency services, for trauma, for baby bottle tooth decay, or early childhood caries

The client Medicaid Identification Form (Form H3087) indicates to the provider the eligibility status of the client for Medicaid services for a specific month. The card also reminds the client that he is eligible for a periodic dental checkup that month. If the client does not receive the dental checkup that month, the client is still entitled to a dental checkup in the following months until one is conducted, as well as other covered dental services. If the card's reminder of the periodic dental checkup does not appear on the card for a particular month, the client is still entitled to other covered dental services. If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period.

Example: *The client requested a second opinion or changed providers.*

The provider should determine if the client is Medicaid-eligible on the day services are to be provided. If the client's Medicaid Identification Form (Form H3087) does not indicate that the client is due for a periodic dental checkup, but the client is requesting one, the same provider may not provide a second periodic checkup during that current six-month period. If the provider did provide one, the provider still may provide other covered dental services.

For ICF-MR clients 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.

Refer to: "Preventive" on page 19-11 for periodicity limitations for prophylaxis.

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19.10.5 Guidelines for Prescribing Dental Radiographs

In November 2004, the ADA in conjunction with the U.S. Food and Drug Administration established Guidelines for Prescribing Dental Radiographs. The guidelines include type of encounter relevant to the patient's age and dental developmental stage.

19.10.6 Billing After Loss of Eligibility

The Texas Medicaid 95-day filing deadline applies to all THSteps and ICF-MR dental services. If a client has lost Medicaid eligibility or turned 21 years of age, continue to file claims for services provided on dates of service the client was eligible. Indicate the actual date of service on the claim form, and enter the authorization number in the appropriate block on each claim filed.

Refer to: "Claims Filing Deadlines" on page 5-4 for more information.

19.11 Mandatory Prior Authorization

Mandatory prior authorization is required for consideration of reimbursement to dental providers who render:

- Orthodontia
- Implants
- Fixed prosthetic services (refer to page 19-23)
- Dental general anesthesia that did not meet the criteria for 22 points
- A combination of inlays/onlays or permanent crowns in excess of four per client, refer to page 19-14 and 19-15
- D7272 (refer to page 19-26)
- D4276
- D7472
- General dental services for clients 21 years of age and older (not residing in an ICF-MR facility) whose dental diagnosis is secondary to and causally related to a life-threatening medical condition

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 19-5.

The prior authorization number is required on claims for processing. If the client is not eligible on the date of service or the claim is incomplete, it will affect reimbursement. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Post-treatment authorization will not be approved for codes that require mandatory prior authorization.

19.12 Criteria for Dental Therapy Under General Anesthesia

The dental provider is responsible for determining whether a client meets the minimum criteria necessary for receiving general anesthesia. Additionally, the dental provider must meet the requirements for chart documentation.

If a client does not meet the criteria for general anesthesia, authorization will be considered with a written request using the THSteps Dental Mandatory Prior Authorization Request Form. Include all appropriate supporting documentation with the submittal. TMHP mails the dental provider a reply to the authorization request. The criteria for general anesthesia applies only to treatment of clients who are younger than 21 years of age or ICF-MR. This form is not required for emancipated minors.

Refer to: "THSteps Dental Mandatory Prior Authorization Request Form" on page B-109 and "Criteria for Dental Therapy Under General Anesthesia" on page 19-33.

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19.12.1 Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia=22.

Age of patient at time of examination	Points
Less than 4 years of age	8
4 and 5 years of age	6
6 and 7 years of age	4
8 years of age and older	2

Treatment Requirements (Carious and/or Abscessed Teeth)	Points
1-2 teeth or one sextant	3
3-4 teeth or 2-3 sextants	6
5-8 teeth or 4 sextants	9
9 or more teeth or 5-6 sextants	12

Behavior of Patient**	Points
Definitely negative–unable to complete exam, patient unable to cooperate due to lack of physical or emotional maturity, and/or disability	10
Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs	4
Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal reponses and are not indications for treatment under general anesthesia	0
** Requires that narrative fully describing circumstances be present in the patient's chart	

Additional Factors**	Points
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**	15
Failed conscious sedation**	15
Medically compromising, handicapping condition**	15
** Requires that narrative fully describing circumstances be present in the patient's chart	

I understand and agree with the dentist's assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE: ____DATE: ______________

Patients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the patient chart. The patient chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST'S SIGNATURE: ____

DATE: ______________License No. _________________________

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19.12.2 Criteria for Dental Therapy Under General Anesthesia, Attachment 1

The following is medical dental policy regarding general anesthesia.

Purpose	To justify general anesthesia for dental therapy, the following documentation is required in the client's dental record.
Elements	Note those required (*) and those as appropriate (**)

1) * Client's Demographics including Date of Birth
2) * Relevant Dental and Medical Health History
   ** including Medical Evaluation Justifying Relevant Medical Condition(s)
3) * Dental Radiographs, Intraoral/Perioral Photography, and/or Diagram of Dental Pathology
4) * Proposed Dental Plan of Care
5) * Signed Consent by Parent/Guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of general anesthesia for dental care has been explained
6) ** Description of Relevant Behavior and Reference Scale
7) ** Other Relevant Narrative Justifying Need for General Anesthesia
8) * Completed Criteria for Dental Therapy Under General Anesthesia form
9) * The dentist's attestation statement and signature may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the chart as a stand-alone form:

I attest that the patient's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the patient's record and is available in my office.

REQUESTING DENTIST'S SIGNATURE: ________________________________

DATE:________________________

Month Day Year

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19.13 Hospitalization and ASC/HASC

Dental services performed in an ambulatory surgical center (ASC), hospital ambulatory surgical center (HASC), or a hospital (either as an inpatient or an outpatient) may be covered by THSteps on the medical or behavioral justification provided, or if one of the following conditions exist: the procedures cannot be performed in the dental office, or the client is severely disabled.

Important: *Contact the individual HMO for precertification requirements related to the hospital procedure.*

Reminder: *If services are precertified, the provider receives a precertification number effective for 90 days.*

In those areas of the state with Medicaid Managed Care, precertification or approval is *required* from the client's HMO for anesthesia and facility charges. It is the dental provider's responsibility to obtain precertification from the client's HMO or managed care plan for facility and general anesthesia services.

To be reimbursed by the HMO, the provider *must* use the HMO's contracted facility and anesthesia provider. These services are included in the capitation rates paid to HMOs, and the facility/anesthesiologist risk nonpayment from the HMO without such approval. Coordination of all specialty care is the responsibility of the client's primary care provider. The primary care provider must be notified by the dentist and/or the HMO of the planned services.

Dentists providing sedation/anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation/anesthesia provided.

The dental provider must be in compliance with the guidelines detailed in "Criteria for Dental Therapy Under General Anesthesia" on page 19-32.

Note: *Post-treatment authorization will not be approved for codes that require mandatory prior authorization.*

19.13.1 Billing TMHP

The examining physician, anesthesiologist, hospital, ASC, or HASC must bill TMHP separately for the medical and facility components of their services. The claim forms used are the CMS-1500 or the HCFA-1450 (UB-92):

- Type of service (TOS) 7, CPT code 00170 with modifier EP, is for the anesthesiologist or certified registered nurse anesthetist (CRNA) to use on the claim form.
- TOS F, CPT code 41899 with modifier EP, is for the facility to use on the claim form.
- Diagnosis codes such as 52100 (dental caries) and 5220 (pulpitis) are to be used on the claim form by both provider types.
- Modifier EP identifies that the service is associated with THSteps.

Provider	Diagnosis Code	TOS	CPT Code
HASC	52100, 5220	F	41899 with modifier EP
ASC	52100, 5220	F	41899 with modifier EP
ANES	52100, 5220	7	00170 with modifier EP
CRNA	52100, 5220	7	00170 with modifier EP
Use CMS-1500 or HCFA-1450			

To satisfy the preadmission history and physical examination requirements of the hospital, ASC, or HASC, a THSteps medical checkup for dental rehabilitation/restoration may be performed by the child's primary care provider. Physicians who are not enrolled as THSteps medical providers should bill for the examination of a client before the procedure with the appropriate evaluation and management code from the following table:

Procedure Code	Place of Service (POS)
1-99202	POS 1 (office)
1-99222	POS 3 (inpatient hospital)
1-99282	POS 5 (outpatient hospital)

Providers enrolled in THSteps Medical should refer to "Exceptions to Periodicity" on page 43-9.

Note: *The dental provider should bill TMHP using the "2002 ADA Dental Claim Form" on page 5-44 to be considered for reimbursement through THSteps Dental Services.*

Refer to: "2002 ADA Dental Claim Electronic Billing" on page 5-43.

19.13.2 Claim Form Completion

All claims, including those from the anesthesiologist and the hospital, ASC, or HASC, must include the appropriate national procedure code(s).

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19.14 Claims Information

All THSteps and ICF-MR claims *must* be received by TMHP within 95 days from each date of service and submitted to the following address:

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

Claims for services may be filed electronically or on paper.

Claims for emergency, orthodontic, or routine services must each be filed on separate forms. Mixing codes will cause the claim to be denied.

A claim submitted for either emergency or orthodontic services must be marked at the proper box for processing.

A THSteps and ICF-MR dental provider cannot bill Medicaid under his individual performing provider identifier for the services provided by one or more associate dentists practicing in his office as employees or independent contractors with specific employer-employee or contractual relationships. These dentists must enroll as THSteps dental providers regardless of employer relationships. The individual provider billing may be reimbursed into a single accounting office to maintain these described relationships.

Note: *A dentist must not use another dentist's provider identifier.*

In any case, a dental group must provide evidence that the practice is 100 percent owned by currently licensed dentists.

The Texas Medicaid Program cannot be billed by a provider for appointments missed by clients. A client with Medicaid coverage cannot be billed for failure to keep an appointment. Only claims for actual services rendered are considered for payment.

Providers should bill Medicaid their usual and customary fees.

The Remittance and Status (R&S) reports received from TMHP should be filed in sequential order in a binder in the provider's office. Electronic R&S reports should be copied for storage.

Refer to: "2002 ADA Dental Claim Filing Instructions" on page 5-43.

"Billing Clients" on page 1-9.

19.14.1 Claim Appeals

Claims filed for appeal must be received by TMHP within 120 days from the date of the R&S report. A claim denied because of age restrictions listed in the Medicaid dental fee schedule may be considered for reimbursement on appeal when client medical necessity is provided to the TMHP Dental Director.

All denied claim appeals (see "Appeals" on page 6-1) must be submitted to TMHP with the exception of a request to waive late filing deadlines. TMHP does not have the authority to waive state or federal mandates regarding claim filing deadlines.

If after all appeal processes at TMHP are exhausted, and the provider remains dissatisfied with TMHP's decision concerning the appeal, the provider may file a complaint with the HHSC Claims Administrator Contract Management Unit.

Refer to: "Administrative Claim Appeals" on page 6-4.

Note: *Providers must exhaust the appeals process with TMHP before filing a complaint to the HHSC Claims Administrator Contract Management Unit.*

Refer to: "Paper Appeals" on page 6-3.

19.14.2 Dental Claims Appeal Information

Providers may use three methods to appeal Medicaid claims to TMHP: telephone (AIS), paper, or electronically.

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

The following claims must be appealed on paper; they *cannot* be appealed either electronically or by using AIS:

- Claims listed on the R&S report as incomplete. These include claims missing required information, such as the signature on the claim. Resubmit the corrected claim with a copy of the R&S for reprocessing to the TMHP physical address, Attn: Inquiry Control Unit
- Claims requiring supporting documentation (for example, operative reports, dental records, dental radiographs, or narratives)
- Claims listed as pending or in process with an explanation of pending status (EOPS) message. These claims have not been finalized at the time the R&S report was generated; and therefore, they cannot be appealed
- Claims denied as past filing deadline. The provider must provide a copy of a previous R&S report as proof the claim was received by TMHP within the filing deadline

To appeal in writing:

- If a claim cannot be appealed electronically or by telephone, appeal the claim on paper by completing the following steps:
  1) Provide a copy of the R&S page where the claim is reported.
  2) Circle one claim per R&S page.
  3) Identify the information that was incorrectly provided and note the correct information that should be used to appeal the claim. If necessary, specify the reason for appealing the claim.
  4) Attach radiographs or other necessary supporting documentation.

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5) If available, attach a copy of the original claim. Claim copies are helpful when the appeal involves dental policy or procedure coding issues.
6) Do not copy supporting documentation on the opposite side of the R&S report.
7) It is strongly recommended that providers submitting paper appeals retain a copy of the documentation being sent. It is also recommended that paper documentation be sent via certified mail with a return receipt requested to establish TMHP's receipt of the claim and the date the claim was received. The provider is urged to retain copies of multiple claim submissions if the Medicaid provider identifier is pending.

Note: *Providers have 95 days from the issuance of the provider identifier to submit claims.*

8) Submit the paper appeal with supporting documentation and any radiographs and adjustment requests to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

To appeal by telephone:

1) Contact the Dental Line at 1-800-568-2460
2) For each claim in question, have the R&S listing the claim and any supporting documents readily available
3) Identify the claim submitted for appeal. The internal control number (ICN) will be requested
4) Supply the information necessary to correct the claim, such as the missing tooth number or letter, the corrected procedure code, surface ID, or Medicaid number

The appeal will appear as finalized or pending on the following week's R&S report.

Providers may also appeal electronically.

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer (PC). The electronic appeals feature can be accessed by a business organization bridging directly into the TMHP EDI Gateway or by using TDHconnect, the free Windows-based software available from TMHP. For additional information, contact the TMHP EDI Help Desk at 1-888-863-3638.

Electronic appeals can increase accuracy of claims processing, resulting in a more efficient case flow to the provider:

- Download and printout capabilities help maintain audit trails for the provider.
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time.

Electronic appeals submission is available to business organizations (for example, billing organizations, vendors, and clearinghouses) and interfaces directly with TMHP EDI or through TDHconnect.

19.14.3 Frequently Asked Questions About Dental Claims

Q Why is routine dental treatment not covered when performed at the same visit as an emergency visit?

A The following are reasons routine dental treatment is not covered when performed at the same visit as an emergency visit:

- The purpose of an emergency claim is to allow the provider to treat a true emergency without the concern that routine dental procedures may be denied.
- Medicaid Program policy guidelines do not allow payment for both types of services to the same provider at the same visit. True emergency claims process through the audit system correctly when "emergency" is checked on either the paper or electronic claim and the Remarks or Narrative section of the claim form describes the nature of the emergency.

Q Why are some claims for oral exams and emergency exams on the same date for the same client denied?

A Medicaid Program policy does not allow an initial oral exam and an emergency exam to be billed on the same date of service for the same client. An emergency exam performed by the same provider in the same six-month time period as an initial exam may be considered for reimbursement only when the claim for the emergency exam indicates it is an emergency and the emergency block is marked. If the claim is not marked as an emergency, the claim will be denied.

Q How are orthodontic bracket replacements reimbursed? Can the client be charged for bracket replacements?

A The provider uses orthodontic procedure code D8690 to claim reimbursement. Medical necessity must be documented in the client record. Payment is subject to retrospective review.

Important: *The client should not be charged for bracket replacement. If the provider charges the client erroneously, the provider refunds any amount paid by the client.*

Q Why could an appeal of a denied claim take a long time?

A An appeal can take a long time if TMHP is required to research the denied claim and determine the reason the claim did not go through the system.

For faster results, providers should submit appeals as soon as possible and not use the entire 120 days allowed to submit the appeal.

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The following are guidelines on filing claims efficiently:

- Use R&S report dates to track filed claims.
- File claims electronically through TMHP EDI. Electronic billing does not allow a claim with an incorrect date to be accepted and processed, which saves time for the provider submitting claims and TMHP in processing claims. Call 1-888-863-3638, for more information about TMHP EDI.
- File claims with the correct information included. Most denied claims result from the omission of dates, signature, and narrative, or incorrect ID numbers such as client Medicaid numbers or provider identifiers.

Q Why are only ten appeals allowed per call?

A There is a limit on appeals per call to allow all providers equal access.

Q Why do reimbursement checks sometimes take a long time to arrive?

A Reimbursement may be delayed if a provider fails to submit claims in a timely manner.

Q Does electronic billing result in delayed payment?

A No. Providers who bill electronically report faster results than billing on paper. Providers are encouraged to use TMHP EDI for claims submission.

The following are helpful hints to a more efficiently processed claim:

- Ensure the provider identifier is on all claims
- Include a proper signature on all paper claims
- Verify client eligibility for procedures
- Verify if the procedure code requires a narrative on the claim; the narrative is for medical necessity
- Include the required client information, including name, birth date, and client number
- Dental auxiliaries cannot enroll in Medicaid; therefore, they cannot bill Medicaid. Any procedure performed by the auxiliary (i.e., the hygienist or the chairside assistant) must be billed by the supervising dentist, using the dentist's provider identifier

Reminders:

- Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions are given to clients to be filled by the pharmacy. The pharmacy is reimbursed by the Medicaid Vendor Drug Program.
- Procedure code D8660 is allowed at different age levels, per provider. If D8660 is billed within six months of D8080, the D8080 will be reduced by the amount that was paid for D8660.
- Prior authorization is required with documentation of medical necessity when replacing lost or broken orthodontic retainers (D8680).
- Prior authorization of orthodontic services is nontransferable. If a client changes an orthodontic provider for any reason, the new provider must submit a separate request for prior authorization. The provider requesting and receiving authorization for the service also must perform the service and submit the claim. Codes listed on the authorization letters are the only codes considered for payment. All other codes billed are denied. Providing the authorization number on the submitted claim results in more efficient claims processing.
- General anesthesia (provided in the dentist office, ambulatory service clinic, and inpatient/outpatient hospital settings) does not require prior authorization, but is required to follow the Criteria for Dental Therapy Under General Anesthesia (see page 19-32) to determine if a client meets the minimum required points for general anesthesia. All THSteps dental charts for dental general anesthesia are subject to retrospective, random review for compliance with the Criteria for Dental Therapy Under General Anesthesia and requirements for chart documentation.
- Do not bill a client unless a formal denial for the requested item/service has been issued stating the service is not a Medicaid benefit and the client has signed the Client Acknowledgement Statement for that specific item/service. *A provider must not bill Medicaid clients if the provided service is a Medicaid benefit.*

Refer to: "Client Acknowledgment Statement" on page 1-10.

19.15 Written Informed Consent and Standards of Care

Only THSteps clients or their parents or legal guardians can give written informed consent. THSteps clients or their parents or legal guardians who can give written informed consent must receive information following an oral evaluation about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for administration of sedation or anesthesia, including risks. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before implementation. The parent or guardian being present at the time of the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 22 TAC §108.2, *Fair Dealing*.

Important: *All standards of care must be adhered to per TSBDE Rules.*

THSteps clients must receive:

- Dental services specified in the treatment plan that meet the standards of care established by the laws relating to the practice of dentistry and the rules and regulations of the TSBDE
- Dental services free from abuse or harm from the provider or the provider's staff
- Only the treatment required to address documented medical necessity that meets professionally recognized standards of healthcare as recognized by the TSBDE

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Refer to: "American Academy of Pediatric Dentistry Periodicity Guidelines" on page N-2

"American Dental Association Guidelines for Prescribing Dental Radiographs" on page N-5

19.16 Parental Accompaniment

THSteps providers are required to comply with the current *Texas Human Resources Code* provisions regarding parental accompaniment.

Refer to: "Parental Accompaniment" on page K-2.

19.17 Reimbursement

The fees included in the Medicaid dental fee schedule are determined as access-based fees under 1 TAC §355.8085. The fees are based upon a percentage of billed charges in accordance with 1 TAC §355.8443 and 1 TAC §355.8445. High volume provider payments for dentists are detailed in "Additional Payments to High-Volume Providers" on page 2-6.

Reimbursement for THSteps and ICF-MR dental services is the lesser of the following:

- The provider's usual and customary fee, which is the fee that the provider charges non-Medicaid clients (including private-pay clients) for the same service. If a provider offers or provides services to non-Medicaid clients at no charge, then the provider cannot bill Medicaid for similar services provided to Medicaid clients. If a provider offers or provides services to non-Medicaid clients at discounted fees or fees reduced in any fashion, including, but not limited to, sliding scales or advertised specials, the provider cannot bill Medicaid for similar services provided to Medicaid clients with fees higher than those available to non-Medicaid clients; *or*
- The maximum fee listed in the "Medicaid Dental Fee Schedule" on page 19-9; *or*
- The adjusted fee, which is below the maximum fee for the specific procedure due to payment limitations specified for that code, because HHSC partially pays for services on the same tooth, or because the degree of difficulty, as determined by review of the radiographs or lab charges, does not justify the maximum fee; *or*
- The fee authorized by TMHP for any dental services identified in the Medicaid dental fee schedule as requiring individual consideration (manually priced).

Reimbursement is limited to services for Medicaid and THSteps or ICF-MR clients for the date of service. It is the provider's responsibility to ensure client eligibility by reviewing the client's Medicaid Identification Form (Form H3087), or the Medicaid Eligibility Verification Form (Form H1027), or by calling AIS at 1-800-925-9126.

Reimbursement for THSteps dental services provided in an FQHC is based on an all-inclusive rate per visit calculated in accordance with 1 TAC §355.8261. Specific dental procedure codes that meet the definition of a visit are marked with an asterisk (*). All other dental procedure codes are processed as informational.

Refer to: 1 TAC §355.8443 and 1 TAC §355.8445 for payment of claims for dental services under EPSDT (THSteps).

"Medicaid Identification Form H3087" on page 4-18.

19.18 Third Party Resources (TPR)

For THSteps and ICF-MR dental claims, *TMHP* is responsible for determining if a third party resource (TPR) exists and for recouping payment from the TPR.

When the client's Medicaid Identification Form (Form H3087) shows a P in the TPR column indicating the presence of other health insurance, THSteps and ICF-MR dental providers are *not* required to pursue TPR. The P does not distinguish between medical or dental. Therefore, when clients do not have a readily available private dental insurance identification/verification, dental providers should bill TMHP for reimbursement.

THSteps and ICF-MR dental providers unable to determine whether the client's other insurance provides coverage for dental services should file the claim directly to TMHP. TMHP will reimburse the claim and pursue payment from any other TPR. If a recoupment is made from another payment resource, TMHP will make the appropriate post-payment reconciliation with the dental provider.

Refer to: "Automated Inquiry System (AIS)" on page -xiii.

19.19 Documentation Requirements

The provider should be certain that all staff members, including dentists, are aware of the following documentation requirements and charting procedures:

- For THSteps and ICF-MR dental claims, providers are not required to submit pre- and post-op radiographs unless it is specifically requested by HHSC, the TMHP Dental Director, or is needed for prior authorization and/or pre-payment review.
- Documentation of all restorative, operative, crown and bridge, and fixed and removable prosthodontics procedures must include medical necessity consistent with professionally recognized standards of health care as recognized by TSBDE. Documentation should include appropriate pretreatment, precementation and postcementation radiographs, study models and working casts, lab prescriptions, and invoices. A panoramic radiograph without additional bitewing radiographs is inadequate as a diagnostic tool for caries detection.
- All documentation must be maintained in the client's record for a period of five years to support the medical necessity at the time of any post payment utilization review. All documentation, including radiographs, must be of diagnostic and appropriate quality.

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- In any situation where radiographs are required but cannot be obtained, then intraoral photographs must be in the chart.
- Any complications, unusual circumstances encountered, morbidity, and mortality must be entered as a complete narrative in the client's record.
- A provider must maintain a minimum standard of care through appropriate and adequate records, including a current history, limited physical examination, diagnosis, treatment plan, and written informed consent as a reasonable and prudent dentist would maintain. These records as well as the actual treatment must be in compliance with all state statutes, the *Dental Practice Act*, and the TSBDE Rules.
- Documentation for endodontic therapy must include the following: the medical necessity, pretreatment, during treatment and post-treatment periapical radiographs, the final size of the file to which the canal was enlarged, and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be entered in the chart. Endodontic therapy must be in compliance with the American Association of Endodontists quality assurance guidelines.
- Documentation for most periodontal services requires a six-point per tooth depth of pocket charting, a complete mouth series of periapical and bitewing radiographs, and any other narratives or supporting documentation consistent with the nationally accepted standards of care of the specialty of periodontics, and which conform to the minimum standard of care for periodontal treatment required of Texas dentists. A panoramic radiograph without additional bitewing or periapical radiographs is considered inadequate for diagnosis of periodontal problems.
- Documentation for surgical procedures requiring a definitive diagnosis for billing a specific ADA code necessitates that a pathology report and a written record of clinical observations be present in the chart, together with any appropriate radiographs, operative reports, and appropriate supporting documentation. All impactions, surgical extractions, and residual tooth root extractions require appropriate preoperative periapical and/or panoramic radiographs (subject to limitations) be present in the chart.
- Any documentation requirements or limitations not mentioned in this manual that are present in the CDT are applicable. The written documentation requirements or limitations in this manual supercede those in the CDT.

19.20 Laboratory Requirements

Dental laboratories must be registered with TSBDE laboratories, and technicians must not be under restrictions imposed by TSBDE or a court.

19.21 Utilization Review

DSHS or a designated entity may conduct utilization reviews through automated analysis of a provider's pattern(s) of practice, including peer group analysis. Such analysis may result in a subsequent on-site utilization review. DSHS or its claims processing contractor may conduct utilization reviews at the direction of the Office of Inspector General (OIG), according to HHSC rules.

Refer to: 25 TAC, Chapter 33, Subchapter H for more information about utilization review.

19.22 Orthodontic Services (THSteps)

19.22.1 Mandatory Prior Authorization

Prior authorization is *required* for THSteps orthodontic services except for procedure code D8660.

If orthodontic treatment is medically indicated, providers are responsible for obtaining authorization for a complete orthodontic treatment plan while the client is eligible for Medicaid and THSteps and younger than 21 years of age.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Upon receipt of authorization of complete treatment plans, providers are to advise clients that they will be able to receive the approved treatment services (e.g. orthodontic adjustments, bracket replacements and retainers), even if they lose Medicaid eligibility or reach 21 years of age. Approved orthodontic treatment *must* be initiated before the loss of Medicaid eligibility and completed within 36 months of the authorization date.

The prior authorization request must contain the date of service that the records were produced.

Important: *The dentist should be certain that radiographs, photographs, and other information are properly packaged to avoid damage. TMHP is not responsible for lost or damaged materials.*

Note: *Submit all orthodontic services for Medicaid Managed Care clients following these guidelines. STAR and STAR+PLUS are not responsible for orthodontic services.*

Requests for orthodontic services *must* be accompanied by all the following documentation:

- An orthodontic treatment plan. The treatment plan must include all procedures required to complete full treatment (such as, extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, appliance removal if indicated, special orthodontic appliances, etc.). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.
- Cephalometric radiograph with tracing models

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- Completed and scored Handicapping Labio-Lingual Deviations (HLD) sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases)
- Facial photographs
- Treatment plan that *must* include all procedures required to complete full treatment (for example, extractions, orthognathic surgery, upper and lower appliances, monthly adjustment, appliance removal if indicated, special orthodontic appliances, bracket replacements, etc.)
- Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (original films—copies are not accepted)
- Any additional pertinent information as determined by the dentist or requested by TMHP's Dental Director

Requests for crossbite therapy require properly trimmed models to be retained in the office and must demonstrate the following criteria:

- *Posterior teeth*. Not end to end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth.
- *Anterior teeth*. The incisal edge of upper should be lingual to the incisal of the opposing arch.

19.22.2 Completion of Treatment Plan

If a client reaches 21 years of age or loses Medicaid eligibility before the authorized *orthodontic treatment* is completed, reimbursement is provided to complete the orthodontic treatment that was authorized and initiated while the client was younger than 21 years of age, eligible for Medicaid and THSteps, and completed within 36 months.

Any nonorthodontic service requested (e.g., extractions or surgeries) must be completed before the loss of client eligibility.

Services *cannot* be added or approved after Medicaid THSteps eligibility has expired.

19.22.3 Benefits and Limitations

Orthodontic services include the following:

- Correction of severe handicapping malocclusion as measured on the Handicapping Labio Lingual Deviation (HLD) Index. Refer to page 19-47 for information on how to score the HDL. A minimum score of 26 points is required for full banding approval (only permanent dentition cases are considered)

Exception: *Retained deciduous teeth and cleft palates with gross malocclusion that will benefit from early treatment. Cleft palate cases do not have to meet the HLD 26-point scoring requirement. However, it is necessary to submit a sufficient narrative and/or outline of the proposed treatment plan when requesting authorization for orthodontic services on cleft palate cases.*

- Crossbite therapy
- Head injury involving severe traumatic deviation
- Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces

The following limitations apply for orthodontic services:

- Orthodontic services for cosmetic purposes only are not a benefit of Medicaid or THSteps.
- Except for D8660, *all* orthodontic procedures require authorization for reimbursement.
- The THSteps client *must* be Medicaid/THSteps-eligible when authorization is requested and the orthodontic treatment plan is initiated. It is the provider's responsibility to see that the client has a current Medicaid Identification Form (Form H3087) or Medicaid Eligibility Verification Form (Forms H1027 and H1027 A-C) and that the date of birth on the form indicates the client is 21 years of age or younger and no limitations are indicated.
- Authorization is issued to the requesting provider only and is not transferable to another provider. If the client changes providers or if the provider stops practicing dentistry for whatever reason, a new prior authorization must be requested (see "Transfer of Services" on page 19-42).

The following procedure codes, policies, and limitations are applied to the processing and payment of orthodontic services under THSteps dental services:

- Procedure code D8660 is allowed when:
  - The client is referred to an orthodontist for a determination whether orthodontic services are indicated and to determine the appropriate time to initiate such services.
  - The client is referred to an orthodontist and elects to receive services from another orthodontic provider because of justifiable reasons.
  - Repeat visits at different age levels are required to determine the appropriate time to initiate orthodontic treatment.
- Procedure code D8680 is payable for one retainer per arch, per lifetime, and may be replaced once because of loss or breakage (prior authorization is required).
- Procedure code D8670 should be billed only when an adjustment to the appliances is provided and may not be billed before the date the orthodontic adjustment was performed. The number of visits for monthly adjustments to the appliances is restricted to the number that was authorized in the treatment plan.
- Procedure code D8670 is paid only in conjunction with a history of braces (code D8080), unless special circumstances exist.
- All orthodontic codes and appliances are global fees.
- Separate fees for adjustments to retainers are not payable.
- The appropriate code should be billed for those appliances required as part of the treatment of cleft palate cases.

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- Special orthodontic appliances may also be used with full banding and crossbite therapy with approval by the TMHP Dental Director.
- Procedure codes D5951, D5952, D5953, D5954, D5955, D5958, D5959, and D5960 are to be used as applicable with documentation of medical necessity. Otherwise, use the appropriate special orthodontic appliance code.
- Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is allowed once per lifetime.

Exception: *Cases of mixed dentition when the treatment plan includes extractions of remaining primary teeth or cleft palate.*

- Crossbite therapy is allowed for primary, mixed, or permanent dentition.
- Do not request crossbite correction (limited orthodontics) for a mixed dentition client when there is a need for full banding in the adult teeth. Crossbite therapy is an inclusive charge for treating the crossbite to completion, and additional reimbursement is not provided for adjustments or maintenance.
- If a case is not approved, the dentist may file a claim for payment of the diagnostic work-up necessary to obtain the authorization using procedure codes D0330, D0340, D0350, *and* D0470. The dentist may receive payment under these procedure codes for no more than two cases out of every ten cases denied. The dentist should determine if the client's condition meets orthodontic coverage criteria before performing a diagnostic work-up.
- Procedure codes D8080, D8050, and D8060, are limited to one per lifetime.

19.22.4 Premature Removal of Appliances

The overall fee for orthodontic appliances (braces, procedure code D8080) includes the removal of appliances. Procedure code D7997 may be used only when the appliances were placed by a different provider with an unaffiliated practice (not a partner or office-sharing arrangement) and one of the following conditions exist:

- There is documentation of a lack of cooperation from the client.
- The client requests premature removal and a release form has been signed by the parent, guardian, or client if he is at least 18 years of age.

Providers must keep a copy of the release form on file and are responsible for this documentation during a review process.

19.22.5 Transfer of Services

Authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new authorization to complete the orthodontic treatment initiated by the original provider.

The following supporting documentation must accompany the new request for orthodontia services and must include the date of service the documentation was obtained (the date of service the records were produced):

- All of the documentation as required for the original provider
- The reason the client left the previous provider
- An explanation of the treatment status
- A compete treatment plan addressing all procedures for which authorization is being requested (such as the number of monthly adjustments or retainers required to complete the case)
- A full diagnostic work-up (D8080) with an HLD Index. The score of 26 points will be modified according to any progress achieved

Exception: *The authorization requests for clients who already have orthodontic appliances and subsequently become eligible for Medicaid do not require models or the HLD score sheet, nor does the client have to meet the HLD Index of 26 points. However, a complete plan of treatment is required.*

Documentation should include the reason for leaving the previous provider and the new plan of treatment. The new provider may submit a full diagnostic work-up (D8080) with scoring. The HLD score of 26 will be modified according to any progress achieved.

Exception: *The authorization requests for clients who already have orthodontic appliances and subsequently become eligible for Medicaid do not require models or the HLD score sheet, nor does the client have to meet the HLD score of 26 (see page 19-48); however, a complete plan of treatment is required.*

To request authorization to complete the orthodontic treatment initiated by another provider, complete a Dental Services Authorization Request Form and send it with the complete plan of treatment and appropriate documentation for orthodontic services and/or crossbite therapy to the TMHP Dental Director at the following address:

Texas Medicaid & Healthcare Partnership
THSteps and ICF-MR Dental Authorization and Information
PO Box 202917
Austin, TX 78720-2917

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19.22.6 Orthodontic Procedure Codes and Fee Schedule

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

Procedure Code	Limitations	Maximum Fee
	Orthodontic Services	
D0330, D0340, D0350, and D0470*	Payment is limited to two denied cases of every ten cases submitted for authorization. D0330 and D0340 and D0350 and D0470 *These four procedure codes, when billed together, replace local procedure code Z2010.*	$100.00
D7280		$87.50
D7997*	Replaces Z2016. Not payable to the dentist who placed the appliance. Includes removal of arch bar and premature removal of braces.	$50.00
	Interceptive Orthodontic Treatment	
D8050*	Replaces Z2018 and 8110D. Limited to one per lifetime.	$340.00
D8060*	Replaces Z2018 and 8120D. Limited to one per lifetime.	$340.00
* = Services payable to an FQHC based for a client encounter.		

19.22.7 Comprehensive Orthodontic Treatment

With implementation of the *Health Insurance Portability and Accountability Act* (HIPAA) code standardization, certain local orthodontia codes were deleted and mapped to a new national procedure code. Effective October 16, 2003, national procedure code D8080 replaced the three orthodontic local procedure codes Z2009, Diagnostic work-up approved, Z2011, Orthodontic appliance, upper, and Z2012, Orthodontic appliance, lower.

National procedure codes do not allow for any work-in-progress or partial billing by separating the three orthodontic components. Claims from Medicaid providers billed in this manner will be denied.

When billing for these services, the local codes must be submitted as remarks codes along with the national procedure code D8080. Local codes (Z2009, Z2011 or Z2012) are placed in the Remarks Code field on electronic claims or Block 35 on paper claims.

Note: *If the remarks code and procedure code D8080 are not submitted, the claim will be denied.*

Each remarks code pays the correct reimbursement rate which, when combined, totals the maximum payment of $775. D8080 must be billed on three separate details, with the appropriate remarks code, even if billing for the work-up and full banding. Billing only one detail for a total of $775 will not be accepted.

Example 1: A client is approved for full banding, but after the initial work-up, the client discontinues treatment. This provider would bill the national code D8080 and place the local code Z2009, Diagnostic work-up approved, in the Remarks/comment field. The claim would pay $175.

Example 2: A client is approved for full banding. The provider continues treatment and places the maxillary bands. The provider would bill the national procedure code D8080 and place the local code Z2009, Diagnostic work-up approved, and Z2011, Maxillary bands, in the Remarks/comment field. The claim would pay $475.

Important: *All electronic claims for D8080 must have the appropriate remarks code associated with the procedure code.*

Providers should adhere to the following guidelines for electronic claim submission so that TMHP can accurately apply the correct remarks code to the appropriate claim detail.

A Diagnostic Procedure Code (DPC) remarks code must be submitted, only once, in the first three bytes of the NTE02 at the 2400 loop.

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Example 1: For a claim with one detail, submitted with procedure code D8080 and remarks code Z2009, enter the information as follows: DPCZ2009. The total billed would be $175.

Example 2: For a claim with two details, where details one and two are procedure code D8080 and the remarks codes are Z2009 and Z2011, enter the information as follows: DPCZ2009Z2011. The total billed would be $475.

Example 3: For a claim with three details, where all three details are submitted separately with procedure code D8080, enter the remarks code based on the order of the claim detail as follows: DPCZ2009Z2011Z2012. The total billed would be $775.

This method ensures accurate and appropriate payment for services rendered and addresses the need for partial billing.

Procedure Code	Limitations	Maximum Fee
D8080*	Replaces Z2009, Z2011, and Z2012. Limited to one per lifetime.	$775.00
Minor Treatment to Control Harmful Habits		
D8210*	See separate table for associated remarks field code.	See separate table
D8220*	See separate table for associated remarks field code.	See separate table
Other Orthodontic Services		
D8660*	Replaces Z2008.	$15.00
D8670*	Replaces Z2013.	$68.10
D8680*	Replaces Z2014 and Z2015.	$100.00
D8690*	Bracket replacement.	$20.00
D8691		NC
D8692		NC
D8999		Manually priced
Special Orthodontic Situations		
D5951		$140.00
D5952		$843.75
D5953		$843.75
D5954		$443.75
D5955		$225.00
D5958		$225.00
D5959		$100.00
D5960		$100.00
*** = Services payable to an FQHC based for a client encounter.**		

Effective for dates of service on or after October 16, 2003, all removable or fixed orthodontic appliances must be billed with national procedure code D8210 or D8220. To ensure appropriate claims processing, the DPC remarks code reflecting the specific service is also required. The appropriate remarks codes must be entered on the authorization request form. Place the appropriate remarks code in Block 35 (Remarks) of the dental paper claim form and in the Comments field of the electronic claim to ensure correct authorization, accurate records, and reimbursement. Failure to enter the DPC remarks code and the appropriate procedure code will not result in claim denial; however, manual intervention is required to process the claim, which may result in a delay of payment.

All electronic claims for special appliances (D8210 and D8220) must have the appropriate DPC remarks code associated with the procedure code.

Providers should adhere to the following steps for electronic claim submission (other than TDHconnect) so that TMHP can accurately apply the correct remarks code to the appropriate claim detail.

The prefix, DPC, must be submitted, only once, and in the first three bytes of the NTE02 at the 2400 loop.

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Example 1: For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two (i.e., D8670) is not submitted with procedure code D8210, enter the information as follows with a space between the DPC remarks codes, as follows: DPC1014D 1046D.

Example 2: For a claim with three details, where details two and three are submitted with procedure code D8210 and detail one (i.e., D8670) is not submitted with procedure code D8210, enter the information with a space after the DPC, as follows: DPC 1014D1046D.

Example 3: For a claim with three details, where all three details are submitted procedure code D8210, in bytes 4–8, submit the DPC remarks code based on the order of the claim detail.

The following table identifies the appropriate DPC remarks codes to use when requesting authorization or billing for procedure code D8210 or D8220:

Procedure Code	Remarks Code	Remarks Code Description	Maximum Fee
		Special Orthodontic Appliances	
D8220*	DPC1000D	Appliance with horizontal projections	$250
D8220*	DPC1001D	Appliance with recurved springs	$250
D8220*	DPC1002D	Arch wires for crossbite correction (for total treatment)	$595
D8220*	DPC1003D	Banded maxillary expansion appliance	$375
D8210*	DPC1004D	Bite plate/bite plane	$100
D8210*	DPC1005D	Bionator	$100
D8210*	DPC1006D	Bite block	$250
D8210*	DPC1007D	Bite-plate with push springs	$250
D8220*	DPC1008D	Bonded expansion device	$225
D8210*	DPC1010D	Chateau appliance (face mask, palatal exp and hawley)	$300
D8210*	DPC1011D	Coffin spring appliance	$275
D8220*	DPC1012D	Crib	$100
D8210*	DPC1013D	Dental obturator, definitive (obturator)	$250
D8210*	DPC1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)	$250
D8220*	DPC1015D	Distalizing appliance with springs	$250
D8220*	DPC1016D	Expansion device	$375
D8210*	DPC1017D	Face mask (protraction mask)	$350
D8220*	DPC1018D	Fixed expansion appliance	$375
D8220*	DPC1019D	Fixed lingual arch	$225
D8220*	DPC1020D	Fixed mandibular holding arch	$100
D8220*	DPC1021D	Fixed rapid palatal expander	$375
D8210*	DPC1022D	Frankel appliance	$100
D8210*	DPC1023D	Functional appliance for reduction of anterior openbite and crossbite	$375
D8210*	DPC1024D	Headgear (face bow)	$150
D8220*	DPC1025D	Herbst appliance (fixed or removable)	$250
D8220*	DPC1026D	Inter-occlusal cast cap surgical splints	$375
D8210*	DPC1027D	Intrusion arch	$100
D8220*	DPC1028D	Jasper jumpers	$100
D8220*	DPC1029D	Lingual appliance with hooks	$100
D8220*	DPC1030D	Mandibular anterior bridge	$175
*** = Services payable to an FQHC based on an all-inclusive rate per visit.**			

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Procedure Code	Remarks Code	Remarks Code Description	Maximum Fee
D8220*	DPC1031D	Mandibular bihelix (similar to a quad helix for mandibular expansion to attempt nonextraction treatment)	$100
D8210*	DPC1032D	Mandibular lip bumper	$100
D8220*	DPC1036D	Mandibular lingual 6x6 arch wire	$100
D8210*	DPC1037D	Mandibular removable expander with bite plane (crozat)	$275
D8210*	DPC1038D	Mandibular ricketts rest position splint	$375
D8210*	DPC1039D	Mandibular splint	$225
D8210*	DPC1040D	Maxillary anterior bridge	$175
D8210*	DPC1041D	Maxillary bite-opening appliance with anterior springs	$100
D8220*	DPC1042D	Maxillary lingual arch with spurs	$100
D8220*	DPC1043D	Maxillary and mandibular distalizing appliance	$100
D8220*	DPC1044D	Maxillary quad helix with finger springs	$325
D8220*	DPC1045D	Maxillary and mandibular retainer with pontics	$175
D8210*	DPC1046D	Maxillary Schwarz	$250
D8210*	DPC1047D	Maxillary splint	$225
D8210*	DPC1048D	Mobile intraoral Arch-Mia (similar to a Bihelix for nonextraction treatment)	$100
D8220*	DPC1049D	Modified quad helix appliance	$275
D8220*	DPC1050D	Modified quad helix appliance (with appliance)	$275
D8220*	DPC1051D	Nance appliance	$100
D8220*	DPC1052D	Nasal stent	$250
D8210*	DPC1053D	Occlusal orthotic device	$175
D8210*	DPC1054D	Orthopedic appliance	$250
D8210*	DPC1055D	Other mandibular utilities	$100
D8210*	DPC1056D	Other maxillary utilities	$100
D8220*	DPC1057D	Palatal bar	$225
D8210*	DPC1058D	Post-surgical retainer	$125
D8220*	DPC1059D	Quad helix appliance held with transpalatal arch horizontal projections	$275
D8220*	DPC1060D	Quad helix maintainer	$275
D8220*	DPC1061D	Rapid palatal expander (RPE), such as quad Helix, Haas, or Menne	$350
D8210*	DPC1062D	Removable bite plate	$100
D8210*	DPC1063D	Removable mandibular retainer	$100
D8210*	DPC1064D	Removable maxillary retainer	$100
D8210*	DPC1065D	Removable prosthesis	$175
D8210*	DPC1066D	Sagittal appliance 2 way	$250
D8210*	DPC1067D	Sagittal appliance 3 way	$350
D8220*	DPC1068D	Stapled palatal expansion appliance	$375
D8210*	DPC1069D	Surgical arch wires	$250
D8210*	DPC1070D	Surgical splints (surgical stent/wafer)	$250
D8210*	DPC1071D	Surgical stabilizing appliance	$250
D8220*	DPC1072D	Thumbsucking appliance, requires submission of models	$175
D8210*	DPC1073D	Tongue thrust appliance, requires submission of models	$100

*** = Services payable to an FQHC based on an all-inclusive rate per visit.**

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Procedure Code	Remarks Code	Remarks Code Description	Maximum Fee
D8210*	DPC1074D	Tooth positioner (full maxillary and mandibular)	$325
D8210*	DPC1075D	Tooth positioner with arch	$100
D8220*	DPC1076D	Transpalatal arch	$100
D8220*	DPC1077D	Two bands with transpalatal arch and horizontal projections forward	$175
D8220*	DPC1078D	W-appliance	$275
* = Services payable to an FQHC based on an all-inclusive rate per visit.			

19.23 Orthodontic Appliances

Effective for dates of service on or after October 16, 2003, all removable or fixed orthodontic appliances must be billed with national procedure code D8210 or D8220. To ensure appropriate claims processing, the local procedure code reflecting the specific service is also required. For paper claim submissions, enter the local procedure code in the remarks section of the claim form. For electronic submissions other than TDHconnect software submissions, follow the steps below to ensure TMHP accurately applies the correct local procedure code to the appropriate claim detail:

1) The DPC prefix must be submitted in the first three bytes of the NTE02 at the 2400 loop. The DPC prefix should only be submitted once.
2) In bytes 4-8, submit the remark code (local procedure code) based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate the detail is not billed with D8210 or D8220.

Example: *For a claim with three details, where details one and three are submitted with procedure code D8210 and detail two is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D. (The space shows that detail two needs no local code.) If all details require a local code, enter DPC, no spaces, and the appropriate local codes.*

To submit using TDHconnect software, enter the local code into the Remarks Code field, located under the details header. The Remarks Code field is the field directly after the Procedure Code field. TDHconnect submitters are not required to manually enter the DPC prefix as it is placed in the appropriate field on the TDHconnect electronic claim.

Failure to follow the above steps will cause the claims to deny.

The prior authorization request must include both the national code and remarks code. However, prior authorization requests may omit the DPC prefix to the eight-digit remarks code.

19.23.1 How to Score the Handicapping Labio-Lingual Deviation (HLD) Index

The orthodontic provider must complete and sign the diagnosis (Angle class).

Cleft Palate

Submit a cleft palate case in the mixed dentition only if it can be justified in a narrative why there should be treatment before the client is in the full dentition.

Note: *Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.*

Severe Traumatic Deviations

Refers to facial accidents only. Points cannot be awarded for congenital deformity. It does not include traumatic occlusions for crossbites.

Overjet in Millimeters

Score the case exactly as measured, then subtract 2 mm (considered the norm), and enter the difference as the score.

Overbite in Millimeters

Score the case exactly as measured, then subtract 3 mm (considered the norm), and enter the difference as the score. This would be double-counting.

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Mandibular Protrusion in Millimeters
Score the case by measurement in mm by the distance from the labial surface of the mandibular incisors to the labial surface of the maxillary incisor. Do not score both overbite and open bite.

Open Bite in Millimeters

Score the case exactly as measured. Measurement should be recorded from the line of occlusion of the permanent teeth—not from ectopically erupted teeth in the anterior segment. *Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.*

Ectopic Eruption

An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge. Do *not* include (score) teeth from an arch if that arch is to be counted in the following category of Anterior Crowding. For each arch, either the ectopic eruption *or* anterior crowding may be scored, but *not* both.

Anterior Crowding

Anterior teeth that require extractions as a prerequisite to gain adequate room to treat the case. If the arch expansion is to be implemented as an alternative to extraction, provide an estimated number of appointments required to attain adequate stabilization. Arch length insufficiency must exceed 3.5 mm to score for crowding on any arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as crowded.

Labio-Lingual Spread in millimeters

The score for this category should be the total, in millimeters, of the anterior spaces.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case *must* be considered *dysfunctional* and have a minimum of *26* points on the HLD index to qualify for any orthodontic care other than crossbite correction. Half-mouth cases cannot be approved.

The intent of the program is to provide orthodontic care to clients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

The proposals for treatment services should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch will be reviewed for duplication of purpose.

If attaining a qualifying score of 26 points is uncertain, provide a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Properly label and protect all records (especially plaster diagnostic models) when shipping. TMHP returns records adequately protected.

Refer to: “HLD Score Sheet” on page 19-48.

19.23.2 HLD Score Sheet

This sheet and a Boley Gauge are required to score.

Procedure:

- Occlude client or models in centric position.
- Record all measurements rounded-off to the nearest millimeter.
- Enter score 0 if the condition is absent.
- Overjet is measured from the most protrusive incisor.
- Overbite is measured from the labio-incisal edge of overlapped anterior tooth or teeth to point of maximum coverage.
- Ectopic eruption and anterior crowding: *Do not double-score.* Record the more serious condition.

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PLEASE PRINT CLEARLY:

<table>
<tr><td colspan="3">Patient Name:</td><td colspan="2">Date of birth:</td><td colspan="2">Medicaid ID:</td></tr>
<tr><td colspan="7">Address: (Street/City/County/State/Zip Code)</td></tr>
<tr><td colspan="6">CONDITIONS OBSERVED</td><td>HLD SCORE</td></tr>
<tr><td colspan="5">Cleft Palate</td><td>Score 15</td><td></td></tr>
<tr><td colspan="5">Severe Traumatic Deviations
Trauma/Accident related only</td><td>Score 15</td><td></td></tr>
<tr><td colspan="6">Overjet in mm. <u>Minus 2 mm.</u>
Example: 8 mm. – 2 mm. = 6 points</td><td>=</td></tr>
<tr><td colspan="6">Overbite in mm. <u>Minus 3 mm.</u>
Example: 5 mm. – 3 mm. = 2 points</td><td>=</td></tr>
<tr><td colspan="4">Mandibular Protrusion in mm.
See definitions/instructions to score (previous page)</td><td colspan="2">x5</td><td>=</td></tr>
<tr><td colspan="4">Open Bite in mm.
See definitions/instructions to score (previous page)</td><td colspan="2">x4</td><td>=</td></tr>
<tr><td colspan="4">Ectopic Eruption (Anteriors Only)
Reminder: Points cannot be awarded on the same arch for Ectopic Eruption and Crowding</td><td colspan="2">Each tooth x3</td><td>=</td></tr>
<tr><td>Anterior Crowding
10 point maximum total for both arches <u>combined</u></td><td>Max.</td><td colspan="2">Mand.</td><td colspan="2">= 5 pts. each arch</td><td>=</td></tr>
<tr><td colspan="6">Labio-Lingual Spread in mm.</td><td>=</td></tr>
<tr><td colspan="6">TOTAL</td><td>=</td></tr>
<tr><td colspan="2">Diagnosis</td><td colspan="5">For TMHP use only
Authorization Number</td></tr>
<tr><td colspan="2">Examiner:</td><td colspan="5">Recorder:</td></tr>
<tr><td colspan="7">Provider’s Signature

Please submit this score sheet with records</td></tr>
</table>

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19.23.3 Doctor of Dentistry Practicing as a Limited Physician

For dental services provided by a Doctor of Dentistry Practicing as a Limited Physician to Medicaid clients of any age, see "Physician" on page 36-1, for a complete description and details.

19.24 Medicaid Dental Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
THSteps-Dental Program:	
Automated Inquiry System (AIS)	xiii
Client Acknowledgement Statement	1-10
TMHP Electronic Data Interchange (EDI)	3-1
THSteps Dental (ADA) Claim Filing Instructions	5-43
TMHP Electronic Claims Submission	5-10
Criteria for Dental Therapy Under General Anesthesia	19-33
Communication Guide	A-1
THSteps Dental Mandatory Prior Authorization Request Form	B-109
THSteps Dental Claim Form Example	D-35
Acronym Dictionary	F-1
Doctor of Dentistry Practicing as a Limited Physician:	
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
Example of CMS-1500 Claim Form	5-26, D-10
Communication Guide	A-1
Acronym Dictionary	F-1

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20

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20.1 Overview

This section of the *Texas Medicaid Provider Procedures Manual* (TMPPM) includes information on family planning services funded by Medicaid and other non-Medicaid funding sources. Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. For information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from the Department of State Health Services (DSHS), refer to the website at www.dshs.state.tx.us/famplan/.

20.2 Funding Sources

TMHP processes family planning claims and encounters for four different funding sources administered through the Community Health Services Section at DSHS and the Texas Health and Human Services Commission (HHSC). These funding sources include Title V, X, XIX, and XX. Agencies across Texas are awarded contracts for Titles V, X, and XX to provide services to low-income individuals who may not qualify for Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities and medical schools, private nonprofit agencies, rural health clinics, and hospital districts. Some contractors receive more than one type of funding. All contractors serve Medicaid-eligible individuals. Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services differ for each funding source. Family planning funding is not used to provide abortion services.

20.2.1 Title V

Title V, or the Maternal and Child Health Block Grant of the *Social Security Act*, was passed in 1935 to provide a variety of services to low-income pregnant women and recently-delivered low-income mothers and their children. Title V funding can be used for several direct health services to women and children including prenatal care, family planning, dysplasia services, well-child care, sick-child care, and dental care for children. Title V also funds population-based projects. Texas receives a limited annual allocation of Title V funds from the federal government. In turn, contractor agencies across Texas are awarded a portion of the state's Title V grant to provide these needed services in their community.

20.2.2 Title X

Congress passed the *Family Planning Services and Population Research Act* in 1970, which added Title X to the *Public Health Services Act* 42 U.S.C 300 et seq. Title X is the only federal legislation that relates solely to family planning. The funding can be used to support payment for clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as direct medical services. Title X funding in Texas also supports population-based activities. Texas receives a limited annual allocation of Title X funds from the federal government. In turn, contractor agencies across Texas receive a portion of the state's Title X grant annually.

20.2.3 Title XIX (Medicaid)

Medicaid, or Title XIX of the *Social Security Act*, was created in Congress in 1965 as part of the "War on Poverty." Reimbursement is on a fee-for-service basis and paid after the services and supplies have been provided to eligible clients.

20.2.4 Title XX

Title XX, or the Social Services Block Grant of the *Social Security Act*, is the social services component of the *Social Security Act*. Title XX functions much like Title XIX (Medicaid) in that the agencies are reimbursed on a fee-for-service basis for services and supplies that have already been supplied to eligible clients. Title XX funds are used for individual and community-wide educational activities, as well as for direct medical care. DSHS receives an annual allocation of Title XX funds from the federal government and transfers a portion of the allocation to DSHS to provide family planning services. In turn, DSHS allocates these limited dollars to contractor agencies across Texas annually.

20.2.5 Guidelines for Family Planning Providers

Family planning services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). Medicaid clients, including limited and managed care clients, are allowed to choose any enrolled family planning service provider.

Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. Services must be provided without regard to age, marital status, sex, race/ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only family planning clients, not their parents, spouses, or any other individuals may consent to the provision of family planning services funded by Title X, XIX, or combined X and XX funds. However, counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult. For family planning services provided by Title V, the consent of a parent or other adult is governed by the *Texas Family Code*, Chapter 32. For more information, visit www.dshs.state.tx.us/famplan/contractor/rider13.shtm.

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20.3 Family Planning Claim Billing

20.3.1 Family Planning and Third Party Insurance

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance resources may jeopardize the client's confidentiality, prior insurance billing *is not a requirement for billing family planning for any title program*.

20.3.2 Claims Information

All family planning services (Titles V, X, XIX, and XX) provided by physicians, PAs, NPs, CNSs, and family planning agencies who also contract with DSHS for Title V, X, or XX must be submitted to TMHP in an approved electronic format or on the Family Planning 2017 (Revised January 2005) claim form. Providers may copy the Family Planning 2017 claim form provided in this manual on page 5-48 or download it from the TMHP website at www.tmhp.com. Medicaid family planning providers who do not also contract with DSHS for Title V, X, or XX, may use either the Family Planning 2017 claim form or the CMS-1500 claim form. Hospitals will continue to use the HCFA-1450 (UB-92) when billing family planning services. federally qualified health centers (FQHCs) may use either the HCFA-1450 (UB-92) or the Family Planning 2017 claim form to bill family planning Medicaid services. However, if an FQHC also contracts with DSHS to provide Titles V, X or XX family planning services, the Family Planning 2017 claim form/format must be used to submit all family planning claims, including Title XIX family planning claims. Call the TMHP Contact Center at 1-800-925-9126 for provider inquiries regarding family planning services, such as reimbursement rates, procedures, or claims filing questions.

20.3.2.1 Medicaid Managed Care

Providers *must* use the CMS-1500 (physician, nonfacility) or HCFA-1450 (UB-92) (hospital) claim forms and submit claims directly to Medicaid Health Maintenance Organizations (HMOs) for Title XIX family planning services. Title V, X, or XX claims must always be submitted to TMHP directly using the Family Planning 2017 (Revised January 2005) claims form/format.

Providers submitting claims for family planning services to TMHP for the Primary Care Case Management (PCCM) may use the Family Planning 2017 claim form. FQHCs submitting claims for family planning services to TMHP for the PCCM may use either the Family Planning 2017 claim form or the UB-92 claim form. However, if an FQHC also contracts with DSHS to provide Titles V, X or XX family planning services, the Family Planning 2017 claim form/format must be used to submit all family planning claims, including Title XIX family planning claims.

Hospitals will continue to use the HCFA-1450 (UB-92) when billing family planning services.

20.3.2.2 Billing HMOs for Out-of-Network Family Planning Services

Medicaid Managed Care including STAR+PLUS HMOs are responsible for reimbursing providers for family planning benefits. A family planning provider does not have to contract with the client's HMO to be reimbursed for family planning services. Title XIX (Medicaid) family planning providers should contact the client's health plan for billing instructions.

20.3.3 Sterilization Consent Form and Instructions

Per federal regulation 42 CFR 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Providers *must* use the consent form provided in this manual on pages B-92 and B-96. Ensure all required fields are completed for timely processing. These fields are listed in "Required Fields" on page 20-5.

Fax the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s). Fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send Family Planning sterilization correspondence to this fax number. Please ensure that both Page 1 and Page 2 of the sterilization consent form are faxed together. Failure to do so may delay claim processing or cause the claim to be denied.

Note: *Hysterectomy Acknowledgment forms discussed in Section 34 are not sterilization consents and should be faxed to 1-512-514-4218.*

20.3.3.1 Sterilization Consent Form Instructions

Clients must be *at least 21 years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exception: *Premature delivery—There must be at least 30 days between the date of consent and the client's expected date of delivery.*

Exception: *Cases of Emergency Abdominal Surgery not associated with pregnancy—There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.*

Listed below are field descriptions for the Sterilization Consent Form published in this manual. Completion of *all* sections is required to validate the consent form, with only two exceptions:

1) Race and ethnicity designation is requested but not required.

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2) The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. However, if this section is only partially completed, the consent will not be accepted as a valid consent.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation. Fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229.

20.3.3.2 Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Date of Birth (month, day, year)
- Client's Name [First and last names are required. This name should match the other *client name* fields on this form as well as on the associated claim(s)].
- Name of Doctor or Clinic
- Name of the Sterilization Operation.
- Client's Signature.
- Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.

Interpreter's Statement (If applicable)

- Name of Language Used by Interpreter.
- Interpreter's Signature.
- Date of Interpreter's Signature (month, day, year).

Statement of Person Obtaining Consent

- Client's Name (first and last names are required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent-The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) - Must be the same date as the client's signature date.
- Facility Name - Clinic/office where the client received the sterilization information.
- Facility Address - Clinic/office where the client received the sterilization information.

Physician's Statement

- Client's Name (first and last names are required).
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD.
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physician's Signature - Stamped or computer-generated signatures are not acceptable.
- Date of Physician's Signature (month, day, year) -This date must be on or after the date of surgery.

Paperwork Reduction Act Statement

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
- Date Client Signed the Consent (month, day, year)
- Provider identifier - Including the nine-digit provider identification number will expedite the processing of the consent form.
- Provider/Clinic Phone Number.
- Provider/Clinic Fax Number (If available).
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.

20.3.4 Use of the Family Planning 2017 Claim Form

To better serve family planning clients and track the family planning services provided, DSHS has mandated the use of the Family Planning 2017 (Revised January 2005) claim form for certain family planning services for Title XIX (Medicaid), if the provider is also a Title V, X, or XX contractor. Use this claim form when submitting claims/encounters for Title V, X, XIX or XX family planning services.

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Medicaid-only providers who do not also contract with DSHS for Title V, X, or XX may use either the Family Planning 2017 claim (Revised January 2005) form or the CMS-1500 claim form when billing the following family planning services; this list is not all-inclusive:

Procedure Code		
9-A4261	9-A4266	1-A4267
1-A4268	1-A4269	1-A9150 *with* modifier FP
1-H1010	1J1055	1-J1056
1-J3490	1-J7302	1-J7300*†
1-S9445 *with* modifier FP	1-S4993	1-55250
1-58600	1-99203 *or* 1-99214 *with* modifier FP*†	1-99213
1-99401 *with* modifier FP	1-99402 *with* modifier FP	1-99429 *with* modifier FP
2-11976	2-55200	2-55250
2-55450	2-55600	2-55605
2-55650	2-57170	2-58300
2-58301	2-58600	2-58605
2-58611	2-58615	2-58660
2-58661	2-58662	2-58670
2-58671	2-58940	2-58700
2-58720		

*** = Services payable to an FQHC based on an all-inclusive rate per visit.**
† = Services payable on an all-inclusive rate per visit for an RHC client.

Managed Care providers submitting claims directly to Medicaid HMOs for family planning services must use the CMS-1500 (physician, nonfacility) or HCFA-1450 (UB-92) (hospital) claim forms. Title V, X, or XX claims must always be submitted to TMHP directly using the Family Planning 2017 (Revised January 2005) claims form/format. Providers submitting claims for family planning services to TMHP for the Primary Care Case Management (PCCM) Program may use the Family Planning 2017 claim form. However, FQHCs submitting claims for family planning services to TMHP for the PCCM may use either the Family Planning 2017 claim form or the UB92 claim form.

20.3.4.1 Electronic TDHconnect Claims in a Title X-Supported Clinic

All claims and encounters for clients at Title X clinics must have Title X checked in the Title X Payment *Level* section under the *Patient* tab of the electronic claim form. This selection ensures that the required fields on the claim form will be completed.

Titles V, XIX, and XX

Clients eligible for Title V, XIX or XX must have the *Title X* box *and* the Funding Source box, to which the claim will be billed (Family Planning Program Block) checked on the Patient tab. This selection keeps claims from being rejected and ensures the collection of all information required for the *Family Planning Annual Report*. The level of practitioner, in the General section of the Claim tab of the electronic claim form, must also be selected by a clinic that uses Title X funds.

Title X Only

The Title X box must be checked and the payment level must be selected in the Title X Payment *Level* block under the Patient tab. Depending on family size and income, the agency designates Title X clients as full pay, partial pay, or no pay for services. The Level of Practitioner in the General section of the Claim tab of the electronic claim form must also be selected.

20.3.4.2 Paper Form: Family Planning 2017 Claim Forms in a Title X-Supported Clinic

Titles V, XIX, and XX

Clients eligible for Title V, XIX, or XX must have the funding source to which the claim will be billed checked in Block 1 of the Family Planning 2017 claim form. These clients need to be counted on the *Family Planning Annual Report* and Block 28, Level of Practitioner, must be completed for every Family Planning 2017 claim form submitted by a clinic that uses Title X funds.

Title X Only

The payment level must be selected in the Title X Only section of Block 1a. Depending on family size and income, the agency designates Title X clients as full pay, partial pay, or no pay for services. Block 28, Level of Practitioner, must also be completed.

Refer to: "Family Planning Annual Report" on page 20-8 for more information.

20.3.4.3 Other Electronic Claims in the Title X-Supported Clinic

Electronic claims that do not use TDHconnect must follow the specifications for electronic claim submission. Providers should contact their commercial software vendor or TMHP through the TMHP website at www.tmhp.com or call the TMHP EDI Help Desk at 1-888-863-3638 for more information.

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20.3.5 Filing Deadlines

Title	Deadline	Appeals
V, X, XX	120 days from the date of service on the claim or date of any third party insurance EOB	120 days from the date of the Remittance and Status (R&S) report on which the claim reached a finalized status
XIX	95 days from the date of service on the claim or date of any third party insurance EOB	120 days from the date of the R&S report on which the claim reached a finalized status

Note: *If the filing deadline falls on a weekend or holiday, the filing deadline is extended until the next business day.*

20.3.6 Claim Appeals

20.3.6.1 Two Appeal Methods to TMHP for Family Planning Titles V, X, and XX

An appeal is a request for reconsideration of a previously dispositioned claim.

Providers may use two methods to appeal Family Planning Program 300 (Titles V, X, and XX) claims to TMHP, electronic or paper.

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

20.3.6.2 Electronic Appeal Submission

Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer (PC). The electronic appeals feature can be accessed by a business organization bridging directly into the TMHP EDI Gateway or by using TDHconnect, the free, Windows-based software available from TMHP.

Advantages of Electronic Appeal Submission

Using electronic appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow.
- Print and download capabilities help maintain audit trails.
- Appeal submission windows can be automatically filled in with electronic R&S report information, thereby reducing data entry time.
- Increases speed of payment processing.

Paper Appeals

Appeal the claim on paper by completing the following steps:

- Make a copy of the R&S page where the claim is reported or other official notification from TMHP.
- Circle one claim per R&S page for each adjustment.
- Identify the incorrect and/or missing information and submit changes that should be used to appeal the claim.
- Attach a copy of supporting medical documentation that is necessary or requested by TMHP.
- Attach a copy of the original claim if available, or the corrected claim form for the appeal. Claim copies are helpful when the appeal involves medical policy or procedure coding issues.

Submit correspondence, adjustments, and appeals to the following address:

Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

20.3.6.3 Disallowed Appeals

If the provider's claim denies with EOB 00008, "Title X provider must provide level of practitioner information," the provider needs to submit a new claim with the correct level of practitioner. This claim denial cannot be appealed using the above-stated methods.

20.4 Family Planning Information

20.4.1 Title V

Agencies that submit claims for Title V Family Planning services must have a Title V contract with DSHS. The DSHS Title V Program determines client eligibility and services policy. Refer to the DSHS Title V Family Planning Manual for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

20.4.2 Title X

Agencies that submit claims for Title X Family Planning services must have a Title X contract with DSHS. DSHS Community Health Services determines client eligibility and services policy. Refer to the DSHS Title X and Title XX Family Planning manual for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

20.4.2.1 Title X Encounter Filing

In clinics supported by Title X funds, it is important to collect encounter data (such as demographics and services provided) for all family planning clients served, even for full-pay clients, regardless of the funding source to which the claim is billed. This data will be used to compile some of the elements of the *Family Planning Annual Report*. Certain fields on the claim form must be completed for all clients seen at Title X clinics, regardless of the funding source to which the claim will be billed.

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Based on the clinic(s) indicated as supported by Title X funds on a provider's most recent request for proposal (RFP) application clinic form(s), Compass21 rejects all claims from Title X clinics that do not contain all the required information regardless of the title being billed.

Clients in a Title X clinic who are not billed to another funding source are considered *Title X-only* clients. In some instances (such as when all Title V or XX funds are expended), services provided to a client normally eligible for another funding source are not billed to that funding source. A client whose income according to family size falls outside the eligibility guidelines for Titles V or XX would also be a *Title X only* client. In these cases, a sliding fee scale that has been approved by the DSHS Community Health Services Section must be used to assess client fees for services received.

While it will not result in a payment from DSHS, a Family Planning 2017 Claim Form with the encounter information must be submitted to TMHP for all Title X-only clients, so that the required encounter data (demographics, etc.) are collected. Encounter forms for Title X clients are filled out the same way as for the other funding sources. Diagnosis information must be entered, and each of the services and/or tests provided to that client during the visit must be listed on the claim form. Sterilizations provided to *partial pay* or *no pay* clients must follow the federal guidelines for sterilizations, and a completed Sterilization Consent Form must be faxed to TMHP at 1-512-514-4229. Forward completed encounter forms to TMHP for processing. Payment for Title X services will follow the current voucher submittal process outlined by the DSHS Claims Processing Unit.

20.4.2.2 Family Planning Annual Report

Compass21 compiles encounter data for each Title X provider to complete portions of the federal Family Planning Annual Report. Data elements such as client demographic information, client income level, lab services utilized, and client birth control methods will be compiled by Compass21. DSHS will forward the completed *Family Planning Annual Report* tables containing these data elements to each Title X provider for verification. However, some data elements of the *Family Planning Annual Report* cannot be collected through the Compass21 billing system. These data elements include provider contact information, client health insurance coverage, the number of clients with limited English proficiency (LEP), and provider revenue. Title X providers are still required to submit the tables containing these data elements to DSHS for inclusion in the *Family Planning Annual Report*.

The *Family Planning Annual Report* requires a profile of medical care physicians and midlevel practitioners supported by Title X funds. This profile includes all practitioners working in Title X clinics, whether or not their salaries are paid with Title X funds. For the *Family Planning Annual Report* profile, primary care or generalist physicians and specialists are classified correctly as Physician in Box 28 (Level of Practitioner) on the claim form. Family planning encounters provided by certified nurse-midwives (CNM), NPs. CNSs, and PAs are categorized correctly as midlevel. Family planning encounters provided by a registered nurse or a licensed vocational nurse are categorized as nurse. Encounters provided by staff not included in the preceding classifications are categorized correctly as other. Only one level can be indicated; if services are provided by more than one staff member, the highest-level staff who provided services to the client should be reported. Compass21 determines if the services provided are medical or non medical encounters to compile the *Family Planning Annual Report*.

20.4.2.3 Payments

Title X encounters submitted will not result in payments to the providers. Providers will continue to submit monthly or quarterly Financial Status Reports (FSR) forms, along with a paper payment voucher, to the DSHS Contract Development and Support Branch and Claims Processing Unit. Title X providers will continue to receive reimbursement from the Comptroller.

20.4.3 Title XIX (Medicaid) Enrollment

20.4.3.1 Enrollment

Only these provider types may be used to bill family planning services under Title XIX (Medicaid): physician, NP, CNS, PA, CNM, FQHC, or family planning agency.

Physicians who wish to provide Medicaid Obstetric and Gynecological (OB-GYN) services are allowed to bypass Medicare enrollment and obtain a Medicaid-only provider identifier for OB-GYN services regardless of provider specialty. Similarly, FQHCs do not need to apply for a separate physician or agency number. Family planning services are payable under the existing FQHC provider identifier using the family planning procedure codes in this section.

Family planning services provided by a rural health clinic (RHC) will not be paid if billed using the RHC provider identifier, but may be billed using a physician or nurse practitioner number, or an RHC may apply for enrollment as a family planning agency and bill using the family planning agency provider identifier. These services provided to an RHC client must be billed using modifiers AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.

Family planning agencies must apply for enrollment with TMHP to receive an agency provider identifier. To be enrolled in the Medicaid program, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Board of Medical Examiners and/or Texas Board of Nurse Examiners requirements.

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- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director's physician license.
- Have an established record of performance in the provision of both medical and educational/counseling family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with DSHS standards of client care for family planning agencies.
- Be approved for family planning services by the DSHS Family Planning Program.

The effective date for participation is the date an approved provider agreement with Medicaid is established and the provider is assigned a Medicaid provider identifier.

A provider cannot be enrolled if his license is due to expire within 30 days. A current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more detailed information about enrollment procedures.

20.4.4 Billing Procedures for Nonfamily Planning Services Provided During a Family Planning Visit

When a nonfamily planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning agency must bill for nonfamily planning services using a physician or nurse practitioner provider identifier. Use the agency provider identifier to bill family planning services only.
- A physician, nurse practitioner, or FQHC must bill both family planning services and nonfamily planning services, using the correct physician, nurse practitioner, or FQHC provider identifier.
- An RHC may bill a rural health encounter for a nonfamily planning medical condition. Use the physician or nurse practitioner provider identifier to bill for family planning services, or if the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency's family planning provider identifier, and the appropriate national place of service (72) for an RHC setting.

20.4.5 Limited Medicaid Coverage

Title XIX (Medicaid) family planning services are exempt from the limited program and rules.

20.4.5.1 Family Planning Services for Undocumented Aliens, Legalized Aliens

Undocumented aliens are identified for limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under the Texas Medicaid Program, these clients are only eligible for emergency services, including emergency labor and delivery. Emergency-only services do not cover family planning under the Texas Medicaid Program to prevent future unintended pregnancies. All providers are strongly encouraged to promote the benefits and availability of family planning services under Titles V, X, and XX for this population. The family planning funding sources cover the provision of contraceptive devices, supplies, counseling, and sterilizations for these clients. Providers are asked to be aware of the importance of referral of these clients to family planning providers who receive Titles V, X, and XX funds with the goal of preventing future unintended pregnancies and births.

20.4.6 Title XX

Agencies that submit claims for Title XX Family Planning services must have a Title XX contract with DSHS. DSHS Community Health Services determines client eligibility and services policy.

The *DSHS Title X and Title XX Family Planning* manual for specific eligibility and policy information is available at www.dshs.state.tx.us/famplan

20.5 Diagnosis Codes

Providers should use one of the following diagnosis codes in conjunction with all procedures and services. The choice of diagnosis code should be based on the type of family planning service performed.

Diagnosis Code	Description	Types of Procedures to be Used With
V2502	General counseling on initiation of other contraceptive measures	
V2509	Other general counseling and advice on contraceptive management	All nonsterilization Family Planning procedures
V251	Insertion of intrauterine contraceptive device	
V252	Sterilization	All sterilization and sterilization-related procedures
V2540	Contraceptive surveillance, unspecified	
V2542	Surveillance of intrauterine contraceptive device	
V258	Other specified contraceptive management	

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Diagnosis Code	Description	Types of Procedures to be Used With
V259	Unspecified contraceptive management	
V615	Multiparity	All sterilization and sterilization-related procedures

20.6 Procedure Codes and Reimbursement Amounts

The procedure codes and reimbursement amounts listed are authorized for family planning billing by family planning agencies (see also 20.6.2.1). Use only the codes listed. Failure to do so may result in claim denials.

20.6.1 Family Planning Annual Exams

Procedure code 1-99203 or 1-99214 with modifier FP and FP diagnosis consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client's problems and needs, and the implementation of an appropriate contraceptive management plan. The annual exam is allowed once per year, per client, per provider. Subsequent visits within the same year must be billed as an office visit or other outpatient visit.

Procedure Code	Fees for Titles V, XIX, and XX
1-99203	$48.27
or	
1-99214	
with	
modifier FP*	$41.46
* = Services payable to an FQHC based on an all-inclusive rate per visit.	

20.6.2 Office or Other Outpatient Visit

Procedure code 1-99213 is allowed for routine contraceptive surveillance, family planning counseling/education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem or follow-up visit the following must occur:

- An update of the client's relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment and/or referral, if indicated
- Education/counseling or referral, if indicated
- Scheduling of office or clinic visit if indicated

20.6.2.1 Office Visits

Depending on the extent of the services provided during the office visit, providers may bill for the maximum allowable fees. Providers are allowed to use the procedure codes below for office or other outpatient visits. In order to receive reimbursement as family planning services, they must bill using an FP modifier and FP diagnosis. Refer to the following procedure codes: 1-99201, 1-99202, 1-99203, 1-99204, 1-99205 and 1-99211, 1-99212, 1-99213, 1-99214 and 1-99215.

20.6.3 Laboratory Procedures

20.6.3.1 Title V

Laboratory tests for Title V clients may be sent to the DSHS laboratory and/or one of its designated affiliates for processing at no cost to the provider. This cost will be covered by the Title V Program, and the DSHS laboratory.

Providers who choose not to use the DSHS laboratories can send their specimens to another laboratory of their choice, but they will not be reimbursed by DSHS for those services. These tests, whether provided by DSHS or another laboratory facility, must be documented on the Family Planning claim form to track the services provided and to collect accurate statewide data.

Refer to: "Titles V and XX" on page 20-11 to identify which tests are provided by DSHS at no cost to Title V contractors.

20.6.3.2 Title XIX

Medicaid family planning service providers must document all laboratory services ordered in the client's medical record as medically necessary and reference an appropriate diagnosis. Any test specimen sent to a laboratory for interpretation should not be billed on the family planning provider's claim. The laboratory bills Medicaid directly for the tests it performs.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services. Only the office or lab actually performing the laboratory test procedure and holding the appropriate CLIA certificate may bill for the procedure.

If a provider does not perform the laboratory procedure, he may be reimbursed one lab-handling fee a day, per client, unless multiple specimens are obtained and sent to different laboratories. Procedure code 1-99000 with modifier FP is paid for handling and/or conveyance of the specimen for transfer from the physician's office to a laboratory.

Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office (place of service [POS] 1) by using the modifier SU, Procedure performed in physician's office (e.g., 5-88150-SU).

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Forward the client's name, address, Medicaid number, and a family planning diagnosis with any specimen, including Pap smears, to the reference laboratory so the laboratory may bill the Texas Medicaid Program for its family planning lab services.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service (i.e., procedure must be billed with a family planning diagnosis).

20.6.3.3 Titles V and XX

The following list of laboratory procedures and reimbursements are those authorized for billing by Titles V and XX family planning service providers with appropriate documentation in the client's record.

Procedure Code	Title V Fee	TItle XX Fee
5-80061	$0*	NA
5-81002	$3.54	$3.54
5-81015	$4.20	$4.20
5-81025	$8.74	$8.74
5-81099	$0*	NA
5-82465	$0*	$6.02
5-82947	$0*	$5.42
5-83020	$0*	NA
5-84478	$7.95	$7.95
5-85013	$3.27	$3.27
5-85018	$3.27	$3.27
5-85025	$11.71	$11.71
5-85660	$7.63	$7.63
5-86580	$7.36	$7.36
5-86592	$0*	$5.90
5-86701	$0*	NA
5-86762	$0*	$19.89
5-87070	$11.90	$11.90
5-87205	$5.90	$5.90
5-87797	$0*	$27.71
5-88150	$0*	$14.60
5-88230	$0*	NA

*** Title V providers do not receive reimbursement for services performed free of charge by the DSHS Laboratory. For correct tracking of services performed, providers are required to include these services on their Title V Family Planning claims filed with TMHP.**

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

20.6.3.4 Title XIX

The following is a list of laboratory procedures and reimbursement amounts authorized for billing by Title XIX family planning service providers with appropriate documentation in the client record. This list is not all-inclusive:

Procedure Code	Title XIX Fee
5-80061	$18.51
5-81000	$4.37
5-81002	$3.54
5-81015	$4.20
5-81025	$8.74
5-81099	MP
5-82465	$6.02
5-82947	$5.42
5-83020	$17.80
5-83718	$11.31
5-83719	$16.08
5-83721	$13.18
5-84478	$7.95
5-84702	$12.07
5-84703	$10.38
5-85013	$3.27
5-85014	$3.27
5-85018	$3.27
5-85025	$10.74
5-85660	$7.63
5-86317	$20.72
5-86403	$14.08
5-86580	$7.36
5-86592	$5.90
5-86689	$26.75
5-86701	$12.28
5-86702	$14.59
5-86703	$18.96
5-86762	$19.89
5-86781	$12.09
5-86850	$16.18
5-86900	$4.12
5-86901	$9.27
5-87070	$11.90
5-87076	$11.16
5-87077	$11.16
5-87086	$11.16
5-87088	$11.18

MP–Manually Priced

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Procedure Code	Title XIX Fee
5-87110	$27.08
5-87205	$5.90
5-87797	$27.71
5-88142	$25.00
5-88150	$14.60
5-88230	$161.00
5-88262	$172.25
1-99000 *with* modifier FP	$3.55
MP–Manually Priced	

20.6.4 Radiology

Radiology services are to be performed for the purpose of localization of an intrauterine device.

Procedure Code	Fee for Titles V, XIX, and XX
4-74000	$22.91
4-74010	$27.00
4-76815	$69.55

20.6.4.1 Title XIX (Medicaid) Only

These procedures can be billed on either the Family Planning 2017 claim form or the CMS-1500 claim form. Physicians, NPs, CNSs, PAs, and FQHCs may bill any radiology code that is medically necessary.

20.6.5 Contraceptive Devices and Related Procedures

Procedure Code	Fee for Titles V, XIX, and XX
9-A4261	$24.22
9-A4266	$10.01
1-J7300	$321.13
1-J7302	$426.97
2-11976	$152.25
2-57170	$38.00
2-58300	$69.00
2-58301	$39.01

Contraceptive Devices

- Procedure codes 1-J7300 or 1-J7302 must be billed with 2-58300 on the same date of service to receive reimbursement for the Copper IUD and the insertion of the IUD.
- An IUD insertion/procurement of the IUD may be reimbursed when billed on the same date of service as a dilation and curettage (2-58120). Procedure code 2-58120 is reimbursed at full allowance. Procedure code 2-58300 is denied as part of another service. Procedure codes 1-J7300 and 1-J7302 are reimbursed at full allowance.
- When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed for the same date of service as the insertion of the IUD, the surgical procedure is paid at full allowance and the IUD insertion billed using procedure code 2-58300 is paid at half the allowed amount.

20.6.5.1 Contraceptive Diagnosis Code Description

Diagnosis Code	Description
V2502	General counseling on initiation of other contraceptive measures
V2509	Other general counseling and advice on contraceptive management
V251	Insertion of intrauterine contraceptive device
V2540	Contraceptive surveillance, unspecified
V2542	Surveillance of intrauterine contra-ceptive device
V258	Other specified contraceptive management
V259	Unspecified contraceptive management
V615	Multiparity

20.6.6 Drugs and Supplies

Procedure Code	Fee for Titles V, XIX, and XX
9-A4261	$24.22
9-A4266	$10.01
1-A4267	$0.22
1-A4268	$2.00
1-A4269	$4.00
1-A9150 * *with* modifier FP	$14.00
1-J1055	$48.10
1-J3490*	$5.90
1-J7304*	$10.62
1-S4993	$2.80
1-90772**	$2.15

*** Titles V and XX only. For Title XIX, clients provide a prescription to be filled through the Vendor Drug Program. **For Title XIX only. Not a payable benefit for Titles V or XX.**

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20.6.6.1 Dispensing Medication

Family planning providers have a choice of dispensing family planning drugs and supplies directly to the client and billing TMHP or giving clients prescriptions to take to a pharmacy. Family planning drugs and supplies that are dispensed directly to the client are billed to TMHP or a Medicaid Managed Care Organization (MCO), whichever is appropriate for the client. Procedure code J3490 may be billed when a prescription medication to treat a genital infection is provided to the client. Procedure code A9150-FP may be billed when a nonprescription medication to treat a monilia infection is provided to the client. Family planning drugs and supplies are exempt from the *three prescriptions per month* rule. Additionally, pharmacies under the Vendor Drug contract are allowed to fill the prescription for up to six months at a time, rather than a one-month supply.

20.6.6.2 Injection Administration—Title XIX (Medicaid Only)

Injection administration billed by a provider is reimbursed separately from the medication. When billing procedure code J1055, the injection administration should be billed using procedure code 1-90772. If billed without procedure code J1055, the procedure must be billed with a family planning diagnosis and a family planning (FP) modifier or with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

20.6.7 Medical Counseling and Education

Procedure Code	Fee for Titles V, XIX, and XX
1-H1010**	$7.61
1-S9445 *with* modifier FP	$7.00
1-S9470*	$30.00
1-99401 *with* modifier FP	$8.42
1-99402 *with* modifier FP	$10.45
1-99411***	$1.50 per person for groups of 5 to 49 $75.00 flat rate for groups of 50 or more
1-99429 *with* modifier FP	$11.67

*** Title V only**
**** This consists of two sessions. Each session may be billed separately or the two sessions may be billed together for a total of $15.22.**
***** Title XX only**

20.6.7.1 Instruction in Natural Family Planning Methods (Per Session)

Procedure code 1-H1010 is intended to instruct a couple or an individual in methods of natural family planning and may consist of two sessions. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

20.6.7.2 Introduction to Family Planning in Hospital Setting/Auspices

Procedure code 1-S9445 with modifier FP consists of an overview of family planning benefits to encourage pregnant or postpartum women to use family planning services following delivery.

20.6.7.3 Title V Only: Nutritionist Visit

Procedure code 1-S9470 is provided by a licensed dietician for clients with a high-risk condition; for example, diabetes, hypertension, lipid disorders, and others. This procedure code may only be billed for clients with a high-risk condition.

20.6.7.4 Method-Specific Education/Counseling

Procedure code 1-99401 with modifier FP provides information about the contraceptive method chosen for use by the client, including its proper use, the possible side effects and complications, its reliability, and its reversibility. The service is provided when initiating a contraceptive method, when changing contraceptive methods, or when having difficulty with a current method.

The educational counseling must include at least the following:

- Verbal and written instructions for correct use of the method and self-monitoring.
- Information regarding the method's mode of action, safety, benefits and effectiveness.
- Information regarding risks, potential side effects, and complications of the method and what to do if they occur.
- Backup method: review when appropriate and instructions on the correct use.

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- When prescribing a diaphragm or cervical cap, include a demonstration of the correct insertion and removal procedures.

20.6.7.5 Problem Counseling

Procedure code 1-99402 with modifier FP is billed when clients have problems they wish to discuss that are not related to a contraceptive method.

Examples include pregnancy, sexually transmitted diseases, social and marital problems, health disorders, sexuality concerns, preconception counseling, and options counseling for an unintended pregnancy. Clients who may become pregnant and in whom the assessment reveals potential pregnancy risks, must receive preconception counseling regarding the modification/reduction of that risk.

20.6.7.6 Title XX Only: Teen Group Counseling

Procedure code 1-99411 is used for group presentations and/or discussions conducted with a minimum of five adolescents 19 years of age and younger. Sessions are reimbursed at $1.50 per person for 5 to 49 people, and a total of $75 for 50 or more participants. Topics for discussion include, but are not limited to, human anatomy, human sexuality, personal physical care and hygiene, skills to resist sexual coercion, methods of family planning, and sexually transmitted diseases. The provider should prepare a written statement for each session which indicates where and when the session was held, the specific topic(s) discussed, and the number of participants. These statements are kept by the provider, and may be reviewed by the DSHS Management Branch staff during site visits.

20.6.7.7 Initial Patient Education

Procedure code 1-99429 with modifier FP is provided to facilitate selection of an effective contraceptive method. Every new client requesting contraceptive services or family planning medical services must be provided initial client education either verbally, in writing, or by audiovisual materials. Over-the-counter contraceptive methods may be provided before the client receives the initial client education but must be accompanied by written instructions on correct use. The initial client education may vary according to the educator's evaluation of the client's current knowledge. It may include the following:

- General benefits of family planning services and contraception
- Information on male and female basic reproductive anatomy and physiology
- Information regarding the benefits and potential side effects and complications of all available contraceptive methods
- Information about all of the clinic's available services, the purpose and sequence of clinic procedures, and routine schedule of return visits
- Breast self-examination rationale and instruction, unless provided during physical exam (for females)
- Information on Human Immunodeficiency Virus (HIV)/Sexually Transmitted Disease (STD) infection and prevention and safer sex discussion

20.6.8 Sterilization and Sterilization-Related Procedures

Sterilization services are a benefit when billed by an agency or physician. Physicians must use the most appropriate Current Procedural Terminology (CPT) procedure code for payment. The codes with the global fees listed in the following table are developed for family planning agencies only:

Procedure Code	Fee for Titles V and XX
1-55250*	$253.75
1-58600*	$1,800.00
*** Global fee (includes all services, i.e., facility, physician, anesthesia, recovery, and pre- and postsurgical care).**	

Note: *Type of service (TOS) 1 must be used by family planning agencies when billing sterilization procedures.*

20.6.8.1 Incomplete Sterilizations

Title V and XX only

For incomplete procedures, one of the following diagnoses must be present on the claim in addition to the diagnosis for sterilization. Use the most appropriate for each situation. Incomplete sterilizations are billed at cost. All charges related to the procedure are tracked cumulatively.

Diagnosis Code	Description
V641	Surgical or other procedure not carried out because of contraindication
V642	Surgical or other procedure not carried out because of patient's decision
V643	Procedure not carried out for other reasons

20.6.8.2 Tubal Ligation

Procedure code 58600 should be used for any sterilization procedure performed on a female client by a family planning agency using Title V, X, XIX, or XX. When billing a sterilization procedure for Title V, X, or XX, include TOS 1 on the claim form. It is paid as a global fee to include preoperative, intraoperative, and postoperative services by all parties involved, (i.e., physician, anesthesiologist, facility, laboratory, etc.). Sterilizations are considered to be permanent, once per lifetime procedures. When a client's claim history shows a previous sterilization, providers will be asked to appeal and must provide supporting documentation for the need for repeat steril-

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ization. *Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.*

Refer to: "Sterilization Consent Form and Instructions" on page 20-4.

20.6.8.3 Vasectomy

Procedure code 55250 should be used for any sterilization procedure performed on a male by a family planning agency using Title V, X, XIX, or XX. It is paid as a global fee to include preoperative, intraoperative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, etc.). Vasectomies are considered to be permanent, once per lifetime procedures. When a client's claim history shows a previous vasectomy, providers will be asked to appeal and must provide supporting documentation for the need for repeat sterilization. *Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.*

Refer to: "Sterilization Consent Form and Instructions" on page 20-4.

20.6.8.4 Anesthesia for Sterilization

Use modifier FP, when reporting anesthesia services for a sterilization procedure.

The following procedure codes require modifier FP, in addition to the regular anesthesia modifier, if the service is sterilization CPT Anesthesia Code.

Procedure Code	
7-00840	7-00851
7-00920	7-00921
7-00922	7-00940
7-00950	

20.6.9 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
TMHP Electronic Claims Submission	5-10
Family Planning 2017Claim Form	5-49
Family Planning 2017 Claim Form Filing Instructions	5-49
Communication Guide	A-1
Acronym Dictionary	F-1

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Section

21

Federally Qualified Health Center (FQHC)

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21.1 Enrollment

To enroll in the Texas Medicaid Program, a federally qualified health center (FQHC) must be receiving a grant under Section 329, 330, or 340 of the *Public Health Service Act* or designated by the U.S. Department of Health and Human Services (HHS) to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver for the Medicare prerequisite at the time of initial enrollment of FQHC parents and satellites. FQHC *look-alikes* are *not* required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers.

Refer to: "Medicare-Medicaid Crossover Claims Pricing" on page 21-2.

A copy of the Public Health Service-issued Notice of Grant Award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to TMHP Provider Enrollment annually. FQHCs are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Medicaid for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service-approved satellites using a Federally Qualified Satellite (FQS) provider identifier that ties back to the parent FQHC provider identifier and tax ID number (TIN). This procedure allows for the parent FQHC to have one provider agreement and one cost report that combines all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill the Texas Medicaid Program directly, the center must have a separate provider identifier from the parent FQHC and will be required to file a separate cost report.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

"Provider Enrollment" on page 1-2 for more information about enrollment procedures.

New FQHCs must file a projected cost report within 90 days of their designation as an FQHC to establish an initial payment rate. The cost report will contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The FQHC must file a cost report within five months of the end of the FQHC's initial fiscal year. The cost settlement must be completed within 11 months of the receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new FQHC location established by an existing FQHC participating in the Texas Medicaid Program will receive the same effective rate as the FQHC establishing the new location. An FQHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

21.1.1 Medicaid Managed Care Enrollment

FQHCs may be eligible to enroll in Medicaid Managed Care as primary care providers. An FQHC that wants to enroll in Medicaid Managed Care as a primary care provider or specialty provider must contact the individual Medicaid Managed Care health plans for enrollment information.

21.2 Reimbursement

FQHCs are reimbursed provider-specific prospective payment system encounter rates in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8261.

To be reimbursed for case management for children and pregnant women (CPW) an FQHC must be approved by the Department of State Health Services (DSHS), Case Management Branch, as a provider of case management services. The FQHC must bill these services using its FQHC provider identifier and the appropriate procedure code for case management of CPW.

Refer to: "Prospective Payment Methodology" in TAC §355.8261 for more information.

"Case Management for Children and Pregnant Women (CPW)" on page 12-1.

21.2.1 Medicare-Medicaid Crossover Claims Pricing

For FQHC Medicare-Medicaid crossover claims, the Texas Medicaid Program pays the difference between the Medicaid encounter rate and any Medicare payment up to a maximum of the Medicaid encounter rate. If the Medicare payment is larger, no payment is made by Medicaid.

21.2.2 Provider Cost Reporting

FQHC providers are required to submit a copy of their Medicare audited cost report with the fiscal year ending on or after January 1 within 15 days of receipt from Medicare. Submit to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

21.3 Benefits and Limitations

Medicaid coverage is limited to services provided by the center that are covered by the Texas Medicaid Program and are reasonable and medically necessary.

When furnished to a client of the FQHC, medically necessary services include physician services; physician assistant services (PA); nurse practitioner (NP) services;

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clinical nurse specialist (CNS) services; clinical psychologist services; clinical social worker services; other mental health services; vision care services; services and supplies necessary for services that would be covered otherwise, if furnished by a physician or a physician service; visiting nurse services to a homebound individual, in the case of those FQHCs located in an area with a shortage of home health agencies; and other ambulatory services included in Medicaid such as family planning, Texas Health Steps (THSteps), birthing center, and maternity service clinic (MSC).

A visit is a face-to-face encounter between an FQHC client and a physician, physician assistant, nurse practitioner, certified nurse-midwife (CNM), visiting nurse, qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The FQHC client has a medical visit and an *other* health visit.

A medical visit is a face-to-face encounter between an FQHC client and a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an FQHC client and a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a THSteps medical checkup.

All services provided that are incident to the encounter should be included in the total charge for the encounter and are not billable as a separate encounter. For example, if an office visit was provided at a charge of $30 and a lab test for $15, the center would bill TMHP procedure code 1-T1015 for $45 and would be reimbursed at the center's encounter rate.

Reminder: *An encounter is defined as "a face-to-face meeting between a client and a physician, physician assistant, NP, CNS, certified nurse midwife (CNM), psychologist, social worker, or a visiting nurse."*

All services (except for family planning, THSteps medical, THSteps dental, immunizations, and case management for high-risk pregnant women and infants) provided during an encounter *must* be billed using procedure code 1-T1015.

Laboratory and radiology services or the services of a licensed vocational nurse (LVN), registered nurse (RN), nutritionist, or dietitian are *not* considered an encounter, because they are incidental to an encounter with one of the above-mentioned health care professionals. Providers should continue to include the cost associated with these services on their cost report (they are allowable but do not constitute an encounter).

When an FQHC sees a client younger than 21 years of age for immunizations that are not part of a THSteps checkup, the FQHC should bill for the administration of the immunization on the HCFA-1450 (UB-92) or CMS-1500 claim form using their FQHC provider identifier and the appropriate Medicaid procedure code. If the client is seen only for immunizations, an encounter should not be billed. There is no change in the billing procedures for those services noted as exceptions. The total billed amount for the service should be the total charge for all services provided during the encounter or incident to the encounter.

Claims should be filed as follows:

Services	Claim Form
CPW case management services	HCFA-1450 (UB-92) or CMS-1500 claim form
THSteps dental services	American Dental Association (ADA) claim form
THSteps medical services	CMS-1500 claim form.

All claims must be filed using the FQHC provider identifier.

Services provided by a health care professional require one of the following modifiers with procedure code 1-T1015, to designate the health care professional providing the services: AH, AM, SA, TD or TE with place of service (POS) 2, or U7.

If more than one health care professional is seen during the encounter, the modifier should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during that encounter.

If the encounter is for antepartum care or postpartum care, the modifier TH must be indicated.

The electronic format or the paper claim form allows for multiple modifiers; therefore, if the antepartum or postpartum care or delivery is provided by a CNM, then modifier SA must be indicated on the claim in addition to the appropriate modifier above.

If a physician of the FQHC provides a service in the hospital such as delivery, the FQHC may elect to bill for that service using the physician's provider identifier, if the contract with the physician indicates this occurrence. If the service is billed using the physician number rather than the FQHC's provider identifier, the costs associated

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with the service must be *excluded* from the cost report and will not be considered during the cost settlement/ encounter rate setting process.

Refer to: The following sections for benefit limitation information:

"Benefits and Limitations" on page 36-8 in the Physician section.

"Benefits and Limitations" on page 38-2 in the Psychologist section.

"Benefits and Limitations" on page 19-9 in the Dental section.

"Benefits and Limitations" on page 10-2 in the Birthing Center section.

"Benefits and Limitations" on page 31-2 in the Maternity Service Clinic section.

"Benefits and Limitations" on page 12-2 in the Case Management for Children and Pregnant Women (CPW) section.

"Benefits and Limitations" on page 29-2 in the Licensed Marriage and Family Therapist (LMFT) section.

"Benefits and Limitations" on page 28-2 in the Licensed Clinical Social Worker (LCSW) section.

"Benefits and Limitations" on page 30-2 in the Licensed Professional Counselors (LPCs) section.

"Benefits and Limitations" on page 45-2 in the VIsion Care (Optometrists, Opticians) section.

21.3.1 Telemedicine

A remote site provider can be an FQHC, RHC, or health care provider such as a physician, APN, or CNM who is able to independently bill the Texas Medicaid Program for an office visit.

FQHC telemedicine providers must submit their claims using the appropriate encounter code and modifiers. Use modifier AM, U7, or SA in the *first* modifier field on the claim form with the modifier GT in the *second* modifier field.

Refer to: "Telemedicine Services" on page 36-19 for more information.

21.3.2 Newborn Eligibility Process for FQHCs

A child is deemed eligible for Medicaid for up to one year if:

- The mother is receiving Medicaid at the time of the child's birth and
- If the child continues to live with the mother
- and if the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant.

Therefore, it is not acceptable to require a deposit for newborn care from a Medicaid client. The child's eligibility ceases if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Important: *Filing a claim for a newborn client under the mother's client number can delay a claim payment.*

Note: *When billing for a Medicaid Managed Care client, providers must adhere to the client's health plan's guidelines for newborn billing.*

Claims with charges for newborn care are submitted separately from charges for the mother. Claims submitted for services provided to a newborn child should be filed using the newborn child's Medicaid number. To expedite the claims processing, enter the mother's name in Block 84 of the Remarks field of the HCFA-1450 (UB-92) claim form. Include this information in Block 4 of the CMS-1500.

To provide information about each child born to a mother eligible for Medicaid, FQHCs with birthing centers should complete Form 7484 *Hospital Report of Newborn Child or Children*. If the newborn's name is known, include it on the form. The use of *Baby Boy* or *Baby Girl* delays the assignment of a number. Filing this form expedites the assignment of a Medicaid number for the newborn child. Do not complete this form for stillbirths.

The FQHC should complete the form within five days of the child's birth and send it to DSHS. This five-day time frame is not mandatory; however, prompt submission will expedite the process of determining the child's eligibility. FQHCs should duplicate the form as needed because HHSC and TMHP do *not* supply this form.

Upon receipt of a completed form, DSHS verifies the mother's eligibility and sends notices within ten days to the hospital or birthing center, attending physician (if identified), mother, and caseworker. The notice includes the child's Medicaid number and the effective date of coverage. HHSC will issue a client Medicaid Identification form (Form H3087) after the child has been added to the eligibility file.

The attending physician's notification letter is sent to the address on file for the license number at the Texas Medical Board. This address must be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018
"Hospital Report (Newborn Child or Children) HHSC Form 7484" on page B-51.

21.4 Claims Information

FQHC services must be submitted to TMHP in approved electronic format or on a HCFA-1450 (UB-92) or CMS-1500 claim form. When filing claims for clients who only have Medicaid, providers may use either a

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HCFA-1450 (UB-92) or CMS-1500 claim form. When filing claims for THSteps medical services, providers must use the CMS-1500 claim form and not the HCFA-1450 claim form. For providers who also have Titles V, X, and XX funding, family planning claims are filed on the “Family Planning 2017 Claim Form” on page 5-48. When filing for a client who has Medicare and Medicaid coverage, providers must file on the same claim form that was filed to Medicare. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply them. The THSteps Dental (ADA) claim form described under FQHC services, Family Planning, Case Management for Children and Pregnant Women, and THSteps services may be submitted electronically.

21.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
HCFA-1450 (UB-92) Claim Filing Instructions	5-32
Dental (ADA) Claim Filing Instructions	5-43
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Federally Qualified Health Center Report (Newborn Child or Children) Form 7484	B-40
Medicaid Audit Request for Claims Summary	B-54
FQHC Encounter (T1015) Claim Example	D-14
FQHC Follow-Up Claim Example	D-14
Acronym Dictionary	F-1

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Section

22

Genetic Services

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22.1 Enrollment

Only full-service genetic providers may enroll in the Texas Medicaid Program. Before enrolling, the provider must contract with the Department of State Health Services (DSHS), for the provision of genetic services. Basic contract requirements are as follows:

- The provider's medical director must be a clinical geneticist (Doctor of Medicine [MD] or Doctor of Osteopathy [DO]) who is licensed by the Texas Medical Board and board eligible/certified by the American Board of Medical Geneticists (ABMG).
- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of the following professional staff: a clinical geneticist (MD or DO) and at least one of the following: nurse, social worker, medical geneticist (Ph.D.), or genetic counselor.

The provider's clinical laboratory (if it has a clinical laboratory) must have received federal Clinical Laboratory Improvement Amendments (CLIA) accreditation from the Centers for Medicare & Medicaid Services (CMS) and must be Medicare-approved. If the provider does not have a clinical laboratory, then the laboratory or laboratories it uses must have at least the same credentials.

Genetic services are administered through the DSHS Case Management and Health Screening Unit. A genetic provider wishing to enroll should contact TMHP, which in turn contacts the DSHS Case Management and Health Screening Unit. DSHS sends a contract application to the interested provider, which should be completed and returned to DSHS. DSHS evaluates the application, and if approved, notifies TMHP to enroll the provider.

For more information, contact:

DSHS Case Management and Health Screening Unit
1100 West 49th Street, MC 1918
Austin, TX 78756-3199
1-512-458-7111, Ext. 2193

TMHP will issue a provider identifier number for genetic services to the provider. Additionally, each genetic professional providing clinical services must obtain a performing provider identifier from TMHP at the following address:

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

A provider cannot be enrolled if his or her license is due to expire within 30 days; a current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

22.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information on Medicaid Managed Care programs.

22.2 Reimbursement

Genetic providers are reimbursed according to the established allowable maximum fee schedule.

TMHP manually prices genetic laboratory services that have no established fee.

Clinical laboratory services billed by a genetic services provider are reimbursed according to reimbursement methodology for these services in accordance with Title 1 *Texas Administrative Code* (TAC) §§355.8081 and §§355.8610, and the *Deficit Reduction Act* (DEFRA) of 1984.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

22.3 Benefits and Limitations

Genetic providers are reimbursed for the provision of genetic services to evaluate clients for the possibility of a genetic disorder, diagnose such disorders, counsel clients regarding such disorders and their implications for family planning, and provide follow-up of clients with known or suspected disorders. These services must be prescribed by a physician (MD, DO) and performed by or under the supervision of a clinical geneticist (MD, DO). These services may include genetic history and physical examination, psychosocial genetic assessment, laboratory services and echography, radiological services, diagnostic procedures, and counseling. Genetic services are payable when provided in the office setting (place of service [POS 1]), in the inpatient hospital setting (POS 3), and in the outpatient hospital setting (POS 5).

The following services are not allowed:

- Genetic services for conditions that usually have no serious psychosocial or medical implications for a client
- Prenatal diagnosis for sex determination of the fetus only, without implications for genetic disease
- Genetic services provided to clients eligible for emergency care only

22.3.1 Genetic Evaluation

The genetic evaluation consists of health history, medical genetics physical examination, and psychosocial genetic assessment.

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22.3.1.1 Health History

Detailed family genetic health history. The interviewer meets with the family to gather extensive medical and family history covering four matriarchal and patriarchal generations. A pedigree is constructed. This history includes any affected individuals in the immediate or extended family, information on pregnancy, plus a developmental, educational, and social history.

Family genetic health history update. This is performed to update the health history. It consists of noting changes, such as the loss of eyesight or change in muscle control, in the health of the client under evaluation. Genetic-related problems identified in newborns or in other family members should also be included in the interval history update.

22.3.1.2 Medical Genetics Physical Examination

This examination varies according to specific client needs, but typically consists of extensive anthropomorphic measurements, including occipital frontal circumference, height, weight, and measurement of inner canthal and outer canthal distances with calculations of interpupillary distances; ear size and ear placement on the head; philtrum length; internipple distance; and finger and palm lengths. The physical examination itself usually entails examination of:

- The head
- The eyes, including funduscopic examination
- The nose, mouth, and oral pharynx
- The ears, including assessment of tympanic membranes
- The neck, including assessment of thyroid gland size
- The chest, including breasts and heart
- The abdomen, including assessment for organ size and assessment for abnormal masses
- Genitalia, and often measurement of size of genital components
- The back
- The extremities, including specific measurement of any joint limitations
- The skin for abnormalities, which often includes Woods light examination for fluorescent depigmented areas
- Neurological assessment, including cranial nerve examination, examination of deep tendon reflexes, and cerebellar and long track motor functions

Photographs are also taken of the client AP (AP means a full frontal [anterior-posterior] not from the side, the diagonal, or from the back) and lateral, both face and total body. Additional photographs are taken of any abnormalities noted upon physical examination for further consultative work and review.

- *Physical Examination (Standard).* The examination is appropriate for follow-up examinations. This examination includes a review of all the information derived from the health history and detailed family genetic history or pedigree construction. The examination is appropriate for:
  - New referrals in which minimum criteria for genetic services are indicated, or in which minimal time is required to make a medical diagnosis or disposition.
  - More complex problems when all pertinent medical data accompanies the referral.
  - Biased evaluation of family members referred for a specific disease.
  - Most follow-up of clients of whom more complete studies have been performed.

  This physical usually encompasses most of the examinations outlined under medical genetic physical examination except for highly specific anthropomorphic tests, such as dermatoglyphics. The standard genetic physical examination is reimbursable once every six months per provider.
- *Physical Examination (Complex).* This examination is applicable for referred clients in whom genetic diseases of a more complex nature are suspected or partially confirmed. All criteria outlined under the medical genetics physical examination will be used, and the information from the health history and detailed family genetic history or pedigree construction will be reviewed.
- *Physical Examination (Comprehensive).* This examination is used for referred clients in whom complex genetic diseases are suspected that require complete and extensive workup. This examination includes the completion of all tasks outlined in the section on the medical genetic physical examination and requires extensive time to make a diagnosis and disposition.

22.3.1.3 Psychosocial Genetic Assessment

Standard. A detailed social history related to the stated reason for referral is obtained to assess family dynamics and psychosocial functioning. The client's primary psychosocial problems and needs are evaluated. The standard psychosocial genetic assessment is reimbursable once per lifetime per provider.

Complex. Clients may receive additional counseling services when more severe family or individual dysfunction is evident as related to the primary reason for referral. The complex psychosocial genetic assessment is reimbursable once per lifetime per provider.

22.3.2 Genetic Counseling

Genetic counseling consists of medical genetic and psychosocial genetic counseling.

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22.3.2.1 Medical Genetic Counseling

Prenatal Counseling. Includes a review of all information obtained in the health history, detailed family genetic history and pedigree construction, as well as the diagnosis established after completion of the medical genetic physical examination. The family is counseled as to how the prenatal diagnosis applies to their case regarding the recurrence risks as well as prenatal diagnostic procedures.

Medical Genetic Counseling. The family is advised of the results of the health history, detailed family genetic history and pedigree construction, and the nature of the diagnosis. It is the counselor's responsibility to explain the diagnosis and establish the implications for the affected individual, immediate family, and extended family. This counseling includes prognosis, recurrence risks, family planning implication, and the options available to family members who are at increased risk for giving birth to individuals with the same condition.

Follow-up Genetic Counseling. Conducted to review the medical genetic counseling results and provide additional information as indicated.

22.3.2.2 Psychosocial Genetic Counseling

Initial psychosocial genetic counseling. Client reactions relating to the genetic disorder are explored and a practical plan of action concerning the client and the family is formulated using the information obtained from the interpretation of the genetic assessment.

Follow-up psychosocial genetic counseling. Conducted to review the psychosocial genetic counseling and provide additional information as indicated.

22.3.3 Cytogenetic Tests Reimbursed to Providers

Certain cytogenetic tests may be reimbursed as a type of service (TOS) 5 to providers other than those enrolled as full-service genetic providers. Reimbursement to those providers is limited to the diagnoses of leukemia and lymphoma.

Refer to: "Cytogenetics Testing for Leukemia and Lymphoma" on page 36-191 for more information.

22.3.4 Genetic Benefit Schedule

22.3.4.1 Genetic Evaluation and Counseling

Service	Procedure Code	Limitations	Maximum Fee
Follow-up Medical Genetic Counseling Follow-up Psychosocial Genetic Counseling	G-99213 *with* modifier TG	One per six months, per provider	$50.76
Family Genetic Health History Update Standard Genetic Physical Exam	G-99214 *with* modifier TG	One per six months, per provider	$81.20
Medical Genetic Counseling Initial Psychosocial Genetic Counseling	G-99215 *with* modifier TG	One per lifetime, per provider	$147.18
Detailed Family Genetic Health History Complex Genetic Physical Exam Standard Psychosocial Genetic Assessment	G-99244 *with* modifier TG	One per lifetime, per provider	$248.68
Detailed Family Genetic Health History Comprehensive Genetic Physical Exam Complex Psychosocial Genetic Assessment	G-99245 *with* modifier TG	One per lifetime, per provider	$370.48
Prenatal Counseling	G-99402 *with* modifier TG	One per pregnancy, per provider*	$50.75
Detailed Family Genetic Health History Prenatal Counseling	G-99404 *with* modifier TG	One per lifetime, per provider	$152.25

*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**

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22.3.4.2 Genetic Diagnostic and Laboratory Procedures

Procedure Code	Limitation	Maximum Fee
G-59000	One per pregnancy, per provider*	$70.37
G-59012	One per pregnancy, per provider*	$183.30
G-59015	One per pregnancy, per provider*	$100.38
Genetic Laboratory Procedures		
G-81099 *or* G-84999 *or* G-85999 *or* G-86849 *or* G-87999 *or* G-88199		Manually priced
G-82013	One per lifetime	$9.77
G-82016	Two per provider, per lifetime	$18.38
G-82017	Two per provider, per lifetime	$13.78
G-82105	One per pregnancy, per provider*	$23.18
G-82106	One per pregnancy, per provider*	$23.18
G-82127	No limit	$18.38
G-82136	No limit	$13.78
G-82139	No limit	$13.78
G-82261	No limit	$13.78
G-82379	No limit	$13.78
G-82492	No limit	$24.96
G-82541	No limit	$24.96
G-82542	No limit	$24.96
G-82543	No limit	$24.96
G-82544	No limit	$24.96
G-82657	Two per provider, per lifetime	$24.96
G-82677	One per pregnancy, per provider*	$33.43
G-82726	Two per provider, per lifetime	$24.96
G-83020	One per lifetime, per provider	$17.80
G-83026	One per lifetime	$3.26
G-83030	One per lifetime	$11.43
G-83033	One per lifetime	$8.24
G-83036	One per lifetime	$13.42
G-83788	No limit	$24.96
G-83789	No limit	$24.96
G-83919	No limit	$22.75
G-84376	Two per provider, per lifetime	$6.43
G-84377	Two per provider, per lifetime	$6.43
G-84378	Two per provider, per lifetime	$3.98
G-84379	Two per provider, per lifetime	$3.98
G-84437		$8.95
G-84450		$7.14
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**		

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Procedure Code	Limitation	Maximum Fee
G-84460		$7.32
G-84479	One per lifetime	$8.95
G-84550	One per lifetime	$6.41
G-84702	One per pregnancy, per provider*	$12.07
G-85018	One per lifetime	$3.27
G-88230	One per lifetime, per provider	$161.00
G-88233	Skin: one per lifetime, per provider Solid Tissue: one per tumor	$194.49
G-88235	One per pregnancy, per provider*	$203.50
G-88237	Initial diagnosis: one per lifetime, per provider After: one per treatment cycle	$174.55
G-88239	One per lifetime, per tissue type	$203.88
G-88240	One per pregnancy or per lifetime if not pregnant	$11.74
G-88241	One per pregnancy	$11.74
G-88245	One per lifetime, per provider	$205.72
G-88248	One per lifetime, per provider	$239.32
G-88249	One per pregnancy or per lifetime if not pregnant	$239.32
G-88261	One per lifetime, per provider	$244.24
G-88262	Only one (G-88262 or G-88263) per lifetime, per provider	$172.25
G-88263	One per lifetime, per provider	$207.67
G-88264	One per lifetime, per provider; one per pregnancy	$172.25
G-88267	One per pregnancy, per provider*	$212.17
G-88269	One per pregnancy, per provider*	$229.85
G-88271		$29.60
G-88272	One per lifetime, per provider; one per pregnancy	$37.00
G-88273	One per lifetime, per provider	$44.40
G-88274	One per lifetime, per provider	$48.10
G-88275	One per lifetime, per provider; one per pregnancy	$55.50
G-88280	One per lifetime, per provider; one per pregnancy, per provider*	$34.68
G-88283	One per lifetime, per provider; one per pregnancy, per provider*	$94.79
G-88285	One per lifetime, per provider; one per pregnancy, per provider*	$26.26
G-88289	One per lifetime, per provider; one per pregnancy, per provider*	$47.58
G-88291		$5.54
G-88299	One per lifetime, per provider	Manually priced

*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**

22.3.4.3 Genetic DNA Testing and Laboratory Enzyme Tests

Effective for dates of service on or after October 16, 2003, DNA testing and laboratory enzyme tests must be billed with procedure code 84999. To ensure appropriate claims processing, the remarks code reflecting the specific service is also required.

Providers should adhere to the following steps for electronic claim submissions so that TMHP can accurately apply the correct remarks code to the appropriate claim detail:

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- A GPC prefix must be submitted in the first three bytes of the NTE02 at the 2400 loop. The GPC prefix should only be submitted once.
- In bytes 4-8, submit the remarks code based on the order of the claim detail (see the following examples).

Example 1: For a claim with three details, where details one and three are submitted with procedure code 84999 and detail two is not submitted with procedure code 84999, enter the following information in the NTE02 at the 2400 loop: GPC4841Z 4964Z, leaving a space between remarks codes for details one and three.

Example 2: For a claim with three details, where details two and three are submitted with procedure code 84999 and detail one is not submitted with procedure code 84999, enter the following information in the NTE02 at the 2400 loop: GPC 4841Z4964Z, leaving a space between the GPC prefix and the remarks code for detail two, and no space between the remarks code for details two and three.

Example 3: For a claim with three details, where all three details are submitted with procedure code 84999, enter the following information in the NTE02 at the 2400 loop: GPC4941Z4861ZY8158, with no spaces between remarks codes.

For paper claim submissions, enter the remarks code in Block 19 of the CMS-1500 claim form.

The following tables identify the appropriate remarks codes to use when billing procedure code 84999.

DNA Testing

The following table identifies exceptions when additional services are allowed:

Remarks Code	Laboratory Test Provided	Limitations	Maximum Fee
4838Z	Cystic fibrosis	One per lifetime, per provider*	$152.25
4839Z	Duchenne muscular dystrophy	One per lifetime, per provider*	$304.50
4840Z	Fragile X mental retardation	One per lifetime, per provider*	$253.75
4841Z	Myotonic dystrophy	One per lifetime, per provider*	$253.75
4842Z	Sickle cell hemoglobinopathy	One per lifetime, per provider*	$253.75
4843Z	Ornithine transcarbamoylase deficiency	One per lifetime, per provider*	$355.25
4844Z	Phenylketonuria	One per lifetime, per provider*	$355.25
4845Z	Thalassemia (alpha)	One per lifetime, per provider*	$355.25
4846Z	Thalassemia (beta)	One per lifetime, per provider*	$355.25
4847Z	Factor VIII deficiency	One per lifetime, per provider*	$304.50
4848Z	Factor IX deficiency	One per lifetime, per provider*	$304.50
4849Z	21-hydroxylase deficiency	One per lifetime, per provider*	$304.50
4850Z	Lesch Nyhan syndrome (HPRT deficiency)	One per lifetime, per provider*	$355.25
4851Z	Other miscellaneous DNA testing	One per lifetime, per provider *	Manually priced
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**			

Fetal DNA Testing

The following table identifies exceptions when additional services are allowed:

Remarks Code	Laboratory Test Provided	Limitations	Maximum Fee
4852Z	Cystic fibrosis	One per pregnancy, per provider*	$152.25
4853Z	Duchenne muscular dystrophy	One per pregnancy, per provider*	$304.50
4854Z	Fragile X mental retardation	One per pregnancy, per provider*	$253.75
4855Z	Myotonic dystrophy	One per pregnancy, per provider*	$253.75
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**			

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Remarks Code	Laboratory Test Provided	Limitations	Maximum Fee
4856Z	Sickle cell hemoglobinopathy	One per pregnancy, per provider*	$253.75
4857Z	Ornithine transcarbamoylase deficiency	One per pregnancy, per provider*	$355.25
4858Z	Phenylketonuria	One per pregnancy, per provider*	$355.25
4859Z	Thalassemia (alpha)	One per pregnancy, per provider*	$355.25
4860Z	Thalassemia (beta)	One per pregnancy, per provider*	$355.25
4861Z	Factor VIII deficiency	One per pregnancy, per provider*	$304.50
4862Z	Factor IX deficiency	One per pregnancy, per provider*	$304.50
4863Z	21-hydroxylase deficiency	One per pregnancy, per provider*	$304.50
4864Z	Lesch Nyhan syndrome (HPRT deficiency)	One per pregnancy, per provider*	$355.25
4865Z	Other miscellaneous DNA Testing	One per pregnancy, per provider*	Manually priced
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**			

Biochemical Tests

If TMHP denies the Health Care Common Procedure Coding System (HCPCS) code billed as *not a benefit* or exceeds the program benefits, providers may appeal with documentation of medical necessity.

Remarks Code	Laboratory Test Provided	Type of Specimen	Limitations	Maximum Fee
Y8150	Alpha-N acetylglucosaminidase	F	Two per provider per lifetime of client per specimen	$73.83
Y8151		AF	One per pregnancy per provider	$73.83
Y8152	Acid lipase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8153		F	Two per provider per lifetime of client per specimen	$83.74
Y8154		AF	One per pregnancy per provider	$83.74
Y8155	Acid phosphatase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8156		F	Two per provider per lifetime of client per specimen	$83.74
Y8157		AF	One per pregnancy per provider	$83.74
Y8158	Adenosine deaminase	RBC	Two per provider per lifetime of client per specimen	$41.09
Y8159		F	Two per provider per lifetime of client per specimen	$83.74
Y8160		AF	One per pregnancy per provider	$83.74
Y8161	Aldolase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8162		F	Two per provider per lifetime of client per specimen	$83.74
Y8163		AF	One per pregnancy per provider	$83.74
Y8164	Arginase	RBC	Two per provider per lifetime of client per specimen	$41.09
Legend for Type of Specimen: F=Fibroblast WB=Whole Blood S=Serum P=Plasma U=Urine T=Tissue WBC=White Blood Cells SB=Skin Biopsy AF=Amniotic Fluid RBC=Red Blood Cells				

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Remarks Code	Laboratory Test Provided	Type of Specimen	Limitations	Maximum Fee
Y8165	Argininosuccinic acid synthetase	Liver	Two per provider per lifetime of client per specimen	$35.53
Y8166	Amino acid qualitative screen	U	Two per provider per lifetime of client per specimen	$8.13
Y8167		P or S	Two per provider per lifetime of client per specimen	$8.13
Y8168	Amino acid quantitative screen	U	Two per provider per lifetime of client per specimen	$128.91
Y8169		P or S	Two per provider per lifetime of client per specimen	$128.91
Y8170	Aryl sulfatase A	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8171		F	Two per provider per lifetime of client per specimen	$83.74
Y8172		AF	One per pregnancy per provider	$83.74
Y8173	Aryl sulfatase B	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8174		F	Two per provider per lifetime of client per specimen	$83.74
Y8175		AF	One per pregnancy per provider	$83.74
Y8176	Beta-aspartylglu-cosaminidase	SB	Two per provider per lifetime of client per specimen	$35.53
Y8177	Cholinesterase-pseudo	S	Two per provider per lifetime of client per specimen	$19.26
Y8178	Cholinesterase-true	WB	Two per provider per lifetime of client per specimen	$23.11
Y8179	Cystathionase	WB	Two per provider per lifetime of client per specimen	$103.37
Y8180		WBC	Two per provider per lifetime of client per specimen	$105.38
Y8181	Cystathionine synthase	SB	Two per provider per lifetime of client per specimen	$105.94
Y8182	Enzyme screen	P	Two per provider per lifetime of client per specimen	$186.18
Y8183	Erythrocyte galactokinase	Any	Two per provider per lifetime of client per specimen	$128.40
Y8186	Alpha-L-fucosidase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8187		F	Two per provider per lifetime of client per specimen	$83.74
Y8188		AF	One per pregnancy per provider	$83.74

Legend for Type of Specimen: F=Fibroblast WB=Whole Blood S=Serum P=Plasma U=Urine T=Tissue WBC=White Blood Cells SB=Skin Biopsy AF=Amniotic Fluid RBC=Red Blood Cells

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Remarks Code	Laboratory Test Provided	Type of Specimen	Limitations	Maximum Fee
Y8189	Beta-galactocerebrosidase	WBC	Two per provider per lifetime of client per specimen	$35.53
Y8190		S	Two per provider per lifetime of client per specimen	$20.30
Y8191		SB	Two per provider per lifetime of client per specimen	Manually priced
Y8192		P	Two per provider per lifetime of client per specimen	Manually priced
Y8193	Galactose transferase	WB	Two per provider per lifetime of client per specimen	$32.74
Y8194	Alpha-galactosidase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8195		F	Two per provider per lifetime of client per specimen	$83.74
Y8196		AF	One per pregnancy per provider	$83.74
Y8197	Beta-galactosidase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8198		F	Two per provider per lifetime of client per specimen	$83.74
Y8199		AF	One per pregnancy per provider	$83.74
Y8200	Glucose-6 phosphate dehydrogenase	WB	Two per provider per lifetime of client per specimen	$25.28
Y8201	Alpha-glucosidase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8202		F	Two per provider per lifetime of client per specimen	$83.74
Y8203		AF	One per pregnancy per provider	$83.74
Y8204	Beta-glucosidase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8205		F	Two per provider per lifetime of client per specimen	$83.74
Y8206		AF	One per pregnancy per provider	$83.74
Y8207	Beta-glucuronidase	S	Two per provider per lifetime of client per specimen	$25.68
Y8208		WBC	Two per provider per lifetime of client per specimen	$41.09
Y8209		F	Two per provider per lifetime of client per specimen	$83.74
Y8210		AF	One per pregnancy per provider	$83.74
Y8211	Glycogen storage disease enzyme assay series	Any	Two per provider per lifetime of client per specimen	$449.39
Y8212	Glycogen debrancher enzyme	Any	Two per provider per lifetime of client per specimen	$329.88
Y8213	GM2 type 2	WBC	Two per provider per lifetime of client per specimen	$19.90
Y8214		SB	Two per provider per lifetime of client per specimen	$105.94
Legend for Type of Specimen: F=Fibroblast WB=Whole Blood S=Serum P=Plasma U=Urine T=Tissue WBC=White Blood Cells SB=Skin Biopsy AF=Amniotic Fluid RBC=Red Blood Cells				

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Remarks Code	Laboratory Test Provided	Type of Specimen	Limitations	Maximum Fee
Y8215	Heparin sulfate N-sulfamidase	F	Two per provider per lifetime of client per specimen	$83.74
Y8216		AF	One per pregnancy per provider	$83.74
Y8217	Hexosaminidase A	S	Two per provider per lifetime of client per specimen	$20.30
Y8218		WBC	Two per provider per lifetime of client per specimen	$126.88
Y8219		SB	Two per provider per lifetime of client per specimen	$36.54
Y8220	Hexosaminidase A and B	S	Two per provider per lifetime of client per specimen	$25.68
Y8221		WBC	Two per provider per lifetime of client per specimen	$41.09
Y8222		F	Two per provider per lifetime of client per specimen	$83.74
Y8223		AF	One per pregnancy per provider	$83.74
Y8224	Hypoxanthine-guanine-phosphoribosyl-transferase	RBC	Two per provider per lifetime of client per specimen	$38.52
Y8225		F	Two per provider per lifetime of client per specimen	$83.74
Y8226		AF	One per pregnancy per provider	$83.74
Y8227	Alpha-L-iduronidase (Hurler and Scheie's S)	WBC	Two per provider per lifetime of client per specimen	$83.74
Y8228		F	Two per provider per lifetime of client per specimen	$83.74
Y8229		AF	One per pregnancy per provider	$83.74
Y8230	Alpha-L-iduronidase sulfatase (Hunter's S)	S	Two per provider per lifetime of client per specimen	$68.06
Y8231	Alpha-mannosidase	WBC	Two per provider per lifetime of client per specimen	$32.10
Y8232		F	Two per provider per lifetime of client per specimen	$83.74
Y8233		AF	One per pregnancy per provider	$83.74
Y8234	Mucolipidosis II (1-cell disease)	WBC	Two per provider per lifetime of client per specimen	$21.83
Y8235	Mucolipidosis II (beta-galactosidase)	SB	Two per provider per lifetime of client per specimen	$105.94
Y8236	Mucolipidosis III (pseudo-Hurler)	SB	Two per provider per lifetime of client per specimen	$93.10
Y8237	Neuraminidase	WB	Two per provider per lifetime of client per specimen	$68.70
Y8238	Nucleoside phosphorylase	RBC	Two per provider per lifetime of client per specimen	$38.52
Y8239		F	Two per provider per lifetime of client per specimen	$83.74
Y8240		AF	One per pregnancy per provider	$83.74

Legend for Type of Specimen: F=Fibroblast WB=Whole Blood S=Serum P=Plasma U=Urine T=Tissue WBC=White Blood Cells SB=Skin Biopsy AF=Amniotic Fluid RBC=Red Blood Cells

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Remarks Code	Laboratory Test Provided	Type of Specimen	Limitations	Maximum Fee
Y8241	Organic acid screen	U	Two per provider per lifetime of client per specimen	$126.88
Y8242	Ornithine transcarbamoylase	Liver	Two per provider per lifetime of client per specimen	$24.29
Y8243	Orotate phosphoribosyl transferase	Any	Two per provider per lifetime of client per specimen	Manually priced
Y8244	Orotidylic-decarboxylase	Any	Two per provider per lifetime of client per specimen	Manually priced
Y8245	Feroxidase	WB	Two per provider per lifetime of client per specimen	$64.20
Y8246	Phenylalanine	P or S	Two per provider per lifetime of client per specimen	$12.84
Y8247	Phosphorylase-B-kinase	Any	Two per provider per lifetime of client per specimen	$329.88
Y8248	PP-ribose-P aminotransferase	Any	Two per provider per lifetime of client per specimen	Manually priced
Y8249	PP-ribose-P synthetase	Any	Two per provider per lifetime of client per specimen	Manually priced
Y8250	Pyruvate kinase	WB	Two per provider per lifetime of client per specimen	$23.11
Y8251	Sphingomyelinase	WBC	Two per provider per lifetime of client per specimen	$41.09
Y8252		F	Two per provider per lifetime of client per specimen	$83.74
Y8253		AF	One per pregnancy per provider	$83.74
Y8254	UDPG transferase	RBC	Two per provider per lifetime of client per specimen	$38.52
Y8255		F	Two per provider per lifetime of client per specimen	$83.74
Y8256		AF	One per pregnancy per provider	$83.74
Y8257	Urine mucopolysaccharides screen (thin-layer chromatography)	U	Two per provider per lifetime of client per specimen	$38.52
Y8258	Urine mucopolysaccharides screen (quantitative study)	U	Two per provider per lifetime of client per specimen	$148.94
Y8259	Xanthine oxidase	Any	Two per provider per lifetime of client per specimen	Manually priced
Y8260	Lactate/pyruvate kinase	S	Two per provider per lifetime of client per specimen	$38.06
Y8261	Lactate/pyruvate tolerance tests	T	Two per provider per lifetime of client per specimen	$203.00

Legend for Type of Specimen: F=Fibroblast WB=Whole Blood S=Serum P=Plasma U=Urine T=Tissue WBC=White Blood Cells SB=Skin Biopsy AF=Amniotic Fluid RBC=Red Blood Cells

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22.3.4.4 Genetic Ultrasound Testing Procedures

Procedure Code	Limitations	Maximum Fee
G-76805	One per pregnancy, per provider*	$104.19
G-76810	One per pregnancy, per provider*	$207.57
G-76811	One per pregnancy, per provider*	$177.63
G-76811 *with* modifier TS	One per pregnancy, per provider*	$97.44
G-76812	One per pregnancy, per provider*	$177.63
G-76812 *with* modifier TS	One per pregnancy, per provider*	$97.44
G-76815	One per pregnancy, per provider*	$69.56
G-76816	One per pregnancy, per provider*	$57.28
G-76818	One per pregnancy, per provider*	$80.47
G-76819	One per pregnancy, per provider*	$70.37
G-76825	One per pregnancy, per provider*	$90.01
G-76826	One per pregnancy, per provider*	$61.92
G-76827	One per pregnancy, per provider*	$83.46
G-76941	One per pregnancy, per provider*	$98.19
G-76945	One per pregnancy, per provider*	$79.92
G-76946	One per pregnancy, per provider*	$60.55
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies the claim.**		

General Genetic Services Limitations

When multiple ultrasound procedure codes are billed on the same day for the same client, the most inclusive code will be paid and all other codes will be denied.

Reimbursement for genetic ultrasound services will be made for the total component (TOS G) only. Professional (TOS I) and technical (TOS T) components are considered a part of the total service.

Reimbursement for referred genetic services will only be made upon proof of formal referral of a client to the consultant by the genetics provider.

Independent consultant, laboratory, counseling, and radiological genetic services:

- Must be billed through the genetic provider under contract with DSHS
- Related to the genetic workup of a client is not a covered benefit

A fetal biophysical profile (G-76818 and G-76819) and an echography (G-76805, G-76810, G-76811, G-76812, G-76815, and G-76816) may be billed on the same day for the same client.

22.4 Claims Information

Genetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

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22.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

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TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission with the TMHP	5-10
Communication Guide	A-1
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Acronym Dictionary	F-1

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Section

23

Hearing Aid and Audiometric Evaluations

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23.1 Enrollment

To enroll in the Texas Medicaid Program, hearing aid professionals (physicians, audiologists, and fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are only eligible to enroll as individuals and facilities. Additionally, audiologists not wanting to enroll as a hearing aid provider are allowed to enroll separately as audiologists.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more information on enrollment procedures.

23.1.1 Medicaid Managed Care Enrollment

Hearing aid providers must enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients.

23.2 Reimbursement

Hearing aids and audiometric services are reimbursed in accordance with 1 Texas Administrative Code (TAC) 355.8141. Hearing evaluations and the first and second revisits are reimbursed according to the maximum allowable fee. Procedure codes 99211 and 99212 should be billed for the first and second revisits, respectively.

Reimbursement for ear molds and the fitting and dispensing fee is limited to the established maximum fee.

Hearing aid procedures indicated with "MR" (Manually Review) must be submitted with the Manufacturer's Suggested Retail Price (MSRP) in the *Comments* field of the claim. If the MSRP is not included in the comments field on the original submission, the claim will be denied. Providers will be required to submit their request as an appeal, and must include an invoice validating the cost of the instrument. The maximum allowable fee for the hearing aid instrument includes:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer's postage and handling charges
- All necessary tubing, cords, and connectors
- Bone conduction headbands
- Telephone coils
- Compression circuits
- Contralateral Routing of Offside Signal (CROS)/ Bilateral Contralateral Routing of Offside Signal (BICROS) features
- Instructions for care and use
- One-month supply of batteries

Charges for hearing aid components must be verified by the manufacturer's invoice and price lists. The fitting and dispensing fee includes the postfitting check of the hearing aid within five weeks after the dispensing date.

Note: *Charges to the client for covered services constitute a breach of the Medicaid contract.*

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

"Billing Clients" on page 1-9 for more information.

23.3 Benefits

Hearing aid services are payable by the Texas Medicaid Program for clients 21 years of age and older. Services for clients younger than 21 are reimbursed through the Program for Amplification for Children of Texas (PACT).

Hearing aid services, including hearing aid instruments are reimbursed when medically necessary. The benefits that are reimbursable for hearing aid services are determined by statutory and fiscal limitations.

23.3.1 Medicaid Clients Younger Than 21 Years of Age

Payment for these services for clients who are Medicaid-eligible and younger than 21 years of age are made through the Department of State Health Services (DSHS) PACT. An appropriate hearing screening is a mandatory part of each medical checkup. When suspicion or indication of a hearing problem occurs, refer Medicaid clients younger than 21 years of age to an enrolled PACT provider. For a list of PACT providers, visit the PACT website at http://www.dshs.state.tx.us/audio/program.shtm, or write to:

DSHS
Program for Amplification for Children of Texas (PACT)
1100 West 49th Street
Austin, TX 78756-3199
1-512-458-7724

23.3.2 Hearing Screenings

23.3.2.1 Newborn Hearing Screening

Health Safety Code, Chapter 47, *Vernon's Texas Codes Annotated* mandates that a newborn hearing screening occur at the birthing facility before hospital discharge. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program according to DSHS standards, and notification to the provider, parents, and DSHS of screening results. There is no additional Medicaid reimbursement for the newborn hearing screening because the procedure is part of the newborn hospital diagnosis related group (DRG) payment. Hospitals must use procedure code 09547 to report this newborn hearing screen on the HCFA-1450 (UB-92) claim form.

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This facility-based screening also meets the physician's required component for hearing screening in the inpatient newborn Texas Health Steps (THSteps) checkup. The physician must ensure that the hearing screening is completed before discharging the newborn or, when the birthing facility is exempt under the law, that there is an appropriate referral for a hearing screening to a birthing facility participating in the newborn hearing screening program.

The physician must discuss the screening results with the parents, especially if the hearing screening results are abnormal, and order an appropriate referral for further diagnostic testing. If the results are abnormal, the parent's or legal guardian's consent must be obtained to send information to DSHS for tracking and follow-up purposes.

If a physician has any concerns about this process, the physician should contact the hospital administrator or the DSHS Audiology Services Program at 1-512-458-7724.

23.3.2.2 Initial Test at Birth

The provider must do the following:

- Verify that the parents received the results of the hearing screen at the birthing facility.
- Check for obvious physical abnormalities.
- Supply a hearing checklist for parents and instructions on its use (this checklist is discussed at the first in-office THSteps medical checkup).
- Provide a referral for further diagnostic audiological testing for an infant with abnormal screening results or who is at high-risk for hearing impairment.

23.3.2.3 Outpatient Hearing Screening and Diagnostic Testing for Children

As part of the THSteps medical checkup, physicians are required to complete the hearing screening component. Separate procedure codes must not be billed when hearing screenings are part of medical checkups or day care/school requirements. Medicaid does not reimburse separately.

For children who are seen in the office setting, THSteps requires a puretone audiometer for visits where objective screening is required. In other childcare settings (e.g., day care; preschool; Head Start; and elementary, middle, and high school), the DSHS Vision and Hearing Screening Program requires that a puretone audiometer be used for hearing screening.

Impedance testing is usually used in the physician's office to monitor children who have a documented history of repeated bouts of otitis media and may be billed separately as a diagnostic hearing test with a THSteps checkup. Impedance testing does not meet the requirements for the sensory screening component of the THSteps checkup.

23.3.2.4 Birth Through Three Years of Age

A hearing screening must be completed during each THSteps medical checkup. A THSteps hearing screening consists of the following:

- An observation and history recording obtained from a responsible adult familiar with the child
- Completion of the Hearing Checklist for Parents form
- Referral of a high-risk child to a physician who renders audiology services

23.3.2.5 Three Through 20 Years of Age

The provider should do the following:

- Assess children with a puretone audiometric hearing screen (1000, 2000, 4000 Hz) at 4 through 10 years of age.
- Perform a subjective hearing evaluation, to include client history and observation of the child for the ability to answer questions and follow directions at all other medical checkups where an audiometric screen is not required.
- Document the results of any school screening audiometric testing program in the 12 months preceding the medical check-up.
- Refer any child or adolescent in preschool through twelfth grade who does not respond to a 25 dB tone at any frequency.

23.3.2.6 Adults Hearing Screening 21 Years of Age and Older

Auditory brainstem response (ABR) and otoacoustic emissions (OAE) audiometry are a benefit of the Texas Medicaid Program for infants, children, and adults and may be used in addition to conventional audiometry for further diagnosis.

23.3.2.7 Hearing Referrals

For all age groups, refer Medicaid-eligible children identified during the THSteps medical checkup as needing a diagnostic hearing evaluation or other hearing services, including hearing aids, to an approved hearing services provider. DSHS provides payment to providers for hearing services provided to low-income children who are not eligible for Medicaid. Services for children whose family income is under 150 percent of the federal poverty income limit (whether or not the child is eligible for Medicaid) are administered through the PACT.

Separate procedure codes may be billed for children who require diagnostic hearing testing. The following diagnostic audiometric testing codes may be billed as appropriate 5/I-92567, 5/I/T-92585, 5-92586, 5/I/T-92587, and 5/I/T-92588.

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23.3.3 Hearing Aid Instrument

Medicaid reimbursement for hearing aid instruments is limited to eligible clients, 21 years of age and older, whose air conduction puretone average in the better ear is 45 dB or greater. The client must have medical necessity for a hearing aid instrument and have no medical contraindications for using a hearing aid. Each client must be offered an appropriate new hearing aid instrument within the Medicaid allowable fee schedule. A hearing aid instrument is reimbursable once every six years.

Important: *TMHP may refer people to the Texas Rehabilitation Commission whose jobs are contingent on possession of a hearing aid as well as people appearing to have vocational potential and who need a hearing aid.*

23.3.3.1 Warranty

Each hearing aid instrument dispensed through the Texas Medicaid Program must be a new and current model that meets the performance specifications indicated by the manufacturer and the client's individual hearing needs. A new hearing aid is one that has never been used and carries a full 12-month manufacturer's warranty. The manufacturer's warranty must be effective for 12 months after the dispensing date.

23.3.3.2 30-Day Trial Period

Providers must allow each Medicaid client a 30-day trial period that gives the client time to determine satisfaction with a purchased hearing aid instrument. The trial period consists of 30 consecutive days beginning with the dispensing date. During the trial period, providers may dispense additional hearing aids as medically necessary until the client is satisfied with the results of the aid, or the provider determines that the client cannot benefit from the dispensing of an additional hearing aid. A new trial period begins with the dispensing date of each hearing aid. Under the Texas Medicaid Program, if the client is not satisfied with the purchased hearing aid instrument, the client may return it to the provider, who must accept it. If the aid is returned within 30 days, the provider may charge the client a rental fee. Obtain a client-signed acknowledgment statement stating the client is responsible for paying the hearing aid rental fees and keep it in the client's file. Providers must allow 30 days to elapse from the hearing aid dispensing date before completing a 30-Day Trial Period Certification Statement.

23.3.3.3 Fitting and Dispensing Visit

This visit includes the hearing aid instrument's fitting, dispensing, and post-fitting check.

23.3.3.4 First Revisit

Additional counseling is available as needed within a period of six months after the post-fitting check. The first revisit, 99211, includes a hearing aid check.

23.3.3.5 Second Revisit

The second revisit procedure code 99212, includes aided sound field testing performed by a contracted evaluator according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry on Form 3503, *Hearing Aid Evaluation Report*. The second revisit is available as needed after the post-fitting check and the first revisit.

The following table lists hearing aid instrument, assessment, and revisit procedure codes.

Note: *Hearing aid procedures indicated with "MR" must be submitted with the MSRP in the Comments field of the claim. If the MSRP is not included in the comments field on the original submission, the claim will be denied. Providers will be required to submit their request as an appeal, and must include an invoice validating the cost of the instrument.*

Procedure Code	Medicaid Fee
99211	$15.55
99212	$22.37
V5010	$44.35
V5011	$50.00
V5030	MR
V5040	MR
V5050	MR
V5060	MR
V5070	MR
V5080	MR
V5090	$100.00
V5100	MR
V5110	$150.00
V5120	MR
V5130	MR
V5140	MR
V5150	MR
V5160	$170.00
V5170	MR
V5180	MR
V5190	MR
V5200	$170.00
V5210	MR
V5220	MR
V5230	MR
V5240	$170.00
V5241	$115.00
V5242	MR
V5243	MR

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Procedure Code	Medicaid Fee
V5244	MR
V5245	MR
V5246	MR
V5247	MR
V5248	MR
V5249	MR
V5250	MR
V5251	MR
V5252	MR
V5253	MR
V5254	MR
V5255	MR
V5256	MR
V5257	MR
V5258	MR
V5259	MR
V5260	MR
V5261	MR
V5262	MR
V5263	MR
V5264	$18.90
V5265	$18.90
V5275	$18.90
V5298	MR
V5299	MR

23.4 Limitations and Exclusions

The following limitations and exclusions apply:

- Reimbursement for a hearing aid instrument is limited to eligible clients, 21 years of age and older, whose air conduction puretone average in the better ear is 45 dB or greater.
- Hearing aid purchases are limited to one every six years with the exception of clients younger than age 21 through PACT.
- Clients younger than age 21 must be referred to PACT.
- Services for residents in nursing facilities (skilled nursing facility [SNF], intermediate care facility [ICF], or extended care facility [ECF]) must be ordered by the attending physician. The order must be on the client's chart and state the condition necessitating hearing aid services and must be signed by the attending physician.
- No payment is made for replacement of batteries or cords.
- No payment is made for repairs or replacements of lost, destroyed, or inappropriate hearing aids.
- No binaural fittings are available except in certain documented cases of legally blind, hearing-impaired clients who have no other available resources. This information must be documented in the client's file as well as on the claim submitted for payment for hearing aid services.
- U.S.-manufactured hearing aids must be considered when the purchase price and quality are comparable to those of foreign manufacturers.
- Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.
- Not included are auditory training, speech, reading, or other rehabilitative services.

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Refer to: "CMS-1500 Claim Filing Instructions" on page 5-24.

23.5 Documentation Requirements

TMHP does not require prior authorization for hearing aids and related procedures. Retain reported audiological and medical information in the client's file until requested. The hearing evaluation must be recommended by a physician (with written medical clearance) for the fitting of a hearing aid by completing the Physician's Examination Report. The Hearing Aid Evaluation Report must include an audiometric assessment. This form must provide objective documentation to support improved communication ability with amplification.

Refer to: "Physician's Examination Report" on page B-69.

"Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)" on page B-41.

23.6 Client Eligibility

The provider determines a client's eligibility for hearing aid services by:

- Asking to see the client's current Medicaid eligibility form (possession of a current Medicaid eligibility form with a check mark in the hearing aid box indicates the client's eligibility for the month)
- Using the Automated Inquiry System (AIS) to determine eligibility for Medicaid and for a hearing aid
- Verifying client eligibility on the TMHP website at www.tmhp.com

Important: *AIS provides claim status, client eligibility, benefit limitations, and current check amount.*

Refer to: "Eligibility Verification" on page 4-4.

"Automated Inquiry System (AIS)" on page -xiii for instructions or contact TMHP Customer Service at 1-800-925-9126.

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23.7 Claims Information

Submit claims for hearing aid services to TMHP on a CMS-1500 claim form or in an approved electronic claims format. Providers must purchase CMS-1500 claim forms from the vendor of their choice; TMHP does not supply them.

Providers supplying hearing aids for STAR+PLUS Medicaid Qualified Medicare beneficiary (MQMB) clients should bill TMHP, not the STAR+PLUS HMO for the hearing aid.

23.7.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
Communication Guide	A-1
Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)	B-41
Physician’s Examination Report	B-69
Hearing Aid Assessments Claim Example	D-15
Acronym Dictionary	F-1

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Section

24

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24.1 Enrollment

To enroll in the Title XIX Texas Medicaid Program, home health services providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Enrolled providers of durable medical equipment (DME) and/or expendable medical supplies will be issued a Durable Medical Equipment-Home Health Services Provider Identifier that is specific to home health providers.

Providers may obtain the application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

For prior authorization requests on the Title XIX Home Health Services contact:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

For general questions, such as claims history information, prior authorization history, procedure codes, procedural matters, or to verify if prior authorization has already been issued, call the TMHP Comprehensive Care Program (CCP)-Home Health Provider Line at 1-800-846-7470.

Refer to: "Provider Enrollment" on page 1-2 for information about enrollment procedures.

24.1.1 Change of Address/Telephone Number

A current physical and mailing address and telephone number must be on file for the agency/company to receive Remittance & Status (R&S) reports, reimbursement checks, Medicaid provider procedures manuals, the *Texas Medicaid Bulletin* (bimonthly update to the *Texas Medicaid Provider Procedures Manual*), and all other TMHP correspondence. Promptly send all address and telephone number changes to TMHP Provider Enrollment at the address listed above in Section 24.1, "Enrollment."

24.1.2 Pending Agency Certification

Home health agencies and DMEH suppliers submitting claims before the enrollment process is complete or without authorization for services issued by TMHP Home Health Services will not be reimbursed. The effective date of enrollment is when all Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Medicaid enrollment, the agency/supplier must contact TMHP's Home Health Services before serving a Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Important: *Do not submit Home Health Services claims for payment until Medicaid certification is received and a prior authorization number (PAN) is assigned.*

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

24.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Medicaid Managed Care" on page 7-4.

24.3 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 *Texas Administrative Code* (TAC) §355.8021(a). The current home health agency fee schedule is available on the TMHP website at www.tmhp.com.

A SN and/or home health aide visit may be provided up to a maximum of 2.5 hours per visit. A combined total of three SN and/or home health aide visits may be reimbursed per day.

All unique procedure codes must be billed according to the description of the procedure code. The quantity billed must be identified and each procedure code must be listed as separate line items on the claim. SN, home health aide, physical therapy (PT), and occupational therapy (OT) visits must be billed in 15 minute increments.

Procedural modifiers are required when billing SN, home health aide, PT, and OT visits.

Modifier	Visit Service Category
U2	SN or home health aide second visit per day
U3	SN or home health aide third visit per day

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Modifier	Visit Service Category
GP	PT
GO	OT

Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021. The current DME fee schedule is available on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126.

TMHP manually prices DME and expendable supplies other than nutritional products that have no established fee, based on the manufacturer's suggested retail price (MSRP) less 18 percent, with documentation of the MSRP submitted by the provider. If there is no MSRP available, reimbursement is at an established percentage of the provider's invoice cost. Nutritional products that require manual pricing are priced at 89.5 percent of the average wholesale price (AWP).

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

24.3.1 Eligibility

To verify client Medicaid eligibility and retroactive eligibility, the home health agency or DMEH/medical supplier should contact the Automated Inquiry System (AIS) at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Effective for dates of service on or after November 14, 2002, home health clients no longer need to meet the homebound criteria to qualify for services. Providers who have received previous denials based on homebound criteria need to appeal their claims with appropriate documentation to include a copy of the claim, R&S statements, and authorization requests.

The Medicaid client must be eligible on the date(s) of services (DOS) and must meet all the following requirements to qualify for Texas Medicaid (Title XIX) Home Health Services:

- Have a medical need for home health professional services, DME, or supplies covered under Home Health Services and as documented in the client's plan of care (POC)
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home
- Receive prior authorization from TMHP for all home health professional services, DME, or supplies

Certain DME/supplies may be obtained without prior authorization although providers must retain a Title XIX Home Health DME/Medical Supplies Physician Order Form reviewed and signed by the treating physician for these clients.

Refer to: "Automated Inquiry System (AIS)" on page xiii.

Note: *Medicaid beneficiaries who are under 21 years of age are entitled to all medically necessary private duty nursing (PDN) services and/or home health SN services. Nursing services are medically necessary when the requested services are nursing services as defined in the Texas Nursing Practice Act and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third-party resource that is financially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and must include supporting documentation. The supporting documentation must clearly and consistently describe the beneficiary's current diagnosis, functional status and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation of how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as PDN services or as Home Health SN services, depending on whether the beneficiary's nursing needs can be met on a per visit basis.*

24.3.1.1 Retroactive Eligibility

When a home health agency is providing services to a client who is pending Medicaid coverage, the agency is responsible for finding out the effective dates for eligibility, which can be done by contacting AIS at 1-800-925-9126 or the TMHP EDI Help Desk at 1-888-863-3638.

Important: *TMHP must receive all documentation and claims for clients with retroactive eligibility within 95 days from the date eligibility was added to TMHP's eligibility file.*

24.3.1.2 Authorization of Retroactive Eligibility

After the client's eligibility is on TMHP's eligibility file, the agency has *95 days from the add date to obtain authorization for services already rendered.* The agency must contact TMHP Home Health Services to obtain authorization for *current services within three business days of the client's eligibility being added to TMHP's eligibility file.* The nurse who made the initial assessment visit in the client's home should make this call.

24.3.2 Prior Authorization

Prior authorization of initial coverage of home health services (SN, home health aide, PT, OT) for an eligible client can be obtained by calling the TMHP Contact Center Home Health Services line at 1-800-925-8957, or by fax to 1-512-514-4209.

- If a client's primary coverage is private insurance, and Medicaid is secondary, prior authorization is required for Medicaid reimbursement.

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- If the primary coverage is Medicare, and Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will only pay the coinsurance.
- If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of receipt of Medicare's final denial letter. The final denial letter from Medicare *must* accompany the authorization request.
- If the service is a Medicaid-only service, prior authorization is required.

The provider is responsible for determining if eligibility is effective by using AIS or an electronic eligibility inquiry through TMHP EDI gateway.

The provider must contact TMHP Home Health Services within three business days of the start of care (SOC) for professional services or the DOS for DME/medical supplies to obtain authorization. Following the registered nurse's (RN) assessment/evaluation of the client in the home setting, the nurse who made the initial assessment visit in the client's home should make this call to answer questions about the client's condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or is lacking medical necessity, the provider will be requested to furnish additional documentation as required to make a decision on the request. Providers have two weeks to submit the requested documentation because it often must be obtained from the client's physician. If the additional documentation is received within the two-week period, authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, authorization is not considered before the date the additional documentation is received. It is the DME/supplier/home health agency's responsibility to contact the physician to obtain the requested additional documentation.

TMHP's Home Health Services toll-free number is 1-800-925-8957. The Home Health Services Authorization Checklist is a useful resource for home health agency providers completing the authorization process. This optional form offers the nurse a detailed account of the client's needs when completed. Contact TMHP In-Home Care Contact Center at 1-800-846-7470 for more information.

Refer to: "Durable Medical Equipment (DME) and Supplies" on page 24-25 for DME/medical supplies prior authorization and "Medicaid Relationship to Medicare" on page 24-59.

Important: *Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.*

24.4 Home Health Services

The benefit period for home health professional services is up to 60 days with a current POC. In chronic and stable situations, DME and supplies ordered on a Title XIX Home Health (DME)/Medical Supplies Physician Order Form may be au*thorized for up to six months* with medical necessity determination. Because a Medicaid client's eligibility period is for one month, providers should bill for a one month supply at a time, even though prior authorization may be granted for up to six months. This extended authorization period begins on the date that clients receive their first authorized home health service. The Texas Medicaid Program allows additional visits, DME, or supplies that have been determined to be medically necessary and have been authorized by TMHP Home Health Services. Providers must retain all orders, Title XIXs, delivery slips, and invoices for all supplies provided to a client and must disclose them to the HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

24.4.1 Client Evaluation

When a home health agency receives a referral to provide home health services, supplies, or DME for a Medicaid-eligible client, the agency-employed RN should evaluate the client in the home before calling TMHP for prior authorization. Although recommended, a home visit is not required if only DME or supplies are needed and being requested by the physician on a Title XIX form. DME or supplies requested on a Home Health Services POC require an RN home evaluation. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician for current reporting.

This evaluation should include assessment of the following:

- Medical necessity for home health services, supplies, or DME
- Safety
- Appropriateness of care in the home setting
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition

Following the RN's assessment/evaluation of the client in the home setting for home health services needs, the agency RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the SOC.

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24.4.2 Physician Supervision—Plan of Care

For the Home Health Services POC to be *valid*, the treating physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in condition.

Important: *Medicare Form 485 is not accepted as a POC. The Texas Medicaid Home Health Services POC is the only acceptable form for reimbursement from Medicaid.*

24.4.2.1 Written Plan of Care

A Home Health Services POC is required for SN services, home health aide services, PT, and OT services. The POC is not required as an attachment with the claim, but it must be retained in the client's medical record with the provider and requesting physician. The client's attending physician must recommend, sign, and date a POC. The POC does not need to be signed by the physician before contacting TMHP for authorization when orders for home care have been received from the physician. The POC shall be initiated by the RN in a clear and legible format. The POC must contain the following information:

- Client Medicaid number
- Physician license number
- Provider Medicaid number
- SOC date for home health services
- All pertinent diagnoses
- Mental status
- Types of services including amount, duration, and frequency
- Equipment/supplies required
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications
- Treatments, including amount and frequency
- Safety measures to protect against injury
- List all community or state agency services the client receives in the home (e.g., primary home care [PHC], community based alternative [CBA], Medically Dependent Children's Program [MDCP])
- Instructions for timely discharge or referral
- Date the client was last seen by the physician. The client must be seen by a physician within *30 days* of the initial SOC and at least once every six months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment. The physician visit may be waived when a diagnosis has already been established by the physician and the recipient is under the continuing care and medical supervision of the physician. Any waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the requesting physician and a copy must be maintained in the providing provider's files.

Physician orders for physical and/or occupational therapy services must include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for an acute or exacerbated event, if the following conditions apply:

- Physical/occupational therapy is being requested
- Specific procedures and modalities are to be used
- Amount, frequency, and duration of therapy needed
- Physical and/or occupational therapy and goals
- Name of therapist who participated in developing the POC is listed

The physician and home health agency nursing, PT, and OT personnel must review the POC as often as the severity of the patient's condition requires or at least once every 60 days. This documentation must be maintained in the client's medical record with the ordering physician and requesting provider. This applies to all written and verbal orders, and plans of care.

Verbal physician orders may only be given to people authorized to receive them under state and federal law. They must be reduced to writing, signed, and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service, and placed in the client's chart. The physician must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. A copy of the written verbal order must be maintained in the client's chart prior to and after being signed by the physician.

The type and frequency of visits, supplies, or DME must appear on the POC before the physician signs the orders, and may not be added after the physician has signed the orders. If any change in the POC occurs during an authorization period (additional visits, supplies, or DME), the home health agency must call TMHP Home Health Services for authorization and maintain a completed revised request POC signed by the physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization. The agency *must* contact TMHP up to three business days after the SOC date for prior authorization.

Refer to: "Home Health Services Plan of Care (POC)" on page B-49.
"Physical Therapy (PT) Services" on page 24-11.

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24.5 Benefits

Home health services include skilled nurse services, home health aide visits, physical therapy visits, occupational therapy visits, DME, and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under 21 years of age if medically necessary. Likewise, time periods for replacement of DME will not apply to Medicaid beneficiaries under 21 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary private duty nursing (PDN) services and/or home health SN services. Nursing services are medically necessary when the requested services are nursing services as defined by the Texas *Nursing Practice Act* and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third party resource financially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must: clearly and consistently describe the beneficiary's current diagnosis, functional status and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as PDN services or as Home Health SN services, depending on whether the beneficiary's nursing needs can be met on a per visit basis.

Important: *When a Medicaid client requires in-home lab related services only, the client must be confined to bed and require ambulance transfer to get to a lab, clinic, or physician's office for authorization to be considered.*

For reimbursement, providers should note the following:

- The client's attending physician must request professional and/or home health aide services through a home health agency, and sign the POC.

Prior authorization is obtained for all professional services, some supplies, and most DME from TMHP within *three business days of SOC*. Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Title XIX Home Health DME/Medical Supplies Physician Order Form that has been completed and signed by the client's attending physician.

- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a quantity of 1 month for supplies billed.
- Nursing, nurse aide, PT, and OT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's provider identifier. File these services on a HCFA-1450 (UB-92) claim form.
- Physical, occupational, and/or speech therapy are always billed as (POS) 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's day care facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only Texas Health Steps-Comprehensive Care Program (THSteps-CCP) therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) in POS 9.
- DME/supplies *must* be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both *must* enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Use the following type of service (TOS) codes when providing home health services:

TOS	Description
1	Medical services (including some injectable drugs)
9	Medical supplies
C	Home Health Procedure
J	Purchase (new)
L	Rental, monthly

24.5.1 Skilled Nursing Services

Home health SN services must be provided by an RN and/or a licensed vocational nurse (LVN) who is currently licensed by the Board of Nurse Examiners for the State of Texas. These services are provided on a part-time or intermittent basis and furnished through an enrolled home health agency. *Part-time* means SN services provided any number of days per week and less than eight hours per day. *Intermittent* means SN services that are not provided daily and are less than eight hours per day. A client can be self-referred, physician referred, or a client's family can request an assessment. The assessment visit determines the need for nursing, PT, OT, DME/supplies, and nursing aide services. SN and/or home health aide visit may be provided up to a maximum of 2.5 hours per visit. A combined total of three SN and/or home health aide visits may be prior authorized per day.

Billable home health SN visits may also include:

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- Nursing visits required to teach the client, the primary caregiver, a family member, and/or neighbor how to administer or assist in a service or activity that is necessary in the care and/or treatment of the client in a home setting
- Nursing visits for SN observation, assessment, and evaluation, provided a physician specifically requests that a nurse visit the client for this purpose (the physician's request must reflect the need for the assessment visit)
- Nursing visits for general supervision of nursing care provided by a home health aide and/or others over whom the RN is administratively or professionally responsible

Note: *Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.*

Home health visits may be used to teach the client or caregiver to safely and effectively perform certain nursing tasks in the home that usually require the skills of a nurse but can be taught to a client or caregiver.

Examples of services that may require the skills of a nurse but can be taught to the client or caregiver are:

- Administration of medication that can be self-administered (subcutaneous [SQ/SC], intramuscular [IM], or intravenous [IV])
- Changing of indwelling catheters
- Application of dressings involving prescribed medications and sterile techniques

Visits to teach the client or caregiver administration of sub-Q, IM, and/or IV injections constitute professional nursing services; however, visits are *not* covered if the following conditions exist:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not Food and Drug Administration (FDA)-approved.
- The administration of medication exceeds therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, and/or neighbor has previously been taught to administer subcutaneous, IM, and IV medications and has demonstrated competency. Nursing visits are not medically necessary once competency has been demonstrated. Non-compliance is not medical necessity for skilled visits.
- The client, a primary caregiver, a family member, and/or neighbor have previously been taught to perform the specific wound care and has demonstrated competency. Nursing visits are not medically necessary once competency has been demonstrated. Non-compliance is not a medical necessity for skilled visits.
- The purpose of the visit is to administer chemotherapeutic agents or blood products.
- The purpose of the visit is pain management.
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B_{12}, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis are not a benefit of Title XIX Home Health Services.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

Home health visits are allowed for short-term teaching of insulin administration and regimen for clients with diabetes. The agency must contact TMHP Home Health Services for further coverage if initial prior authorization is not adequate.

TMHP does not require prior approval for up to two PRN SN visits per 60-day authorization (one per 30 days when necessary), when the following criteria are met:

- These visits must be within a 60-day authorization period when at least one SN visit has been prior authorized.
- If a PRN visit is necessary, *PRN* should be noted on the claim form. For electronic billing, indicate date of PRN in the comment section.
- A 30-day period is calculated from the beginning date of coverage recorded on the confirmation letter and is not to be equated with the calendar months.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for PDN information.

Important: *TMHP Home Health Services will not issue authorization of SN visits addressing hyperbilirubinemia if the client has an open authorization for phototherapy. Phototherapy is reimbursed as a daily global fee and includes coverage of visits by a registered nurse for teaching and monitoring the client, customary and routine laboratory work.*

Important: *TMHP Home Health Services will not issue authorization of SN visits addressing total parenteral nutrition (TPN)/hyperalimentation if the client has open authorization for the TPN/hyperalimentatin. TPN/hyperalimentation is reimbursed as a daily global fee and includes coverage of visits by a registered nurse for teaching and monitoring the client, customary and routine laboratory work, and enteral supplies and equipment.*

Refer to: "In-Home Total Parenteral Hyperalimentation Supplier" on page 27-1 and "Home Phototherapy Devices" on page 24-34.

Skilled Nursing Visits Procedure Code

Use procedure code C-G0154 to submit claims for SN visits provided through a home health agency.

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24.5.1.1 Supplies Submitted With a Plan of Care

The cost of incidental supplies used during a SN visit or a home health aide visit may be added to the charge of the visit ($10 maximum for supplies and included in C-G0154 visit code).

Medical supplies left at the home for the client or a subsequent home health nurse to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services unit.

A home health agency provider may request prior authorization for supplies/DME by utilizing either the Home Health Services POC or the Title XIX Home Health DME/Medical Supplies Physician Order Form.

The home health agency may utilize the Home Health Services POC to submit a prior authorization of supplies/DME that will be used in conjunction with the professional services provided by the agency, such as SN, PT, or OT. The home health agency's DMEH provider identifier must be submitted on the POC and all of the supplies that are requested must be listed in the supplies section of the POC. The POC does not require an MD signature prior to submission for prior authorization of professional services/DME and supplies.

If the home health agency utilizes the Title XIX Home Health DME/Medical Supplies Physician Order Form, the agency must complete Section A. The physician must complete Section B, and sign prior to submission to TMHP for prior authorization of the requested supplies/DME.

The following information is required to consider these supplies for authorization:

- Item description
- Procedure code
- Quantity of each supply requested
- MSRP for items that do not have a maximum fee assigned

24.5.1.2 Canceling an Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Title XIX form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Title XIX form.

24.5.2 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not covered if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not FDA-approved.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, and/or neighbor has been taught or can be taught to administer SQ/SC, IM, and IV injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

24.5.3 Home Health Aide Services

Home health aide services to provide personal care under the supervision of an RN, licensed PT, or OT employed by the home health agency are covered benefits. A SN and/or home health aide visit may be provided up to a maximum of 2.5 hours per visit. A combined total of three SN and/or home health aide visits may be prior authorized per day. Home health aide criteria includes:

- The primary purpose of a home health aide visit must be to provide personal care services when there is no available caregiver and the client is bed bound.
- Home health aide services are for short-term needs. If a client has long-term needs, home health aide services can be considered on a short-term basis to allow long-term arrangements to be made.
- Duties of a home health aide include the performance of simple procedures such as personal care, ambulation, exercise, range of motion, safe transfer, positioning, and household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.
- An RN or therapist must prepare legible written instructions for home health aide services as appropriate.
- The requirements for home health aide supervision are as follows:
    - When only home health aide services are being furnished to a client, an RN must make a supervisory visit to the client's residence at least once every 60 days. The RN *must* complete the supervisory visit when the home health aide is present and providing services, to observe the care the client is receiving and to update the POC.
    - When SN care, PT, or OT are also being furnished to a client, an RN must make a supervisory visit

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to the client's residence at least every two weeks.

- When only PT or OT is furnished in addition to the home health aide services, the appropriate skilled therapist may make the supervisory visits in place of an RN.
- All supervisory visits must be in writing and maintained in the client's medical record.

- Visits made primarily for performing housekeeping services are not covered.

Important: *Refer clients requiring extended attendant care to HHSC In-Home and Family Support Services.*

24.5.3.1 Home Health Aide Procedure Code

Use procedure code C-G0156 to submit claims for home health aide visits provided through a home health agency.

24.5.4 Physical Therapy (PT) Services

To be payable as a Texas Medicaid (Title XIX) Home Health Services benefit, physical therapy services must be:

- Requested for a payable ICD-9-CM diagnosis code.
- Provided by a PT who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners, or PT assistant who is licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners who assists and is supervised by a licensed PT.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.
- The evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition.
- Specific goal-directed activities to achieve a functional level of mobility and communication and prevent further dysfunction within a reasonable length of time based on the therapist's evaluation and physician's assessment and POC.
- PT plan of care should encourage the client and other caregivers to learn self-therapy skills to the greatest extent possible while still providing all medically necessary services.
- Provided only until the patient has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not reimbursed. Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.
- Services are billed by the home health agency and reimbursed to the home health agency.
- Independently-enrolled therapists are not paid under Texas Medicaid (Title XIX) Home Health Services.

Important: *PT authorization must be requested by the home health agency's RN and recommended to be done after the RN home assessment. Requests are not accepted, nor authorization granted, directly to the PT or assistant PT.*

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Texas Medicaid (Title XIX) Home Health Services benefit will receive those services through THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.4.1 Physical Therapy Prior Authorization Procedures

To obtain prior authorization for PT services provided through a home health agency, providers should contact TMHP Home Health Services at 1-800-925-8957. To facilitate a determination of medical necessity and avoid unnecessary denials, home health agencies must provide physical therapy goals, accurate diagnostic information (including ICD-9-CM diagnosis codes and physical therapy procedure codes) at the time a request is made using the POC.

Use the procedure codes listed in "Physical Therapy/ Occupational Therapy Procedure Codes" on page 24-12 of this manual to submit claims for PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code for the PT service billed on a HCFA-1450 (UB-92) claim form.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for physical therapy services that are not billed as home health services.
"Modifiers" on page 5-21.

24.5.4.2 Limitations

Physical therapy must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. Physical therapy is to be billed with current procedural terminology (CPT) procedure codes.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is the point at which maximal improvement has been documented and further improvement ceases. The PT-only procedure codes C-97001 and C-97002 are used.

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24.5.5 Physical Therapy/Occupational Therapy Procedure Codes

Procedure Code		
C-97012	C-97014	C-97016
C-97018	C-97024	C-97026
C-97028	C-97032	C-97033
C-97035	C-97039	C-97110
C-97112	C-97116	C-97124
C-97139	C-97140	C-97530
C-97535	C-97542	

Therapy services that can be designated either as PT or OT must be requested and billed with the correct procedural modifier.

Modifier	Visit Service Category
GP	PT
GO	OT

24.5.6 Occupational Therapy (OT) Services

To be payable as a Texas Medicaid (Title XIX) Home Health Services benefit, occupational therapy services must be:

- Requested for a payable ICD-9-CM diagnosis code.
- Provided by an occupational therapist who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners or by an OT assistant who is licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners to assist in the practice of occupational therapy and is supervised by a licensed occupational therapist.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.

Important: *OT authorization must be requested by the home health agency's RN and recommended to be done after the RN assessment. Requests are not accepted, nor authorization granted, directly to the occupational therapist or OT assistant.*

- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition.
- For specific goal-directed activities to achieve a functional level of mobility and communication and prevent further dysfunction within a reasonable length of time based on the therapist's evaluation.
- Billed by the home health agency. Independently enrolled therapists are not paid directly for home health services.
- Provided only until the patient has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not reimbursed.

  Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

Refer to: "Occupational Therapists (THSteps-CCP Only)" on page 43-55.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Texas Medicaid (Title XIX) Home Health Services benefit will receive those services through THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.6.1 Occupational Therapy Prior Authorization Procedures

To obtain prior authorization for OT services provided through a home health agency, providers should contact TMHP Home Health Services at 1-800-925-8957. To facilitate a determination of medical necessity and avoid unnecessary denials, home health agencies must provide accurate diagnostic information, including ICD-9-CM diagnosis codes, occupational therapy procedure codes, and the occupational therapy treatment plan and goals.

Use the codes listed under "Physical Therapy/Occupational Therapy Procedure Codes" on page 24-12 of this manual to submit claims for OT services that are provided through a home health agency. Bill OT services on a HCFA-1450 (UB-92) claim form.

24.5.6.2 Limitations

Occupational therapy must be billed with the AT modifier. Services must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. Occupational therapy is billed using CPT procedure codes.

The AT modifier is described as "representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy." If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is the point at which maximal improvement has been documented and further improvement ceases. The OT-only procedure codes C-97003 and C-97004 are used.

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24.5.7 Medical Supplies

Medical supplies are covered benefits if they meet the following criteria:

- A completed Title XIX Home Health DME/Medical Supplies Physician Order Form, prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME and supplies. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Title XIX form must include the procedure codes and quantities for the services requested. A copy of the completed Title XIX form must be maintained by the DME provider and the original must be kept by the prescribing physician in the client's medical file.
- The provider *must* contact TMHP within three business days of providing the supplies to the client and obtain authorization, if required.
- The requesting provider and ordering physician must keep all Title XIX Home Health DME/Medical Supplies Physician Order Form and Addendum to Title XIX Home Health DME/Medical Supplies Physician Order Form on file. The physician must maintain the original signed Title XIX copy in their records. Providers *must retain* individual delivery slips or invoices for each DOS that document the date of delivery for all supplies provided to a client and must disclose them to HHSC or its designee upon request. Documentation of delivery must include *one* of the following:
    - Delivery slip or invoice signed and dated by client/caregiver
    - A dated carrier tracking document with shipping date and delivery date, which must be attached to the delivery slip or invoice

Important: *These records and claims must be retained for a minimum of five years from the date of service or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

- The requesting provider or ordering physician must document medical supplies as medically necessary in the client's POC or on a *completed* Title XIX Home Health DME/Medical Supplies Physician Order Form and Addendum to Title XIX Home Health DME/Medical Supplies Physician Order Form. TMHP must prior authorize most medical supplies. They must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client's POC.

HHSC/TMHP reserves the right to request the Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) and/or Addendum to Title XIX Home Health DME/Medical Supplies Physician Order Form at any time.

- Some medical supplies may be obtained without prior authorization; however, the provider must retain a copy of the completed POC or Title XIX form in the client's file. For medical supplies not requiring prior authorization, a completed Title XIX form may be valid for a maximum of six months, unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Title XIX form is required at the end of the determined duration of need.

Refer to: The list of DME/medical supplies that may be provided without prior authorization in "Diabetic Supplies/Equipment" on page 24-14; "Nebulizers" on page 24-46; "Vaporizers" on page 24-47; "Incontinence Supplies" on page 24-18; and "Procedure Codes Removed From Prior Authorization" on page 24-56. The items must be used for therapeutic purposes and directly relate to the client's needs and POC.

Note: *All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.*

Important: *Client eligibility can change monthly. Providers are responsible for verifying eligibility before providing supplies.*

- Clients with ongoing needs may receive up to six months of prior authorizations for some expendable medical supplies under Home Health Services when requested on a Title XIX form. Providers may deliver medical supplies as ordered on a Title XIX form for up to six months from the date of the physician's signature. In these instances, a review of the supplies requested by the physician familiar with the client's condition, and a new Title XIX form is required for each new prior authorization request. Requests for authorization can be made up to 60 days before the start of the new authorization period. Professional Home Health Services prior authorization requests require a review by the physician familiar with the client's condition and a physician signature every 60 days when requested on a POC.

Important: *These records and claims must be retained for a minimum of five years from the date of service or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.*

- If a client or caregiver has been instructed and supervised on proper wound care technique and no longer requires SN services, the home health agency (enrolled as a DMEH provider) can continue to provide supplies that enable the client or caregiver to administer care. Supplies may be provided as long as the client meets home health services criteria. The following supplies are those considered essential to the physician-prescribed treatment of an ill or injured client in their own home. Items not listed may, in selected instances, be required for a particular client. Consideration is given on an individual case basis to items not on this list that are medically documented by the physician's POC. *An RN must evaluate the client in the home setting before the initiation of the POC or have a Title XIX Home*

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Health Durable DME/Medical Supplies Physician Order Form completed and signed by a treating physician serving as a POC for DME and/or supplies.

The DOS is the date on which supplies are delivered to the client and/or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date. The provider must maintain the records supporting documentation that an item was not billed prior to delivery. These records are subject to retrospective review.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

Refer to: "Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)" on page B-44 and "Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form" on page B-46 for copies of forms.

"Durable Medical Equipment Supplier (THSteps-CCP Only)" on page 43-39 for specific information about certain DME and medical supplies.

"Medicare/Medicaid Authorization" on page 24-60 for a list of supplies that do not require prior authorization.

"Eligibility" on page 24-5.

24.5.7.1 Supply Procedure Codes

When submitting supplies on the CMS-1500 claim form, itemize the supplies, including quantities, and also provide the Healthcare Common Procedure Coding System (HCPCS) national procedure codes.

24.5.7.2 Canceling an Authorization

The client has the right to choose their DME/medical supply provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Title XIX form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Title XIX form.

24.5.8 Diabetic Supplies/Equipment

Diabetic supplies and equipment are a benefit through Title XIX Home Health services. The following requirements must be met to qualify for reimbursement under Medicaid Home Health Services:

- The client must be eligible for home health benefits.
- The equipment must be medically necessary.
- The criteria appropriate for the requested equipment must be met.
- Federal financial participation must be available.
- The requested equipment or supplies must be safe for use in the home.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

Glucose monitors and external insulin pumps that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. The durable medical equipment may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate or applicable, and the measures to be taken to prevent reoccurrence must be submitted. Additional services may be reimbursed with prior authorization based on documentation of medical necessity.

In situations where the equipment has been abused or neglected by the client, the client's family or the caregiver, a referral to the Department of State Healthcare Services (DSHS) THSteps Case Management unit will be made by the Home Health Services unit for clients under 21 years of age. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and the equipment.

A Texas Medicaid-eligible client may obtain diabetic supplies and related testing equipment through Title XIX Home Health Services. The following requirements must be met to qualify for reimbursement under Medicaid Home Health Services:

A completed Home Health (Title XIX) DME/Medical Supplies Physician Order Form that prescribes the durable medical equipment and/or medical supplies must be signed and dated by a prescribing physician who is familiar with the client before supplying any medical equipment or supplies. All signatures must be current, unaltered, original, and hand written. Computerized or stamped signatures will not be accepted. The completed Title XIX form must be maintained by the provider and the prescribing physician in the client's medical record. The physician must maintain the original signed copy of the Title XIX form. The completed Title XIX form is valid for a period up to six months from the physician's signature date.

The physician must indicate on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form how many times a day the client is required to test blood glucose levels.

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24.5.8.1 Blood Testing Supplies

Blood testing supplies for diagnoses other than those listed in Table B may be considered for prior authorization with documentation of medical necessity. Quantities will be prior authorized based on the documentation of medical necessity related to the number of tests ordered per day by the physician.

Quantities of blood testing supplies beyond those listed in Table A, when requested for a diagnosis listed in Table B, may be considered for prior authorization with documentation of medical necessity related to the number of tests the physician ordered per day. Blood testing supplies will be reimbursed for the quantities listed in Table A or the quantity that was prior authorized.

The quantity of blood testing supplies billed for a one month supply should relate to the number of tests ordered per day by the physician.

Requests for a quantity greater than those listed in Table A require prior authorization through TMHP Home Health Services.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP. Glucose tabs/gel may be billed with procedure code 9-A9150.*

Blood glucose test/reagent strips (9-A4253) and home glucose disposable monitors with test strips (9-A9275) are limited to a combined total of four per month without prior authorization.

The procedure codes for the diabetic supplies listed in Table A do not require prior authorization, up to the quantities listed in the table, when provided to a client with a diagnosis from Table B.

Table A: Diabetic Supplies, Procedures, and Limitations

Procedure Code	Maximum Limit
1-A9150	1 per six months
9-A4233	1 per 6 months
9-A4234	1 per 6 months
9-A4235	1 per 6 months
9-A4236	1 per 6 months
9-A4250	2 boxes per month
9-A4253	4 boxes per month *combined total with 9-A9275*
9-A4256	2 per year
9-A4258	2per year
9-A4259	2 boxes per month
9-A9275	4 per month *combined total with 9-A4253*

Table B: Diagnosis Codes

Diagnosis Code	Description
25000	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
25001	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled
25002	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
25003	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled
25010	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
25011	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled
25012	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled
25013	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled
25020	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled
25021	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled
25022	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled
25023	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled
25030	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled
25031	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled
25032	Diabetes with other coma, type II or unspecified type, uncontrolled
25033	Diabetes with other coma, type I [juvenile type], uncontrolled
25040	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled
25041	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled
25042	Diabetes with renal manifestations, type II or unspecified type, uncontrolled

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Diagnosis Code	Description
25043	Diabetes with renal manifestations, type I [juvenile type], uncontrolled
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled
25062	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled
25070	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
25071	Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled
25072	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
25073	Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled
25080	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
25081	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled
25082	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
25083	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled
25090	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled
25091	Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled
25092	Diabetes with unspecified complication, type II or unspecified type, uncontrolled
25093	Diabetes with unspecified complication, type I [juvenile type], uncontrolled
64800	Diabetes mellitus of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64801	Diabetes mellitus of mother, with delivery
64802	Diabetes mellitus of mother, with delivery, with mention of postpartum complication
64803	Antepartum diabetes mellitus
64804	Postpartum diabetes mellitus
64880	Abnormal glucose tolerance of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64881	Abnormal glucose tolerance of mother, with delivery
64882	Abnormal glucose tolerance of mother, with delivery, with mention of postpartum complication
64883	Abnormal glucose tolerance of mother, antepartum
64884	Abnormal glucose tolerance of mother, postpartum
7751	Neonatal diabetes mellitus

Diagnoses not listed above may be considered by HHSC with supporting documentation of medical necessity.

Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified by HHSC.

24.5.8.2 Blood Glucose Monitors

A blood glucose monitor is a portable battery-operated meter used to determine the level of blood sugar (glucose). Home glucose monitor procedure codes J-E0607, J/L-E2101, and J/L-E2100 are a benefit of Texas Medicaid (Title XIX) Home Health Services.

Prior authorization is not required for the purchase of a standard blood glucose monitor (J-E0607), but is limited to the diagnoses listed in Table B above. Diagnoses not listed will be considered with a prior authorization request and supporting documentation of medical necessity.

Continuous glucose monitors are not a benefit of Texas Medicaid Title XIX Home Health Services.

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Blood glucose monitors with special features (J-E2100 and J-E2101) may be considered for prior authorization with documentation that supports the medical necessity of the special feature requested.

Purchase of a blood glucose monitor with integrated voice synthesizer (J-E2100) may be prior authorized with documentation that includes a diagnosis of diabetes and significant visual impairment and a statement from the physician that the client is unable to use a regular monitor and the visual impairment is not correctable.

Purchase of a blood glucose monitor with integrated lancing/blood sample (J-E2101) may be prior authorized with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related to, but not limited to, neuropathy, seizure activity, cerebral palsy, or Parkinson's. The documentation must include a statement from the physician that the client is unable to use a regular monitor and has a significant manual dexterity impairment that is not correctable.

The documentation and a completed Title XIX form must be submitted to the Medicaid Home Health Unit for prior authorization.

24.5.8.3 Insulin and Insulin Syringes

Insulin and insulin syringes, all sizes, are reimbursed through the Vendor Drug Program pursuant to a physician’s prescription. The Vendor Drug Program enrolls pharmacies only.

24.5.8.4 Insulin Pump

The following procedure codes for the external insulin pumps and associated supplies are a benefit of the Texas Medicaid Program. Note that a replacement leg bag may be requested with procedure code 9-A9900. *The initial leg bag is part of the purchase of the pump.*

Table C: Insulin Pump Crosswalk Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-A4230	10 per month
9-A4231	15 per month
9-A4232	10 per month
9-A4632	1 per month
9-A6257	15 per month
9-A6258	15 per month
9-A6259	15 per month
9-A9900	Replacement only
J-E0784	1 per 5 years
L-E0784	3 months trial

Prior authorization is required for external insulin pumps (J/L-E0784) with carrying cases and their related supplies. The external insulin pump supplies may be reimbursed separately in addition to the external insulin pump rental.

The following information, which must be documented on the External Insulin Infusion Pump form, is the minimum documentation required for consideration of medical necessity:

- Lab values, current and past blood glucose levels, including glycosylated hemoglobin (Hb/A1C) levels
- History of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity and/or very low insulin requirements
- Any wide fluctuations in blood glucose before mealtimes
- Any Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL
- Day-to-day variations in work schedule, mealtimes and/or activity level, which require multiple insulin injections
- Completed, signed, and dated Title XIX Home Health DME/Medical Supplies Physician Order Form

The external insulin pump may be considered for purchase after it has been rented for three months and the physician provides documentation that it is the appropriate equipment for the client and the client is compliant with use. This documentation and a newly completed Title XIX form and new External Insulin Infusion Pump form must be submitted to TMHP Home Health Services for prior authorization. The external insulin pump supplies are not included in the external insulin pump rental.

An internal insulin pump will not be prior authorized, because reimbursement for the pump is included in the reimbursement for the surgery to place the insulin pump.

A determination will be made by the prior authorization nurse as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and the age of the equipment.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the diabetic equipment or supplies.

24.5.9 Incontinence Supplies and Equipment

Incontinence supplies and DME are defined as disposable supplies, such as diapers/briefs/liners, wipes, underpads, or DME, such as a bedside commode, used by a client who has a medical condition that results in an impairment of urination and/or stooling, or renders them unable to ambulate safely to the bathroom (with or without mobility aids). For the purpose of this policy, permanent impairment of urination and/or stooling is defined as a condition that is not expected to be medically or surgically corrected and that is of long and indefinite duration (at least three months).

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Incontinence supplies, urinals, and bed pans do not require prior authorization up to their allowed maximum limitations. Prior authorization is required for incontinence supplies if amounts greater than the maximum limits are medically necessary. Incontinence supplies billed for a one-month period should be based on the frequency/ quantity ordered by the physician on the Title XIX form.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health benefit will receive those services through THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.9.1 Incontinence Supplies

Skin Sealants/Protectants/Moisturizers/Ointments may be considered for reimbursement with prior authorization for clients who have a medical condition that results in chronic incontinence and increased risk of skin breakdown. Skin sealants, protectants, moisturizers and ointments are limited to a maximum of two per month. Prior authorization for clients younger than 4 years of age must be obtained through THSteps-CCP.

Note: Diapers *are defined as incontinence items attached with tabs.* Briefs *are defined as incontinence items that do not attach with tabs and are slip-on items, such as pull-ups.*

Diapers/briefs/liners may be considered for reimbursement without prior authorization for clients 4 years of age and older who have a medical condition that results in chronic incontinence. A combination of diapers/briefs/liners may be considered for reimbursement. A total accumulation of one or more of the following products is limited to a maximum of 300 per month: diapers/briefs/liners. Amounts beyond 300 per month require prior authorization. Reusable diapers/ briefs are not a benefit of Texas Medicaid Title XIX Home Health.

Note: *Gloves used to change diapers/briefs (including pull-ups) are not a benefit of Texas Medicaid Title XIX Home Health.*

Diaper wipes may be considered for reimbursement without prior authorization for clients 4 years of age and older who also receive diapers/briefs. Diaper wipes are limited to a maximum of two boxes per month.

Note: *Providers are to bill procedure code A4335 instead of procedure code A5120 when providing diaper wipes. Inappropriate billing of A5120 will cause the procedure to deny.*

Underpads may be considered for reimbursement without prior authorization for clients who also receive diapers/ briefs, urine collection devices, or bowel management supplies. Underpads are limited to a maximum of 150 per month without prior authorization. Reusable underpads are *not* a benefit of Texas Medicaid Home Health.

Note: *The Title XIX form for the supplies listed above must reflect a one month's supply of the incontinence product. More than the maximum allowed amount should not be on the Title XIX form, unless it has been prior authorized.*

Ostomy supplies may be considered for reimbursement without prior authorization. The physician must specify the type of ostomy device/system to be used and how often it is to be changed on the Title XIX form. The quantity of ostomy supplies billed for a one-month period should relate to the number of changes per month based on the frequency ordered by the physician.

Urine Collection Devices. The home setting is considered a clean environment, not a sterile one. Sterile incontinence supplies will not be reimbursed in the home setting except when requested by a physician familiar with the client for the following:

- Indwelling urinary catheters
- Intermittent catheters for clients who:
    - Are immunosuppressed
    - Have radiologically documented vesicoureteral reflux
    - Are pregnant and have a neurogenic bladder
    - Have a history of distinct, recurrent urinary tract infections, defined as a minimum of two within the prior 12-month period, while on a program of clean intermittent catheterization

Note: *Nonsterile gloves may be considered for reimbursement with prior authorization when a family member or friend is performing the catheterization. Sterile gloves for catheterization are not a benefit of Texas Medicaid Title XIX Home Health except as noted above. Nonsterile/sterile gloves for use by a health care provider in the home setting, such as an RN, LVN, or attendant, are not a benefit of Texas Medicaid Title XIX Home Health.*

Indwelling catheters and related supplies may be considered for reimbursement without prior authorization for clients who have a documented medical condition that results in a permanent impairment of urination. Indwelling catheters and related supplies are limited to a maximum of two per month. More than two indwelling catheters and related insertion supplies per month requires prior authorization. The physician must indicate on the Title XIX form how often the client is required to change their indwelling catheter.

Intermittent catheters and related supplies may be considered for reimbursement for those who have a documented medical condition that results in a permanent impairment of urination. Intermittent catheters and related supplies are limited to a maximum of 120 per month. More than 120 intermittent catheters and related insertion supplies requires prior authorization. The physician must indicate on the Title XIX form how often the client is required to perform intermittent catheterization.

External urinary collection devices, such as male external catheters and female collection devices, and related supplies may be considered for reimbursement for clients who have a documented and/or diagnosed medical condition that results in a permanent impairment of urination. External urinary collection devices are limited to 31 per month. Prior authorization is required for medically necessary services beyond the limits listed in the Inconti-

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nence Procedures and Limitations table. The physician must indicate on the Title XIX form how often the client is required to change their external urinary collection device.

External urinary collection devices for clients younger than 4 years of age require prior authorization through THSteps-CCP. Documentation of a medical condition that results in an increased urine and/or stool output beyond the typical output for this age group is required for reimbursement consideration.

24.5.9.2 Incontinence Equipment

Incontinence equipment may be considered for reimbursement for clients 4 years of age and older who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Urinals and bed pans may be considered for reimbursement without prior authorization for clients who have a documented and/or diagnosed medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids). Urinals and bed pans are purchase only. Urinals and bed pans are limited to two per year.

Commode chairs and foot rests will be considered for reimbursement based on the level of need. The client must meet the criteria for the level commode chair or foot rest requested.

Reimbursement may be considered for a commode chair with or without foot rest if the client also has a stationary bath chair without a commode cutout.

Level 1: Stationary Commode Chair

A stationary commode chair may be considered for reimbursement with prior authorization for clients who have a medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Use procedure codes J-E0163 or J-E0165 when filing a claim for a stationary commode chair.

Level 2: Mobile Commode Chair

A mobile commode chair may be considered for reimbursement for clients who have a documented medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Mobile commode chair with fixed or removable arms:

- In addition to meeting the criteria for a Level 1 commode chair, the client must be on a bowel program and require a combination commode/bath chair for performing the bowel program and bathing after.
- A mobile commode chair will be considered for reimbursement with prior authorization only if the client does not also have any type of bath chair. If the client meets the criteria for a stationary bath chair, prior authorization of a stationary chair may be considered.
- Use the procedure codes J-E0164 and J-E0166 for a mobile commode chair.

Level 3: Custom Commode Chair

A custom stationary or mobile commode chair may be considered for reimbursement with prior authorization for clients who have a documented medical condition that results in an inability to ambulate to the bathroom safely (with or without mobility aids).

Custom stationary or mobile commode chair with fixed or removable arms and head, neck, and/or trunk support attachments:

- In addition to meeting the criteria for a Level 1 or 2 commode chair, the client must have a medical condition that results in an inability to support their head, neck, and/or trunk without assistance.
- A mobile custom commode chair may be considered for reimbursement only if the client does not also have any type of bath chair.
- Use procedure codes J-E0163-TG, J-E0164-TG, J-E0165-TG, or J-E0166-TG when billing for a custom stationary or mobile commode chair.

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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.
- Use procedure code J-E0168 and modifiers TF and TG for an extra-wide/heavy-duty commode chair.

A *foot rest* is used to support feet during use of commode chair.

The client must meet 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.

Commode chairs are limited to one per five years and replacement pails or pans are limited to a maximum of one per year. Commode chairs with a seat lift mechanism are not a benefit of Texas Medicaid Home Health Services. Documentation must support the medical necessity of a customized commode chair or the addition of attachments to a standard commode chair.

24.5.9.3 Incontinence Procedure Codes With Limitations

Note: *Any service or combination of services not identified with a # next to the procedure code, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Items identified with a # always require prior authorization. Requests for prior authorization of diaper wipes that exceed more than two boxes per month will not be considered through Home Health Services.*

Procedure Code	Maximum Limitation
9-A4310	2 per month
9-A4311	2 per month
9-A4312	2 per month
9-A4313	2 per month

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Procedure Code	Maximum Limitation
9-A4314	2 per month
9-A4315	2 per month
9-A4316	2 per month
9-A4320	2 per month
9-A4327	4 per month
9-A4328	4 per month
9-A4330	As needed
9-A4335	2 per month
9-A4338	2 per month
9-A4340	2 per month
9-A4344	2 per month
9-A4346	2 per month
9-A4349	31 per month
9-A4351	120 per month
9-A4351-SC	120 per month
9-A4352	120 per month
9-A4353	120 per month
9-A4354	2 per month
9-A4355	2 per month
9-A4356	2 per month
9-A4357	2 per month
9-A4358	2 per month
9-A4359	4 per year
9-A4361	As needed
9-A4362	As needed
9-A4364	As needed
9-A4365	1 per month
9-A4367	As needed
9-A4368	As needed
9-A4369	As needed
9-A4371	As needed
9-A4372	As needed
9-A4373	As needed
9-A4375	As needed
9-A4376	As needed
9-A4377	As needed
9-A4378	As needed
9-A4379	As needed
9-A4380	As needed
9-A4381	As needed
9-A4382	As needed
9-A4383	As needed
9-A4384	As needed
9-A4385	As needed

Procedure Code	Maximum Limitation
9-A4387	As needed
9-A4388	As needed
9-A4389	As needed
9-A4390	As needed
9-A4391	As needed
9-A4392	As needed
9-A4393	As needed
9-A4394	As needed
9-A4395	As needed
9-A4396	As needed
9-A4397	As needed
9-A4398	As needed
9-A4399	As needed
9-A4400	As needed
9-A4402	4 per month
9-A4404	As needed
9-A4405	As needed
9-A4406	As needed
9-A4407	As needed
9-A4408	As needed
9-A4409	As needed
9-A4410	As needed
9-A4413	As needed
9-A4414	As needed
9-A4415	As needed
9-A4418	As needed
9-A4420	As needed
9-A4421	As needed
9-A4422	As needed
9-A4428	As needed
9-A4455	4 per month
9-A4554	150 per month
9-A4927	1 per month
9-A5051	As needed
9-A5052	As needed
9-A5053	As needed
9-A5054	As needed
9-A5055	As needed
9-A5061	As needed
9-A5062	As needed
9-A5063	As needed
9-A5071	As needed
9-A5072	As needed
9-A5073	As needed

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Procedure Code	Maximum Limitation
9-A5081	As needed
9-A5082	As needed
9-A5093	As needed
9-A5102	2 per month
9-A5105	4 per year
9-A5112	2 per month
9-A5113	2 per month
9-A5114	2 per month
9-A5120	1 per month
9-A5121	As needed
9-A5122	As needed
9-A5126	As needed
9-A5131	1 per month
9-A5200	2 per month
9-A6250	2 per month
9-T4521	*300 per Month
9-T4522	*300 per Month
9-T4523	*300 per Month
9-T4524	*300 per Month
9-T4525	*300 per Month
9-T4526	*300 per Month
9-T4527	*300 per Month
9-T4528	*300 per Month
9-T4529	*300 per Month
9-T4530	*300 per Month
9-T4531	*300 per Month
9-T4532	*300 per Month
9-T4533	*300 per Month
9-T4534	*300 per Month
9-T4535	*300 per Month
J-E0163#	1 per 5 years
J-E0163-TG#	1 per 5 years
J-E0164#	1 per 5 years
J-E0164-TG#	1 per 5 years
J-E0166#	1 per 5 years
J-E0166-TG#	1 per 5 years
J-E0167#	1 per year
J-E0168#	1 per 5 years
J-E0168-TF#	1 per 5 years
J-E0168-TG#	1 per 5 years
J-E0175#	1 per 5 years
J-E0275	2 per year
J-E0276	2 per year
J-E0325	2 per year
J-E0326	2 per year

Refer to: The Diapers/Briefs/Liners section of “Incontinence Supplies and Equipment” on page 24-17 for an explanation of the item limitations identified with an asterisk (*).

24.5.9.4 Modifiers

Modifier	
TF	TG

24.5.10 Wound Care Supplies and/or Systems

Wound care supplies and systems are designed to assist in healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician. A wound care system includes a medical device and its component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy. Wound care supplies and wound care systems may be considered for reimbursement through Texas Medicaid Title XIX Home Health.

Refer to: “Wound Care Supplies and/or Systems” on page 24-21 for more information.

Prior authorization is required for all the medical supplies and wound care systems addressed in this policy and provided through TMHP Home Health Services.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

24.5.10.1 Wound Care Supplies

Nonsterile/clean wound care supplies may be considered for prior authorization when documentation supports medical necessity. The home setting is considered a clean environment, not a sterile environment.

Sterile wound care supplies, other than those required with a wound care system, may be considered for prior authorization when documentation supports medical necessity and justifies that nonsterile/clean wound care supplies will not meet the client’s needs.

Note: *Established tracheostomies and/or enteral feeding tubes/buttons are not considered wounds, and dressing supplies will not be considered for prior authorization.*

To request prior authorization for wound care supplies, the following documentation must be provided:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client’s overall health status
- Appropriate medical history related to the current wound:

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- Wound measurements to include length, width and depth, any tunneling and/or undermining
- Wound color, drainage (type and amount) and odor, if present
- The prescribed wound care regimen, to include frequency, duration and supplies needed
- Treatment for infection, if present

- The client's use of a pressure reducing mattress and/or cushion, when appropriate
- Identification of the client, family member, or friend who will be instructed how to perform and will be responsible for the wound care

Note: *Nonsterile gloves may be considered for reimbursement when necessary to perform medical wound care provided by the client, a family member, or a friend. The home health nursing agency must provide their staff with the appropriate safety supplies as stated in the Occupational Safety and Health Administration (OSHA) requirements.*

24.5.10.2 Wound Care System

A wound care system includes a medical device and its component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy. Wound care systems may be considered for reimbursement through TMHP Home Health Services when prior authorized.

A wound care system may be considered for reimbursement for clients with a Stage III or IV chronic, nonhealing wound, such as a pressure, venous stasis, diabetic ulcer, postsurgical wound dehiscence, nonadhering skin grafts, or surgical flaps required for covering such wounds.

Types of wound care systems include the following:

- *Thermal wound care system.* A heating element provides and maintains a warm, moist wound environment and protects the wound during the healing process by sealing it with an adhesive drape and applying intermittent heat to the surrounding tissue.
- *Sealed suction wound care system.* Sealed intermittent suction provides and maintains a moist wound environment and protects the wound during the healing process by sealing it with an adhesive drape and applying continuous or intermittent suction.
- *Pulsatile jet irrigation wound care system.* Pulsatile jet irrigation uses antibiotics or water under pressure to irrigate the wound and uses suction to remove the irrigation fluid and debris.

Note: *Portable hyperbaric oxygen chambers that are placed directly over the wound and provide higher concentrations of oxygen to the damaged tissue are not a benefit of Texas Medicaid Title XIX Home Health Services.*

24.5.10.3 Thermal Wound Care System

A thermal wound care system consists of an occlusive pocketed wound cover with foam buffer to cover the wound, a warming card that is placed in the wound cover pocket and an electric temperature control unit (TCU). A thermal wound care system delivers safe, controlled warmth to the wound site and peri-wound tissue—without touching the wound. This warmth temporarily increases blood flow and subcutaneous oxygen to the wound and surrounding area to facilitate healing.

Dressing changes associated with a thermal wound care system are performed every one to three days, depending on the amount of exudate produced by the wound. The warming card is used on a single client, but is not required to be changed during treatment except to accommodate a decreasing wound size. The TCU is rented monthly. The client, family, or caregiver can be taught to perform a thermal wound care system dressing change.

The procedure codes 9-A6000, L-E0231, and L-E0232 are used for a thermal wound care system.

24.5.10.4 Sealed Suction Wound Care System

A sealed suction wound care system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized vacuum pump. A sealed suction wound care system uses continuous or intermittent subatmospheric pressure to evacuate the excess interstitial fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease peri-wound induration.

Dressing changes associated with a sealed suction wound care system are performed every one to three days depending on the amount of exudate produced by the wound. The computerized vacuum pump is rented monthly. An RN is required to perform a sealed suction wound care system dressing change.

Use the procedure codes L-E2402 and 9-A655 for a sealed suction wound care system.

24.5.10.5 Pulsatile Jet Irrigation Wound Care System

A pulsatile jet irrigation wound care system consists of a pistol-style hand piece with a trigger to control the pulsatile jet. A suction pump is used to remove the fluid. The wound is then dressed using standard wound care supplies.

Dressing changes associated with a pulsatile jet irrigation wound care system are performed every one to three days depending on the amount of exudate produced by the wound. An RN is required to perform a pulsatile jet irrigation wound care system dressing change.

Use procedure code L-E1399 for a pulsatile jet irrigation wound care system.

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24.5.10.6 Wound Care System Criteria

Initial Criteria

Initial prior authorization for a wound care system may be considered for reimbursement for up to a 30-day period.

Extension Criteria

Medically necessary prior authorized extensions may be considered for reimbursement for 30-day periods up to a maximum of four months when documentation supports continued significant improvement in wound healing. Wound care systems may be considered for reimbursement beyond four months of treatment on a case-by-case basis after review by the medical director or designee.

24.5.10.7 Prior Authorization

To request prior authorization for a wound system, the documentation listed below must be provided on the Statement of Initial Wound Therapy System In-Home Use Form or the Statement for Recertification of Wound Therapy System In-Home Use Form and submitted with the Title XIX form. The original documentation must be maintained by the prescribing physician in the client's medical record. A copy of these documents must be maintained by the requesting provider.

- Accurate diagnostic information pertaining to the underlying diagnosis/condition and any other medical diagnoses/conditions, including the client's overall health status.
- The client's use of a pressure reducing mattress, when appropriate.
- Albumin level within the last 30 days:
    - If the albumin level is below 3.0, documentation must show that nutritional supplement is in place.
- Hemoglobin A1c obtained within last 30 days if the client has a diagnosis of diabetes mellitus.
- Appropriate medical history related to the current wound:
    - Documentation that the wound is free of necrotic tissue and infection, or if infection is present, that it is being treated with antibiotics, including the name of the antibiotic, dosage, frequency, and route of administration.
    - Wound measurements to include length, width, and depth, any tunneling and/or undermining.
    - For recertification, documentation that the wound is improving.
    - Wound color, drainage (type and amount), and odor if present.
- The prescribed wound care regimen, to include frequency, duration, and supplies needed.
- Identification of the family member, friend, or caregiver who agrees to be available to assist client during this time and agreement of this person not to operate the negative pressure or the pulsatile jet irrigation system if used.
- Documentation that a registered nurse is performing the wound care when a negative pressure or pulsatile jet irrigation wound care system is used. All requirements for SN care must be met.

Wound care system supplies are limited to a maximum of:

- 15 dressing kits or supplies for 15 dressings per wound per month unless documentation supports that the wound size requires more than one dressing kit for each dressing change or if the physician has ordered more frequent dressing changes.
- 10 suction canister sets per month for wound care systems that require suction unless documentation supports evidence of high-volume drainage, defined as greater than 90 ml per day. For high-volume exudative wounds, a stationary pump with the largest capacity canister must be used. Extra canisters related to equipment failure are not considered medically necessary.

Wound care systems and related supplies will not be considered for reimbursement, nor prior authorized, when:

- The client has one of the following contraindications:
    - A fistula to the body
    - Wound ischemia
    - Gangrene
    - Skin cancer in the wound margins
    - Presence of necrotic tissue, including bone (nonapplicable to the pulsatile jet irrigation wound care system)
    - Osteomyelitis (unless it is being treated; the treatment must be identified)
    - Less than six months to live
- In the documented judgement of the treating physician, adequate wound healing has occurred and the wound care system is no longer required.
- No measurable wound healing has occurred over the previous 30-day period.
- A wound care system was used for four months or more in the inpatient setting before discharge, except when documentation supports continued significant improvement in wound healing.
- The wound care equipment and supplies are no longer being used by the client. Stand-by use equipment and supplies are not a benefit of Texas Medicaid Home Health Services.

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24.5.10.8 Wound Care Procedures and Limitations

Procedure Code	Maximum Limitation
9-A4213	As needed
9-A4217	As needed
9-A4244	1 per month
9-A4246	1 per month
9-A4247	1 per month
9-A4450	20 per month
9-A4452	20 per month
9-A4455	4 per month
9-A4462	As needed
9-A4930	As needed
9-A6000	15 per month
9-A6010	As needed
9-A6011	As needed
9-A6021	As needed
9-A6022	As needed
9-A6023	As needed
9-A6024	As needed
9-A6025	As needed
9-A6154	As needed
9-A6196	As needed
9-A6197	As needed
9-A6198	As needed
9-A6199	As needed
9-A6200	As needed
9-A6201	As needed
9-A6202	As needed
9-A6203	As needed
9-A6204	As needed
9-A6205	As needed
9-A6206	As needed
9-A6207	As needed
9-A6208	As needed
9-A6209	As needed
9-A6210	As needed
9-A6211	As needed
9-A6212	As needed
9-A6213	As needed
9-A6214	As needed
9-A6215	As needed
9-A6216	As needed
9-A6217	As needed
9-A6218	As needed
9-A6219	As needed
9-A6220	As needed
9-A6221	As needed
9-A6222	As needed
9-A6223	As needed
9-A6224	As needed
9-A6228	As needed
9-A6229	As needed
9-A6230	As needed
9-A6231	As needed
9-A6232	As needed
9-A6233	As needed
9-A6234	As needed
9-A6235	As needed
9-A6236	As needed
9-A6237	As needed
9-A6238	As needed
9-A6239	As needed
9-A6240	As needed
9-A6241	As needed
9-A6242	As needed
9-A6243	As needed
9-A6244	As needed
9-A6245	As needed
9-A6246	As needed
9-A6247	As needed
9-A6248	As needed
9-A6251	As needed
9-A6252	As needed
9-A6253	As needed
9-A6254	As needed
9-A6255	As needed
9-A6256	As needed
9-A6257	As needed
9-A6258	As needed
9-A6259	As needed
9-A6260	As needed
9-A6261	As needed
9-A6262	As needed
9-A6266	As needed
9-A6402	As needed
9-A6403	As needed
9-A6404	As needed
9-A6410	As needed
9-A6411	As needed

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Procedure Code	Maximum Limitation
9-A6412	As needed
9-A6441	As needed
9-A6442	As needed
9-A6443	As needed
9-A6444	As needed
9-A6445	As needed
9-A6446	As needed
9-A6447	As needed
9-A6448	As needed
9-A6449	As needed
9-A6450	As needed
9-A6451	As needed
9-A6452	As needed
9-A6453	As needed
9-A6454	As needed
9-A6455	As needed
9-A6456	As needed
9-A6550	15 per month
9-T1999	As needed
L-E0231	1 per month
L-E0232	1 per month
L-E2402	1 per month

24.5.11 Durable Medical Equipment (DME) and Supplies

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed for the requested equipment must be met.
- The equipment requested must be medically necessary, and federal financial participation must be available.
- The client's health status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.
- The client must be seen by a physician within one year of the date of service.

A completed Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) prescribing the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME equipment and supplies. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Title XIX form must include the procedure codes and quantities for services requested. The completed Title XIX form must be maintained by the DME provider and the prescribing physician in the client's medical record. The completed Title XIX form with the original signature must be maintained by the prescribing physician.

Prior authorization is required for most DME and services provided through Medicaid Home Health. These services include accessories, modifications, adjustments, and repairs for the equipment.

The date last seen by the physician must be within the past 12 months unless a physician waiver is obtained. The physician's signature on the Title XIX is only valid for 90 days prior to the initiation of services.

Obtain authorization within *three business days* of providing the service by calling TMHP Home Health Services, or faxing the Title XIX form to Home Health Services. A determination will be made as to whether the equipment will be rented, purchased, repaired, modified, or denied based on the client's medical necessity.

To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization, the physician must provide correct and complete information supporting the medical necessity of the equipment and/or supplies requested, including:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status.
- Diagnosis/condition causing the impairment resulting in a need for the equipment and/or supplies requested.

The provider must have the client sign the DME Certification and Receipt Form on page B-35 for all purchased DME for Medicaid clients before submitting a claim for payment. *The client's signature means the DME is the property of the client.* The certification form also requires the name of the item and the date the client received the DME. The DME supplier should retain this form, not submit it with the claim.

The provider must keep all Title XIX Home Health DME/Medical Supplies Physician Order Forms and Addendum to Title XIX Home Health DME/Medical Supplies Physician Order Forms on file. Providers must retain delivery slips or invoices and the DME Certification and Receipt Form documenting the item and date of delivery for all DME provided to a client and must disclose them to HHSC or its designee on request.

- The DME must be used for medical or therapeutic purposes, and supplied through an enrolled DMEH provider in compliance with the client's POC.
- These records and claims must be retained for a minimum of five years from the date of service or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

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Note: *All purchased equipment must be new upon delivery to client. Used equipment may be utilized for lease, but when purchased, must be replaced with new equipment.*

Important: *HHSC/TMHP reserves the right to request the Title XIX Home Health DME/Medical Supplies Physician Order Form and/or Addendum to Title XIX Home Health DME/Medical Supplies Physician Order Form at any time.*

DME must meet the following requirements to qualify for reimbursement under Medicaid Home Health Services:

- The client received the equipment as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client's needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

DME must:

- Be medically necessary due to illness or injury or to improve the functioning of a body part, as documented by the physician in the client's POC or the Title XIX form.
- Be prior authorized by TMHP Home Health Services for rental or purchase of supplies for most equipment. Some equipment does not require prior authorization. Prior authorization for equipment rental can be issued for up to six months based on diagnosis and medical necessity. If an extension is needed, requests can be made up to 60 days before the start of the new authorization period with a new Title XIX form.
- Meet the client's existing medical and treatment needs.
- Be considered safe for use in the home.
- Be provided through an enrolled DMEH provider/supplier.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

DME that has been delivered to the client's home and then found to be inappropriate for the client's condition will not be eligible for an upgrade within the first six months following purchase unless there had been a significant change in the client's condition, as documented by the physician familiar with the client. All adjustments and modifications within the first six months after delivery are considered part of the purchase price.

Important: *All DME purchased for a client becomes the Medicaid client's property upon receipt of the item. This property includes equipment delivered which will not be prior authorized or reimbursed in the following instances:*

- Equipment delivered to the client before the physician signature date on the POC or Title XIX form or Addendum
- Equipment delivered more than three business days before obtaining prior authorization from TMHP Home Health Services and meets the criteria for purchase

Additional criteria:

- TMHP Home Health Services will make the final determination whether DME will be rented, purchased, or repaired based on the client's duration and use needs.
- Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment.
- Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.
- DME repair will be considered based on the age of the item and cost to repair it.
- A request for repair of DME must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the vendor or DME provider of the repairs. Rental equipment may be provided to replace purchased medical equipment for the period of time it will take to make necessary repairs to purchased medical equipment.
- If a DME/medical supply provider is unable to deliver an authorized piece of equipment or supply, the provider should allow the client the option of obtaining the equipment or supplies from another provider.

Items and/or services addressed are reimbursed at a maximum fee determined by HHSC. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases and rentals are reimbursed at the MSRP minus a discount as determined by HHSC.

DME is anticipated to last a minimum of five years and may be considered for replacement when five years have passed and the equipment is no longer functional and repairable. The DME may then be considered for prior authorization. Replacement of equipment will be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, with the measures to be taken to prevent reoccurrence, must be submitted.

Replacement, adjustments, modifications, or repairs will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver. A referral to the Department of State Health Services (DSHS) Medical Case Management Unit will be made by TMHP Home Health Services (or CCP unit, where appropriate) for clients younger than 21 years of age. Providers will be notified that the state will be monitoring this client's services.

Prior authorization is required for replacement. Replacement will be considered in at least one of the following situations:

- After the maximum limitation time has elapsed and the DME is no longer functional and/or repairable
- When irreparable damage has occurred

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Documentation, which must accompany a request, includes a statement from the prescribing physician, which includes:

- A copy of the fire or police report
- The cause of the loss or damage and what measures will be taken to prevent reoccurrence

Important: *Those who supply DME equipment and supplies to Medicaid Managed Care clients must obtain a prior authorization form. Services and supplies for STAR+PLUS Medicaid Qualified Medicare Beneficiary (MQMB) clients should be billed to Medicare first. If denied, submit them to TMHP to consider. The STAR+PLUS health plan is not responsible for these services.*

Cancelling an authorization

The client has the right to choose his DME/medical supply provider and change providers. If the client changes providers, TMHP must receive a change of provider letter with a new Title XIX form. The client must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Title XIX form.

Repairs

Repairs will not be authorized in situations where the equipment has been abused or neglected by the patient, patient's family, or caregiver.

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

For clients requiring wheelchair repairs only, the date last seen by physician does not need to be filled in on the Title XIX Home Health DME/Medical Supplies Physician Order Form.

Covered medical equipment (rental, purchase, or repairs) includes, but is not limited to:

- Manual or powered wheelchairs: *noncustomized,* including medically justified seating, supports, and equipment, or *customized,* specifically tailored or individualized, wheelchairs, including appropriate medically justified seating, supports, and equipment not to exceed an amount specified by HHSC

Example: *If a wheelchair is requested, the provider should define additional items needed, such as foot rests or crutch holders, removable arms, or special attachments.*

- Canes, crutches, walkers, and trapeze bars
- Bed pans, urinals, bedside commode chairs, elevated commode seats, bath chairs/benches/seats, and bath tub rails that are not wall-mounted
- Electric and nonelectric hospital beds, mattresses, and bed-side rails
- Air flotation or air pressure mattresses and cushions
- Reasonable and appropriate appliances for measuring blood pressure and blood glucose suitable to the client's medical situation to include replacement parts and supplies
- Freestanding lifts for assisting the client to ambulate within their residence or to transfer the client from one piece of equipment to another
- Pumps for feeding tubes and IV administration
- Respiratory or oxygen-related equipment

Payment may be authorized for repair of purchased DME. Maintenance of rental equipment (including repairs) is the supplier's responsibility. The toll-free number for TMHP Home Health Services is 1-800-925-8957. Requests for repairs must include the cost estimate, reasons for repairs, age of equipment, and serial number.

Refer to: "Physician Supervision—Plan of Care" on page 24-7.

"DME Certification and Receipt Form" on page B-35.

"Home Health Services Plan of Care (POC)" on page B-49.

"Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)" on page B-44 and *Addendum to* "Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form" on page B-46.

"Procedure Codes Removed From Prior Authorization" on page 24-56 for equipment that does not require prior authorization.

"Provider Enrollment" on page 1-2.

24.5.12 Augmentative Communication Device (ACD) System

Augmentative communication device (ACD) systems are a benefit of Texas Medicaid Home Health and require prior authorization. ACD systems for clients younger than 21 years of age who do not meet the criteria for home health services may be considered under THSteps-CCP.

Refer to: "ACD Procedure Codes and Limitations" on page 24-31 for more information.

24.5.12.1 ACD Systems

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with expressive speech-language disorder to meet their functional speech-language needs. An ACD system electronically represents vocabulary or ideas and expresses messages. For the purpose of this policy, the term "ACD system" refers to the ACD and all medically necessary components and accessories.

An ACD system is a benefit of Texas Medicaid and may be considered for prior authorization as a Texas Medicaid (Title XIX) Home Health Services benefit when the following home health services eligibility criteria are met:

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- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation must be available.
- The requested equipment or supplies must be safe for use in the home.

Note: *ACD systems for clients under 21 years of age who do not meet the criteria for home health services may be considered under the THSteps-CCP Program.*

24.5.12.2 Prior Authorization and Required Documentation

Prior authorization is required for rental or purchase of an ACD system provided through Texas Medicaid (Title XIX) Home Health Services. To obtain prior authorization, the following documentation must be submitted:

Before requesting prior authorization, a completed Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form), prescribing the DME and /or accessories must be signed and dated by a physician familiar with the client. All signatures must be original, unaltered, and handwritten. Computerized or stamped signatures will not be accepted. The date of the Title XIX form can be no more than three months before the service start date. The completed Title XIX form must include the procedure codes and quantities for services requested and must be maintained by the DME provider and the prescribing physician in the client's medical record.

- To facilitate a determination of medical necessity and avoid unnecessary denials when requesting prior authorization for an ACD system, the physician must provide correct and complete information supporting the medical necessity of the equipment and/or supplies requested, including:
  - Diagnosis/condition causing impairment of communication
  - Accurate diagnostic information pertaining to any other medical diagnoses/conditions, to include the client's overall health status

The formal written ACD system evaluation completed, signed, and dated by a speech-language pathologist (SLP), which contains all of the following information:

- Medical status/condition and medical diagnoses underlying the client's expressive speech-language disorder that gives rise to the need for an ACD system
- Current expressive speech-language disorder, including the type, severity, anticipated course of the disorder, and present language skills
- A description of the practical limitations of the client's current aided and unaided modes of communication
- Other forms of therapy/intervention that have been considered and ruled out
- The rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate, least costly alternative for the client and how the recommended system will benefit the client
- Documentation that the client possesses the cognitive and physical abilities to use the recommended system
- A comprehensive description of how the ACD system will be integrated into the client's everyday life, including home, school, or work
- A treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client and, if appropriate, the client's caregiver, and a therapy schedule for the client to gain proficiency in using the ACD system
- A description of the client's speech-language goals and how the recommended ACD system will assist the client in achieving these goals
- A description of the anticipated changes, modifications or upgrades of the ACD system necessary to meet the client's short and long term speech-language needs
- Identification of the assistance/support needed by, and available to, the client to use and maintain the ACD system
- A statement that the SLP is financially independent of the ACD system manufacturer/vendor

Note: *Texas Medicaid may request additional information to clarify or complete a request for an ACD system and accessories.*

The SLP evaluation must be dated before the date on the physician's prescription (Title XIX form).

An ACD system is expected to serve the client's needs for an extended period of time. *Refer to "Replacement" on page 24-31 for additional information.*

24.5.12.3 Procedure Codes for ACD Systems and Accessories

ACDs and Access Devices

A digitized speech device, sometimes referred to as a "whole message" speech output device, utilizes words or phrases that have been recorded by someone other than the ACD system user for playback upon command of the ACD system user. A digitized speech device is identified with one of the procedure codes J/L-E2500, J/L-E2502, J/L-E2504, and J/L-E2506.

A synthesized speech device is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to pre-recorded messages, but can independently create messages as their communication needs dictate.

Synthesized speech devices that produce messages primarily by spelling and require the user to make physical contact with a keyboard, touch screen, or other display are identified with the procedure code J/L-E2508.

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Other synthesized devices allow multiple methods of message formulation through letters, words, pictures, or symbols. Such devices also allow for multiple methods of access including direct physical contact with a keyboard or touch screen; and one or more tools that aid in direct selection, including joystick, head mouse, infrared and light pointers, scanning device or morse code. These synthesized speech devices are reimbursed with procedure code J/L-E2510.

Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

- ACD
- Basic essential software (except for software purchased specifically to enable a client owned computer or personal digital assistant (PDA) to function as an ACD system)
- Batteries
- Battery charger, power supplies, A/C, and/or other adapters
- Interface cables
- Adequate memory to allow for system expansion within a five year time frame
- All basic operational training necessary to instruct the client and family/caregiver(s) in the use of the ACD system
- Manufacturer's warranty
- Computer software that enables a client-owned personal laptop or desktop computer (PC) or PDA to function as an ACD system may be covered as an ACD system.
    - Requests for ACD software may be considered for prior authorization if the software is more cost effective than an ACD system.
    - If an ACD system is more cost-effective than adapting the client owned laptop PC or PDA, an ACD system will be considered for prior authorization instead of the ACD software.
    - If software is purchased, installation of the program and technical support are included in the reimbursement for the software. Rental of ACD system software is not a benefit. Speech generating software is identified with procedure code J/L-E2511.

Note: *Either an ACD system or ACD software for a client-owned laptop or desktop PC or PDA may be authorized, but not both.*

24.5.12.4 ACD System Accessories

Accessories for rental or purchase are a benefit of Texas Medicaid (Title XIX) Home Health Services if the criteria for ACD system authorization are met *and* the medical necessity of *each* accessory is clearly documented in the SLP written evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth/expansion of the ACD system (such as a memory card), should be included in the initial prescription/Title XIX for purchase.

The following accessories may be considered for reimbursement using procedure code J/L-E2599. if the criteria for ACD system authorization are met *and* the medical necessity for *each* accessory is clearly documented in the written evaluation:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words or symbols via direct selection or tools that aid in direct selection techniques such as optical head pointers, joysticks, and ACD scanning devices
- Gross motor access devices, such as switches and buttons, may be considered for clients with poor head and hand control
- Fine motor, head control access devices, such as laser or infrared pointers, may be considered for clients with poor hand control and good head control
- Moisture guard
- Extended warranty if cost beneficial

Use procedure code J/L-E2599 when billing for accessories for speech generating devices.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered to attach an ACD. The make, model, and purchase date of the wheelchair or table is required when requesting a wheelchair mounting device. Up to two mounting devices may be considered for prior authorization for the same client. Mounting systems are identified with procedure code J/L-E2512.

24.5.12.5 Noncovered ACD System Items

Items that are not related to the ACD system, or software components which are not necessary to operate the system, are not a benefit of the Texas Medicaid Program. These items include but are not limited to carrying case, printer, voice prosthetic, and artificial larynx.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive these services through THSteps-CCP.*

24.5.12.6 Prior Authorization

Prior authorization for an ACD system and accessories (rental or purchase) must be requested using the information that follows:

- Medical diagnosis and how it relates to the client's communication needs
- Any significant medical information pertinent to ACD system use
- Limitations of client's current communication abilities/system/devices

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- Statement as to why the prescribed ACD system is the most effective, including a comparison of benefits versus other alternatives
- Complete description of the ACD system with all accessories, components, mounting devices, and/or modifications necessary for client use (must include manufacturer's name, model number, and retail price)
- Documentation that the client is mentally, emotionally, and physically capable of operating the device
- An evaluation and assessment must be conducted by a licensed speech-language pathologist in conjunction with other disciplines, such as physical or occupational therapies. The prescribing physician should base the prescription on the professional evaluation and assessment

The prior authorization request must the include specifications for the ACD system, all component accessories necessary for the proper use of the ACD, and all necessary therapies and/or training. It is recommended that the preliminary evaluation for an ACD system include the involvement of an occupational therapist and/or physical therapist to address the client's seating/postural needs and the motor skills required to utilize the ACD system. An evaluation and assessment by a licensed speech-language pathologist must include the following information:

- Communication status and limitations
- Speech and language skills assessment that includes the prognosis for speech and/or written communication
- Cognitive readiness
- Interactional/behavioral and social abilities
- Capabilities—including intellectual, postural, sensory (visual and auditory), and physical status
- Motivation to communicate
- Residential, vocational, and educational setting
- Alternative ACD system considered with comparison of capabilities
- How the ACD system will be implemented and integrated into environments
- Ability to meet projected communication needs—growth potential and how long it will meet the client's needs
- Anticipated changes, modifications, or upgrades with projected time frames (short and long term)
- Training plan—who, what, when, where

24.5.12.7 Trial Period/Rental/Purchase

In order to ensure and ascertain that the client's needs are met in the most cost effective manner, an ACD system will not routinely be prior authorized for purchase until the client has completed a 30-day trial period that included experience with the requested system. Prior authorization may be provided for rental during this trial period. All components, such as access devices, mounting devices and lap trays necessary for use, must be evaluated during this trial period.

In the situation where an ACD system is not available for rental, purchase can be considered with documentation that the client has had experience with the requested system at school or in another setting.

A trial period is not required when replacing an existing ACD system unless the client's needs have changed and another ACD system or access device is being considered.

To obtain prior authorization for ACD system rental, all of the following documentation must be submitted:

- A formal written evaluation completed by an SLP.
- A Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) listing the prescribed ACD system, access device and accessories such as a mounting device, must be completed, signed, and dated by the physician.

Purchase

Purchase of an ACD system may be considered for prior authorization when all of the following ACD system criteria are met:

- A formal written evaluation/re-evaluation must be completed by an SLP before requesting an ACD system purchase. The evaluation/re-evaluation must include documentation that the client has had sufficient experience with the requested ACD system through trial/rental, school, or another setting.
- A Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) listing the prescribed ACD system, access device and accessories such as a mounting device, must be completed, signed and dated by the physician.

24.5.12.8 DME Certification

The DME certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the date the client received the DME, the item(s) name, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

24.5.12.9 Reimbursement

Items and/or services addressed in this section are either reimbursed at a maximum fee determined by HHSC or through manual pricing. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases are reimbursed at MSRP minus a discount as determined by HHSC.

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24.5.12.10 Non-Warranty Repairs

Non-warranty repairs of an ACD system may be considered for prior authorization with documentation from the manufacturer explaining why the repair is not covered by the warranty. A request for prior authorization of ACD system repair(s) not covered by warranty must be submitted with the following procedure codes. Use procedure code 9-E1340 and J-E1399 for replacement parts.

24.5.12.11 Replacement

An ACD system is anticipated to last a minimum of five years.

- A formal written evaluation completed by an SLP is required for replacement.
- When appropriate, a copy of the police or fire report, with the measures to be taken to prevent reoccurrence, must be submitted.
- In situations where the equipment has been abused or neglected by the client, the client's family, or the caregivers, the Home Health Services Prior Authorization Unit will make a referral to the DSHS THSteps Case Management Program for clients under 21 years of age. The provider will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Prior authorization for replacement may be considered within five years or more from the purchase date or when the ACD system is no longer functional, and either cannot be repaired or it is not cost effective to repair.

Prior authorization for replacement may be considered with five years of purchase when there has been a significant change in the client's condition such that the current device no longer meets the client's communication needs or the ACD system is no longer functional and either cannot be repaired or it is not cost effective to repair.

Note: *ACD system replacements for clients under 21 years of age that do not meet the criteria in this section may be considered through THSteps-CCP.*

24.5.12.12 ACD Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-E1340	As needed, with documentation of warranty coverage
J-E2500	1 per 5 years
J-E2502	1 per 5 years
J-E2504	1 per 5 years
J-E2506	1 per 5 years
J-E2508	1 per 5 years
J-E2510	1 per 5 years
J-E2511	1 per 5 years
J-E2512	1 per 5 years
J-E2599	As needed, with documentation of warranty coverage
L-E2500	1 per month
L-E2502	1 per month
L-E2504	1 per month
L-E2506	1 per month
L-E2508	1 per month
L-E2510	1 per month
L-E2511	1 per month
L-E2512	1 per month
L-E2599	1 per 5 years

24.5.13 Bath and Bathroom Equipment

Bath and bathroom equipment is DME that is included in a treatment protocol, serves as a therapeutic agent for life and health maintenance, and is required to treat an identified medical condition. Bath and bathroom equipment may be considered for reimbursement for those clients who have physical limitations that require assistive equipment for bathing, showering, or bathroom use.

Note: *THSteps eligible clients who qualify for medically necessary services beyond the limits of this Texas Medicaid (Title XIX) Home Health Services benefit may be considered under the Texas Health Steps- Comprehensive Care Program (THSteps-CCP).*

The following criteria must be met to qualify for Title XIX Home Health Services:

- The client must be eligible for home health benefits
- The criteria listed in this policy for the requested supplies/equipment must be met
- Federal financial participation must be available
- The requested equipment must be safe to use in the home

DME covered by Texas Medicaid must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

Bath seats are not considered for children younger than one year of age or weighing less than 30 pounds. Authorization is required for all bath and bathroom equipment and related supplies, including any accessories, modifications, adjustments, replacements and repairs to the equipment. The bath and bathroom equipment must be able to accommodate a 20 percent change in the client's height and weight. To request prior authorization for bath or bathroom equipment, the following documentation must be provided:

- Accurate diagnosis/condition information which pertains to the underlying diagnosis/condition and any other medical diagnoses/conditions. The diagnosis

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information should include the client's overall health status, other medical needs, developmental level, functional mobility of the client, and an explanation of why regular bath or bathroom equipment does not meet the client's needs
- The age, height, and weight of the client
- Assessment of the client's home to ensure the requested equipment can be safely accommodated
- Anticipated changes in the client's needs to include anticipated modifications or accessory needs, as well as the growth potential of any custom shower/bath equipment

Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts.

Hand-Held Shower Wand

Hand-held shower with attachments will only be authorized if other bath/shower equipment authorization criteria have been met and a shower chair/tub transfer bench has been authorized, or if the client currently owns this equipment. Prior authorization of a handheld shower includes all attachments and accessories. Providers must use procedure code J-E1399 to bill a hand-held shower or shower wand.

Bath/Shower Chairs

Bath/shower chairs may be considered for those clients who cannot safely use a regular bath tub or shower. Bath/shower chairs, tub stool/benches and tub transfer benches are grouped into three levels of design to assist the client based on their physical condition and mobility status.

Level 1 Group

A level 1 bath/shower chair is defined as stationary equipment.

Level 1 devices may be considered if the client meets either of the following two criteria:

- Is unable to stand independently or is unstable while standing
- Is unable to independently enter or exit the shower/tub due to limited functional use of the upper or lower extremities and one of the following:
    - Maintains the ability to ambulate short distances (with or without assistive device)
    - Has a condition that is defined as a short-term disability without a concomitant long-term disability (including, but not limited to postoperative status).

Level 2 Group

A level 2 device is defined as mobile equipment with or without a commode cut out. A level 2 device may be considered if the client has good upper body stability and one of the following:

- Has impaired functional ambulation, including, but not limited to lower body paralysis, osteoarthiritis
- Is nonambulatory.

The client must have a shower that is adapted for rolling equipment; ramps are not acceptable for access to showers.

Level 3 Group

A level 3 device is a custom stationary or mobile chair with or without a commode cut out. A level 3 device may be considered if the client requires trunk and/or head/neck support or positioning to accommodate conditions that include, but are not limited to, spasticity or frequent/uncontrolled seizures.

A bath/shower chair may be prior authorized for clients who meet the level 1, 2, or 3 criteria. A custom bath/shower chair may be considered for reimbursement only if the client does not also have any type of commode chair.

A level 3 custom bath/shower chair may be prior authorized only if the client does not also have any type of commode chair. The client must have a shower that is adapted for rolling equipment; ramps will not be prior authorized for access to showers. A tub transfer bench may be considered if the client meets the Level 1 or 2 criteria. A tub stool/bench may be prior authorized for clients who meet the level 1 criteria.

A heavy duty tub transfer bench may be considered for clients who meet the level 1 or 2 criteria and who weigh more than 200 pounds.

Bathroom Equipment

Non-fixed toilet rails, bathtub rail attachments, and raised toilet seats may be considered for prior authorization for a client who has decreased functional mobility and is unable to safely self-toilet or self-bathe without assistive equipment.

Portable Sitz Bath

A portable sitz bath, may be considered for prior authorization if the client requires any of the following:

- Cleaning, irrigation, or pain relief of a perianal wound
- Relief of pain associated with the pelvic area (hemorrhoids, bladder, vaginal infections, prostate infections, herpes, testicle disorders)
- Muscle toning for bowel and bladder incontinence

Bath Lifts

A bath lift may be considered for prior authorization if the client has:

- An inability to transfer to the bathtub/shower independently using assistive devices (including but not limited to, a cane, walker, bathtub rails)
- The client requires maximum assistance by the caregiver to transfer to the bathtub/shower
- The client's bathroom and tub/shower meet the manufacturer's recommended depth, width, and height for safe bath lift installation and operation

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Home adaptation for use of medical equipment is not a benefit of Texas Medicaid (Title XIX) Home Health Services. The following are payable procedure codes for bath and bathroom equipment:

Procedure Code	Maximum Limitation
J-E0160	2 per year
J-E0161	2 per year
J-E0240	1 every 5 years
J-E0243	1 every 5 years
J-E0244	1 every 5 years
J-E0245	1 every 5 years
J-E0246	1 every 5 years
J-E0247	1 every 5 years
J-E0248	1 every 5 years
J-E0621	1 per year
J-E0625	1 every 5 years
J-E0630	1 every 5 years
J-E1399	As needed
L-E0161	1 every 5 years
L-E0625	1 per month

Modifications, Adjustments, and Repairs

All modifications/adjustments within the first six months after delivery are considered part of the purchase price.

Modifications to custom equipment may be prior authorized should a change occur in the client's needs, capabilities, or physical/mental status which cannot be anticipated. Documentation must include all projected changes in the clients mobility needs, the date of purchase, the serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

A maximum of one hour of labor for adjustments may be prior authorized as needed after the first six months following delivery.

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity. Technician fees are considered part of the cost of the repair.

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

Bathroom/toilet lift rentals may be prior authorized during the period of repair up to a maximum of four months per lifetime per client.

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

24.5.14 Blood Pressure Devices

Blood pressure devices are a payable benefit of Texas Medicaid (Title XIX) Home Health Services when:

- Medically necessary and appropriate
- Prescribed by a physician
- The client has one of the following covered diagnoses: essential or secondary hypertension, hypertensive heart disease, hypertensive renal disease, chronic pulmonary heart disease, heart failure, nephritis or nephropathy, acute renal failure, or hypertension complicating pregnancy, childbirth, and the puerperium. When billing for these devices use procedure codes 9-A4660 and 9-A4670

If the client is not eligible for home health services, blood pressure devices may be provided under THSteps-CCP for clients younger than 21 years of age.

Prior authorization is required for blood pressure devices. Electronic blood pressure devices are not a benefit through Texas Medicaid (Title XIX) Home Health Services. Rental of electronic blood pressure devices may be prior authorized through THSteps-CCP for clients *younger than 12 months of age.*

Refer to: "Electronic Blood Pressure Monitoring Device" on page 43-46 for more information.

24.5.15 Breast Pumps

Breast pumps, procedure codes J-E0602 and J-E0603, are payable for mothers or their infants.

Breast pumps must be:

- Prior authorized through TMHP Home Health Services
- Purchased only
- Limited to once every three years

A manual breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity.

An electric breast pump may be considered for purchase only with appropriate documentation supporting medical necessity and an explanation of why a manual breast pump was not effective. Supporting documentation may include an evaluation from a lactation consultant or RN, such as an experienced perinatal nurse.

Replacement of the breast pump will be considered when loss or irreparable damage has occurred, with a copy of the police or fire report when appropriate, and with the measures to be taken to prevent reoccurrence. Replacement will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver.

Procedure code J/L-E0604 is not a benefit of Texas Medicaid (Title XIX) Home Health Services.

Note: *Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).*

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24.5.16 Continuous Passive Motion (CPM) Device

A continuous passive motion (CPM) device may be considered for prior authorization through Title XIX Home Health Services. Reimbursement for a CPM device is considered after joint surgery, such as knee replacement, when prescribed by a physician and submitted with clinical documentation of medical necessity/appropriateness.

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Use procedure code L-E0935 when billing for a CPM machine.

Note: *THSteps eligible clients who qualify for medically necessary services beyond the limits of this Texas Medicaid (Title XIX) Home Health Services benefit may be considered under the THSteps-CCP.*

24.5.17 Elastomeric Devices

Elastomeric devices are a payable benefit of Texas Medicaid (Title XIX) Home Health Services when prescribed by a physician, supported with documentation of medical necessity and appropriateness, and required for short-term medication administration only.

When billing for these devices use procedure code E1399.

Note: *Elastomeric devices for clients under 21 years of age who do not meet criteria for Title XIX Home Health Services may be considered under THSteps-CCP.*

24.5.18 Home Phototherapy Devices

Home phototherapy is an all-inclusive service. Any laboratory and/or nursing services required are included in the reimbursement for the home phototherapy. Home phototherapy must be prior authorized under a provider identifier enrolled as a DME supplier. When billing for home phototherapy, use procedure code L-E0202. Home phototherapy is reimbursed on a daily basis and is limited to once per day. Reimbursement for therapeutic home phototherapy is considered for infants with hyperbilirubinemia who are older than 24 hours of age when the home phototherapy is prescribed by a physician and clinical documentation supports medical necessity/appropriateness.

Authorization is required and providers must maintain documentation of medical necessity, including:

- For clients 24 hours of age to 7 days of age:
    - Onset of jaundice more than 24 hours of age but less than 7 days of age
    - Serum bilirubin 12-20 mg/dL (170-340 umol/L)
- For clients more than 7 days old, the medical director or designee must review the request for prior authorization:
    - Total and direct bilirubin levels before initiation of phototherapy, at 7 days and any serial bilirubins done during therapy
    - Serum bilirubin of 17-20 mg/dL (290-340 umol/L)
    - Type of feeding, whether formula or breast milk
    - Physician's POC for intervention after 7 days

Note: *THSteps eligible clients who qualify for medically necessary services beyond the limits of this Texas Medicaid (Title XIX) Home Health Services benefit may be considered under THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.19 Hospital Beds

Requests for a hospital bed must include a Title XIX Home Health DME/Medical Supplies Physician Order Form including client height and weight. Include documentation of the following:

- The client's medical need
- The client's condition and functional level
- Growth potential of equipment if applicable
- Necessity of hospital bed versus current bed
- Necessity of manual bed versus electric bed
- Manufacturer's product information and MSRP

Note: *If the client is not eligible for home health services, hospital beds may be provided under THSteps-CCP for clients younger than 21 years of age.*

Hospital beds require prior authorization.

Hospital beds may be considered for those clients who cannot safely use a regular bed. To request prior authorization for a hospital bed, the following documentation must be submitted:

- Accurate diagnostic information pertaining to the underlying medical diagnoses/conditions (e.g., gastrostomy feeding, suctioning, ventilator dependent, other respiratory equipment/ventilation assistance devices) to include the client's overall health status
- The client's height and weight
- The client's condition and functional mobility status
- The client's use of any pressure-reducing support surfaces, if applicable

A hospital bed without side rails and/or mattress is not a benefit of Texas Medicaid (Title XIX) Home Health Services. Side rails or mattresses may be considered for reimbursement for replacement only. A replacement mattress or side rails may be considered if a client's condition requires a replacement of an innerspring mattress or side rails and it is a patient-owned hospital bed.

The following types of hospital beds are addressed in this policy:

- A fixed height hospital bed with manual head and leg elevation adjustments but no height adjustment
- A variable height hospital bed with manual head and leg elevation adjustments and manual height adjustment
- A semielectric bed with manual height adjustment and with electric head and leg elevation adjustments

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- A full electric bed has an electric head and leg adjustment, plus electric height adjustment
- Heavy-duty hospital beds:
  - A heavy-duty, extra wide hospital bed is capable of supporting a patient who weighs more than 350 pounds, but no more than 600 pounds *or*
  - A extra heavy-duty, extra wide hospital bed is capable of supporting a patient who weighs more than 600 pounds

A hospital bed is not one that is typically sold as furniture. A home furniture bed may consist of a frame, box spring and mattress. It is a fixed height and has no head or leg elevation adjustments.

A fixed height bed may be considered for reimbursement when the following criterion is met:

- The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to conditions such as congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been used and found to be ineffective.

Use procedure code J/L-E0250.

A variable height hospital bed may be considered for reimbursement if the patient meets the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

Use procedure code J/L-E0255.

A semi-electric hospital bed may be considered for reimbursement if the patient meets the criteria for a variable height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

Use procedure code J/L-E0260.

A fully electric bed may be considered if the manufacturer's product information and MSRP for manually priced items documentation is included for clients who cannot function without a fully electric bed. A fully electric bed may be considered for reimbursement if found to increase the client's ability to self-care and will not be authorized for the convenience of the care giver.

Use procedure code J/L-E0265.

A heavy-duty, extra wide hospital bed is capable of supporting a patient who weighs more than 350 pounds, but no more than 600 pounds. An extra heavy-duty, extra wide hospital bed is capable of supporting a patient who weighs more than 600 pounds. These beds may be considered for reimbursement if the client meets the criteria for one of the other hospital beds and whose weight meets the description of a heavy-duty hospital bed.

Use procedure codes J/L-E0303 and J/L-E0304.

Accessories

All accessories must be prior authorized.

A trapeze bar attached to a bed (J/L-E0910 or J/L-E0911) may be considered for reimbursement if the client needs this device to sit up, to change body position, for other medical reasons, or to get in or out of bed.

Free standing trapeze equipment (J/L-E0912 or J/L-E0940) may be considered for reimbursement if the patient does not have a covered hospital bed but the patient needs this device to sit up to change body position for other medical reasons, or to get in or out of bed.

An over-bed table (J/L-E0315) may be considered for reimbursement if client is bed bound and needs the equipment for treatments.

A safety enclosure (J/L-E0316) used to prevent a patient from leaving the bed is not a benefit of the Texas Medicaid (Title XIX) Home Health Services.

Traction equipment, such as procedure codes J/L-E0890, J/L-E0947, and J/L-E0948, (excluding procedure codes J/L-E0910 and J/L-E0940 trapeze devices) are not a benefit of Texas Medicaid (Title XIX) Home Health Services.

Pressure-Reducing Support Surfaces

Pressure-reducing support surfaces must be prior authorized.

A pressure-reducing support surface includes three separate groups of mattress/mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy and/or to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

Pressure-reducing support surfaces are a benefit of Texas Medicaid (Title XIX) Home Health Services on a case-by-case basis. To request prior authorization for a pressure-reducing support surface the following documentation must be provided:

- Client's overall health status and all other medical diagnosis/condition (e.g., history of decubitus)
- Documentation of the client's limited mobility or confinement to a bed
- Previous use of pressure-reducing support surfaces with client outcome, (e.g., wound improvement, stasis, or degradation)
- Current wound therapy if any
- Wound measurements to include location, length, width, depth, any undermining and/or tunneling, and odor if applicable

Pressure-reducing support surfaces containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multilayer product).

A support surface that does not meet the characteristics specified in the pressure-reducing support surface policy may be denied as not medically necessary.

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Texas Medicaid (Title XIX) Home Health Services will only cover alternating air mattresses and low-air-loss beds when they meet the definition of DME. Air mattresses that are not durable or made to withstand prolonged use do not meet the definition of DME.

For all types of pressure-reducing support surfaces, the support surface provided for the client should be one in which the client does not *bottom out*. The Centers for Medicare & Medicaid Services (CMS) defines "bottoming out" as when an outstretched hand, palm up, between the undersurface of the overlay or mattress and in an area under the bony prominence can readily palpate the bony prominence (coccyx or lateral trochanter). This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

24.5.19.1 Criteria for Grouping Levels

Group 1 Support Surface

Group 1 Support Surface may be considered if the client is completely immobile without assistance, *or* either of the following first two criteria:

- The client has limited mobility, *or*
- The client has an existing pressure ulcer on the pelvis or trunk, *and*

And at least one of these four criteria:

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

Group 2 Support Surface

A Group 2 support surface may be considered if the client has limited mobility.

The client must meet both of the following criteria:

- Multiple stage II ulcers on the trunk or pelvis
- Has been on a comprehensive ulcer treatment program for at least the past month which has included the use of a Group 1 support surface

The client must also have at least one of the following:

- The ulcers have remained the same or worsened over the past month
- There are large or multiple stage III or IV pressure ulcers on the trunk or pelvis
- A myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the last 60 days, and have been on a Group 2 or 3 support surface immediately before discharge from the hospital or a nursing facility (discharge within the past 30 days)

Group 3 Support Surface

A Group 3 support surface may be considered if *all* the following criteria are met:

- Presence of a stage III or IV ulcer.
- Severely limited mobility rendering the client bed or chair bound.
- Without an air-fluidized bed, the client would be institutionalized.
- The client has been placed on a Group 2 support surface for at least a month before ordering the air-fluidized bed with the ulcer(s) not improving or worsening.
- There has been at least weekly assessment of the wound by the physician, a nurse or other licensed health care professional and the treating physician has done a comprehensive evaluation of the client's condition within the week before ordering the air-fluidized bed.
- A trained adult caregiver is available to assist the client with activities of daily living, maintaining fluid balance, supplying dietary needs, aiding in repositioning and skin care, administering prescribed treatments, recognizing and managing altered mental status, and managing the air-fluidized bed system and its potential problems, such as leakage.
- The physician continues to reevaluate and direct the home treatment regimen monthly.
- All other alternative equipment has been considered and ruled out.

The existence of any one of the following conditions may result in noncoverage of the air-fluidized bed:

- Coexisting pulmonary disease (the lack of firm back support can render coughing ineffective and dry air inhalation thickens pulmonary secretions.
- Wounds requiring moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material (if wet-to-dry dressings are being utilized, dressing changes must be frequent enough to maintain their effectiveness).
- The caregiver is unwilling or unable to provide the type of care required by the client on an air-fluidized bed.
- The home's structural support or electrical system cannot safely accommodate the air-fluidized bed.

The groups for pressure-reducing support surfaces used in this policy are defined as follows.

24.5.19.2 Group 1 Support Surfaces

Each of the support surfaces described below are covered when medical necessity criteria for Group 1 support surfaces are met.

Pressure pads for mattresses/nonpowered pressure-reducing mattress overlays are designed to be placed on top of a standard hospital or home mattress. Pressure pads/nonpowered pressure-reducing mattress overlays for mattresses with the following features may be considered for reimbursement with documentation of medically necessity:

- A gel or gel-like layer with a height of two inches or greater

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- An air mattress overlay with interconnected air cells that are inflated with an air pump and a cell height of three inches or greater
- A water mattress overlay with a filled height of three inches or greater
- A foam mattress overlay with *all* the following features:
  - Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a nonconvoluted overlay
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover

Nonpowered pressure-reducing mattresses are designed to be placed directly on a hospital bed frame. Nonpowered pressure-reducing mattresses, with the following features, may be considered for reimbursement with documentation supporting medical necessity:

- A foam mattress with *all* the following features is covered:
  - A foam height of five inches or greater
  - Foam with a density and other qualities that provide adequate pressure reduction
  - Durable, waterproof cover
  - Can be placed directly on a hospital bed frame

An air, water, or gel mattress is designed to be placed directly on a hospital bed frame. An air, water or gel mattress with *all* the following features may be considered for reimbursement:

- A height of five inches or greater
- Durable, waterproof cover

Powered pressure reducing mattress overlay systems (alternating pressure or low air loss) are designed to be placed on top of a standard hospital or home mattress. A powered pressure reducing mattress overlay system, with *all* the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of air cells, or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduces pressure, and prevents bottoming out.

24.5.19.3 Group 2 Support Surfaces

Each of the support surfaces described below are covered when medical necessity criteria for Group 2 support surfaces are met.

Powered pressure-reducing mattress (alternating pressure low air loss, or powered flotation without air loss) is designed to be placed directly on a hospital bed frame. This device with *all* the following features may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress.
- Inflated cell height of the air cells through which air is being circulated is five inches or greater.
- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattress), and air pressure to provide adequate patient lift, reduce pressure, and prevent bottoming out.
- A surface designed to reduce friction and shear.

A semi-electric hospital bed with fully integrated powered pressure-reducing mattress that has all of the features described above may be considered for reimbursement when documentation supports medical necessity.

An advanced nonpowered pressure-reducing mattress overlay is designed to be placed on top of a standard hospital or home mattress. This device, with *all* the following features, may be considered for reimbursement when documentation supports medical necessity.

- Height and design of individual cells which provide significantly more pressure reduction than Group 1 overlay and prevent bottoming out.
- Total height of five inches or greater.
- A surface designed to reduce friction and shear.
- The manufacture product information substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

A powered pressure-reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) is designed to be placed on top of a standard hospital or home mattress designed to reduce friction and shear. This device, with *all* the following features, may be considered for reimbursement when documentation supports medical necessity:

- The system includes an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay.
- Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater.

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- Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out.

An advanced nonpowered pressure-reducing mattress is designed to be placed directly on a hospital bed frame. This device with *all* the following features may be considered for reimbursement when documentation supports medical necessity:

- Height and design of individual cells which provide significantly more pressure than a Group 1 mattress and prevent bottoming out.
- Total height of five inches or greater.
- A surface designed to reduce friction and shear.
- Documented evidence substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

Sheepskin and lambs wool pads are covered under the same conditions as alternating pressure pads and mattresses (Group 2 pressure-reducing support surfaces).

24.5.19.4 Group 3 Support Surfaces

Initial prior authorization for a Group 3 pressure-reducing support surface will be for no more than 30 days. Prior authorized extensions may be considered for reimbursement in increments of 30-day periods, up to a maximum of four months, when documentation supports continued significant improvement in wound healing. Coverage beyond four months will be on a case-by-case basis after review by the medical director or designee.

An air-fluidized bed uses warm air under pressure to set small ceramic beads in motion, which simulate the movement of fluid. When the client is placed in the bed, his body weight is evenly distributed over a large surface area, which creates the sensation of floating. Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

24.5.19.5 Decubitus Care Accessories

A bed blanket cradle (keeps bed covers from touching affected skin) may be considered for reimbursement when documentation supports medical necessity (e.g., diabetic ulcers, decubiti or burns, or gouty arthritis).

A heel or elbow protector may be considered for reimbursement when documentation supports medical necessity.

The staging of pressure ulcers used in this policy is as follows:

Stage I: Observable pressure related alteration of intact skin whose indicators are as follows:

- Compared to the adjacent or opposite area on the body may include changes in one of more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching).
- The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

24.5.19.6 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
J-E0184	1 every 5 years
J-E0185	1 every 5 years
J-E0186	1 every 5 years
J-E0187	1 every 5 years
J-E0198	1 every 5 years
J-E0199	1 every 5 years
J-E0255	1 every 5 years
J-E0260	1 every 5 years
J-E0265	1 every 5 years
J-E0271	1 every 5 years
J-E0303	1 every 5 years
J-E0304	1 every 5 years
J-E0305	1 every 5 years
J-E0310	1 every 5 years
J-E0315	1 every 5 years
J-E0371	1 every 5 years
J-E0372	1 every 5 years
J-E0373	1 every 5 years
J-E0910	1 every 5 years
J-E0920	1 every 5 years
J-E0940	1 every 5 years
J-E0946	1 every 5 years
L-E0184	1 per month
L-E0185	1 per month
L-E0186	1 per month
L-E0187	1 per month

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Procedure Code	Maximum Limitation
L-E0193	1 per month
L-E0194	1 per month
L-E0196	1 per month
L-E0197	1 per month
L-E0198	1 per month
L-E0250	1 per month
L-E0255	1 per month
L-E0260	1 per month
L-E0265	1 per month
L-E0277	1 per month
L-E0303	1 per month
L-E0304	1 per month
L-E0371	1 per month
L-E0372	1 per month
L-E0373	1 per month
L-E0910	1 per month
L-E0920	1 per month
L-E0940	1 per month
L-E0946	1 per month

24.5.20 Reflux Slings and Wedges

Texas Medicaid (Title XIX) Home Health Services may cover reflux slings or wedges for clients who are younger than 12 months of age. These may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate. Reflux slings, wedges, or covers require prior authorization.

If the client is not eligible for home health services, reflux slings and wedges may be provided under THSteps-CCP.

24.5.21 Special Needs Car Seats and Travel Restraints

Special needs car seats and travel restraints are not services available under Texas Medicaid Home Health.

Refer to: "Special Needs Car Seats and Travel Restraints" on page 43-52 for details about coverage through THSteps-CCP.

24.5.22 Mobility Aids

Medical appliances and equipment including mobility aids such as canes, crutches, walkers, and wheelchairs are reimbursed to assist clients to move about in their environment.

Mobility aids are a benefit through the Title XIX Home Health Services when the following criteria are met:

- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested equipment must be met.
- The equipment requested must be medically necessary.
- Federal financial participation must be available.
- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.

Note: *THSteps-eligible clients who have a medical need for services beyond the limits of this Texas Medicaid (Title XIX) Home Health Services benefit may be considered under THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.22.1 Canes, Crutches, and Walkers

Canes, crutches, and/or walkers may be prior authorized as a home health service with documentation supporting medical necessity and appropriateness of the requested item. This documentation by a physician familiar with the client must include information on the clients impaired mobility.

24.5.22.2 Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary devices and are not a benefit of Texas Medicaid. If a child requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through THSteps-CCP or a wheelchair may be considered for reimbursement with prior authorization from TMHP Home Health Services.

24.5.22.3 Wheelchairs

A wheelchair is a professionally manufactured seating system mounted on a four- or six-wheeled base, with a combination of tires and casters especially for the use of propelling the occupant.

A wheelchair may be considered for prior authorization for short-term use or purchase as a home health service with documentation supporting the medical necessity and appropriateness of the requested item. This documentation by a physician familiar with the client must include information on the client's impaired mobility.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the wheelchair is usable in the home such as doors and halls wide enough, no obstructions.

Manual Wheelchairs–Standard

Standard manual wheelchairs may be prior authorized for short-term rental or for purchase, if the client has a condition which does not require specialized seating, and

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the client is unable to ambulate a minimum of 10 feet (e.g., AIDS, sickle cell anemia, fractures, chronic respiratory/cardiac diagnosis, or chemotherapy).

24.5.22.4 Seating Assessment for Manual and Power Custom Wheelchairs

To request prior authorization for a custom manual/power wheelchair, a seating assessment must be completed by a physician or a licensed physical or occupational therapist using the procedure codes 1-97001 and 1-97003.

The following documentation must be provided:

- A seating evaluation and seating measurements, performed by a physician or a licensed occupational or physical therapist, which includes specifications for exact mobility/seating equipment, all necessary accessories, and how the client and/or family will be trained in the use of the equipment.
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the wheelchair. A wheelchair must have a growth potential, which must accommodate 20 percent of height and weight changes.
- Significant medical information pertinent to mobility and requested equipment including intellectual, postural, physical, sensory (visual and auditory), and physical status. Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, as well as any recent changes in the client's physical and/or functional status, and any expected/potential surgeries that will improve or further limit mobility.
- A description of the current mobility/seating equipment, how long the client has been in the current equipment and why it no longer meets the client needs.
- Client's height, weight, and a description of where the equipment is to be used.
- Manufacturer's retail pricing information, with itemized pricing including the description of the specific base, any attached seating system components and any attached accessories.

If the wheelchair assessment form is completed by a physician, reimbursement is considered part of the physician office visit and will not be authorized using the above therapy procedure codes.

24.5.22.5 Manual Wheelchairs—Custom

Custom manual wheelchairs may be considered for reimbursement for those clients who cannot safely use a standard manual wheelchair.

24.5.22.6 Levels for Custom Manual Wheelchairs

Level 1 is a basic standard wheelchair.

Level 2 is a custom system with growth potential, including components for posture support.

Level 3 is a custom system that meets the Level 2 definition with the addition of a molded seating system, tilt and space and reclining capacities.

24.5.22.7 Power Wheelchairs—Standard

Standard power wheelchairs may be prior authorized for short-term rental use up to six months, or for purchase, if the client has a condition which does not require specialized seating, the client is unable to ambulate a minimum of 10 feet and is unable to self-propel a manual wheelchair (e.g., AIDS, sickle cell anemia, fractures, chronic respiratory/cardiac diagnosis, or chemotherapy).

Prior authorization for a standard power wheelchair requires all documentation necessary for a custom manual wheelchair, as well as the following documentation:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client *must* be able to operate a power wheelchair independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a power wheelchair.
- How the power wheelchair will be operated such as joystick, head pointer, puff and go.
- The capability of the caregiver/client to care for the power wheelchair and accessories.
- The capability of the client to understand how the power wheelchair operates.

Rental of a manual wheelchair may be prior authorized when the client's power wheelchair is being repaired or replaced.

24.5.22.8 Power Wheelchairs—Custom

Custom power wheelchairs may be considered for reimbursement for the client who cannot safely use a manual wheelchair, is unable to ambulate a minimum of 10 feet, is unable to self-propel a manual wheelchair (e.g., AIDS, sickle cell anemia, fractures, chronic respiratory/cardiac diagnosis, or chemotherapy), and is unable to safely use a standard power wheelchair.

Prior authorization for a custom power wheelchair requires all documentation necessary for a custom manual wheelchair, as well as the following:

- The client's physical and mental ability to receive and follow instructions related to responsibilities of using equipment. The client *must* be able to operate a power wheelchair independently. The therapist must provide written documentation that the client is physically and cognitively capable of managing a power wheelchair.
- How the power wheelchair will be operated such as joystick, head pointer, or puff and go.
- The capability of the caregiver/client to care for the power wheelchair and accessories.
- The capability of the client to understand how the power wheelchair operates.

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An attendant control system is not a benefit of the Texas Medicaid Program. For safety, all power chairs are to include a stop switch.

Note: *Seat lift chairs, seat elevators, or mechanisms, including those used for power wheelchairs, are not a benefit of the Texas Medicaid Program.*

24.5.22.9 Levels for Power Wheelchairs

Level 1 is a basic power wheelchair.

Level 2 is a custom system with growth potential, including components for posture support.

Level 3 is a custom system with the addition of a molded seating system, tilt and space and reclining capacities. Labor for the molded seating system is limited to 15 hours or less.

Rental of a manual wheelchair may be prior authorized when the client's power wheelchair is being repaired or replaced.

24.5.22.10 Scooters

A scooter is a professionally manufactured, three or four-wheeled motorized base with a professionally manufactured basic seating system for clients who have little or no positioning needs.

Scooters may be approved for a short term rental or initial three-month trial period based on documentation supporting the medical necessity and appropriateness of the device.

Scooters may be considered for reimbursement for ambulatory impaired clients with good head, trunk and arm/hand control, without a diagnosis of progressive illness such as progressive neuromuscular diseases such as amyotrophic lateral sclerosis (ALS).

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the scooter is usable in the home such as doors and halls wide enough, no obstructions.

All scooters must have a growth potential, which must accommodate 20 percent of height and weight changes.

To request prior authorization for a scooter the client must not own or be expected to require a power wheelchair within five years of the purchase of a scooter.

All documentation required for a standard power wheelchair must be provided, along with the following documentation:

- The client's physical and cognitive ability to receive and follow instructions related to the responsibilities of using the equipment
- The ability of the client to physically and cognitively operate the scooter independently
- The capability of the client to care for the scooter and understand how it operates

Custom seating for scooters is not a benefit of Texas Medicaid (Title XIX) Home Health Services.

Repairs to scooters will be considered only for those scooters purchased by the Texas Medicaid Program.

24.5.22.11 Client Lift

A lift is a portable transfer system used to move a client from bed to chair and chair to bed.

A client lift will not be authorized for the convenience of a caregiver.

24.5.22.12 Hydraulic Lift

Prior authorization for a hydraulic lift may be considered with the following documentation:

- The client must be unable to assist in his own transfers
- The weight of the client and the weight capacity of the requested lift
- The availability of a caregiver
- Training by the provider to the client and the caregiver on the safe use of the lift

24.5.22.13 Electric Lift

Prior authorization for an electric lift may be considered with the above documentation and additional documentation addressing why a hydraulic lift will not meet the client's needs.

Barrier free lifts are not a benefit of the Texas Medicaid Program.

24.5.22.14 Standers

A stander is a device used for the client with neuromuscular conditions who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcification.

Standers, including all accessories, require prior authorization.

Prior authorization may be considered for the standers with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory potential
- Anticipated benefits of the equipment
- Frequency and amount of time of a standing program
- Anticipated length of time the client will require this equipment
- Client's height/weight/age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

Standers, gait trainers, and parapodiums will not be authorized for a client within one year of each other.

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24.5.22.15 Gait Trainers

Gait trainers are devices with wheels used to train clients with ambulatory potential. They provide the same benefits as the stander, in addition to assisting with gait training.

Prior authorization for the gait trainer may be considered with the same criteria as the stander, plus documentation by the physician familiar with the client that the client has ambulatory potential and will benefit from a gait training program.

Standers, gait trainers, and parapodiums/standing frames/braces/vertical standers will not be authorized for a client within one year of each other.

24.5.22.16 Batteries and Battery Charger

A battery charger and initial batteries are included as part of the purchase of a power wheelchair.

Replacement batteries or a battery charger may be considered for reimbursement under Texas Medicaid Home Health if they are no longer under warranty.

To request prior authorization for replacement batteries or a battery charger, the provider must document the date of purchase and serial number of the currently owned wheelchair as well as the reason for the replacement batteries or battery charger.

Documentation required supporting the need to replace the batteries or battery charger must include:

- Why the batteries are no longer meeting the client's needs, and/or
- Why the battery charger is no longer meeting the client's needs.

A maximum of one hour of labor may be considered for reimbursement to install new batteries. Labor is not reimbursed with the purchase of a new power wheelchair, or with replacement battery chargers.

24.5.22.17 Accessories

Pressure support cushions for wheelchairs may be considered for prior authorization with documentation of medical necessity.

24.5.22.18 Modifications

Prior authorization may be considered for modifications to custom equipment should a change occur in the client's needs, capabilities, or physical/mental status, which cannot be anticipated. Documentation must include the following:

- All projected changes in the client's mobility needs
- The date of purchase and serial number of the current equipment, and the cost of purchasing new equipment versus modifying current equipment. All modifications within the first six months after delivery are considered part of the purchase price

24.5.22.19 Adjustments

A maximum of one hour of labor for adjustments may be considered for reimbursement through Texas Medicaid (Title XIX) Home Health Services as needed after the first six months from delivery.

All adjustments within the first six months after delivery are considered part of the purchase price.

24.5.22.20 Repairs

Repairs to client-owned equipment may be considered for reimbursement with prior authorization under Texas Medicaid (Title XIX) Home Health Services.

Technician fees are considered part of the labor cost on the repair.

Providers are responsible for maintaining documentation in the client's medical record specifying repairs.

Rentals may be considered for reimbursement during the period of repair.

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

24.5.22.21 Replacement

A request for replacement of equipment and/or accessories may be considered for reimbursement and must include an order from the prescribing physician familiar with the client and an assessment by a physician, licensed occupational or physical therapist with documentation supporting why the current equipment is no longer meeting the client's needs.

Replacement, adjustments, modifications and repairs will not be authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver.

24.5.22.22 Wheelchair Ramp—Portable and Threshold

A portable ramp is defined as a ramp that is a unit able to be carried as needed to access a home. A threshold ramp provides access over elevated thresholds.

Portable wheelchair ramps, defined as weighing no more than 90 pounds and/or measuring no more than 10 feet in length, may be considered for reimbursement under Home Health Services when documentation supports medical necessity and appropriateness of equipment. One portable and/or one threshold ramp for wheelchair access to homes may be considered for prior authorization with the following documentation:

- The date of purchase and serial number of the client's wheelchair or documentation of a wheelchair request being reviewed for purchase
- Diagnosis with duration of expected need

Ramps may be considered for rental for short term disabilities.

Ramps may be considered for purchase for long term disabilities.

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Mobility aid lifts for vehicles, and vehicle modifications are not reimbursed through Texas Medicaid.

Note: *Permanent ramps, vehicle ramps and home modifications are not a benefit of the Texas Medicaid Program.*

24.5.22.23 Procedure Codes and Limitations for Mobility Aids

Procedure Code	Maximum Limit
Canes	
J-E0100	Every 5 years
J-E0105	Every 5 years
Crutches	
9-A4635	As needed
J-E0110	Every 5 years
J-E0111	Every 5 years
J-E0112	Every 5 years
J-E0114	Every 5 years
J-E0116	Every 5 years
J-E0153	Every 5 years
L-E0110	4 months maximum
L-E0111	4 months maximum
L-E0112	4 months maximum
L-E0114	4 months maximum
L-E0116	4 months maximum
Walkers	
9-A4636	As needed
9-A4637	As needed
J-E0130	Every 5 years
J-E0135	Every 5 years
J-E0141	Every 5 years
J-E0143	Every 5 years
J-E0144	Every 5 years
J-E0147	Every 5 years
J-E0148	Every 5 years
J-E0149	Every 5 years
J-E0154	Every 5 years
J-E0155	Every 5 years
J-E0157	Every 5 years
J-E0158	Every 5 years
J-E0159	Every 5 years
L-E0130	4 months maximum
L-E0135	4 months maximum
L-E0141	4 months maximum
L-E0143	4 months maximum
L-E0144	4 months maximum
L-E0147	4 months maximum
L-E0148	4 months maximum
L-E0149	4 months maximum
Gait Trainers	
J-E8001	1 per day
Seating Assessments	
1-97001	As needed
1-97003	As needed
Wheelchairs	
9-A4631	1 per year
J-E0950	2 per year
J-E0951	2 per year
J-E0952	2 per year
J-E0958	1 per year
J-E0960	As needed
J-E0961	2 per year
J-E0969	1 per year
J-E0970	1 pair per year
J-E0971	1 pair per year
J-E0973	1 per year
J-E0974	1 per year
J-E0990	2 per year
J-E0992	1 per year
J-E0994	2 per year
J-E0995	2 per year
J-E0997	2 per year
J-E0998	2 per year
J-E0999	2 per year
J-E1002	Every 5 years
J-E1003	Every 5 years
J-E1004	Every 5 years
J-E1005	Every 5 years
J-E1006	Every 5 years
J-E1007	Every 5 years
J-E1008	Every 5 years
J-E1009	Every 5 years
J-E1011	As needed
J-E1014	Every 5 years
J-E1015	2 per year
J-E1016	2 per year
J-E1017	2 per year
J-E1018	2 per year
J-E1020	Every 5 years
J-E1028	Every 5 years
J-E1029	Every 5 years
J-E1050	Every 5 years
J-E1060	Every 5 years

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Procedure Code	Maximum Limit
J-E1070	Every 5 years
J-E1083	Every 5 years
J-E1084	Every 5 years
J-E1085	Every 5 years
J-E1086	Every 5 years
J-E1087	Every 5 years
J-E1088	Every 5 years
J-E1089	Every 5 years
J-E1090	Every 5 years
J-E1092	Every 5 years
J-E1093	Every 5 years
J-E1100	Every 5 years
J-E1110	Every 5 years
J-E1130	Every 5 years
J-E1140	Every 5 years
J-E1150	Every 5 years
J-E1160	Every 5 years
J-E1161	Every 5 years
J-E1170	Every 5 years
J-E1171	Every 5 years
J-E1172	Every 5 years
J-E1180	Every 5 years
J-E1190	Every 5 years
J-E1195	Every 5 years
J-E1200	Every 5 years
J-E1220	Every 5 years
J-E1220-TF	Every 5 years
J-E1220-TG	Every 5 years
J-E1229	Every 3 years
J-E1231	Every 5 years
J-E1232	Every 5 years
J-E1233	Every 5 years
J-E1234	Every 5 years
J-E1235	Every 5 years
J-E1236	Every 5 years
J-E1237	Every 5 years
J-E1238	Every 5 years
J-E1240	Every 5 years
J-E1250	Every 5 years
J-E1260	Every 5 years
J-E1270	Every 5 years
J-E1280	Every 5 years
J-E1285	Every 5 years
J-E1290	Every 5 years

Procedure Code	Maximum Limit
J-E1295	Every 5 years
J-E1296	Every 5 years
J-E1297	Every 5 years
J-E1298	Every 5 years
L-E1020	1 per month
L-E1050	1 per month
L-E1060	1 per month
L-E1070	1 per month
L-E1083	1 per month
L-E1084	1 per month
L-E1085	1 per month
L-E1086	1 per month
L-E1087	1 per month
L-E1088	1 per month
L-E1089	1 per month
L-E1090	1 per month
L-E1092	1 per month
L-E1093	1 per month
L-E1100	1 per month
L-E1110	1 per month
L-E1130	1 per month
L-E1140	1 per month
L-E1150	1 per month
L-E1160	1 per month
L-E1161	1 per month
L-E1170	1 per month
L-E1171	1 per month
L-E1172	1 per month
L-E1180	1 per month
L-E1190	1 per month
L-E1195	1 per month
L-E1200	1 per month
L-E1231	1 per month
L-E1232	1 per month
L-E1233	1 per month
L-E1234	1 per month
L-E1235	1 per month
L-E1236	1 per month
L-E1237	1 per month
L-E1238	1 per month
L-E1240	1 per month
L-E1250	1 per month
L-E1260	1 per month
L-E1270	1 per month

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Procedure Code	Maximum Limit
L-E1280	1 per month
L-E1285	1 per month
L-E1290	1 per month
L-E1295	1 per month
J-E2211	Every 6 months
J-E2219	Every 6 months
Safety Equipment	
J-E0700	1 per year
J-E0942	1 per year
J-E0944	1 per year
J-E0945	1 per year
J-E0978	1 per year
J-E0979	1 per year
J-E0980	1 per year
J-E2205	1 per 3 years
J-E2206	1 per 3 years
J-E2291	1 per 3 years
J-E2292	1 per 3 years
J-E2293	1 per 3 years
J-E2294	1 per 3 years
J-E2368	As needed
J-E2369	As needed
J-E2370	As needed
J-E2618	1 per years
Pressure Cushions	
J-E2601	1 per years
J-E2602	1 per years
J-E2603	1 per years
J-E2604	1 per years
J-E2605	1 per years
J-E2606	1 per years
J-E2607	1 per years
J-E2608	1 per years
J-E2609	1 per years
J-E2611	1 per years
J-E2612	1 per years
J-E2613	1 per years
J-E2614	1 per years
J-E2615	1 per years
J-E2616	1 per years
J-E2617	1 per years
J-E2618	Every 5 years
J-E2619	1 per years
J-E2620	1 per years

Procedure Code	Maximum Limit
J-E2621	1 per years
Scooters	
J-E1230	Every 5 years
L-E1230	1 per month/maximum limit 3 months
Miscellaneous	
9-A9900	As needed
9-E1340	As needed
J-E0621	1 per year
J-E0630	Every 5 years
J-E0635	Every 5 years
J-E1399	As needed
J-E2361	1 per 5 years
J-E2363	1 per 5 years
J-E2366	1 per 5 years
J-K0108	As needed
L-E0630	1 per month
L-E0635	1 per month
L-E1399	As needed

24.5.23 Respiratory Equipment

Respiratory equipment is defined as any device that assists a client's ventilation. Respiratory equipment and supplies may be provided in the home under Texas Medicaid (Title XIX) Home Health Services.

The following respiratory equipment requires prior authorization:

- Intermittent positive pressure breathing device
- Electrical percussor
- Intrapulmonary percussive ventilation (IPV)
- High-frequency chest wall compression system
- Cough-stimulating device
- Continuous positive airway pressure (CPAP) system
- Bi-level positive airway pressure system without backup (such as BPAP S)
- Bi-level positive airway pressure system with backup (such as BiPAP ST)
- All home mechanical ventilation equipment
- Home oxygen systems
- Rental of equipment includes all necessary supplies, adjustments, repairs, and replacement parts

Note: *Respiratory equipment and related supplies that are not covered under Texas Medicaid (Title XIX) Home Health Services may be considered for reimbursement through THSteps-CCP for clients younger than 21 years of age, who are THSteps-CCP eligible (e.g., clients residing in residential treatment centers).*

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24.5.23.1 Nebulizers

A nebulizer is a device with a compressor that delivers respiratory medications by inhalation in the form of a mist.

Medications for use with the nebulizer will not be reimbursed to a DME company. These medications may be considered under the Vendor Drug Program.

Nebulizers do *not* require prior authorization for the diagnoses listed below. Other diagnoses require prior authorization and may be considered based on review of documentation by HHSC or its designee.

Nebulizers may be reimbursed for purchase only, and that purchase is limited to one every five years.

Procedure code J-E0570 must be used for purchase of the nebulizer.

Diagnosis Code	Description
1363	Pneumocytosis
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
4660	Acute bronchitis
46611	Acute bronchiolitis due to respiratory syncytial virus (RSV)
46619	Acute bronchiolitis due to other infec-tious organisms
4801	Pneumonia due to respiratory syncytial virus
486	Pneumonia, organism unspecified
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis
49120	Obstructive chronic bronchititis, without exacerbation
49121	Obstructive chronic bronchitis, with (acute) exacerbation
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysematous bleb
4928	Other emphysema
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma, with (acute) exacerbation
49310	Intrinsic asthma, unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma, with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma, with (acute) exacerbation
49381	Exercise induced bronchospasm
49382	Cough variant asthma
49390	Asthma, unspecified type, unspecified
49391	Asthma, unspecified type, with status asthmaticus
49392	Asthma, unspecified type, with (acute) exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmers' lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	Ventilation pneumonitis
4958	Other specified allergic alveolitis and pneumonitis
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction, not elsewhere classified
5070	Pneumonitis due to inhalation of food or vomitus
5071	Pneumonitis due to inhalation of oils and essences
5078	Pneumonitis due to other solids and liquids
5533	Diaphragmatic hernia without mention of obstruction or gangrene
7469	Unspecified congenital anomaly of the heart
769	Respiratory distress syndrome in newborn
7707	Chronic respiratory disease arising in the perinatal period
78609	Other
7861	Stridor

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The following nebulizer supplies may be billed with the diagnosis codes listed above:

Procedure Codes		
9/J-A4617	9-A7003	9-A7004
9-A7006	9-A7007	9-A7011
9-A7013	9-A7015	9-A7016
9-A7018		

Ultrasonic nebulizers do not require prior authorization for the diagnoses listed below. Procedure code J-E0575 must be used when billing for the ultrasonic nebulizer.

The ultrasonic nebulizer will be reimbursed only for the following diagnosis codes:

Diagnosis Code	Description
1363	Pneumocystosis
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations

The following supplies may be billed with the ultrasonic nebulizer using procedure codes 9-A7009 and 9-A7014.

24.5.23.2 Vaporizers

The vaporizer is a machine that creates a mist, which is released into the air.

Vaporizers do *not* require prior authorization for the diagnoses listed below.

Vaporizers may be reimbursed for purchase only, and that purchase is limited to once every five years.

Procedure code J-E0605 must be used when billing for the vaporizer.

Vaporizers will be reimbursed for the following diagnoses only:

Diagnosis Code	Description
462	Acute pharyngitis
4644	Croup
4650	Acute laryngopharyngitis
4658	Acute upper respiratory infections of other multiple sites
4659	Acute upper respiratory infections of unspecified site
4660	Acute bronchitis
4661	Acute bronchiolitis
46611	Acute bronchiolitis due to respiratory syncytial virus (RSV)
46619	Acute bronchiolitis due to other infectious organisms

24.5.23.3 Humidification Units

Humidification units for nonmechanically ventilated clients will be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Use procedure code J-E1399 when billing for humidification units for nonmechanically ventilated clients. Procedure code J-E1399 will be reimbursed with a maximum fee of $1,230.00 or MSRP less 18 percent, which ever is the lesser cost. Supplies to be used with client owned humidification units will be considered for purchase and must be billed with the appropriate HCPCS code for each item requested. Documentation of medical necessity must be included with submission of the request.

24.5.23.4 Secretion Clearance Devices

Incentive Spirometer

Incentive spirometers, including electronic spirometers, are not a benefit of the Texas Medicaid (Title XIX) Home Health.

Intermittent Positive-Pressure Breathing (IPPB) Devices

Intermittent positive-pressure breathing is the application of positive pressure, frequently with aerosols or humidity, to a spontaneously breathing client, as a short-term treatment. Each treatment usually does not last more than 15 or 20 minutes.

IPPB devices require prior authorization.

The IPPB machine may be reimbursed for rental only, and that rental is limited to once per month for a maximum of four months per lifetime.

Rental of the IPPB device includes all supplies, such as humidification and tubing.

Procedure code L-E0500 must be used when billing for the IPPB.

Purchase of the IPPB device (J-E0500) is not a benefit.

The IPPB device may be authorized for the following diagnoses:

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations

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Diagnosis Code	Description
33510	Spinal muscular atrophy, unspecified
33511	Kugelberg-welander disease
33519	Other spinal muscular atrophy
3591	Hereditary progressive muscular dystrophy
496	Chronic airway obstruction, not elsewhere classified
514	Pulmonary congestion and hypostasis
515	Postinflammatory pulmonary fibrosis
5162	Pulmonary alveolar microlithiasis
5163	Idiopathic fibrosing alveolitis
5185	Pulmonary insufficiency following trauma and surgery

Other diagnoses may be considered based on review of documentation by HHSC or its designee.

Mucous Clearance Valve (e.g., Flutter®)

The mucous clearance valve is a small handheld device that provides positive expiratory pressure (PEP) therapy for clients who have chronic obstructive pulmonary disease (COPD), chronic bronchitis, cystic fibrosis, atelectasis, or other conditions producing retained secretions.

The mucous clearance valve requires prior authorization.

The mucous clearance valve is age-restricted to 6 years of age and older.

The mucous clearance valve may be reimbursed for purchase only, and that purchase is limited to one every five years.

Procedure code J-S8185 must be used for the purchase of a mucous clearance valve.

The mucous clearance valve will be reimbursed for the following diagnosis codes only:

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
490	Bronchitis, not specified as acute or chronic
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis
49120	Obstructive chronic bronchitis, without exacerbation
49121	Obstructive chronic bronchitis, with (acute) exacerbation
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysema bleb
4928	Other emphysema
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma, with (acute) exacerbation
49310	Intrinsic asthma, unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma, with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma, with (acute) exacerbation
49381	Exercise induced bronchospasm
49382	Cough variant asthma
49390	Asthma, unspecified type, unspecified
49391	Asthma, unspecified type, with status asthmaticus
49392	Asthma, unspecified type, with (acute) exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmers' lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	Ventilation pneumonitis
4958	Other specified allergic alveolitis and pneumonitis
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction NEC

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24.5.23.5 Electrical Percussor

An electrical percussor is a device that produces vibrations when applied to the chest wall. The purpose of this device is to improve the effectiveness of chest physiotherapy.

The electrical percussor device requires prior authorization.

The electrical percussor may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to one every five years and rental is limited to once per month for a maximum of four months per lifetime.

In addition to the completed Title XIX form, a description of all previous courses of therapy and why they did not adequately assist the client in airway mucus clearance is required to obtain authorization for an electrical percussor.

The procedure codes J-E0480 and L-E0480 must be used when billing for the percussor.

24.5.23.6 Chest Physiotherapy Devices

Either an IPV, cough-stimulating device, *or* the high-frequency chest wall compression system (HFCWCS) generator with vest is prior authorized. These systems are *not* prior authorized simultaneously.

Note: *Chest physiotherapy to promote bronchial drainage that is performed by a therapist or any other health care professional, including a private duty nurse, will not be authorized during the period of time that the high-frequency chest wall compression system, cough-stimulating device, or intrapulmonary percussion ventilation device is prior authorized.*

Prior authorization for the equipment in this section requires a Title XIX form and the Medicaid Certification of Medical Necessity for High-Frequency Chest Wall Compression or Intrapulmonary Percussive Ventilation Initial or Extended Authorization Form completed by a physician familiar with the client.

High-Frequency Chest Wall Compression System

A HFCWCS is composed of an inflatable vest and an air-pulse generator. The generator produces high-frequency pressure pulses, which rapidly inflate and deflate the vest, creating oscillation of the chest wall.

Payment of the HFCWCS is limited to the following diagnosis codes:

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations

A HFCWCS is reimbursed only when it is demonstrated that other mechanical devices or chest physical therapy by a caregiver and/or self have been ineffective.

The HFCWCS requires prior authorization. Requests may be considered for prior authorization for the initial three-month rental of a HFCWCS generator and vest. All of the following information must be provided:

- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include the information that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective
- A physician's statement of a trial of the high-frequency chest wall compression system in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system, including a statement that the client has not exacerbated any gastrointestinal manifestations nor caused aspiration and exacerbation of pulmonary manifestations nor an exacerbation of seizure activity secondary to the use of the system
- Diagnosis and background history including complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations and/or history of school, work, or extracurricular activity absences due to diagnosis-related complications
- Any recent illnesses and/or complications
- Medical diagnosis or other limitations preventing the client/caregiver from doing chest physiotherapy

Prior authorization for an extension of another three months rental may be considered with the above documentation.

Requests for authorization of the purchase of a HFCWCS generator may be considered based on the outcome of a six-month rental period and the following required documentation.

Documentation of vest tolerance and positive outcomes/results of therapy, including:

- Physician's description/assessment of the effectiveness such as decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work or extracurricular activity absences due to diagnosis related complications
- The frequency and compliance graphs for the six-month period showing use of the system at least 50 percent of the maximum time prescribed by the physician for each day
- Respiratory status, including any recent hospitalization
- A statement that the client has not exacerbated any gastrointestinal manifestations nor caused aspiration and exacerbation of pulmonary manifestations nor an exacerbation of seizure activity secondary to the use of the system

Rental cost of the HFCWCS applies toward the purchase price.

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A HFCWCS generator purchase and vest purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer.

Procedure code J/L-E0483 must be used when requesting reimbursement.

Intrapulmonary Percussive Ventilation (IPV)

IPV, such as Impulsator® offers a form of physical therapy which is pneumatically delivered. The IPV delivers mini-bursts of gas into the lungs at a high-frequency with aerosol therapy and positive pressure. Its purpose is to mobilize secretions.

The IPV requires prior authorization.

The IPV may be reimbursed for monthly rental only and includes all accessories.

Procedure code L-E0481 must be used when requesting authorization for rental of the IPV.

The IPV may be reimbursed for the following cystic fibrosis diagnosis codes. Other diagnoses may be considered based on review of documentation by HHSC or its designee:

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
3351	Spinal muscular atrophy
33510	Spinal muscular atrophy, unspecified
33511	Kugelberg-welander disease
33519	Other spinal muscular atrophy
3591	Hereditary progressive muscular dystrophy
496	Chronic airway obstruction, not elsewhere classified

Other diagnoses will be considered based on review of documentation by HHSC or its designee.

The IPV is reimbursed only when it is demonstrated that an electric/pneumatic percussor or chest physical therapy by a caregiver and/or self have not been effective.

The IPV may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations and/or history of school, work, and extracurricular activity absences due to diagnosis related complications.
- Any medical reasons why the client/caregiver cannot do chest physiotherapy.
- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include information on why other treatments have not been tried, and that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

Cough-Stimulating Device (Cofflator)

The cough-stimulating device (cofflator) assists clients in secretion clearance by applying positive pressure to the airway via mask, mouthpiece or tracheostomy adapter. It then cycles to negative pressure stimulating a cough response.

The cough-stimulating device requires prior authorization.

The cough-stimulating device may be reimbursed for monthly rental only and includes all supplies.

Procedure code L-E0482 must be used when requesting rental of a cough-stimulating device.

The cough-stimulating device may be reimbursed for those clients with chronic pulmonary disease and/or neuromuscular disorders that affect the respiratory musculature.

The cough-stimulating device may be approved initially for a three-month rental period based on the following required documentation:

- Diagnosis and background history including recent illnesses, complications, medications used, history of any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations, results of pulmonary function studies if applicable, and/or history of school/work/extracurricular activity absences due to diagnosis related complications.
- Medical reasons why the client/caregiver cannot do chest physiotherapy.
- A description of all previous therapy courses that have been tried and why these treatments did not adequately assist the client in airway mucus clearance. This must include information on why other treatments have not been tried, and that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

Requests for prior authorization of an extension must include documentation by the physician familiar with the client that the client is compliant with the use of the equipment and that the treatment is effective.

Positive Airway Pressure System Devices

In addition to the Title XIX form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form must be completed by the physician familiar with the client and submitted by the provider for all positive pressure system devices.

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24.5.23.7 Continuous Positive Airway Pressure (CPAP) System

a CPAP system is used to provide noninvasive positive air pressure through the nose with a mask or nasal pillows to prevent the collapse of the oropharyngeal walls during sleep. It is used primarily for the treatment of obstructive sleep apnea.

The continuous positive airway pressure system requires prior authorization.

The continuous positive airway pressure system may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month.

Procedure code J/L-E0601 must be used when requesting authorization for the rental or purchase of the continuous positive airway pressure system.

Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the authorization period expires. After the current authorization period expires, then the criteria in the following paragraph applies to any further authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new authorization period.

The CPAP may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

CPAP may be approved initially for three months if the duration of the symptoms is at least six months and one of the following:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than 15 per hour
- The Sleep Study RDI or AHI is greater than 10 per hour with the lowest oxygen saturation during the study is less than 80 percent

24.5.23.8 Pediatric CPAP Changes

One of the following oxygen saturation levels may be used for clients under 21 years of age:

- An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air
- An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client

Authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Title XIX form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

24.5.23.9 Bilevel Positive Airway Pressure System (BiPAP S) Without Backup

A BiPAP S is used to provide noninvasive inspiratory positive airway pressure and expiratory positive airway pressure through the nose with a mask to prevent the collapse of the oropharyngeal walls during sleep. This equipment is used primarily for obstructive sleep apnea.

The BiPAP S requires prior authorization.

The BiPAP S may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to a maximum of once every five years with medical necessity. Reimbursement for rental is limited to once per month.

The BiPAP S will not be authorized once a CPAP is purchased.

Procedure code L/J-E0470 must be used when requesting authorization for the rental or purchase of the BiPAP S.

Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the authorization period expires. After the current authorization period expires, then the criteria in the following paragraph applies to any further authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the time of purchase, if the item is purchased after a rental period.

The BiPAP S may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

The BiPAP S may be approved initially for three months if the following conditions are met:

- The client has demonstrated the inability to tolerate the CPAP system, *and*
- Duration of symptoms of at least six months, and
- The Sleep Study RDI or AHI is greater than 15 per hour, *or*
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent or oxygen saturation equal to or less than 92 percent for clients under 21 years of age.

Prior authorization for purchase after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours per night and symptoms are improved as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with a new completed Title XIX form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

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Rental of CPAP/BiPAP S includes all supplies. CPAP/BiPAP S may be rented up to a maximum of 13 months. The equipment is considered purchased after 13 months rental.

24.5.23.10 Bilevel Positive Airway Pressure System With Backup (BiPAP ST)

A BiPAP ST is used to provide timed noninvasive inspiratory positive airway pressure and expiratory positive airway pressure through the nose with a mask when BiPAP S has been proven ineffective or through a tracheostomy.

The BiPAP ST requires prior authorization.

The rental of a BiPAP ST may be reimbursed only once per month.

Purchase of the BiPAP ST is not a benefit.

The BiPAP ST may be approved initially for a three-month rental period based on documentation supporting the medical necessity and appropriateness of the device.

Either procedure code L-E0471 or L-E0472 must be used when requesting authorization for the rental of the BiPAP ST.

BiPAP ST may be approved initially for three months if the following conditions are met:

- A diagnosis of central sleep apnea, or a neuromuscular disease producing respiratory insufficiency, *and*
- Sleep study records central apnea greater than 5 RDI or AHI per hour, *or*
- Sleep study records central sleep apnea greater than 1 RDI or AHI per hour.
- The client has an arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent by transcutaneous oximetry associated with a diagnosis of neuromuscular respiratory insufficiency or failure (not COPD).

Continued authorization for rental after the initial three-month rental period may be granted if the client is continuing to use the equipment at a minimum four hours per night and has a transcutaneous saturation greater than 88 percent while using the equipment as documented by a physician familiar with the client. This documentation of compliance and effectiveness must be provided with the above documentation plus a new completed Title XIX form and a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form.

Home Mechanical Ventilation Equipment

Ventilators are used for clients who do not have adequate respiratory function. Continuous use ventilators are used for 12 or more hours per day. Intermittent use ventilators are used for less than 12 hours per day.

Mechanical ventilation is either provided by positive pressure ventilation (volume ventilator) or negative pressure ventilation (iron lung).

All ventilators require prior authorization.

The completed Title XIX form must specify all ventilator settings and must be maintained by the DME provider and the prescribing physician in the client's medical record.

24.5.23.11 Volume Ventilators

A volume ventilator may operate, using room air and/or oxygen, in various phases, modes and variables, which are time controlled, pressure controlled, volume controlled or a combination of these. A volume ventilator may be operated in any of the following:

Ventilation Modes

- Control
- Assist control
- Synchronized intermittent mandatory ventilation (SIMV)
- CPAP

Breath Types

- Spontaneous (patient triggered and cycled)
- Ventilator assisted (patient or machine triggered and/or cycled) (e.g., pressure support or pressure-assisted)
- Mandatory (machine triggered and/or machine cycled)

The volume ventilator is prior authorized for rental only for those clients who have a tracheostomy.

The monthly ventilator rental includes all ventilator supplies, such as (but not limited to):

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- All humidification systems including supplies and solutions (i.e., sterile/distilled water)
- Compressors and supplies
- Tracheostomy filters/heating moisture exchangers

The procedure codes L-E0450, L-E0463, and L-E0464 must be used when requesting the volume ventilator.

24.5.23.12 Negative Pressure Ventilators

A negative pressure ventilator decreases atmospheric pressure to a predetermined negative pressure immediately outside the chest or body to allow passive lung expansion from normal air pressure.

Negative pressure ventilators may be prior authorized for rental only for individuals who have the ability to speak, eat, drink and do not have a tracheostomy.

The ventilator rental includes all component parts (pillow, mattress, gaskets, etc.).

Procedure code L–E0460 must be used when requesting a negative pressure ventilator.

One of the following devices may be authorized with a portable negative pressure ventilator using procedure codes J/L-E0457 and J/L-E0459.

The application devices may be reimbursed for an initial *three-month* rental period.

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The listed application devices may be purchased following the initial three-month rental period depending on the physician's predicted length of treatment and the patient's compliance.

The purchase of a chest shell (cuirass) and chest wrap is limited to a maximum of one every five years. Reimbursement for rental is limited to once per month for a total of four months.

24.5.23.13 Ventilator Service Agreement

A ventilator service agreement may be prior authorized for a client who owns their own ventilator, when documentation supports medical necessity/appropriateness for continued ventilator usage.

A ventilator service agreement requires prior authorization, which must include submission of a completed Title XIX form and the ventilator service agreement. The completed Title XIX form must include all ventilator settings.

The completed Title XIX form and the Ventilator Service Agreement form must be maintained by the provider and the prescribing physician in the client's medical record.

A ventilator service agreement may be reimbursed only once per month.

Procedure code 9-A9900 must be used when requesting the ventilator service agreement.

The client-owned ventilator must be functional at the time of the request for prior authorization and documentation must include the make, model number, serial number, and the date of ventilator purchase and all ventilator settings.

The ventilator service agreement contract may be considered for renewal every six months.

The provider must agree to include all of the following components in the ventilator service agreement:

- Ensure that all routine service procedures as outlined by the ventilator manufacturer are followed
- Provide all internal filters, external filters, tracheostomy filters, and all ventilator circuits (with the exhalation valve) as a part of the ventilator service agreement
- Provide a respiratory therapist and back-up ventilator on a 24-hour call basis
- Provide monthly home visits by a certified respiratory therapist to verify proper functioning of the ventilator system and the client's status. The provider must maintain documentation on monthly visits
- Provide a substitute ventilator while the manufacturer's recommended preventive maintenance is being performed on the client owned ventilator. The substitute ventilator must be provided free for a minimum of six weeks

Ventilator rental will not be authorized during the first six weeks while the client-owned ventilator is being maintained or repaired, per the ventilator service agreement. After these six weeks, a ventilator may be rented until the client-owned ventilator is returned to the client.

Requests for a continued six-month authorization of a ventilator service agreement must include the above documentation and the following:

- The recommended preventive maintenance schedule for the ventilator make and model
- Documentation of the monthly ventilator/client assessments
- Documentation of all service performed during the previous service agreement

24.5.23.14 Oxygen Therapy

Oxygen therapy is defined as supplemental oxygen administration for the purpose of relieving hypoxemia and preventing damage to the tissue cells as a result of oxygen deprivation.

All oxygen therapy and related equipment requires prior authorization.

Oxygen therapy home delivery systems may be reimbursed for rental only once per month.

Rental of oxygen equipment includes all supplies and refills.

Supplies and refills may be prior authorized for those clients that own their own oxygen systems.

One of the following clinical indications should be present when requesting approval for in-home oxygen therapy:

- Bronchopulmonary dysplasia and other respiratory diagnoses due to prematurity
- Respiratory failure or insufficiency
- Cluster headaches
- Hypoxemia-related symptoms and findings that might be expected to improve with oxygen therapy (examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic corpumonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache)
- Severe lung disease, such as COPD, diffuse interstitial lung disease, whether known or unknown etiology such as cystic fibrosis, bronchiectasis or widespread pulmonary neoplasm.

Note: *In addition to the completed Title XIX form, a Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form must be completed by the physician familiar with the client and submitted by the provider.*

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24.5.23.15 Initial Oxygen Therapy Medical Necessity Certification

Authorization of home oxygen therapy for the initial period of three months will be granted if the Title XIX form and the Medicaid Certificate of Medical Necessity for CPAP or BiPAP or Oxygen Therapy form is completed and all of the following conditions are met:

- Symptoms have a duration of at least three months (or less with special circumstances)
- For clients under 21 years of age one of the following parameters must be used:
  - An oxygen saturation of 89 to 92 percent, taken at rest, breathing room air
  - An oxygen saturation less than 92 percent with documentation of medical necessity provided by a physician familiar with the client
- An arterial PO2 at or below 56 mm Hg, or an arterial oxygen saturation at or below 89 percent, taken at rest, breathing room air, or during sleep and associated with signs or symptoms reasonably attributed to hypoxemia
- Hypoxemia associated with obstructive sleep apnea must be unresponsive to CPAP or BiPAP therapy before oxygen therapy can be approved. In these cases, coverage is provided only for use of oxygen during sleep, and then only one type of delivery system will be covered
- Portable oxygen systems are covered when the medical documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside the home environment. Portable oxygen systems are not covered when traveling outside the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep
- A client who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest and who subsequently experiences a decreased arterial PO2 of 55 mm Hg or below, or decreased arterial oxygen saturation of 88 percent or below during exercise. In this case supplemental oxygen can be provided if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.

In-home oxygen therapy can be approved for cluster headaches with the documentation of the following clinical indications:

- Neurological evaluation with diagnosis, *and*
- Documented failed medication therapy

Note: *Lab values are not indicated with this diagnosis.*

24.5.23.16 Oxygen Therapy Recertification

Authorization of oxygen therapy after an initial three-month rental period may be granted with the submission of a new completed Title XIX form and a new Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy form and the following:

- Documentation of continued need
- Documentation of client compliance by the physician familiar with the client

Note: *The initial Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy Form cannot be used for recertification purposes.*

24.5.23.17 Oxygen Therapy Home Delivery System Types

The oxygen concentrator systems are the preferred (standard) delivery system of in-home oxygen therapy. This type of system concentrates oxygen molecules from the ambient air, generating concentrations of up to 90 to 98 percent.

Procedure code L-E1390 must be used for the rental of an oxygen concentrator system.

The reimbursement payment for the rental of the procedure code L-E1390 includes, but is not limited to, cannula or mask, tubing, and humidification. These items will not be reimbursed separately.

If other types of oxygen therapy home delivery systems are required, documentation of medical necessity exception must be provided.

Other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks) (L-E0424)
- Liquid oxygen reservoir systems (L-E0439)

Note: *The reimbursement for compressed gas cylinder and liquid oxygen reservoir systems includes all of the supplies that are noted in the procedure code description.*

- Portable oxygen systems—Portable oxygen therapy may be authorized if the medical necessity conditions are met, and the medical documentation indicates that the client is mobile in the home and would benefit from the use of a portable oxygen system in the home or at school.
  - Portable oxygen systems are not covered for clients who qualify for oxygen solely based on blood gas studies obtained during sleep.
  - The procedure codes L-E0431 and L-E0434 must be used for the portable oxygen systems.
  - Rental of the portable oxygen system includes all supplies and refills. Refills for a client-owned system must be obtained from a DSHS-licensed vendor.

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24.5.23.18 Tracheostomy Tubes

A tracheostomy tube fits into a tracheal stoma and is used for those clients who have undergone surgical tracheostomy. The procedure codes and modifiers noted in the following tables may be used when requesting prior authorization for a tracheostomy tube. Prior authorization requests must provide sufficient information to support the determination of medical necessity for the requested item.

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Authorization for a tracheostomy tube will be considered with procedure code 9-A7520 or 9-A7521. The manufacturer's retail pricing information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization.

Procedure code 9-A4623 may be used when requesting prior authorization for the tracheostomy tube inner cannula.

An inner cannula is limited to one per month and will not be prior authorized when a custom manufactured tracheostomy tube (9-A7520-TG or 9-A7521-TG) is requested.

24.5.23.19 Pulse Oximetry

Pulse oximeters are not a benefit of Texas Medicaid (Title XIX) Home Health Services.

Authorization for reimbursement of sensor probes (reusable or disposable) may be considered only for those with a client owned pulse oximeter (e.g., purchased through another source).

Procedure code 9-A4606 should be used for reimbursement of sensor probes (reusable or disposable).

24.5.23.20 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Limitations
Nebulizers	
9-A4617	2 per month
9-A7003	2 per month
9-A7004	2 per month
9-A7006	2 per month
9-A7007	2 per month
9-A7011	Every 6 months
9-A7013	1 per month
9-A7015	2 per month
9-A7016	2 per month
9-A7018	4 per month
9-S8101	2 per month
J-E0570	Every 5 years
Ultrasonic Nebulizers	
9-A7009	Every 2 years
9-A7014	1 per year
J-E0575	Every 5 years
Vaporizers	
J-E0605	Every 5 years
Intermittent Positive-Pressure Breathing (IPPB) Device	
L-E0500	4 months per life
Mucous Clearance Valve (i.e., Flutter)	
J-S8185	Every 5 years
Chest Physiotherapy Devices	
9-A7025	Every 5 years
9-A7026	Every 5 years
J-E0480	Every 5 years
J-E0483	Life
L-E0480	1 per month
L-E0481	1 per month
L-E0482	1 per month
L-E0483	1 per month
CPAP/BiPAP	
9-A7034	Every 3 months
9-A7035	Every 6 months
9-A7037	1 per month
9-A7038	Every 6 months
J-E0470	1 per 5 years
J-E0471	1 per 5 years
J-E0561	1 per 5 years
J-E0562	1 per 5 years
J-E0601	Every 5 years
L-E0470	1 per month
L-E0472	1 per month
L-E0561	1 per month
L-E0562	1 per month
L-E0601	1 per month
Home Mechanical Ventilator Equipment	
9-A4481	31 per month
9-A4483	31 per month
9-A4611	Every 5 years
9-A4612	Every 5 years
9-A4613	Every 5 years
9-A4614	2 per year
9-A4623	1 per month
9-A4629	31 per month
9-A7520	1 per month
9-A7520-TF	1 per month
9-A7520-TG	1 per month

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Procedure Code	Limitations
9-A7521	1 per month
9-A7521-TF	1 per month
9-A7521-TG	1 per month
9-A7525	4 per month
9-A7526	8 per month
9-L8501	2 per year
J-E0457	Every 5 years
J-E0459	Life
J-S8189	Limited per policy
L-E0450	1 per month
L-E0457	1 per month
L-E0459	1 per month
L-E0460	1 per month
L-E0463	1 per month
L-E0464	1 per month
Ventilator Maintenance Agreement	
9-A9900	1 per month
Oxygen Therapy	
9-A4615	Every 2 weeks
9-A4616	Every 3 months
9-A4618	4 per month
J-E0565	Every 5 years
J-E1353	1 per year
L-E0424	1 per month
L-E0431	1 per month
L-E0434	1 per month
L-E0439	1 per month
L-E0441	1 per month
L-E0442	1 per month
L-E0443	1 per month
L-E0444	1 per month
L-E0565	1 per month
L-E1390	1 per month
L-K0738	1 per month
Suction Pumps	
9-A4605	10 per month
9-A4624	90 per month
9-A4628	2 per month
9-A7000	4 per month
9-A7002	8 per month
J-E0600	Every 5 years
Miscellaneous	
9-A4606	4 per month
9-A4627	Every 6 months
J-S8999	1 per year
L-E1399	Limited by policy
*** The ventilator service agreement is limited to no more than one per month.**	

When procedure code L-K0738 is billed with procedure code L-E0431, procedure code L-E0431 will be denied.

24.5.24 Procedure Codes Removed From Prior Authorization

The procedure codes listed in the following table do *not* require prior authorization for clients receiving services under Texas Medicaid (Title XIX) Home Health Services. Although prior authorization is not required, providers must retain a completed Title XIX Home Health DME/ Medical Supplies Physician Order Form (Title XIX form) for these clients. For medical supplies not requiring prior authorization, a completed Title XIX form may be valid for a maximum of six months unless the physician indicates the duration of need is less. If the physician indicates the duration of need is less than six months, then a new Title XIX form is required at the end of the duration of need. It is expected that reasonable, medically necessary amounts will be provided. Use of these services is subject to retrospective review.

Procedure Codes		
Nebulizer Supplies/Equipment*		
9-A4614	9-A4627	9-S8101
J-E0570	J-E0575	L-E0580
Incontinence Supplies**		
9-A4310	9-A4311	9-A4312
9-A4313	9-A4314	9-A4315
9-A4316	9-A4320	9-A4321
9-A4322	9-A4326	9-A4327
9-A4328	9-A4330	9-A4335
9-A4338	9-A4340	9-A4344
9-A4346	9-A4351	9-A4352
9-A4353	9-A4354	9-A4355
9-A4356	9-A4357	9-A4358
9-A4359	9-A4402	9-A4554
9-A5102	9-A5105	9-A5112
9-A5113	9-A5114	9-A5120
9-A5121	9-A5122	9-A5131

*** Prior authorization is required for certain diagnoses. Refer to “Nebulizers” on page 24-46**
**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to “Incontinence Supplies and Equipment” on page 24-17**

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24.5.25 Enteral Products for Adults

24.5.25.1 Nutritional Products and Supplies

Enternal nutritional products are those food products that are included in an enteral treatment protocol. They serve as a therapeutic agent for health maintenance and are required to treat an identified medical condition. Nutritional products, supplies, and equipment may be provided in the home under Texas Medicaid (Title XIX) Home Health Services.

Enteral products are a benefit under Texas Medicaid (Title XIX) Home Health Services for clients 21 years of age and older who require tube feeding as their sole source of nutrition. Prior authorization is required for all enteral products. Requests are reviewed for reasonable amounts. Enteral products for clients who can take nutrition by mouth and/or used as a supplement will not be prior authorized.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested supplies/equipment must be met.
- The supplies/equipment requested must be medically necessary.
- Federal financial participation (FFP) must be available.
- The client's nutritional status would be compromised without the requested enteral nutritional products/supplies/equipment.

24.5.25.2 Enteral Nutritional Products

All enteral nutritional products paid under the Texas Medicaid Program are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate "B" code (as documented by the Statistical Analysis DME Regional Carrier [SADMERC] Product Classification List for Enteral Nutrition in effect at the time) and with the appropriate modifier based on the product's average wholesale price (AWP) less 10.5 percent (as documented by the Red Book).

It is the provider's responsibility to know the correct "B" code, the correct units of 100 calories, and the modifier for requesting prior authorization and for payment. Supporting documentation for these components must be maintained in the provider's records and be made available upon request by HHSC or TMHP. Payment is based on the lower of billed charges or the Medicaid allowed fee, with the Medicaid allowed fee based on the appropriate "B" code, modifier, and units of 100 calories.

It is the provider's responsibility to know when products are discontinued by the manufacturer, when container sizes change and when names change. Please submit requests for prior authorization and payment accordingly.

The Palmetto GBA SADMERC Product Classification List is located on its website (www.palmettogba.com).

24.5.25.3 Enteral Feeding Pumps

Enteral feeding pumps are a benefit of Texas Medicaid (Title XIX) Home Health Services for those clients who require enteral feeding. The Title XIX request for enteral feeding pumps and supplies must be completed, signed, and dated by a physician familiar with the client before requesting prior authorization.

Sole source enteral nutrition for clients 21 years of age and older should be prior authorized through TMHP Home Health Services.

Nasogastric and Gastrostomy/Jejunostomy Tubes

Nasogastric feeding tubes require prior authorization. Additional devices may be reimbursed if documentation submitted indicates medical necessity.

Nonobturated gastrostomy/jejunostomy tubes will be limited to two per year. Additional tubes may be reimbursed if documentation submitted indicates medical necessity, such as infection at gastrostomy site, leakage or occlusion. Obturated gastrostomy tube replacements are performed in the physicians office or outpatient setting and are not a benefit of Texas Medicaid (Title XIX) Home Health Services.

Enteral Supplies

Enteral feedings may require some or all the following supplies:

- Needleless syringes, any size
- Enteral extension tubing
- Gravity bags/nutritional containers

Syringes without needles are considered reusable for enteral administration of medication. These syringes are limited to eight per month.

Irrigation syringes, bulb or piston, for enteral administration of nutritional products are limited to four per month.

A food scale is payable for clients on specific diets with foods measured in grams (e.g., ketogenic diets). This service requires prior authorization and has a maximum allowable fee of $60.

Important: *Medical nutritional products for clients younger than 21 years of age remain a benefit of THSteps-CCP.*

Enteral products are a benefit under Texas Medicaid (Title XIX) Home Health Services for clients 21 years of age and older who require tube feeding as their sole source of nutrition. Prior authorization is required for all enteral products. Requests are reviewed for reasonable amounts. Enteral products for clients who can take nutrition by mouth and/or used as a supplement will not be authorized.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP.*

Procedure Codes		
9-B4100	9-B4150	9-B4152

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Procedure Codes		
9-B4153	9-B4154	9-B4155
9-B4157		

Modifier	Fee Per Unit
U1	$0.30
U2	$0.50
U3	$0.70
U4	$0.85
U5	$1.05
U6	$1.70
U7	$2.00
U8	$2.50
U9	$3.00
UA	$4.00
UB	$5.00
UC	$6.00
UD	Manually priced

Note: *TMHP Home Health Services will not issue authorization of enteral products/supplies/equipment if the client is receiving TPN/hyperalimentation. TPN/Hyperalimentation is reimbursed as a daily global fee to cover visits by a registered nurse for teaching and monitoring the client, customary and routine laboratory work, and enteral supplies and equipment.*

Refer to: "In-Home Total Parenteral Hyperalimentation Supplier" on page 27-1.

24.5.26 Limitations, Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available.

For clients who are younger then 21 years of age and who are eligible to receive THSteps services, refer to "THSteps-Comprehensive Care Program (CCP)" on page 43-33 to find which of these items are covered for THSteps CCP.

Texas Medicaid (Title XIX) Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, car seats
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Allergy injections
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Any supplies or equipment used in a physician's office, or inserted by a physician (for example, low profile gastrostomy tube)
- Apnea monitors
- Blood products (the administration or the supplies and equipment used to administer blood products)
- Cardiac telemetry monitoring
- Chemotherapy administration or the supplies and equipment used to administer chemotherapy
- Developmental therapy
- Diapers and wipes for clients younger than 4 years of age
- Drugs or biologicals (except as specifically provided for in this manual)
- Dynamic Orthotic Cranioplasty (DOC)
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, heater/air conditioner filters, space heaters, fans, water purification systems, vacuum cleaners, treatments for dust mites, rodents, and insects
- Homemaker services. Clients requiring this type of care should contact their local DSHS office for information about community-based programs for primary home care, day activities, or other related services
- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment
- Inpatient rehabilitation
- Medical social services
- Mental health psychiatric services
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B_{12}, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis
- Nutritional counseling
- Orthotics, braces, prosthetics
- Pain management, such as a Transcutaneous Electrical Nerve Stimulator (TENS)
- Parapodiums
- Pneumocardiograms
- Private duty nursing
- Respite care (caregiver relief)
- Seat lift mechanisms and seat lift chairs

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- Services payable by any health, accident, other insurance coverage, or by a private or other governmental benefit system or legally liable third party resource
- Shipping, freight, delivery travel time
- SN visits when:
  - The medication is not considered medically necessary to the treatment of the individual's illness or is not FDA-approved
  - The administration of medication exceeds therapeutic frequency or duration by accepted standards of medical practice
  - A medical reason does not prohibit the administration of the medication by mouth
  - The client, a primary caregiver, a family member, and/or neighbor has previously been taught to administer SQ/SC, IM and IV injections medications and has demonstrated competency
  - The purpose of the visit is to administer chemotherapeutic agents or blood products
  - The purpose of the visit is pain management
- Speech therapy
- Structural changes to homes, domiciles, or other living arrangements
- Vehicle mechanical and/or structural modifications, such as wheelchair lefts
- Visits made primarily for performing housekeeping services are not covered by Texas Medicaid (Title XIX) Home Health Services. These requests should be referred to in-home and family support service at HHSC

Refer to: "Medicaid Program Limitations and Exclusions" on page 1-17.

24.6 Medicaid Relationship to Medicare

24.6.1 Possible Medicare Clients

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive.

Home health providers should follow these guidelines:

- Clients younger than 65 of age years without Medicare Part A or B:
  - If the agency erroneously submits a SOC notice to Medicare and does not contact TMHP for authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not covered.
- Clients older than 65 years of age without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the denial letter from Medicare.
  - If the agency receives a Medicare denial letter and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the denial letter from Medicare, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the Medicare remittance notice and final review decision letter before considering the request for authorization.

24.6.2 Benefits for Medicare/Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary coinsurance and providers must contact Medicare first for authorization and reimbursement. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients. Home health service authorizations may be given for home health aide services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, physical therapy, or occupational therapy are not a part of the client's care.
- When the medical supplies, equipment, or appliances are not a benefit of Medicare Part B and are a benefit of Texas Medicaid (Title XIX) Home Health Services.

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

Note: *If the client has Medicare Part B coverage, contact Medicare for authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the coinsurance and deductible on the electronic crossover claim.*

TMHP will not authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: "Third Party Resources" on page 4-13.

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24.6.3 Medicare/Medicaid Authorization

Contact TMHP for authorization of Medicaid services (based on medical necessity and benefits of Texas Medicaid (Title XIX) Home Health Services) within 30 days of the date on the Medicare final denial letter.

Note: *For MQMB clients, do not submit authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. The Medicaid program is only responsible for premiums, coinsurance, and/or deductibles on these clients. Providers should not submit prior authorization requests to TMHP Home Health Services on these clients.

24.6.4 Medicare/Medicaid Authorization and Reimbursement

To ensure Medicare benefits are used first in accordance with Texas Medicaid Program regulations, the following procedures apply when requesting Medicaid authorization and payment of home health services for clients.

Contact TMHP for authorization of Medicaid services (based on medical necessity and benefits of Texas Medicaid (Title XIX) Home Health Services) within 30 days of the date on the Medicare final denial letter. Fax a copy of the original Medicare final denial letter and the Medicare appeal review letter to TMHP Home Health Services for prior authorization.

A Medicare denial letter is not required when a client is eligible for Medicare/Medicaid and needs home health aide visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial home health aide visit and at least every 60 days (on the same day a home health aide visit is made) thereafter as long as no skilled need exists. A SN supervisory visit is reimbursable, but a SN visit made for the primary purpose of assessing a client's nursing care is not.

The SOC date will be the date of the first requested Medicare home health services visit as listed on the original Medicare denial letter.

Note: *Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

When the client is older than 65 years of age or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, TMHP Home Health Services uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: "Skilled Nursing Services" on page 24-8.

24.7 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 *Code of Federal Regulations* (CFR) §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less.

Important: *When providing CCP services and general home health services, the provider must file these on two separate HCFA-1450 (UB-92) forms with the appropriate PAN, and should send them to the appropriate address.*

Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services.

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Documentation should be sent to TMHP Provider Enrollment at the address indicated in "Written Communication with TMHP" on page xi.

24.8 Claims Information

Use only type of business (TOB) 331 in Form Locator (FL) 4 of the HCFA-1450 (UB-92). Other TOBs are invalid and result in claim denial.

Submit home health professional services to TMHP in an approved electronic format or on a HCFA-1450 (UB-92) claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase HCFA-1450 (UB-92) and CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

The PAN must appear on the UB-92 claim in Block 63 and in Block 23 of the CMS-1500. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Refer to: "HCFA-1450 (UB-92) Claim Filing Instructions" on page 5-32.
"Claims Filing" on page 5-1 for more information on electronic billing.

24.9 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
HCFA-1450 (UB-92) Claim Filing Instructions	5-32
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
DME Certification and Receipt Form	B-35
External Insulin Pump	B-39
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS]; Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]-Initial Request)	B-55
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS); Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]-Extended Request)	B-56
Title XIX Home Health DME/Medical Supplies Physician Order Form Instructions	B-44
Title XIX Home Health DME/Medical Supplies Physician Order Form	B-46
Home Health Services Plan of Care (POC)	B-48
Home Health Services Plan of Care (POC) Instructions	B-49
Home Health Services Prior Authorization Checklist	B-50
Wheelchair Seating Evaluation Form (THSteps-CCP/Home Health Services) (next six pages)	B-118
Home Health Services DME/Medical Supplies Claim Example	D-16
Home Health Services SN Visit Claim Example	D-16
Home Health Services SN Visit and Physical Therapy Claim Example	D-17
Acronym Dictionary	F-1

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Section

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Hospital (Medical/Surgical Acute Care Facility)

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25.1 General Information

25.1.1 Introduction

The information in this section is intended for traditional Texas Medicaid hospital (medical/surgical acute care facility) providers. The section provides information about the Texas Medicaid Program's benefits, policies, and procedures applicable to acute care hospitals in the inpatient and outpatient setting.

***Note:** Although Medicaid Managed Care providers must provide all medically necessary Medicaid-covered services to eligible clients, these providers must refer to the respective health plan documentation for specific information about hospital services, claims filing, etc.*

Refer to: "PCCM Expansion" on page 7-21.

While this section contains some claims filing and appeals information, hospitals should continue to refer to "Claims Filing" on page 5-1 and "Appeals" on page 6-1 for more comprehensive information about these subjects. An effort has been made to provide comprehensive information about hospital services in this section; however, hospital providers are encouraged to review other sections of the manual for specific requirements for special programs such as the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) and other pertinent material impacting health care providers rendering care in the hospital setting.

Refer to: "Procedure Codes Requiring Prior Authorization" on page 36-343 for a list of procedures requiring prior authorization. Also, review the index and individual sections for other information about prior authorization requirements.

25.1.2 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable Centers for Medicare & Medicaid Services (CMS) Cost Report Form.

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file should be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under "Written Communication with TMHP" on page xi. For questions or assistance call TMHP Medicaid Audit at 1-512-514-3648.

Annual cost reports must be filed as follows:

- Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital's fiscal year along with any amount due to the Texas Medicaid Program.
- TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Field audits are conducted when necessary.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary:
    - Audited or settled without audit Medicare Cost Report
    - Medicare Notice of Amount of Program Reimbursement
    - Medicare Audit Adjustment Report, if applicable

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested on microfiche or paper by mailing a "Medicaid Audit Request for Claims Summary" on page B-54 to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

25.1.3 Third Party Liability Reporting

Hospitals and providers enrolled in the Texas Medicaid Program are required to inform TMHP about circumstances that may result in third party liability for health care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and Providers should mail or fax the Tort Response Form for accidents and Other insurance Form for Health Insurance to the following address:

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

Fax: 1-512-514-4225

Refer to: "Third Party Resources" on page 4-13 for more information.

"Tort Response Form" on page B-114.

"Other Insurance Form" on page B-62.

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25.1.4 Medicaid Relationship to Medicare

The Texas Medicaid Program makes coinsurance and deductible payments on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

Exception: *If the Medicare payment amount equals or exceeds the Medicaid payment rate, HHSC is not required to pay the Medicare Part A and/or Part B deductible/ coinsurance/copay on a crossover claim.*

The Texas Medicaid Program provides 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for *both* Medicare and Medicaid, Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A
- Medicare Part A deductible for the first three pints of whole blood or packed red cells

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client's Part B coverage. The ancillary charges include the following:
  - Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
  - X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
  - Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
  - Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
  - Leg, arm, back and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client's physical condition
  - Physical therapy services
  - Speech pathology services
  - Dialysis treatments
- Submit to Medicaid the remaining Part A charges on a HCFA-1450 (UB-92) claim form (or its electronic equivalent) indicating in Block 84 that the client is eligible for Medicare Part B benefits only. The client's health insurance claim (HIC) number must appear on the Medicaid claim in Block 84. TMHP *must* receive these charges within 95 days of the last date of service on the claim.

Refer to: "Medicare Crossover Reimbursement" on page 2-8 for more information.

25.1.5 Nursing Facility Admission

The revised Client Assessment, Review, and Evaluation (CARE) Form 3652-A must be used for admissions to a nursing facility. Hospital social workers and nurses making referrals and discharge plans that anticipate transfer to a nursing facility must complete this form.

To order new forms, specify that the order is for the CARE Form 3652-A and mail the request to the following address:

Texas Department of Aging and Disability Services
PO Box 149030 (MC E-205, Provider Forms)
Austin, TX 78714-9030
Fax: 1-512-438-3548
www.dads.state.tx.us/handbooks/mpm-ltcf/5000/5720.htm

25.2 Inpatient

25.2.1 Enrollment

To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2 for more information about CLIA.

25.2.1.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by CMS and the United States Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

Contact the TMHP Contact Center at 1-800-925-9126 to obtain the Medicaid hospital participation agreement.

25.2.1.2 Psychiatric Hospital/Facility (THSteps-CCP)

Refer to: "Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-71 for enrollment and other program information.

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25.2.1.3 Hospital Ambulance

A hospital supplying ambulance services must enroll *separately* from the hospital.

Refer to: “Enrollment” on page 8-2 for ambulance enrollment requirements.

25.2.1.4 Certified Registered Nurse Anesthetist (CRNA) Services

CRNAs must enroll and bill according to the instructions given in “Certified Registered Nurse Anesthetist (CRNA)” on page 15-1. Hospitals *cannot* bill for CRNA services using their hospital ambulatory surgical center (HASC) or hospital provider identifier.

25.2.1.5 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: “Medicaid Managed Care” on page 7-4 for more information.

25.2.1.6 Hospital Transplant Centers

Hospital providers can refer to “Enrollment” on page 25-4 for enrollment and other related information.

25.2.2 Reimbursement

25.2.2.1 Prospective Payment Methodology

Inpatient hospital stays except in children’s hospitals and psychiatric facilities (THSteps-CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to the Texas Medicaid Program’s utilization review requirements.

The DRG reimbursement includes all facility charges (for example, laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Medicaid clients.

Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (i.e., psychiatric or rehabilitation). Because all Medicaid inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the HCFA-1450 (UB-92) claim form, to be considered for payment.

Prior authorization is not required for psychiatric admissions to acute care hospitals for reimbursement; however, admissions must be medically necessary and are subject to retrospective utilization review by HHSC.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

In accordance with legislative direction included in the 2006-2007 *General Appropriations Act* (Article II, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), a rate reduction will be applied to inpatient hospital services rendered to non-Medicare Supplemental Security Income (SSI) and SSI-related Medicaid clients. The rate reduction will affect hospital providers within the Bexar, Dallas, El Paso, Lubbock, Tarrant, Nueces, Harris, and Travis service areas that are reimbursed by DRG.

Hospitals with 100 or fewer licensed beds are currently reimbursed the greater of the amount the hospital received under the prospective payment system (the DRG) or the amount the hospital would have received under the *Tax Equity and FIscal Responsibility Act* (TEFRA) *of 1982* principles of reimbursement. If the reimbursement under TEFRA principles is greater than the amount of reimbursement received under the DRG system, the difference is reimbursed to the hospital. This determination is made with a tentative settlement and subsequent adjustments if applicable. A final cost settlement of the hospital’s fiscal year-end applies to hospital fiscal years beginning on or after September 1, 1989.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Refer to: “Children’s Hospitals” on page 25-6.
“Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)” on page 43-71 for more reimbursement information.

25.2.2.2 Client Transfers

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. Services must be medically necessary and are subject to the Texas Medicaid Program’s utilization review requirements.

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HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be billed as *one* admission under the provider identifier. Admissions billed inappropriately are identified and denied during the utilization review process and may result in intensified review.

Note: *To ensure correct payor identification, providers that receive transfer patients from another hospital must put the admit date of the billing hospital in Block 17 on the UB-92.*

25.2.2.3 Observation Status to Inpatient Admission

When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 24 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are billed on the inpatient claim (type of bill [TOB] 111).

25.2.2.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients younger than 21 years of age as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid. The R&S report reflects the outlier reimbursement payment and defines the type of outlier paid.

Day Outliers

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

Hospitals should use the following formula to calculate the day outliers for dates of admission on or after September 1, 2002. To calculate the day outlier payment amount, the number of outlier days must first be determined:

Number of Days Allowed-DRGs Threshold = Outlier Days

SDA x DRG relative weight (Divided by) Mean length of stay	x	Outlier Days	x	0.70	=	Day outlier amount

Cost Outliers

To establish a *cost outlier,* TMHP determines the outlier threshold by using the full DRG payment amount multiplied by 1.5 *or* an amount determined by selecting the lesser of the universal mean of the current base year data multiplied by 11.14 *or* the hospital's SDA multiplied by 11.14. The calculation that yields the amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under TEFRA principles, and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

Hospitals should use the following formulas to calculate the day outliers for dates of admission on or after September 1, 2002. Effective September 1, 2002, (date of admission) the Universal Mean is $3,328.89.

To calculate the cost outlier amount, the cost threshold must first be determined. Three calculations and two comparisons are necessary:

A) 11.14 x Universal Mean ($3,328.89) = $37,083.83

B) 11.14 x SDA = ____________________Comparison 1: Take lesser of number A or B.

C) 1.5 x DRG Relative Weight X SDA = __________________ Comparison 2: Greater of number C and Comparison 1 is the cost threshold

Allowed amount x reimbursement rate = ______________

Result of A minus cost threshold = ___________________

Result of B x0.70 = cost outlier amount

25.2.2.5 Children's Hospitals

Inpatient hospital stays in designated children's hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated children's hospitals are reimbursed on a percentage of the hospital's standard charges derived from the hospital's most recent tentative or final Medicaid cost report settlement.

To be designated as a children's hospital, the hospital must have a provider agreement with Medicare and be engaged in delivering services to patients who are predominantly younger than 18 years of age. A designated children's hospital is excluded from the Medicare/Medicaid prospective payment system per 42 *Code of Federal Regulations* (CFR) (Subsection) 412.23.

Note: *Children's hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital's fiscal year end.*

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25.2.2.6 Hospital Transplant Center Approval

In-State Facility Approval Process

All facilities choosing to participate in the Texas Medicaid Transplant Program will be monitored and approved by HHSC. The transplant facility should be approved by Medicare as a transplant center before applying to the Texas Medicaid Program unless the transplant facility is in a designated Children's Hospital. Texas Medicaid will not reimburse for transplants in the hospitals that do not have current approval by HHSC. Exception(s) may be considered if the transplant type is not available in Texas.

All transplant facilities who wish to perform organ transplants for clients of the Texas Medicaid Program must have current certification and be in continuous compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN) criteria, receive certification from the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). The Texas Medicaid Program does not approve or reimburse transplants in facilities that are not certified and in "good standing" with these credentialing organizations.

Those facilities whose status of "good standing" has been suspended for any reason by the national credentialing bodies will not be approved by the Texas Medicaid Program to provide transplant services until this status has been restored.

Important: *The facility must notify HHSC within three working days of any change in compliance or certification status from UNOS and NMDP. Failure to notify HHSC within three working days of any changes in compliance or certification status may result in disapproval of current and pending transplant requests or recoupment of reimbursement. Submit notification information to:*

Texas Health and Human Services Commission
1100 West 49th Street, H-310
Austin, TX 78756
Attn: Medicaid/CHIP Benefits–Transplant Facility Approvals

Out-of-State Facilities

The Texas Medicaid Program requires that all transplant facilities requesting approval to perform transplants for Texas medicaid clients must provide proof of transplant facility certification. HHSC approval is dependent upon compliance with the transplant facility criteria of the OPTN and certification from the UNOS or the NMDP. In order for the Texas Medicaid Program to pay for an out-of-state transplant, the facility and professional providers must be enrolled as Texas Medicaid providers. The out-of state transplant facilities must submit documentation about relevant transplant facility UNOS or NMDP certification as required by HHSC.

Texas licensed physicians may request prior authorization for transplant services to be performed at out-of-state facilities when the:

- Facilities are nationally recognized as Centers of Excellence.
- Required organ transplants are not available in Texas.
- Services are medically necessary, reasonable, and federally allowable.
- The client is enrolled in the Texas Medicaid Program.

25.2.3 Benefits and Limitations

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. The Medicaid program also reimburses for medically necessary services in the outpatient setting to include day surgery and outpatient observation. Services must be medically necessary and are subject to the Texas Medicaid Program's utilization review requirements. Services must also be billed to TMHP per Medicaid policy and procedures.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit including meals, special diets, and general nursing services; and an allowance for bed and board in private accommodations including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons as certified by the physician. The authorized signature in Block 85 of the HCFA-1450 (UB-92) claim form certifies that the billing hospital has a record on file that the services provided were ordered by a physician. Additionally, the hospital must document the medical necessity for a private room such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information should be included in Block 84 or attached to the claim.
- Whole blood and packed red cells reasonable and necessary for treatment of illness or injury if they are not available without cost
- Maternity care (includes usual and customary care for all female clients)
- All medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology
- Newborn care (includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems)

Circumstances requiring the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a Cesarean section must be documented. Continuation of hospitalization is covered for the infant when the mother is required to remain hospitalized for medical reasons and must be documented.

Take-home drugs, self-administered drugs, or personal comfort items are not benefits of the Medicaid program nor THSteps-CCP, except when received by prescription through the Vendor Drug Program.

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Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are the following:

- A prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. This exception allows an additional 30 days of inpatient care that begins with the date of the transplant. For example, if the transplant occurs on the 15th day of an inpatient stay, the additional 30 days would allow a total of 45 days.
- THSteps-eligible clients when a medically necessary condition exists.
- Some Medicaid Managed Care clients. See "Medicaid Managed Care" on page 7-4.

Important: *Medicaid reimbursement for services cannot exceed the limitations.*

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 are recouped. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

Note: *Dollar or day limitations are not applicable for clients younger than 21 years of age.*

25.2.3.1 Hysterectomy Services

Medically necessary hysterectomies are reimbursable when the physician obtains an appropriate acknowledgment statement from the client. Medicaid does not reimburse for hysterectomies performed for the sole purpose of sterilization.

The physician's signature acknowledging the client's sterility is not required on the claim. The acknowledgment statement must be maintained in the physician's files and is subject to retrospective review. A modifier, PM or PS, must continue to be submitted on the claim or a copy of the signed certification may be attached to the paper claim.

When TMHP receives a valid acknowledgment statement, the client's eligibility file is updated to reflect receipt. Subsequent claims TMHP receives for the hysterectomy are referenced to the acknowledgment statement.

Refer to: "Hysterectomy Acknowledgment Form" on page B-52.

25.2.3.2 Newborn Services

Eligibility Process

A child is deemed eligible for Medicaid for up to 12 months of age if the mother is receiving Medicaid at the time of the child's birth, the child continues to live with the mother, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child's eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household.

Hospitals should complete the HHSC Form 7484, "Hospital Report (Newborn Child or Children) HHSC Form 7484" on page B-51, to provide information about each child born to a mother eligible for Medicaid. If the newborn's name is known, the name must be on the form. *The use of Baby Boy or Baby Girl delays the assignment of a number.* Filing this form will expedite the assignment of a Medicaid client number for the newborn child. The form should not be completed for stillbirths. The form should be completed by the hospital within five days of the child's birth and should be sent to HHSC at the address identified on the form. The five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child's eligibility. Hospitals should duplicate the form as needed. HHSC, DADS, and TMHP do not supply the forms.

Note: *Providers may call the HHSC Bureau of Vital Statistics at 1-800-452-9115 for details on how to transmit newborn information electronically.*

After receiving a completed form, HHSC verifies the mother's eligibility and within 10 days sends notices to the hospital, mother, caseworker, and attending physician if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification Form (Form H3087).

Providers should submit address changes to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

The attending physician's notification letter is sent to the address on file by license number at the Texas Medical Board. It is imperative the address be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Claims submitted for services provided to a newborn child eligible for Medicaid are filed using the newborn child's Medicaid client number.

Note: *When billing for a Medicaid Managed Care client, providers must adhere to the Medicaid Managed Care health plans' guidelines for newborn billing.*

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Screening

A newborn hearing screening must be offered to all newborns as part of their newborn hospital stay. This screening procedure is not diagnostic and will not reimburse separately from the usual newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants.

For more information about newborn hearing screening contact:

Bureau of Children's Health
1100 West 49th Street
Austin, TX 78756
1-512-458-7726
www.dshs.state.tx.us/audio/default.shtm

All newborns who have abnormal screening results should be referred to a local Program for Amplification for Children in Texas (PACT) provider for follow-up care. PACT provides services and hearing aids for children from birth through 20 years of age who have permanent hearing loss and are eligible for Medicaid. Obtain a current list of PACT providers at www.dshs.state.tx.us/audio/program.shtm or the following address:

DSHS
PACT Health Screening Branch
1100 West 49th Street, MC-1918
Austin, TX 78756-3199
1-800-252-8023

Refer newborns with suspected genetic disorders or with a positive newborn screening test for a genetic work-up as appropriate.

Refer to: "Genetic Services" on page 22-1.

Hepatitis B Immunizations

Newborns should be given the first dose of hepatitis B vaccine before discharge from the hospital or birthing center. Hepatitis B vaccine for newborns is provided by the Texas Vaccines for Children (TVFC) Program. Hospitals and birthing centers may obtain vaccine at no cost by enrolling in the TVFC Program. For more information on enrolling in the TVFC Program, refer to "Texas Vaccines for Children Program Packet" on page H-6 or call the DSHS Immunization Division toll-free at 1-800-252-9152.

The recommended administration of the hepatitis B vaccine to newborns before discharge from the hospital has been established as the standard of care and should not be considered as a reason to upcode to a different DRG. The reimbursement for the administration of hepatitis B vaccine to newborns is included in the DRG payment. The Texas Medicaid Program will not reimburse for the cost of the vaccine for newborns. Providers must enroll in the TVFC Program to obtain vaccine at no cost.

Consult the vaccine package insert for information on proper administration and dosing.

25.2.3.3 Psychiatric Services

Inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Texas Medicaid Program. Admissions must be medically necessary and are subject to the Texas Medicaid Program's retrospective utilization review (UR) requirements. The UR requirements are applicable regardless of the hospital's designation of the psychiatric unit versus medical/surgical unit.

Admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not a benefit of the Texas Medicaid Program. Additionally, admissions for chronic diagnoses such as mental retardation, organic brain syndrome, or chemical dependency or abuse are not covered benefits for acute care hospitals without an accompanying medical complication or medical condition. The HCFA-1450 (UB-92) claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

Additional coverage may be allowed for clients who are eligible for Medicaid and younger than 21 years of age through THSteps-CCP.

Note: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists who provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR behavioral health organization (BHO).*

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for more information.

"Medicaid Managed Care" on page 7-4 for more information or contact the client's BHO.

Providers rendering services to STAR and STAR+PLUS clients must contact the respective managed care plan.

25.2.3.4 Rehabilitation Services

Inpatient rehabilitation services are covered benefits when provided in a general acute care hospital setting with an acute condition or an acute exacerbation of a chronic illness in which rehabilitation services are medically necessary in the usual course, treatment, and management of the illness.

All services must be documented as medically necessary and ordered by a physician. When submitting the claim, the hospital must include the physician's written treatment plan supporting the medical necessity of the hospitalization and services.

All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Extensions beyond the regular scope of Medicaid may be offered under THSteps-CCP.

Refer to: "Physical Therapists/Independent Practitioners" on page 35-1 for more information.

"Benefits and Limitations" on page 43-14.

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25.2.3.5 Organ/Tissue Transplant Services

Prior Authorization

Prior authorization for a transplant is *mandatory* and approved *only* if the physician indicates the transplant will be performed in an approved Texas Medicaid transplant facility. If the facility indicated on the original authorization request is not a Medicaid-approved transplant facility, the physician needs to designate a different approved facility before the authorization is given. Transplant facilities are reviewed for approval each year. TMHP issues prior authorizations for dates within the facility approval period.

Note: *If the client is a Medicaid Managed Care client, all prior authorizations for transplants will need to be obtained from the client's health plan.*

If the transplant has not been performed by the end of the authorization period, physicians need to apply for an extension. Fax inquiries for authorization extensions to TMHP Special Medical Prior Authorization at 1-512-514-4213. Prior authorization is required for the following services (this noninclusive list is subject to change):

- Stem cell transplant
- Heart transplant
- Single lung transplant with bronchial anastomosis
- Double sequential lung transplant with bilateral bronchial anastomosis
- Combined heart/lung transplant
- Liver transplant
- Kidney transplant

The prior authorization number (PAN) must be entered in Block 63 (Treatment Authorization Code) of the HCFA-1450 (UB-92) claim form.

Cornea transplants do not require prior authorization.

Documentation supplied with the prior authorization request should include a complete history and physical, a statement of the client's current medical problems and status, and meet the criteria specified in the individual transplant policy for which the facility is requesting prior authorization.

If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day preoperative and six weeks postoperative period also will be denied, regardless of who provides the service, (i.e., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with one of the Texas Medicaid Program approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Heart Transplants

Heart transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document a critical medical need with the New York Heart Association (NYHA) Class III or IV cardiac disease as shown below:

- *Class III.* Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (e.g., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain
- *Class IV.* Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Or the facility must document:

- Congenital heart disease
- Valvular heart disease
- Viral cardiomyopathy
- Familial or restrictive cardiomyopathy
- Heart transplant will result in a return to improved functional independence
- Absence of comorbidities, such as:
  - Severe pulmonary hypertension
  - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder
  - Uncontrolled HIV infection or AIDS-defining illness
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen

Prior authorization for a heart/lung transplant must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant will be considered on an individual basis.

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All heart transplant services provided by facilities and professionals must be prior authorized by HHSC or its designee.

Documentation supplied with the prior authorization request must address the criteria above and must be medically necessary, reasonable, and federally-allowable.

Liver Transplants

Authorization of liver transplantation requires documentation of life-threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid program, the facility must document the following:

- A critical medical need with a likelihood of a successful clinical outcome
- Liver disease in these categories:
    - Primary cholestatic liver disease
    - Other cirrhosis: alcoholic, hepatitis C (non-A, non-B), hepatitis B
    - Fulminant hepatic failure
    - Metabolic diseases
    - Malignant neoplasms
    - Benign neoplasms
    - Biliary atresia
- Absence of comorbidities such as:
    - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder
    - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen

Documented psychiatric instability is a contraindication for transplant if it is severe enough to jeopardize incentive for adherence to medical regimen.

Payment for liver transplant professional services will be made under procedure code 2/8-47135 or 2/8-47136. These procedures include six months of professional postoperative care. Separate charges for a choledochojejunostomy (Roux-en-y) should be denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the Medicaid-eligibility of the client.

Two assistant surgeons will be allowed for liver transplant surgery using procedure codes 2/8-47135 and 2/8-47136.

Lung Transplants

Lung transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double) transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document the following:

- A critical medical need with a likelihood of a successful clinical outcome
- Symptoms at rest that are directly related to chronic pulmonary disease and which result in severe functional limitation
- End-stage pulmonary diseases in these categories:
    - Obstructive lung disease
    - Restrictive lung disease
    - Cystic fibrosis
    - Pulmonary hypertension
- Absence of comorbidities such as:
    - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder
    - Multiple organ compromise secondary to infection, malignancy, or a condition with no known cure
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen

Documented psychiatric instability is a contraindication for transplant if it is severe enough to jeopardize incentive for adherence to medical regimen.

Prior authorization for a heart/lung transplant must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant will be considered on an individual basis.

Program Limitations

If a transplant has been prior authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be covered, beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay. Physician services that HHSC or its designee determines to be reasonable and medically necessary also are covered during the 30-day period. Day limitations do not apply for clients under 21 years of age.

Expenses for a single inpatient hospital admission for an authorized transplant are not included in the annual $200,000.00 inpatient expenditure cap. Dollar limitations do not apply for clients under 21 years of age.

All program coverage limits are applied.

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The above guidelines also apply to one subsequent re-transplant, because of rejection, as a lifetime benefit. A subsequent transplant is not included in the prior authorization for the initial transplant; it must be prior authorized separately.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection.

Transplants also are covered under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Medicaid will pay only the deductible or coinsurance portion as applicable. Prior authorization must be obtained for Medicaid only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Medicaid will not pay a transplant service denied by Medicare for a Medicare-eligible client.

If a Medicaid client receives a transplant in a facility that is not approved by the Texas Medicaid Program, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under the Texas Medicaid Program. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable. Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by the Texas Medicaid Program. Services unrelated to the transplant surgery will be paid separately.

Important: *Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.*

The DRG payment for the transplant includes procurement of the organ and services associated with the organ procurement. Medicaid does not pay for solid organs procured by a facility for supply to an organ procurement organization (OPO). The *Omnibus Budget Reconciliation Act* of 1986 (OBRA 86) Public Law 99-509 added Section 1138 of the *Social Security Act,* which defines conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of 42 CFR Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital's medical record. Expenses incurred by a living donor for transplants will not be reimbursed separately.

Refer to: "Reimbursement" on page 2-2.

25.2.4 Utilization Review

Utilization review activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the *Social Security Act*, Sections 19-02 and 19-03. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of the Texas Medicaid Program.

Utilization review may also occur by an examination of particular claims or services not within the usual screening review when a specific utilization review is requested by HHSC or the Texas Attorney General's Office.

25.2.4.1 Responsibilities

The HHSC Office of Inspector General (OIG)/Utilization Review (UR) Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits or on a mail-in basis.

25.2.4.2 Utilization Review Process

The inpatient utilization review process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- *Admission review*. Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP) and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Quality review*. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.
- *DRG validation*. Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, discharge status, principal diagnosis, secondary diagnosis (complications or comorbidity), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care. The medical record must reflect that any services reimbursed

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by the Texas Medicaid Program were ordered by the attending physician, certified nurse-midwife, or nurse practitioner.

Important: *All services, supplies, or items billed are medically necessary for the client's diagnosis or treatment as certified on claim submission.*

Refer to: "Provider Certification/Assignment" on page 1-8

When an admission denial or a denial of continued stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or the days of stay denied. When a DRG is reassigned as a result of utilization review, the payment to the hospital is adjusted.

If an inpatient admission is denied, but a physician's order is present documenting the client originally was placed in observation, the UR unit may authorize the rebilling of services rendered during the first 23 hours on an outpatient claim.

Admission Review

Review personnel assess the medical necessity of an admission by comparing documentation present in the medical record with elements in the TMRP Hospitalization Screening Criteria. For an admission to be approved, an indication for hospitalization and treatment criteria must be met. Cases that do not meet both screening criteria are referred to a physician consultant for determination of the medical necessity of the inpatient admission. If the TMRP Hospitalization Screening Criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Important: *Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG Medicaid Program Integrity (MPI) for determination of a sanction.*

Important: *Effective for admissions on or after September 1, 2006, the HHSC/OIG/UR Unit will use* evidence-based guidelines *to perform retrospective utilization reviews of inpatient hospital claims for Medicaid clients.*

Readmission Review

If a hospital admission or readmission occurs within 30 days of a previous discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity.

Transfers from one facility to another and readmissions are also subject to review.

HASC Surgical Procedures

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

Quality Review

Each Medicaid case is evaluated for quality client care, adequacy of discharge planning, and medical stability of the patient at discharge. To accomplish this review, CMS Generic Quality Screens and discharge screens included in the TMRP Hospitalization Screening Criteria are used. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG, MPI section, for possible payment hold (withholding Medicaid claims payments until verification of the completed corrective action has been received) and/or exclusion from the Texas Medicaid Program.

Diagnosis-Related Group Validation

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client's age, sex, admission date, discharge date, discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, *or* has clinically significant implications for future healthcare needs.

The coding of diagnoses that have clinically significant implications for future health care needs applies *only* to newborns and *must* be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or comorbidities for DRG assignment.

Refer to: "Medicaid Program Limitations and Exclusions" on page 1-17

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; or have been omitted, codes may be deleted, changed, or added. All diagnosis/procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly,

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the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

25.2.4.3 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Billing

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. The Texas Medicaid Program, through its hospital utilization review activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims. To enhance compliance with Texas Medicaid fee-for-service hospital billing and decrease the submission of inappropriate inpatient hospital claims, adhere to the following suggestions:

- Physicians and hospital personnel, primarily case managers, utilization review, and billing staff, should become familiar with the Hospital Inpatient Screening Criteria used by the HHSC staff in performing reviews of hospital medical records related to paid, inpatient hospital claims. The criteria provide guidelines for review staff to assist with the determination of medical necessity of inpatient stays. The Medicaid Hospital Inpatient Screening Criteria is available on the HHSC website at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml.
- Initially admit clients in observation status if the physician feels that it is reasonable to expect that the client may be able to be discharged within 24 hours. If the client is initially admitted in observation status (per physician order), the stay is more than 24 hours, and the hospital submits an inpatient claim, the hospital is given the opportunity to rebill the first 24 hours of services on an outpatient claim if the inpatient claim is subsequently denied per retrospective utilization review.
- When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable when the physician makes the changes to the admitting order before the hospital submits the claim for payment.
- This correction in admission status avoids errors in billing and the potential need for a more lengthy appeal process. If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

25.2.4.4 Hospitals Reimbursed Under TEFRA

For all Medicaid admissions identified for review, the TEFRA review process consists of the following major components:

- *Admission review*. Determination of the medical necessity of the admission. For purposes of the TMRP and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Continued stay review*. Determination of the medical necessity of each day of stay.
- *Quality of care review*. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

Important: *TEFRA Hospitals are required to submit all charges.*

HHSC OIG UR Unit staff review the complete medical record to make decisions about the medical necessity of the admission, continued stay, and quality of care.

25.2.4.5 Technical Denials (DRG Prospective Payment and TEFRA)

On Site Reviews

The following information describes on site reviews:

- If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.
- If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax machine. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Note: *A notarized business record affidavit is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: “Retention of Records and Access to Records and Premises” on page 1-6

Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax machine. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the

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complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Hospital inpatient claim payments that have been recouped because of a technical denial may not be rebilled on an outpatient claim.

Note: *A notarized business record affidavit is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.*

Refer to: “Retention of Records and Access to Records and Premises” on page 1-6

25.2.4.6 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

Notice to Physicians: Medicaid payment to hospitals is based, in part, on each client’s principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.

Important: *The acknowledgment of penalty notice must be specific to the Texas Medicaid Program. Medicare penalty notices are not accepted.*

25.2.4.7 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI for determination of a sanction.

25.2.4.8 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC’s UR unit to the HHSC UR/Medical Appeals unit. A UR/Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC’s UR unit nor TMHP are responsible for UR appeals.

Refer to: “Utilization Review Appeals” on page 6-7.

25.2.5 Claims Information

Inpatient hospital services must be submitted to TMHP in an approved electronic format or on a HCFA-1450 (UB-92) claim form. Providers must purchase HCFA-1450 claim forms from the vendor of their choice; TMHP does not supply them.

Hospitals may submit *information only* claims to TMHP when one of the following situations exists. Hospitals should use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third party resource/other insurance exceeds the Medicaid allowed amount.

Refer to: “HCFA-1450 (UB-92) Claim Filing Instructions” on page 5-32 for claims completion instructions.

25.2.5.1 Claim Filing Resources

Refer to the following sections and forms on the page numbers listed below when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
HCFA-1450 (UB-92) Claim Filing Instructions	5-32
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Medicaid Audit Request for Claims Summary	B-54
Hospital Report (Newborn Child or Children) HHSC Form 7484	B-51
Hospital-Based ASC Claim Example	D-17
Hospital Inpatient Claim Example	D-18
Hospital Outpatient	D-18
Acronym Dictionary	F-1

25.3 Outpatient

25.3.1 Enrollment

To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

All providers of laboratory services must comply with CLIA rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

Hospital Eligibility Through Change of Ownership

Under procedures set forth by CMS and HHS, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

Contact the TMHP Contact Center at 1-800-925-9126 to obtain the Medicaid hospital participation agreement.

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25.3.1.1 Hospital Ambulatory Surgical Center

Hospitals certified and enrolled in the Texas Medicaid Program are assigned a nine-digit HASC provider identifier exclusively for billing day surgeries.

Refer to: “Day Surgery” on page 25-16.

“Ambulatory Surgical Center (ASC)” on page 9-1 for more information.

25.3.1.2 Hospital Ambulance

A hospital supplying ambulance services must enroll *separately* from the hospital.

Refer to: “Enrollment” on page 8-2 for ambulance enrollment requirements.

25.3.1.3 Certified Registered Nurse Anesthetist

Hospital-employed CRNAs must enroll and bill according to instructions in “Certified Registered Nurse Anesthetist (CRNA)” on page 15-1.

Note: *Hospitals cannot bill for CRNA services using their HASC or hospital provider identifier.*

25.3.1.4 Medicaid Managed Care Enrollment

To be reimbursed for services provided to Medicaid Managed Care clients, hospital providers must enroll with the Medicaid Managed Care health plan in which the clients are enrolled.

Refer to: “Medicaid Managed Care” on page 7-4 for more information.

25.3.2 Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital’s most recent tentative Medicaid cost report settlement. Reimbursement for outpatient hospital services for high-volume providers is 84.48 percent of allowable cost. For the remaining providers, reimbursement for outpatient hospital services is 80.3 percent of allowable cost. A high-volume provider is defined as one that was paid at least $200,000 during calendar year 2000.

All clinical laboratory services are reimbursed at 60 percent of the prevailing charge except for those hospitals identified by Medicare as sole community hospitals. These hospitals are reimbursed at 62 percent of the prevailing charges for services provided to clients in the outpatient setting and 60 percent to clients in the inpatient setting. Clinical pathology consultations continue to be allowed for reimbursement.

Refer to: “Provider Cost and Reporting” on page 25-3 for more information about the calculation of the interim rate.

“Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2 for important information.

25.3.2.1 Day Surgery

Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to an ambulatory surgical center (ASC) for similar services, the hospital’s actual charge, or the allowable cost determined by HHSC. Hospitals must bill *all* scheduled day surgeries under their HASC provider identifier using TOB 131.

To avoid delays in claims processing payment, file scheduled outpatient surgical procedures using the hospital’s ASC/HASC provider identifier and appropriate type of service (TOS) F-Healthcare Common Procedure Coding System (HCPCS) procedure code. ASC/HASC providers indicate the appropriate TOS F-HCPCS facility procedure code in Block 44 of the HCFA-1450 (UB-92) claim form, instead of the *International Classification of Diseases Ninth Revision Clinical Modification* (ICD-9-CM) procedure code in Block 80 of the HCFA-1450 (UB-92) claim form.

File claims for emergency, unscheduled outpatient surgical procedures with separate charges (lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital’s provider identifier.

Reimbursement of ASC/HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Providers are sent a list of these codes and payment categories after enrollment with the Texas Medicaid Program and when periodic updates occur. The rates implemented by Medicaid on April 1, 1995, remain in effect. To acquire a list of approved procedures, call the TMHP Contact Center at 1-800-925-9126.

Refer to: “Day Surgery” on page 25-16 for more information on day surgery and outpatient observation.

“Procedure Codes Requiring Prior Authorization” on page 36-343.

“TMHP Website” on page 3-2 for more information on obtaining fee schedules.

ASC/HASC Global Services

The ASC/HASC payment represents a global payment and includes room charges and supplies. Covered services provided are billed as one inclusive charge. All facility services provided in conjunction with the surgery (for example, laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or billed separately.

Routine X-ray and laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. All nonroutine laboratory and X-ray services, provided with emergency conditions, may be billed separately with documentation that the complicating condition arose after the initiation of the surgery.

No separate payment outside of the ASC/HASC reimbursement rate will be made for prosthetic devices. Medical and prosthetic devices such as implantable pumps and intraocular lenses, may be supplied by the ASC/HASC and implanted, inserted or otherwise applied during a covered surgical procedure.

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Multiple surgeries

When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. Surgical procedures performed in the hospital's outpatient departments (emergency or treatment rooms) are to be billed under the hospital's provider identifier, using TOB 131 (outpatient claim).

Elective/Scheduled Day Surgeries

These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed. Providers must bill (TOB 131) the scheduled day surgery as an outpatient procedure using the HASC provider identifier.

Complications following Elective/Scheduled Day Surgeries

If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 24 hours). The observation period must be billed on an outpatient claim (TOB 131) using the hospital's provider identifier. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) should be included on the inpatient claim (TOB 111) using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should still be billed as an outpatient procedure under the HASC provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under "Hospital Outpatient Observation Room Services" on page 25-25.

Inpatient Admissions After Day Surgery

If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be billed as an outpatient procedure (TOB 131), using the hospital's HASC provider identifier. The inpatient admission is to be billed as an inpatient claim (TOB 111), using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should not be included on the inpatient claim. The inpatient admission *must* be medically necessary and is subject to retrospective review.

Emergency/Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the emergency room and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures should be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must bill unscheduled day surgery procedures and emergency services as outpatient procedures. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be billed on the same outpatient claim.

Providers *must* bill the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital's provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 24 hours). The observation period must be billed on the same outpatient claim (TOB 131) using the hospital's provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under "Hospital Outpatient Observation Room Services" on page 25-25.

Complications following Emergency/Unscheduled Day Surgery

If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) should be included on the inpatient claim (TOB 111) using the hospital's provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services should not be included on the inpatient claim since they are to be billed (TOB 131) as outpatient procedures under the hospital's provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under "Hospital Outpatient Observation Room Services" on page 25-25.

ASA Physical Status and Heart Disease Classifications

If a client is admitted for a day surgery procedure—whether scheduled or emergency—and has either an American Society of Anesthesiologists (ASA) Classification of Physical Status of III, IV, or V or Classification of Heart Disease III or IV (refer to Texas Medicaid Hospital Screening Criteria), the procedure may be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the hospital's provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

The ASA classifications of physical status consist of five classes:

- *Class I*. A patient who has no organic disease or in whom the disease is localized and causes no systemic disturbance.
- *Class II*. A patient exhibiting *mild* to moderate systemic disturbance that may or may not be associated with the surgical complaint and that interferes only moderately with the patient's regular activities and general physiologic equilibrium.

Example: *Non- or only slightly-limiting organic heart disease, mild diabetes, hypoglycemia, essential hypertension, or anemia; extreme obesity; chronic*

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bronchitis.

- *Class III*. A patient exhibiting *severe* systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient's activities.

Example: *Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.*

- *Class IV*. A patient exhibiting *extreme* systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient's regular activities, and that has already become life-threatening.

Example: *Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.*

- *Class V*. The rare person who is *moribund* (in a dying state) before operation, whose preoperative condition is such that he or she is expected to die within 24 hours even though not subjected to the additional strain of operation.

Example: *Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.*

The Classification of Heart Disease consists of four classes:

- *Class I*. No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- *Class II*. Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- *Class III*. Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- *Class IV*. Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

Incomplete Day Surgeries

When ASC/HASC providers bill the Texas Medicaid Program for an incomplete surgical procedure, the following information *must* be included on the claim:

- Modifier 73 or 74
- Facilities must use either the following diagnosis codes or modifier to indicate an incomplete surgical procedure, TOS F:

Diagnosis Code	Description
V641	Surgical or other procedure not carried out because of contraindication
V642	Surgical or other procedure not carried out because of patient's decision
V643	Procedure not carried out for other reasons

Claims billed with diagnosis codes V641, V642, V643 and modifier 73 and 74 suspend for review of the medical documentation submitted with the claim. Providers must submit the operative report, the anesthesia report, and state why the operation was not completed.

Reimbursement to ASC/HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of ASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources
- Reimburse at 33 percent of ASC group payment schedule up to the administration of anesthesia
- Reimburse at 50 percent of ASC group payment schedule after the administration of anesthesia but before incision
- Reimburse at 100 percent of ASC group payment schedule after incision

Surgeries canceled because of incomplete preoperative procedures are *not* reimbursed.

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25.3.2.2 Revenue Codes (Outpatient Hospital)

UB-92 revenue codes must be used to bill outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

Revenue Code	Description	Comments
	Pharmacy	
B-250	General classification	
B-251	Generic drugs	
B-252	Non-generic drugs	
B-253	Take Home drugs	Not a benefit
B-254	Drugs incident to other diagnostic services	
B-255	Drugs incident to radiology	
B-256	Experimental drugs	Not a benefit
B-257	Nonprescription drugs	
B-258	IV solutions	
B-259	Other pharmacy	
B-630	Drugs requiring specific identification	HCPCS code required
B-631	Single source drug	HCPCS code required
B-632	Multiple source drug	HCPCS code required
B-633	Restrictive prescription	HCPCS code required
B-634	Erythropoietin (EPO) less than 10,000 units	HCPCS code required
B-635	Erythropoietin (EPO) 10,000 or more units	HCPCS code required
B-636	Drugs requiring detailed coding	HCPCS code required
B-637	Self-administrable drugs	Not a benefit
	IV Therapy	
B-260	General classification	
B-261	Infusion pump	
B-262	IV therapy/pharmacy services	
B-263	IV therapy/drug/supply delivery	
B-264	IV therapy/supplies	
B-269	Other IV therapy	
	Medical/Surgical Supplies and Devices	
B-270	General classification	
B-271	Nonsterile supply	
B-272	Sterile supply	
B-273	Take-home supplies	Not a benefit
B-274	Prosthetic/orthotic devices	Not a benefit
B-275	Pacemaker	
B-276	Intraocular lens	
B-277	Oxygen–take-home	Not a benefit
B-278	Other implants	Not a benefit
B-279	Other supplies/devices	Not a benefit
B-620	Medical/surgical supplies	Not a benefit
B-621	Supplies incident to radiology	
B-622	Supplies incident to other diagnostic services	

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

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Revenue Code	Description	Comments
B-623	Surgical dressings	
B-624	FDA investigational devices	Not a benefit
	Oncology	
B-280	General classification	
B-289	Other oncology	
	Laboratory	
B-300	General classification	Not a benefit
B-301	Chemistry	Not a benefit
B-302	Immunology	Not a benefit
B-303	Renal patient (home)	Not a benefit
B-304	Nonroutine dialysis	Not a benefit
B-305	Hematology	Not a benefit
B-306	Bacteriology and microbiology	Not a benefit
B-307	Urology	Not a benefit
B-309	Other laboratory	Not a benefit
	Laboratory Pathological	
B-310	General classification	Not a benefit
B-311	Cytology	Not a benefit
B-312	Histology	Not a benefit
B-314	Biopsy	Not a benefit
B-319	Other pathology	Not a benefit
	Radiology–Diagnostic	
B-320	General classification	Not a benefit
B-321	Angiocardiography	Not a benefit
B-322	Arthrography	Not a benefit
B-323	Arteriography	Not a benefit
B-324	Chest X-ray	Not a benefit
B-329	Other diagnostic radiology	Not a benefit
	Radiology–Therapeutic	
B-330	General classification	Not a benefit
B-331	Chemotherapy–injected	Not a benefit
B-332	Chemotherapy–oral	Not a benefit
B-333	Chemotherapy–radiation therapy	Not a benefit
B-335	Chemotherapy–IV	Not a benefit
B-339	Other therapeutic radiology	Not a benefit
	Nuclear Medicine	
B-340	General classification	Not a benefit
B-341	Diagnostic	Not a benefit
B-342	Therapeutic	Not a benefit
B-349	Other nuclear medicine	Not a benefit
	Computerized Tomography (CT) Scan	
B-350	General classification	Not a benefit

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

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Revenue Code	Description	Comments
B-351	Head scan	Not a benefit
B-352	Body scan	Not a benefit
B-359	Other CT scans	Not a benefit
	Operating Room Services	
B-360	General classification	
B-361	Minor surgery	
B-369	Other operating room services	
	Anesthesia	
B-370	General classification	
B-371	Anesthesia incident to radiology	
B-372	Anesthesia incident to other diagnostic services	
B-374	Acupuncture	Not a benefit
B-379	Other anesthesia	
	Blood	
B-380	General classification	Not a benefit
B-381	Packed red cells	Not a benefit
B-382	Whole blood	Not a benefit
B-383	Plasma	Not a benefit
B-384	Platelets	Not a benefit
B-385	Leucocytes	Not a benefit
B-386	Other components	Not a benefit
B-387	Other derivatives (cryoprecipitates)	Not a benefit
B-389	Other blood	Not a benefit
	Blood Storage and Processing	
B-390	General classification	
B-391	Blood administration	Not a benefit
B-399	Other blood storage and processing	Not a benefit
	Other Imaging Services	
B-400	General classification	Not a benefit
B-401	Diagnostic mammography	Not a benefit
B-402	Ultrasound	Not a benefit
B-403	Screening mammography	Not a benefit
B-404	Positron emission tomography	Not a benefit
B-409	Other imaging services	Not a benefit
	Respiratory Services	
B-410	General classification	
B-412	Inhalation services	
B-413	Hyperbaric oxygen therapy	
B-419	Other respiratory services	Not a benefit
	Physical Therapy	
B-420	General classification	Not a benefit
B-421	Visit charge	Not a benefit

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

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Revenue Code	Description	Comments
B-422	Hourly charge	Not a benefit
B-423	Group rate	Not a benefit
B-424*	Evaluation or re-evaluation	HCPCS code required
B-429	Other physical therapy	Not a benefit
	Occupational Therapy	
B-430	General classification	Not a benefit
B-431	Visit charge	Not a benefit
B-432	Hourly charge	Not a benefit
B-433	Group rate	Not a benefit
B-434	Evaluation or re-evaluation	Not a benefit
B-439	Other occupational therapy	Not a benefit
	Speech-Language Pathology	
B-440	General classification	Not a benefit
B-441	Visit charge	Not a benefit
B-442	Hourly charge	Not a benefit
B-443	Group rate	Not a benefit
B-444*	Evaluation or re-evaluation	HCPCS code required
B-449	Other speech-language pathology	Not a benefit
	Emergency Room	
B-450	General classification	
B-456	Urgent care	
B-459	Other emergency room	
	Pulmonary Function	
B-460	General classification	Not a benefit
B-469	Other pulmonary function	Not a benefit
	Audiology	
B-470	General classification	Not a benefit
B-471	Diagnostic	Not a benefit
B-472	Treatment	Not a benefit
B-479	Other Audiology	Not a benefit
	Cardiology	
B-480	General classification	Not a benefit
B-481	Cardiac cath lab	Not a benefit
B-482	Stress test	Not a benefit
B-489	Other cardiology	Not a benefit
	Clinic	
B-510	General classification	
B-511	Chronic pain center	
B-512	Dental clinic	
B-513	Psychiatric clinic	
B-514	OB-GYN clinic	
B-515	Pediatric clinic	

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

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Revenue Code	Description	Comments
B-516	Urgent Care clinic	
B-517	Family Practice clinic	
B-519	Other clinic	
	Freestanding Clinic	
B-520	General classification	
B-523	Family practice clinic	
B-526	Urgent care clinic	
B-529	Other freestanding clinic	
	Magnetic Resonance Technology (MRT)	
B-610	General classification	Not a benefit
B-611	Magnetic Resonance Imaging (MRI) brain (including brainstem)	Not a benefit
B-612	MRI spinal cord (including spine)	Not a benefit
B-619	Other MRT	Not a benefit
	Cast Room	
B-700	General classification	
B-709	Other cast room	
	Recovery Room	
B-710	General classification	
B-719	Other recovery room	
	Labor Room/Delivery	
B-720	General classification	
B-721	Labor	
B-722	Delivery	
B-723	Circumcision	
B-724	Birthing center	
B-729	Other labor room/delivery	
	EKG/ECG (Electrocardiogram)	
B-730	General classification	Not a benefit
B-731	Holter monitor	Not a benefit
B-732	Telemetry	Not a benefit
B-739	Other EKG/ECG	Not a benefit
	EEG (Electroencephalogram)	
B-740	General classification	Not a benefit
B-749	Other EEG	Not a benefit
	Gastrointestinal Services	
B-750	General classification	
B-759	Other gastrointestinal	
	Treatment or Observation Room	
B-760	General classification	
B-761	Treatment room	
B-762	Observation room	

*** HCPCS procedure code is required in addition to revenue code for accurate claims processing.**

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Revenue Code	Description	Comments
B-769	Other treatment/observation room	
	Preventive Care Services	
B-770	General classification	Not a benefit
B-771	Vaccine administration	Not a benefit
B-779	Other preventive care services	Not a benefit
	Lithotripsy	
B-790	General classification	Not a benefit
B-799	Other lithotripsy	Not a benefit
	Other Diagnostic Services	
B-920	General classification	Not a benefit
B-921	Peripheral vascular lab	Not a benefit
B-922	Electromyelogram	Not a benefit
B-923	Pap smear	Not a benefit
B-924	Allergy test	Not a benefit
B-925	Pregnancy test	Not a benefit
B-929	Other diagnostic service	Not a benefit
* HCPCS procedure code is required in addition to revenue code for accurate claims processing.		

25.3.3 Benefits and Limitations

Outpatient hospital services are diagnostic, therapeutic, and rehabilitative services that are provided to clients by or under the direction of a physician in a licensed hospital setting.

Benefits do not include drugs and biologicals taken home by the client. Supplies provided by a hospital supply room for use in physicians' offices in the treatment of clients in the outpatient setting are not reimbursable.

Take-home drugs and supplies are covered in the outpatient setting for outpatients when supplied by prescription through the Vendor Drug Program.

Outpatient hospital services include those services performed in the emergency room (ER) clinic or observation room. In instances of sudden illness or injury, the client may receive treatment in the emergency room and be discharged, placed on observation status, or admitted as an inpatient. If a client goes from the emergency room to an observation room, the hospital is reimbursed only for the observation room charges: not the emergency room charges. If a client visits the emergency room more than once in one day, the times must be given for each visit. If the client ultimately 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 inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the emergency room or clinic.

Outpatient hospital services must be itemized by date of service. Procedure repeated over a period of time should be billed for each separate date of service. Do *not* combine multiple dates of service on the same line detail.

Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the fee is less than what the Medicaid payment would be for the service.

Refer to: "Medicaid Program Limitations and Exclusions" on page 1-17 for more information about noncovered items/services.

25.3.3.1 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day. Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

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Emergency department room charges may be billed using the following revenue codes:

Revenue Code	Description
B-450 *or* B456 *or* B-459	Emergency room *or* Emergency room, urgent care *or* Emergency room–other
B-761	Treatment room
B-762	Observation room

Emergency department ancillary services include laboratory services, radiology services, respiratory therapy services, and diagnostic studies, such as EKGs, CT scans, and supplies. Ancillary services should be billed on a HCFA-1450 (UB-92) claim form using the appropriate procedure codes such as the Current Procedural Terminology (CPT) code or the HCPCS code indicating the procedures or services performed.

According to federal legislation, if any individual presents at the hospital's emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

Medicaid claims administrators and Medicaid Managed Care Organizations (MCOs) are prohibited from requiring prior authorization or primary care provider notification for emergency services including those that are needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

The Texas Medicaid Program provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not covered.

The Texas Medicaid Program provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are covered also when the client's health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

25.3.3.2 Hospital Outpatient Observation Room Services

Outpatient means a client is in an organized medical facility, and receives, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the client remains in the facility past midnight.

Some patients, while not requiring an inpatient hospital admission, may require an extended period of observation (less than 24 hours) in the hospital environment on an outpatient basis. The client is considered an outpatient if he or she remains in the hospital for less than 24 consecutive hours and is discharged to home from an outpatient observation status.

Observation services may be provided in any part of the hospital where a patient can be assessed, examined, monitored, or treated.

If a physician's order for outpatient observation is present in the patient's medical record, per Title 1 *Texas Administrative Code* (TAC) §371.206(b), the Texas Medicaid Program considers reimbursement to the hospital for outpatient observation services based on the facility's reimbursement rate.

Hospitals may bill medically necessary outpatient services provided during the initial period of observation on TOB 131. The hospital outpatient observation room service commences with the first clinical contact of the client by professional/licensed staff of the hospital.

Because the unit associated with the observation room charge (B-762) is considered to be *hours*, claims submitted with observation room *units* exceeding 23 hours are denied with EOB code 643, Claim indicates outpatient charges in excess of 23 hours. Facilities should resubmit these outpatient claims as appeals with charges for the initial 23 hours only.

Any service *ordered within* the initial 24 hour period may be included on the outpatient claim *if a physician's order for the service is within* the observation period time frame but hospital scheduling limitations prevent the service from being performed before 23-hours has expired. Any services ordered *after* the initial 24 hours must *not* be included on the outpatient claim nor billed to the client.

To receive reimbursement for physician-*ordered* services that are medically necessary and *exceed* the 24-hour period from the initial point of contact, the claim may be submitted as an inpatient stay. All observation room charges, outpatient charges (except ambulatory surgical procedure codes as listed in the current ASC/HASC fee schedule), and emergency room charges for an inpatient claim are included in the reimbursement methodology and are not reimbursed separately (charges for an observation room on an inpatient claim should be coded with revenue code 760).

It is important to realize that any inpatient stay billed to the Texas Medicaid Program is subject to retrospective review by the HHSC UR unit with the possibility for denial if the admission is determined not medically necessary. If the inpatient admission is denied as not medically necessary, UR may allow services rendered during the

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first 23 hours (less than 24 hours) to be rebilled to TMHP as an outpatient claim if a physician's order for outpatient observation is present in the hospital medical record (per Title 1 TAC §371.206[b]). The claim must be submitted to THMP within 120 days from the date of the UR notification letter.

The following documentation must accompany the revised bill:

- Revised HCFA-1450 (UB-92) claim form containing the required data for outpatient billing for medically necessary outpatient services
- Copy of the UR notification letter indicating services may be rebilled

When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable under the Texas Medicaid Program when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement. A hospital is not allowed to convert a patient from observation status to inpatient admission status without a physician's order.

25.3.3.3 Outpatient Total Parenteral Hyperalimentation

Outpatient parenteral hyperalimentation may be administered only as a life-sustaining measure, and the procedure must be prior authorized in writing. Claims for hyperalimentation therapy administered as a nutritional supplement are denied.

25.3.3.4 Aerosol Treatment

Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are covered by the Texas Medicaid Program. These treatments must be coded with revenue code B-412, Respiratory services–inhalation services.

Effective April 1, 2004, the following revised diagnosis codes will be payable for aerosol treatments:

Diagnosis Code	Description
49120	Obstructive chronic bronchitis, without exacerbation
49121	Obstructive chronic bronchitis, with (acute) exacerbation
49122	Obstructive chronic bronchitis with acute bronchitis
49300	Exstrinsic asthma, unspecified
49302	Extrinsic asthma, with (acute) exacerbation
49310	Instrinsic asthma, unspecified
49312	Instrinsic asthma, with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49322	Chronic obstructive asthma, with (acute) exacerbation
49381	Exercise induced bronchospasm
49382	Cough variant asthma
49392	Asthma, unspecified type, with (acute) exacerbation
5173	Acute chest syndrome

Payment for aerosol therapy is limited to the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
0796	Respiratory syncytial virus (RSV)
1363	Pneumocystosis
27700	Cystic fibrosis, without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
46400	Acute laryngitis without mention of obstruction
46401	Acute laryngitis with obstruction
46410	Acute tracheitis without mention of obstruction
46411	Acute tracheitis with obstruction
46420	Acute laryngotracheitis without mention of obstruction
46421	Acute laryngotracheitis with obstruction
46430	Acute epiglottitis without mention of obstruction
46431	Acute epiglottitis with obstruction
4644	Croup
46450	Supraglottitis unspecified without obstruction
46451	Supraglottitis unspecified with obstruction
4660	Acute bronchitis
46611	Acute bronchiolitis due to RSV
46619	Acute bronchiolitis due to other infectious organisms
4786	Edema of larynx
47875	Laryngeal spasm
4788	Upper respiratory tract hypersensitivity reaction, site unspecified
48284	Pneumonia due to legionnaires' disease
490	Bronchitis, not specified as acute or chronic
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis

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Diagnosis Code	Description
49120	Obstructive chronic bronchitis, without exacerbation
49121	Obstructive chronic bronchitis, with acute exacerbation
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysematous bleb
4928	Other emphysema
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma, with (acute) exacerbation
49310	Intrinsic asthma, unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma, with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma, with (acute) exacerbation
49390	Asthma, unspecified type, unspecified
49391	Asthma, unspecified type, with status asthmaticus
49392	Asthma, unspecified type, with (acute) exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmer's lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	'Ventilation' pneumonitis
4958	Other specified allergic alveolitis and pneumonitis
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction, not elsewhere classified
5184	Acute edema of lung, unspecified
5186	Allergic bronchopulmonary aspergillosis

Medications used in aerosol therapy are reimbursed separately and must be billed using the appropriate HCPCS procedure code. Saline used in aerosol therapy is denied as part of the aerosol therapy.

Revenue code B-412, Inhalation services, billed for aerosol therapy in the recovery room after outpatient surgery (billed on an outpatient claim) is also allowable as it is a necessary adjunct to the postoperative recovery of a client who has undergone general anesthesia.

Revenue code B-412 includes the inhalers listed below and is payable in the outpatient setting (place of service [POS] 5) when it is the *only* therapy billed on that day:

- Beclomethasone dipropionate (Vanceril or Beclovent oral inhalers)
- Isoproterenol sulfate (Iso-Autohaler, Luf-Iso Inhaler, Medihaler-Iso, Norisodrine Aerohaler)
- Isoproterenol Hydrochloride (Iprenol, Vapo-Iso inhalers)
- Albuterol (Proventil or Ventolin inhalers)
- Metaproterenol Sulfate (Alupent Metered Dose inhaler, Metaprel inhaler, Alupent 10 mL, Alupent 30 mL)
- Epinephrine Bitartrate (Medihaler-Epi and Primatene Mist Suspension inhaler)
- Phenylephrine Bitartrate (Duo-Medihaler)
- Isoetharine Mesylate inhalation aerosol (Bronkometer)
- Dexamethasone Sodium Phosphate (Turbinaire or Respihaler)

When revenue code B-412, Respiratory services–inhalation services, is billed on the same day for both aerosol therapy and inhalers, only one service is allowed, not both.

Intermittent positive pressure breathing (IPPB) treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

25.3.3.5 Pentamidine Aerosol

Aerosol pentamidine treatments will be reimbursed using procedure code 1-94642.

Additionally, the provider may also be reimbursed for the medication using procedure code 1-J2545.

Payment for aerosol pentamadine treatments is limited to the following diagnosis codes:

Diagnosis Code	Description
042	HIV disease
07951	Human t-cell lymphotrophic virus, type I (HTLV-I)
07952	Human t-cell lymphotrophic virus, type II (HTLV-II)
07953	Human immunodeficiency virus, type 2 (HIV-2)
1363	Pneumocystosis
48284	Pneumonia due to legionnaires' disease
5186	Allergic bronchopulmonary aspergillosis

Aerosol pentamidine treatments are limited to one treatment every 28 days.

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25.3.3.6 Pulmonary Function Studies

When CPT codes 5-94014 and 5-94015 are billed together, CPT code 5-94015 denies as part of CPT code 5-94014.

25.3.3.7 Chemotherapy Administration

Hospitals submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

Use the following revenue codes when administering chemotherapy in the following settings:

Revenue Code	Description
B-264	IV therapy, IV therapy/supplies
B-450 *or* B456 *or* B-459	Emergency room *or* Emergency room, urgent care *or* Emergency room–other
B-510 *or* B-511 *or* B-512 *or* B-514 *or* B-515 *or* B-516 *or* B-517 *or* B-519	Clinic *or* Clinic–chronic pain center *or* Clinic–dental *or* Clinic; OB/GYN *or* Clinic; pediatric *or* Clinic, urgent care clinic *or* Clinic, family practice clinic *or* Clinic–other
B-761	Treatment room
B-762	Observation room

25.3.3.8 Bacillus Calmette-Guerin (BCG) Vaccine

Procedure code 1-J9031, is a covered benefit of the Texas Medicaid Program for the diagnosis codes listed below. Procedure code 1-90586, is also a covered benefit of the Texas Medicaid Program for the following diagnosis codes:

Diagnosis Code	Description
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
2337	Carcinoma in-situ of the bladder

Intravesical BCG vaccines will autodeny for all other diagnoses.

Procedure code 1-90585, is a covered benefit of the Texas Medicaid Program for diagnosis code V032, Need for prophylactic vaccination and inoculation against BCG.

25.3.3.9 Tetanus Injections, Acute Care

Tetanus toxoid absorbed and Tetanus immune globulin, human, are benefits of the Texas Medicaid Program. These injections are diagnosis-restricted to cover injuries listed in the diagnosis table below.

Tetanus toxoid absorbed is an immunization used to prevent tetanus. It produces immunity to tetanus by promoting antibody production. The tetanus immune globulin provides a passive immunity for injuries that are over 24 hours old, extensively contaminated and/or for the client who has had less than two tetanus toxoid injections in a lifetime. Therefore, both of these injections can be given on the same day for the same injury event.

Tetanus toxoid and tetanus immune globulin should be billed with procedure codes 1-J1670 and 1-90703.

Tetanus toxoid and tetanus immune globulin injections are covered for injuries, such as puncture wounds, burns or abrasions. These injections are restricted to the diagnosis codes listed in the following table:

Diagnosis Code	Description
80000	Closed fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified
80001	Closed fracture of vault of skull without mention of intracranial injury, with no loss of consciousness
80002	Closed fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80003	Closed fracture of vault of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80004	Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
80005	Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80006	Closed fracture of vault of skull without mention of intra cranial injury, with loss of consciousness of unspecified duration
80009	Closed fracture of vault of skull without mention of intracranial injury, with concussion, unspecified
80010	Closed fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified
80011	Closed fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness
80012	Closed fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80013	Closed fracture of vault of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80014	Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80015	Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80016	Closed fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80019	Closed fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified
80020	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80021	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80022	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness

Diagnosis Code	Description
80023	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80024	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80025	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80026	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80029	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80030	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80031	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness
80032	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80033	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80034	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80035	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80036	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80039	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified

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Diagnosis Code	Description
80040	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80041	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80042	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80043	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80044	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80045	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80046	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80049	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
80050	Open fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified
80051	Open fracture of vault of skull without mention of intracranial injury, with no loss of consciousness
80052	Open fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80053	Open fracture of vault of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80054	Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80055	Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80056	Open fracture of vault of skull without mention of intracranial injury, with loss of consciousness of unspecified duration
80059	Open fracture of vault of skull without mention of intracranial injury, with concussion, unspecified
80060	Open fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified
80061	Open fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness
80062	Open fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80063	Open fracture of vault of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80064	Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80065	Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80066	Open fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80069	Open fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified
80070	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80071	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80072	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80073	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80074	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
80075	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80076	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80079	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80080	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80081	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness
80082	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80083	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80084	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80085	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80086	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80089	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80090	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80091	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80092	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80093	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80094	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80096	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80099	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
80100	Closed fracture of base of skull without mention of intra cranial injury, with state of consciousness unspecified
80101	Closed fracture of base of skull without mention of intra cranial injury, with no loss of consciousness
80102	Closed fracture of base of skull without mention of intra cranial injury, with brief (less than one hour) loss of consciousness
80103	Closed fracture of base of skull without mention of intra cranial injury, with moderate (1-24 hours) loss of consciousness
80104	Closed fracture of base of skull without mention of intra cranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80105	Closed fracture of base of skull without mention of intra cranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80106	Closed fracture of base of skull without mention of intra cranial injury, with loss of consciousness of unspecified duration
80109	Closed fracture of base of skull without mention of intra cranial injury, with concussion, unspecified
80110	Closed fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified
80111	Closed fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness
80112	Closed fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness

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Diagnosis Code	Description
80113	Closed fracture of base of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80114	Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80115	Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80116	Closed fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80119	Closed fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified
80120	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80121	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80122	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80123	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80124	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80125	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80126	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80129	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80130	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80131	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness
80132	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80133	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80134	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80135	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80136	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80139	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80140	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80141	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80142	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80143	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80144	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
80145	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80146	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80149	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
80150	Open fracture of base of skull without mention of intracranial injury, with state of consciousness unspecified
80151	Open fracture of base of skull without mention of intracranial injury, with no loss of consciousness
80152	Open fracture of base of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80153	Open fracture of base of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80154	Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80155	Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80156	Open fracture of base of skull without mention of intracranial injury, with loss of consciousness of unspecified duration
80159	Open fracture of base of skull without mention of intracranial injury, with concussion, unspecified
80160	Open fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified
80161	Open fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness
80162	Open fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80163	Open fracture of base of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
80164	Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80165	Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80166	Open fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80169	Open fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified
80170	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80171	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80172	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80173	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80174	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80175	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80176	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80179	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80180	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80181	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness

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Diagnosis Code	Description
80182	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80183	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80184	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80185	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80186	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80189	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80190	Open fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80191	Open fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80192	Open fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80193	Open fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80194	Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80195	Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80196	Open fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration

Diagnosis Code	Description
80199	Open fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
8020	Closed fracture of nasal bones
8021	Open fracture of nasal bones
80220	Closed fracture of unspecified site of mandible
80221	Closed fracture of condylar process of mandible
80222	Closed fracture of subcondylar process of mandible
80223	Closed fracture of coronoid process of mandible
80224	Closed fracture of unspecified part of ramus of mandible
80225	Closed fracture of angle of jaw
80226	Closed fracture of symphysis of body of mandible
80227	Closed fracture of alveolar border of body of mandible
80228	Closed fracture of other and unspecified part of body of mandible
80229	Closed fracture of multiple sites of mandible
80230	Open fracture of unspecified site of mandible
80231	Open fracture of condylar process of mandible
80232	Open fracture of subcondylar process of mandible
80233	Open fracture of coronoid process of mandible
80234	Open fracture of unspecified part of ramus of mandible
80235	Open fracture of angle of jaw
80236	Open fracture of symphysis of body of mandible
80237	Open fracture of alveolar border of body of mandible
80238	Open fracture of body of mandible, other and unspecified
80239	Open fracture of multiple sites of mandible
8024	Closed fracture of malar and maxillary bones
8025	Open fracture of malar and maxillary bones
8026	Closed fracture of orbital floor (blow-out)
8027	Open fracture of orbital floor (blow-out)
8028	Closed fracture of other facial bones
8029	Open fracture of other facial bones

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Diagnosis Code	Description
80300	Other closed skull fracture without mention of intracranial injury, with state of consciousness unspecified
80301	Other closed skull fracture without mention of intracranial injury, with no loss of consciousness
80302	Other closed skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80303	Other closed skull fracture without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80304	Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80305	Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80306	Other closed skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration
80309	Other closed skull fracture without mention of intracranial injury, with concussion, unspecified
80310	Other closed skull fracture with cerebral laceration and contusion, with state of consciousness unspecified
80311	Other closed skull fracture with cerebral laceration and contusion, with no loss of consciousness
80312	Other closed skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80313	Other closed skull fracture with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80314	Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80315	Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80316	Other closed skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration

Diagnosis Code	Description
80319	Other closed skull fracture with cerebral laceration and contusion, with concussion, unspecified
80320	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80321	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80322	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80323	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80324	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80325	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80326	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80329	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80330	Other closed skull fracture with other and unspecified intracranial hemorrhage, with state of unconsciousness unspecified
80331	Other closed skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness
80332	Other closed skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80333	Other closed skull fracture with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80334	Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
80335	Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80336	Other closed skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80339	Other closed skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified
80340	Other closed skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80341	Other closed skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness
80342	Other closed skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80343	Other closed skull fracture with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80344	Other closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80345	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80346	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80349	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified
80350	Other open skull fracture without mention of injury, with state of consciousness unspecified
80351	Other open skull fracture without mention of intracranial injury, with no loss of consciousness
80352	Other open skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80353	Other open skull fracture without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80354	Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80355	Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80356	Other open skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration
80359	Other open skull fracture without mention of intracranial injury, with concussion, unspecified
80360	Other open skull fracture with cerebral laceration and contusion, with state of consciousness unspecified
80361	Other open skull fracture with cerebral laceration and contusion, with no loss of consciousness
80362	Other open skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80363	Other open skull fracture with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80364	Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80365	Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80366	Other open skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80369	Other open skull fracture with cerebral laceration and contusion, with concussion, unspecified
80370	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80371	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness

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Diagnosis Code	Description
80372	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80373	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80374	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80375	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80376	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80379	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80380	Other open skull fracture with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80381	Other open skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness
80382	Other open skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80383	Other open skull fracture with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80384	Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80385	Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80386	Other open skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80389	Other open skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified
80390	Other open skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80391	Other open skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness
80392	Other open skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80393	Other open skull fracture with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80394	Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80395	Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80396	Other open skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80399	Other open skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified
80400	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified
80401	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness
80402	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80403	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80404	Closed fractures involving skull or face with other bones, without mention or intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
80405	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80406	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration
80409	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with concussion, unspecified
80410	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified
80411	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness
80412	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80413	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80414	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80415	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80416	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80419	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified
80420	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80421	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80422	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80423	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80424	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80425	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80426	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80429	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80430	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80431	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness
80432	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80433	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80434	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level

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Diagnosis Code	Description
80435	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80436	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80439	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified
80440	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80441	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness
80442	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80443	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80444	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80445	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80446	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80449	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified
80450	Open fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified
80451	Open fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness
80452	Open fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80453	Open fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80454	Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80455	Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80456	Open fractures involving skull or face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration
80459	Open fractures involving skull or face with other bones, without mention of intracranial injury, with concussion, unspecified
80460	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified
80461	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness
80462	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80463	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80464	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80465	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
80466	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80469	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified
80470	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80471	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80472	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80473	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80474	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80475	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80476	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80479	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80480	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80481	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness
80482	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80483	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80484	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80485	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss consciousness, without return to pre-existing conscious level
80486	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80489	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified
80490	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80491	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness
80492	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80493	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80494	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80495	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level

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Diagnosis Code	Description
80496	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80499	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified
80500	Closed fracture of cervical vertebra, unspecified level
80501	Closed fracture of first cervical vertebra
80502	Closed fracture of second cervical vertebra
80503	Closed fracture of third cervical vertebra
80504	Closed fracture of fourth cervical vertebra
80505	Closed fracture of fifth cervical vertebra
80506	Closed fracture of sixth cervical vertebra
80507	Closed fracture of seventh cervical vertebra
80508	Closed fracture of multiple cervical vertebrae
80510	Open fracture of cervical vertebra, unspecified level
80511	Open fracture of first cervical vertebra
80512	Open fracture of second cervical vertebra
80513	Open fracture of third cervical vertebra
80514	Open fracture of fourth cervical vertebra
80515	Open fracture of fifth cervical vertebra
80516	Open fracture of sixth cervical vertebra
80517	Open fracture of seventh cervical vertebra
80518	Open fracture of multiple cervical vertebrae
8052	Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
8053	Open fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
8054	Closed fracture of lumbar vertebra without mention of spinal cord injury
8055	Open fracture of lumbar vertebra without mention of spinal cord injury
8056	Closed fracture of sacrum and coccyx without mention of spinal cord injury
8057	Open fracture of sacrum and coccyx without mention of spinal cord injury
8058	Closed fracture of unspecified part of vertebral column without mention of spinal cord injury
8059	Open fracture of unspecified part of vertebral column without mention of spinal cord injury
80600	Closed fracture of C1-C4 level with unspecified spinal cord injury
80601	Closed fracture of C1-C4 level with complete lesion of cord
80602	Closed fracture of C1-C4 level with anterior cord syndrome
80603	Closed fracture of C1-C4 level with central cord syndrome
80604	Closed fracture of C1-C4 level with other specified spinal cord injury
80605	Closed fracture of C5-C7 level with unspecified spinal cord injury
80606	Closed fracture of C5-C7 level with complete lesion of cord
80607	Closed fracture of C5-C7 level with anterior cord syndrome
80608	Closed fracture of C5-C7 level with central cord syndrome
80609	Closed fracture of C5-C7 level with other specified spinal cord injury
80610	Open fracture of C1-C4 level with unspecified spinal cord injury
80611	Open fracture of C1-C4 level with complete lesion of cord
80612	Open fracture of C1-C4 level with anterior cord syndrome
80613	Open fracture of C1-C4 level with central cord syndrome
80614	Open fracture of C1-C4 level with other specified spinal cord injury
80615	Open fracture of C5-C7 level with unspecified spinal cord injury
80616	Open fracture of C5-C7 level with complete lesion of cord
80617	Open fracture of C5-C7 level with anterior cord syndrome
80618	Open fracture of C5-C7 level with central cord syndrome
80619	Open fracture of C5-C7 level with other specified spinal cord injury
80620	Closed fracture of T1-T6 level with unspecified spinal cord injury
80621	Closed fracture of T1-T6 level with complete lesion of cord
80622	Closed fracture of T1-T6 level with anterior cord syndrome
80623	Closed fracture of T1-T6 level with central cord syndrome
80624	Closed fracture of T1-T6 level with other specified spinal cord injury
80625	Closed fracture of T7-T12 level with unspecified spinal cord injury

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Diagnosis Code	Description
80626	Closed fracture of T7-T12 level with complete lesion of cord
80627	Closed fracture of T7-T12 level with anterior cord syndrome
80628	Closed fracture of T7-T12 level with central cord syndrome
80629	Closed fracture of T7-T12 level with other specified spinal cord injury
80630	Open fracture of T1-T6 level with unspec-ified spinal cord injury
80631	Open fracture of T1-T6 level with complete lesion of cord
80632	Open fracture of T1-T6 level with anterior cord syndrome
80633	Open fracture of T1-T6 level with central cord syndrome
80634	Open fracture of T1-T6 level with other specified spinal cord injury
80635	Open fracture of T7-T12 level with unspec-ified spinal cord injury
80636	Open fracture of T7-T12 level with complete lesion of cord
80637	Open fracture of T7-T12 level with anterior cord syndrome
80638	Open fracture of T7-T12 level with central cord syndrome
80639	Open fracture of T7-T12 level with other specified spinal cord injury
8064	Closed fracture of lumbar spine with spinal cord injury
8065	Open fracture of lumbar spine with spinal cord injury
80660	Closed fracture of sacrum and coccyx with unspecified spinal cord injury
80661	Closed fracture of sacrum and coccyx with complete cauda equina lesion
80662	Closed fracture of sacrum and coccyx with other cauda equina injury
80669	Closed fracture of sacrum and coccyx with other spinal cord injury
80670	Open fracture of sacrum and coccyx with unspecified spinal cord injury
80671	Open fracture of sacrum and coccyx with complete cauda equina lesion
80672	Open fracture of sacrum and coccyx with other cauda equina injury
80679	Open fracture of sacrum and coccyx with other spinal cord injury
8068	Closed fracture of unspecified vertebra with spinal cord injury

Diagnosis Code	Description
8069	Open fracture of unspecified vertebra with spinal cord injury
80700	Closed fracture of rib(s), unspecified
80701	Closed fracture of one rib
80702	Closed fracture of two ribs
80703	Closed fracture of three ribs
80704	Closed fracture of four ribs
80705	Closed fracture of five ribs
80706	Closed fracture of six ribs
80707	Closed fracture of seven ribs
80708	Closed fracture of eight or more ribs
80709	Closed fracture of multiple ribs, unspecified
80710	Open fracture of rib(s), unspecified
80711	Open fracture of one rib
80712	Open fracture of two ribs
80713	Open fracture of three ribs
80714	Open fracture of four ribs
80715	Open fracture of five ribs
80716	Open fracture of six ribs
80717	Open fracture of seven ribs
80718	Open fracture of eight or more ribs
80719	Open fracture of multiple ribs, unspecified
8072	Closed fracture of sternum
8073	Open fracture of sternum
8074	Flail chest
8075	Closed fracture of larynx and trachea
8076	Open fracture of larynx and trachea
8080	Closed fracture of acetabulum
8081	Open fracture of acetabulum
8082	Closed fracture of pubis
8083	Open fracture of pubis
80841	Closed fracture of ilium
80842	Closed fracture of ischium
80843	Multiple closed pelvic fractures with disruption of pelvic circle
80849	Closed fracture of other specified part of pelvis
80851	Open fracture of ilium
80852	Open fracture of ischium
80853	Multiple open pelvic fractures with disruption of pelvic circle
80859	Open fracture of other specified part of pelvis
8088	Unspecified closed fracture of pelvis
8089	Unspecified open fracture of pelvis

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Diagnosis Code	Description
8090	Fracture of bones of trunk, closed
8091	Fracture of bones of trunk, open
81000	Closed fracture of clavicle, unspecified part
81001	Closed fracture of sternal end of clavicle
81002	Closed fracture of shaft of clavicle
81003	Closed fracture of acromial end of clavicle
81010	Open fracture of clavicle, unspecified part
81011	Open fracture of sternal end of clavicle
81012	Open fracture of shaft of clavicle
81013	Open fracture of acromial end of clavicle
81100	Closed fracture of scapula, unspecified part
81101	Closed fracture of acromial process of scapula
81102	Closed fracture of coracoid process of scapula
81103	Closed fracture of glenoid cavity and neck of scapula
81109	Closed fracture of other part of scapula
81110	Open fracture of scapula, unspecified part
81111	Open fracture of acromial process of scapula
81112	Open fracture of coracoid process
81113	Open fracture of glenoid cavity and neck of scapula
81119	Open fracture of other part of scapula
81200	Fracture of unspecified part of upper end of humerus, closed
81201	Fracture of surgical neck of humerus, closed
81202	Fracture of anatomical neck of humerus, closed
81203	Fracture of greater tuberosity of humerus, closed
81209	Other closed fractures of upper end of humerus
81210	Fracture of unspecified part of upper end of humerus, open
81211	Fracture of surgical neck of humerus, open
81212	Fracture of anatomical neck of humerus, open
81213	Fracture of greater tuberosity of humerus, open
81219	Other open fracture of upper end of humerus
81220	Fracture of unspecified part of humerus, closed
81221	Fracture of shaft of humerus, closed
81230	Fracture of unspecified part of humerus, open
81231	Fracture of shaft of humerus, open
81240	Fracture of unspecified part of lower end of humerus, closed
81241	Supracondylar fracture of humerus, closed
81242	Fracture of lateral condyle of humerus, closed
81243	Fracture of medial condyle of humerus, closed
81244	Fracture of unspecified condyle(s) of humerus, closed
81249	Other closed fractures of lower end of humerus
81250	Fracture of unspecified part of lower end of humerus, open
81251	Supracondylar fracture of humerus, open
81252	Fracture of lateral condyle of humerus, open
81253	Fracture of medial condyle of humerus, open
81254	Fracture of unspecified condyle(s) of humerus, open
81259	Other fracture of lower end of humerus, open
81300	Closed fracture of upper end of forearm, unspecified
81301	Fracture of olecranon process of ulna, closed
81302	Fracture of coronoid process of ulna, closed
81303	Monteggia’s fracture, closed
81304	Other and unspecified closed fractures of proximal end of ulna (alone)
81305	Fracture of head of radius, closed
81306	Fracture of neck of radius, closed
81307	Other and unspecified closed fractures of proximal end of radius (alone)
81308	Fracture of radius with ulna, upper end (any part), closed
81310	Open fracture of upper end of forearm, unspecified
81311	Fracture of olecranon process of ulna, open
81312	Fracture of coronoid process of ulna, open
81313	Monteggia’s fracture, open
81314	Other and unspecified open fractures of proximal end of ulna (alone)
81315	Fracture of head of radius, open
81316	Fracture of neck of radius, open

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Diagnosis Code	Description
81317	Other and unspecified open fractures of proximal end of radius (alone)
81318	Fracture of radius with ulna, upper end (any part), open
81320	Fracture of shaft of radius or ulna, unspecified, closed
81321	Fracture of shaft of radius (alone), closed
81322	Fracture of shaft of ulna (alone), closed
81323	Fracture of shaft of radius with ulna, closed
81330	Fracture of shaft of radius or ulna, unspecified, open
81331	Fracture of shaft of radius (alone), open
81332	Fracture of shaft of ulna (alone), open
81333	Fracture of shaft of radius with ulna, open
81340	Closed fracture of lower end of forearm, unspecified
81341	Colles' fracture, closed
81342	Other closed fractures of distal end of radius (alone)
81343	Fracture of distal end of ulna (alone), closed
81344	Fracture of lower end of radius with ulna, closed
81345	Torus fracture of radius
81350	Open fracture of lower end of forearm, unspecified
81351	Colles' fracture, open
81352	Other open fractures of distal end of radius (alone)
81353	Fracture of distal end of ulna (alone), open
81354	Fracture of lower end of radius with ulna, open
81380	Closed fracture of unspecified part of forearm
81381	Fracture of unspecified part of radius (alone), closed
81382	Fracture of unspecified part of ulna (alone), closed
81383	Fracture of unspecified part of radius with ulna, closed
81390	Fracture of unspecified part of forearm, open
81391	Fracture of unspecified part of radius (alone), open
81392	Fracture of unspecified part of ulna (alone), open
81393	Fracture of unspecified part of radius with ulna, open
81400	Closed fracture of carpal bone, unspecified

Diagnosis Code	Description
81401	Closed fracture of navicular (scaphoid) bone of wrist
81402	Closed fracture of lunate (semilunar) bone of wrist
81403	Closed fracture of triquetral (cuneiform) bone of wrist
81404	Closed fracture of pisiform bone of wrist
81405	Closed fracture of trapezium bone (larger multangular) of wrist
81406	Closed fracture of trapezoid bone (smaller multangular) of wrist
81407	Closed fracture of capitate bone (os magnum) of wrist
81408	Closed fracture of hamate (unciform) bone of wrist
81409	Closed fracture of other bone of wrist
81410	Open fracture of carpal bone, unspecified
81411	Open fracture of navicular (scaphoid) bone of wrist
81412	Open fracture of lunate (semilunar) bone of wrist
81413	Open fracture of triquetral (cuneiform) bone of wrist
81414	Open fracture of pisiform bone of wrist
81415	Open fracture of trapezium bone (larger multangular) of wrist
81416	Open fracture of trapezoid bone (smaller multangular) of wrist
81417	Open fracture of capitate bone (os magnum) of wrist
81418	Open fracture of hamate (unciform) bone of wrist
81419	Open fracture of other bone of wrist
81500	Closed fracture of metacarpal bone(s), site unspecified
81501	Closed fracture of base of thumb (first) metacarpal
81502	Closed fracture of base of other metacarpal bone(s)
81503	Closed fracture of shaft of metacarpal bone(s)
81504	Closed fracture of neck of metacarpal bone(s)
81509	Closed fracture of multiple sites of metacarpus
81510	Open fracture of metacarpal bone(s), site unspecified
81511	Open fracture of base of thumb (first) metacarpal

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Diagnosis Code	Description
81512	Open fracture of base of other metacarpal bone(s)
81513	Open fracture of shaft of metacarpal bone(s)
81514	Open fracture of neck of metacarpal bone(s)
81519	Open fracture of multiple sites of metacarpus
81600	Closed fracture of phalanx or phalanges of hand, unspecified
81601	Closed fracture of middle or proximal phalanx or phalanges of hand
81602	Closed fracture of distal phalanx or phalanges of hand
81603	Closed fracture of multiple sites of phalanx or phalanges of hand
81610	Open fracture of phalanx or phalanges of hand, unspecified
81611	Open fracture of middle or proximal phalanx or phalanges of hand
81612	Open fracture of distal phalanx or phalanges of hand
81613	Open fracture of multiple sites of phalanx or phalanges of hand
8170	Multiple closed fractures of hand bones
8171	Multiple open fractures of hand bones
8180	Ill-defined closed fractures of upper limb
8181	Ill-defined open fractures of upper limb
8190	Multiple closed fractures involving both upper limbs, and upper limb with rib(s) and sternum
8191	Multiple open fractures involving both upper limbs, and upper limb with rib(s) and sternum
82000	Fracture of unspecified intracapsular section of neck of femur, closed
82001	Fracture of epiphysis (separation) (upper) of neck of femur, closed
82002	Fracture of midcervical section of femur, closed
82003	Fracture of base of neck of femur, closed
82009	Other transcervical fracture of femur, closed
82010	Fracture of unspecified intracapsular section of neck of femur, open
82011	Fracture of epiphysis (separation) (upper) of neck of femur, open
82012	Fracture of midcervical section of femur, open
82013	Fracture of base of neck of femur, open
82019	Other transcervical fracture of femur, open

Diagnosis Code	Description
82020	Fracture of unspecified trochanteric section of femur, closed
82021	Fracture of intertrochanteric section of femur, closed
82022	Fracture of subtrochanteric section of femur, closed
82030	Fracture of unspecified trochanteric section of femur, open
82031	Fracture of intertrochanteric section of femur, open
82032	Fracture of subtrochanteric section of femur, open
8208	Fracture of unspecified part of neck of femur, closed
8209	Fracture of unspecified part of neck of femur, open
82100	Fracture of unspecified part of femur, closed
82101	Fracture of shaft of femur, closed
82110	Fracture of unspecified part of femur, open
82111	Fracture of shaft of femur, open
82120	Fracture of lower end of femur, unspecified part, closed
82121	Fracture of femoral condyle, closed
82122	Fracture of lower epiphysis of femur, closed
82123	Supracondylar fracture of femur, closed
82129	Other fracture of lower end of femur, closed
82130	Fracture of lower end of femur, unspecified part, open
82131	Fracture of femoral condyle, open
82132	Fracture of lower epiphysis of femur, open
82133	Supracondylar fracture of femur, open
82139	Other fracture of lower end of femur, open
8220	Closed fracture of patella
8221	Open fracture of patella
82300	Closed fracture of upper end of tibia
82301	Closed fracture of upper end of fibula
82302	Closed fracture of upper end of fibula with tibia
82310	Open fracture of upper end of tibia
82311	Open fracture of upper end of fibula
82312	Open fracture of upper end of fibula with tibia
82320	Closed fracture of shaft of tibia
82321	Closed fracture of shaft of fibula
82322	Closed fracture of shaft of fibula with tibia
82330	Open fracture of shaft of tibia

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Diagnosis Code	Description
82331	Open fracture of shaft of fibula
82332	Open fracture of shaft of fibula with tibia
8234	Torus fracture
82340	Torus fracture, tibia alone
82341	Torus fracture, fibula alone
82342	Torus fracture, fibula with tibia
82380	Closed fracture of unspecified part of tibia
82381	Closed fracture of unspecified part of fibula
82382	Closed fracture of unspecified part of fibula with tibia
82390	Open fracture of unspecified part of tibia
82391	Open fracture of unspecified part of fibula
82392	Open fracture of unspecified part of fibula with tibia
8240	Fracture of medial malleolus, closed
8241	Fracture of medial malleolus, open
8242	Fracture of lateral malleolus, closed
8243	Fracture of lateral malleolus, open
8244	Bimalleolar fracture, closed
8245	Bimalleolar fracture, open
8246	Trimalleolar fracture, closed
8247	Trimalleolar fracture, open
8248	Unspecified fracture of ankle, closed
8249	Unspecified fracture of ankle, open
8250	Fracture of calcaneus, closed
8251	Fracture of calcaneus, open
82520	Fracture of unspecified bone(s) of foot (except toes), closed
82521	Fracture of astragalus, closed
82522	Fracture of navicular (scaphoid) bone of foot, closed
82523	Fracture of cuboid bone, closed
82524	Fracture of cuneiform bone of foot, closed
82525	Fracture of metatarsal bone(s), closed
82529	Other fracture of tarsal and metatarsal bones, closed
82530	Fracture of unspecified bone(s) of foot (except toes), open
82531	Fracture of astragalus, open
82532	Fracture of navicular (scaphoid) bone of foot, open
82533	Fracture of cuboid bone, open
82534	Fracture of cuneiform bone of foot, open
82535	Fracture of metatarsal bone(s), open
82539	Other fractures of tarsal and metatarsal bones, open

Diagnosis Code	Description
8260	Closed fracture of one or more phalanges of foot
8261	Open fracture of one or more phalanges of foot
8270	Other, multiple and ill-defined fractures of lower limb, closed
8271	Other, multiple and ill-defined fractures of lower limb, open
8280	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, closed
8281	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, open
8290	Fracture of unspecified bone, closed
8291	Fracture of unspecified bone, open
8300	Closed dislocation of jaw
8301	Open dislocation of jaw
83100	Closed dislocation of shoulder, unspecified site
83101	Closed anterior dislocation of humerus
83102	Closed posterior dislocation of humerus
83103	Closed inferior dislocation of humerus
83104	Closed dislocation of acromioclavicular (joint)
83109	Closed dislocation of other site of shoulder
83110	Open dislocation of shoulder, unspecified
83111	Open anterior dislocation of humerus
83112	Open posterior dislocation of humerus
83113	Open inferior dislocation of humerus
83114	Open dislocation of acromioclavicular (joint)
83119	Open dislocation of other site of shoulder
83200	Closed dislocation of elbow, unspecified site
83201	Closed anterior dislocation of elbow
83202	Closed posterior dislocation of elbow
83203	Closed medial dislocation of elbow
83204	Closed lateral dislocation of elbow
83209	Closed dislocation of other site of elbow
83210	Open dislocation of elbow, unspecified site
83211	Open anterior dislocation of elbow
83212	Open posterior dislocation of elbow
83213	Open medial dislocation of elbow
83214	Open lateral dislocation of elbow
83219	Open dislocation of other site of elbow
83300	Closed dislocation of wrist, unspecified part

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Diagnosis Code	Description
83301	Closed dislocation of radioulnar (joint), distal
83302	Closed dislocation of radiocarpal (joint)
83303	Closed dislocation of midcarpal (joint)
83304	Closed dislocation of carpometacarpal (joint)
83305	Closed dislocation of metacarpal (bone), proximal end
83309	Closed dislocation of other part of wrist
83310	Open dislocation of wrist, unspecified part
83311	Open dislocation of radioulnar (joint), distal
83312	Open dislocation of radiocarpal (joint)
83313	Open dislocation of midcarpal (joint)
83314	Open dislocation of carpometacarpal (joint)
83315	Open dislocation of metacarpal (bone), proximal end
83319	Open dislocation of other part of wrist
83400	Closed dislocation of finger, unspecified part
83401	Closed dislocation of metacarpophalangeal (joint)
83402	Closed dislocation of interphalangeal (joint), hand
83410	Open dislocation of finger, unspecified part
83411	Open dislocation of metacarpophalangeal (joint)
83412	Open dislocation interphalangeal (joint), hand
83500	Closed dislocation of hip, unspecified site
83501	Closed posterior dislocation of hip
83502	Closed obturator dislocation of hip
83503	Other closed anterior dislocation of hip
83510	Open dislocation of hip, unspecified site
83511	Open posterior dislocation of hip
83512	Open obturator dislocation of hip
83513	Other open anterior dislocation of hip
8360	Tear of medial cartilage or meniscus of knee, current
8361	Tear of lateral cartilage or meniscus of knee, current
8362	Other tear of cartilage or meniscus of knee, current
8363	Dislocation of patella, closed
8364	Dislocation of patella, open
83650	Closed dislocation of knee, unspecified part
83651	Anterior dislocation of tibia, proximal end, closed
83652	Posterior dislocation of tibia, proximal end, closed
83653	Medial dislocation of tibia, proximal end, closed
83654	Lateral dislocation of tibia, proximal end, closed
83659	Other dislocation of knee, closed
83660	Dislocation of knee, unspecified part, open
83661	Anterior dislocation of tibia, proximal end, open
83662	Posterior dislocation of tibia, proximal end, open
83663	Medial dislocation of tibia, proximal end, open
8370	Closed dislocation of ankle
8371	Open dislocation of ankle
83800	Closed dislocation of foot, unspecified part
83801	Closed dislocation of tarsal (bone), joint unspecified
83802	Closed dislocation of midtarsal (joint)
83803	Closed dislocation of tarsometatarsal
83804	Closed dislocation of metatarsal (bone), joint unspecified
83805	Closed dislocation of metatarsophalangeal (joint)
83806	Closed dislocation of interphalangeal (joint), foot
83809	Closed dislocation of other part of foot
83810	Open dislocation of foot, unspecified part
83811	Open dislocation of tarsal (bone), joint unspecified
83812	Open dislocation of midtarsal (joint)
83813	Open dislocation of tarsometatarsal (joint)
83814	Open dislocation of metatarsal (bone), joint unspecified
83815	Open dislocation of metatarsophalangeal (joint)
83816	Open dislocation of interphalangeal (joint), foot
83819	Open dislocation of other part of foot
83900	Closed dislocation, cervical vertebra, unspecified
83901	Closed dislocation, first cervical vertebra
83902	Closed dislocation, second cervical vertebra
83903	Closed dislocation, third cervical vertebra
83904	Closed dislocation, fourth cervical vertebra
83905	Closed dislocation, fifth cervical vertebra

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Diagnosis Code	Description
83906	Closed dislocation, sixth cervical vertebra
83907	Closed dislocation, seventh cervical vertebra
83908	Closed dislocation, multiple cervical vertebrae
83910	Open dislocation, cervical vertebra, unspecified
83911	Open dislocation, first cervical vertebra
83912	Open dislocation, second cervical vertebra
83913	Open dislocation, third cervical vertebra
83914	Open dislocation, fourth cervical vertebra
83915	Open dislocation, fifth cervical vertebra
83916	Open dislocation, sixth cervical vertebra
83917	Open dislocation, seventh cervical vertebra
83918	Open dislocation, multiple cervical vertebrae
83920	Closed dislocation, lumbar vertebra
83921	Closed dislocation, thoracic vertebra
83930	Open dislocation, lumbar vertebra
83931	Open dislocation, thoracic vertebra
83940	Closed dislocation, vertebra, unspecified site
83941	Closed dislocation, coccyx
83942	Closed dislocation, sacrum
83949	Closed dislocation, other vertebra
83950	Open dislocation, vertebra, unspecified site
83951	Open dislocation, coccyx
83952	Open dislocation, sacrum
83959	Open dislocation, other vertebra
83961	Closed dislocation, sternum
83969	Closed dislocation, other location
83971	Open dislocation, sternum
83979	Open dislocation, other location
8398	Closed dislocation, multiple and ill-defined sites
8399	Open dislocation, multiple and ill-defined sites
8400	Acromioclavicular (joint) (ligament) sprain
8401	Coracoclavicular (ligament) sprain
8402	Coracohumeral (ligament) sprain
8403	Infraspinatus (muscle) (tendon) sprain
8404	Rotator cuff (capsule) sprain
8405	Subscapularis (muscle) sprain
8406	Supraspinatus (muscle) (tendon) sprain
8407	Superior glenoid labrum lesion
8408	Sprain of other specified sites of shoulder and upper arm
8409	Sprain of unspecified site of shoulder and upper arm
8410	Radial collateral ligament sprain
8411	Ulnar collateral ligament sprain
8412	Radiohumeral (joint) sprain
8413	Ulnohumeral (joint) sprain
8418	Sprain of other specified sites of elbow and forearm
8419	Sprain of unspecified site of elbow and forearm
84200	Sprain of unspecified site of wrist
84201	Sprain of carpal (joint) of wrist
84202	Sprain of radiocarpal (joint) (ligament) of wrist
84209	Other wrist sprain
84210	Sprain of unspecified site of hand
84211	Sprain of carpometacarpal (joint) of hand
84212	Sprain of metacarpophalangeal (joint) of hand
84213	Sprain of interphalangeal (joint) of hand
84219	Other hand sprain
8430	Iliofemoral (ligament) sprain
8431	Ischiocapsular (ligament) sprain
8438	Sprain of other specified sites of hip and thigh
8439	Sprain of unspecified site of hip and thigh
8440	Sprain of lateral collateral ligament of knee
8441	Sprain of medial collateral ligament of knee
8442	Sprain of cruciate ligament of knee
8443	Sprain of tibiofibular (joint) (ligament) superior, of knee
8448	Sprain of other specified sites of knee and leg
8449	Sprain of unspecified site of knee and leg
84500	Unspecified site of ankle sprain
84501	Deltoid (ligament), ankle sprain
84502	Calcaneofibular (ligament) ankle sprain
84503	Tibiofibular (ligament) sprain, distal
84509	Other ankle sprain
84510	Unspecified site of foot sprain
84511	Tarsometatarsal (joint) (ligament) sprain
84512	Metatarsaophalangeal (joint) sprain
84513	Interphalangeal (joint), toe sprain
84519	Other foot sprain

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Diagnosis Code	Description
8460	Lumbosacral (joint) (ligament) sprain
8461	Sacroiliac (ligament) sprain
8462	Sacrospinatus (ligament) sprain
8463	Sacrotuberous (ligament) sprain
8468	Other specified sites of sacroiliac region sprain
8469	Unspecified site of sacroiliac region sprain
8470	Neck sprain
8471	Thoracic sprain
8472	Lumbar sprain
8473	Sprain of sacrum
8474	Sprain of coccyx
8479	Sprain of unspecified site of back
8480	Sprain of septal cartilage of nose
8481	Jaw sprain
8482	Thyroid region sprain
8483	Sprain of ribs
84840	Sternum sprain, unspecified part
84841	Sternoclavicular (joint) (ligament) sprain
84842	Chondrosternal (joint) sprain
84849	Other sprain of sternum
8485	Pelvic sprain
8488	Other specified sites of sprains and strains
8489	Unspecified site of sprain and strain
8500	Concussion with no loss of consciousness
85011	Concussion, with loss of consciousness of 30 minutes or less
85012	Concussion with loss of consciousness from 31 minutes to 59 minutes
8502	Concussion with moderate loss of consciousness
8503	Concussion with prolonged loss of consciousness and return to pre-existing conscious level
8504	Concussion with prolonged loss of consciousness, without return to pre-existing conscious level
8505	Concussion with loss of consciousness of unspecified duration
8509	Concussion, unspecified
85100	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified
85101	Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness

Diagnosis Code	Description
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-exisiting conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified
85110	Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration
85119	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified
85120	Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified
85121	Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness

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Diagnosis Code	Description
85122	Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85123	Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85124	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85129	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified
85130	Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified
85131	Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified
85140	Cerebellar or brain stem contusion without mention of open intracranial wound, with state of consciousness unspecified
85141	Cerebellar or brain stem contusion without mention of open intracranial wound, with no loss of consciousness
85142	Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85149	Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified
85150	Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified
85151	Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness
85152	Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85153	Cerebellar or brain stem contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85155	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration
85159	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified

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Diagnosis Code	Description
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified
85170	Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified
85171	Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness
85172	Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness

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Diagnosis Code	Description
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of conscious-ness of unspecified duration
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified

Diagnosis Code	Description
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85230	Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85231	Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85232	Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85233	Subdural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85236	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85239	Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85250	Extradural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85251	Extradural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85252	Extradural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85253	Extradural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85255	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85256	Extradural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness

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Diagnosis Code	Description
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

Diagnosis Code	Description
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85400	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with state of consciousness unspecified
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with concussion, unspecified
85410	Intracranial injury of other and unspecified nature, with open intracranial wound, with state of consciousness unspecified
85411	Intracranial injury of other and unspecified nature, with open intracranial wound, with no loss of consciousness
85412	Intracranial injury of other and unspecified nature, with open intracranial wound, with brief (less than one hour) loss of consciousness
85413	Intracranial injury of other and unspecified nature, with open intracranial wound, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
85414	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85415	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85416	Intracranial injury of other and unspecified nature, with open intracranial wound, with loss of consciousness of unspecified duration
85419	Intracranial injury of other and unspecified nature, with open intracranial wound, with concussion, unspecified
8600	Traumatic pneumothorax without mention of open wound into thorax
8601	Traumatic pneumothorax with open wound into thorax
8602	Traumatic hemothorax without mention of open wound into thorax
8603	Traumatic hemothorax with open wound into thorax
8604	Traumatic pneumohemothorax without mention of open wound into thorax
8605	Traumatic pneumohemothorax with open wound into thorax
86100	Unspecified injury of heart without mention of open wound into thorax
86101	Contusion of heart without mention of open wound into thorax
86102	Laceration of heart without penetration of heart chambers or open wound into thorax
86103	Laceration of heart with penetration of heart chambers, without mention of open wound into thorax
86110	Unspecified injury of heart with open wound into thorax
86111	Contusion of heart with open wound into thorax
86112	Laceration of heart without penetration of heart chambers, with open wound into thorax
86113	Laceration of heart with penetration of heart chambers and open wound into thorax
86120	Unspecified injury of lung without open wound into thorax
86121	Contusion of lung without open wound into thorax

Diagnosis Code	Description
86122	Laceration of lung without open wound into thorax
86130	Unspecified injury of lung with open wound into thorax
86131	Contusion of lung with open wound into thorax
86132	Laceration of lung with open wound into thorax
8620	Injury to diaphragm without mention of open wound into cavity
8621	Injury to diaphragm with open wound into cavity
86221	Injury to bronchus without open wound into cavity
86222	Injury to esophagus without mention of open wound into cavity
86229	Injury to other specified intrathoracic organs without mention of open wound into cavity
86231	Injury to bronchus with open wound into cavity
86232	Injury to esophagus with open wound into cavity
86239	Injury to other specified intrathoracic organs with open wound into cavity
8628	Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity
8629	Injury to multiple and unspecified intrathoracic organs with open wound into cavity
8630	Injury to stomach without mention of open wound into cavity
8631	Injury to stomach with open wound into cavity
86320	Injury to small intestine, unspecified site, without open wound into cavity
86321	Injury to duodenum without open wound into cavity
86329	Other injury to small intestine without open wound into cavity
86330	Injury to small intestine, unspecified site, with open wound into cavity
86331	Injury to duodenum with open wound into cavity
86339	Other injury to small intestine with open wound into cavity
86340	Injury to colon, unspecified site, without mention of open wound into cavity
86341	Injury to ascending (right) colon without open wound into cavity

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Diagnosis Code	Description
86342	Injury to transverse colon without open wound into cavity
86343	Injury to descending (left) colon without open wound into cavity
86344	Injury to descending (left) colon without open wound into cavity
86345	Injury to rectum without open wound into cavity
86346	Injury to multiple sites in colon and rectum without open wound into cavity
86349	Other injury to colon and rectum, without open wound into cavity
86350	Injury to colon, unspecified site, with open wound into cavity
86351	Injury to ascending (right) colon with open wound into cavity
86352	Injury to transverse colon with open wound into cavity
86353	Injury to descending (left) colon with open wound into cavity
86354	Injury to sigmoid colon with open wound into cavity
86355	Injury to rectum with open wound into cavity
86356	Injury to multiple sites in colon and rectum with open wound into cavity
86359	Other injury to colon and rectum with open wound into cavity
86380	Injury to gastrointestinal tract, unspecified site, without open wound into cavity
86381	Injury to pancreas head without mention of open wound into cavity
86382	Injury to pancreas body without mention of open wound into cavity
86383	Injury to pancreas tail without mention of open wound into cavity
86384	Injury to pancreas, multiple and unspecified sites, without open wound into cavity
83685	Injury to appendix without open wound into cavity
86389	Injury to other and unspecified gastrointestinal sites without open wound into cavity
86390	Injury to gastrointestinal tract, unspecified site, with open wound into cavity
86391	Injury to pancreas head with open wound into cavity
86392	Injury to pancreas body with open wound into cavity
86393	Injury to pancreas tail with open wound into cavity
86394	Injury to pancreas, multiple and unspecified sites, with open wound into cavity
86395	Injury to appendix with open wound into cavity
86399	Injury to other and unspecified gastrointestinal sites with open wound into cavity
86400	Unspecified injury to liver without mention of open wound into cavity
86401	Hematoma and contusion of liver without mention of open wound into cavity
86402	Laceration of liver, minor, without mention of open wound into cavity
86403	Laceration of liver, moderate, without mention of open wound into cavity
86404	Laceration of liver, major, without mention of open wound into cavity
86405	Laceration of liver, unspecified, without mention of open wound into cavity
86409	Other injury to liver without mention of open wound into cavity
86410	Unspecified injury to liver with open wound into cavity
86411	Hematoma and contusion of liver with open wound into cavity
86412	Laceration of liver, minor, with open wound into cavity
86413	Laceration of liver, moderate, with open wound into cavity
86414	Laceration of liver, major, with open wound into cavity
86415	Laceration of liver, unspecified, with open wound into cavity
86419	Other injury to liver with open wound into cavity
86500	Unspecified injury to spleen without mention of open wound into cavity
86501	Hematoma of spleen, without rupture of capsule, without mention of open wound into cavity
86502	Capsular tears to spleen, without major disruption of parenchyma, without mention of open wound into cavity
86503	Laceration of spleen extending into parenchyma without mention of open wound into cavity
86504	Massive parenchymal disruption of spleen without mention of open wound into cavity
86509	Other injury into spleen without mention of open wound into cavity
86510	Unspecified injury to spleen with open wound into cavity

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Diagnosis Code	Description
86511	Hematoma of spleen, without rupture of capsule, with open wound into cavity
86512	Capsular tears to spleen, without major disruption of parenchyma, with open wound into cavity
86513	Laceration of spleen extending into parenchyma, with open wound into cavity
86514	Massive parenchyma disruption of spleen with open wound into cavity
86519	Other injury to spleen with open wound into cavity
86600	Unspecified injury to kidney without mention of open wound into cavity
86601	Hematoma of kidney, without rupture of capsule, without mention of open wound into cavity
86602	Laceration of kidney without mention of open wound into cavity
86603	Complete disruption of kidney parenchyma, without mention of open wound into cavity
86610	Unspecified injury to kidney with open wound into cavity
86611	Hematoma of kidney, without rupture of capsule, with open wound into cavity
86612	Laceration of kidney with open wound into cavity
86613	Complete disruption of kidney parenchyma, with open wound into cavity
8670	Injury to bladder and urethra without mention of open wound into cavity
8671	Injury to bladder and urethra with open wound into cavity
8672	Injury to ureter without mention of open wound into cavity
8673	Injury to ureter with open wound into cavity
8674	Injury to uterus without mention of open wound into cavity
8675	Injury to uterus with open wound into cavity
8676	Injury to other specified pelvic organs without mention of open wound into cavity
8677	Injury to other specified pelvic organs with open wound into cavity
8678	Injury to unspecified pelvic organ without mention of open wound into cavity
8679	Injury to unspecified pelvic organ with open wound into cavity
86800	Injury to unspecified intra-abdominal organ without mention of open wound into cavity
86801	Injury to adrenal gland without mention of open wound into cavity

Diagnosis Code	Description
86802	Injury to bile duct and gallbladder without mention of open wound into cavity
86803	Injury to peritoneum without mention of open wound into cavity
86804	Injury to retroperitoneum without mention of open wound into cavity
86809	Injury to other and multiple intra-abdominal organs without mention of open wound into cavity
86810	Injury to unspecified intra-abdominal organ, with open wound into cavity
86811	Injury to adrenal gland, with open wound into cavity
86812	Injury to bile duct and gallbladder, with open wound into cavity
86813	Injury to peritoneum with open wound into cavity
86814	Injury to retroperitoneum with open wound into cavity
86819	Injury to other and multiple intra-abdominal organs, with open wound into cavity
8690	Internal injury to unspecified or ill-defined organs without mention of open wound into cavity
8691	Internal injury to unspecified or ill-defined organs with open wound into cavity
8700	Laceration of skin of eyelid and periocular area
8701	Laceration of eyelid, full-thickness, not involving lacrimal passages
8702	Laceration of eyelid involving lacrimal passages
8703	Penetrating wound of orbit, without mention of foreign body
8704	Penetrating wound of orbit with foreign body
8708	Other specified open wounds of ocular adnexa
8709	Unspecified open wound of ocular adnexa
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
8712	Rupture of eye with partial loss of intraocular tissue
8713	Avulsion of eye
8714	Unspecified laceration of eye
8715	Penetration of eyeball with magnetic foreign body
8716	Penetration of eyeball with (nonmagnetic) foreign body

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Diagnosis Code	Description
8717	Unspecified ocular penetration
8719	Unspecified open wound of eyeball
87200	Open wound of external ear, unspecified site, uncomplicated
87201	Open wound of auricle, uncomplicated
87202	Open wound of auditory canal, uncomplicated
87210	Open wound of external ear, unspecified site, complicated
87211	Open wound of auricle, complicated
87212	Open wound of auditory canal, complicated
87261	Open wound of ear drum, uncomplicated
87262	Open wound of ossicles, uncomplicated
87263	Open wound of eustachian tube, uncomplicated
87264	Open wound of cochlea, uncomplicated
87269	Open wound of other and multiple sites, uncomplicated
87271	Open wound of ear drum, complicated
87272	Open wound of ossicles, complicated
87273	Open wound of eustachian tube, complicated
87274	Open wound of cochlea, complicated
87279	Open wound of other and multiple sites, complicated
8728	Open wound of ear, part unspecified, without mention of complication
8729	Open wound of ear, part unspecified, complicated
8730	Open wound of scalp, without mention of complication
8731	Open wound of scalp, complicated
87320	Open wound of nose, unspecified site, uncomplicated
87321	Open wound of nasal septum, uncomplicated
87322	Open wound of nasal cavity, uncomplicated
87323	Open wound of nasal sinus, uncomplicated
87329	Open wound of multiple sites, uncomplicated
87330	Open wound of nose, unspecified site, complicated
87331	Open wound of nasal septum, complicated
87332	Open wound of nasal cavity, complicated
87333	Open wound of nasal sinus, complicated
87339	Open wound of multiple sites, complicated

Diagnosis Code	Description
87340	Open wound of face, unspecified site, uncomplicated
87341	Open wound of cheek, uncomplicated
87342	Open wound of forehead, uncomplicated
87343	Open wound of lip, uncomplicated
87344	Open wound of jaw, uncomplicated
87349	Open wound of other and multiple sites, uncomplicated
87350	Open wound of face, unspecified site, complicated
87351	Open wound of cheek, complicated
87352	Open wound of forehead, complicated
87353	Open wound of lip, complicated
87354	Open wound of jaw, complicated
87359	Open wound of other and multiple sites, complicated
87360	Open wound of mouth, unspecified site, uncomplicated
87361	Open wound of buccal mucosa, uncomplicated
87362	Open wound of gum (alveolar process), uncomplicated
87363	Tooth (broken) (fractured) (due to trauma), without mention of complication
87364	Open wound of tongue and floor of mouth, uncomplicated
87365	Open wound of palate, uncomplicated
87369	Open wound of other and multiple sites, uncomplicated
87370	Open wound of mouth, unspecified site, complicated
87371	Open wound of buccal mucosa, complicated
87372	Open wound of gum (alveolar process), complicated
87373	Tooth (broken) (fractured) (due to trauma), complicated
87374	Open wound of tongue and floor of mouth, complicated
87375	Open wound of palate, complicated
87379	Open wound of other and multiple sites, complicated
8738	Other and unspecified open wound of head without mention of complication
8739	Other and unspecified open wound of head, complicated
87400	Open wound of larynx with trachea, uncomplicated
87401	Open wound of larynx, uncomplicated

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Diagnosis Code	Description
87402	Open wound of trachea, uncomplicated
87410	Open wound of larynx with trachea, complicated
87411	Open wound of larynx, complicated
87412	Open wound of trachea, complicated
8742	Open wound of thyroid gland, without mention of complication
8743	Open wound of thyroid gland, complicated
8744	Open wound of pharynx, without mention of complication
8745	Open wound of pharynx, complicated
8748	Open wound of other and unspecified parts of neck, without mention of complication
8749	Open wound of other and unspecified parts of neck, complicated
8750	Open wound of chest (wall), without mention of complication
8751	Open wound of chest (wall), complicated
8760	Open wound of back, without mention of complication
8761	Open wound of back, complicated
8770	Open wound of buttock, without mention of complication
8771	Open wound of buttock, complicated
8780	Open wound of penis, without mention of complication
8781	Open wound of penis, complicated
8782	Open wound of scrotum and testes, without mention of complication
8783	Open wound of scrotum and testes, complicated
8784	Open wound of vulva, without mention of complication
8785	Open wound of vulva, complicated
8786	Open wound of vagina, without mention of complication
8787	Open wound of vagina, complicated
8788	Open wound of other and unspecified parts of genital organs, without mention of complication
8789	Open wound of other and unspecified parts of genital organs, complicated
8790	Open wound of breast, without mention of complication
8791	Open wound of breast, complicated
8792	Open wound of abdominal wall, anterior, without mention of complication
8793	Open wound of abdominal wall, anterior, complicated

Diagnosis Code	Description
8794	Open wound of abdominal wall, lateral, without mention of complication
8795	Open wound of abdominal wall, lateral, complicated
8796	Open wound of other and unspecified parts of trunk, without mention of complication
8797	Open wound of other and unspecified parts of trunk, complicated
8798	Open wound(s) (multiple) of unspecified site(s), without mention of complication
8799	Open wound(s) (multiple) of unspecified site(s), complicated
88000	Open wound of shoulder region, without mention of complication
88001	Open wound of scapular region, without mention of complication
88002	Open wound of axillary region, without mention of complication
88003	Open wound of upper arm, without mention of complication
88009	Open wound of multiple sites of shoulder and upper arm, without mention of complication
88010	Open wound of shoulder region, complicated
88011	Open wound of scapular region, complicated
88012	Open wound of axillary region, complicated
88013	Open wound of upper arm, complicated
88019	Open wound of multiple sites of shoulder and upper arm, complicated
88020	Open wound of shoulder region, with tendon involvement
88021	Open wound of scapular region, with tendon involvement
88022	Open wound of axillary region, with tendon involvement
88023	Open wound of upper arm, with tendon involvement
88029	Open wound of multiple sites of shoulder and upper arm, with tendon involvement
88100	Open wound of multiple sites of shoulder and upper arm, with tendon involvement
88101	Open wound of elbow, without mention of complication
88102	Open wound of wrist, without mention of complication
88110	Open wound of forearm, complicated
88111	Open wound of elbow, complicated
88112	Open wound of wrist, complicated

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Diagnosis Code	Description
88120	Open wound of forearm, with tendon involvement
88121	Open wound of elbow, with tendon involvement
88122	Open wound of wrist, with tendon involvement
8820	Open wound of hand except fingers alone, without mention of complication
8821	Open wound of hand except fingers alone, complicated
8822	Open wound of hand except fingers alone, with tendon involvement
8830	Open wound of fingers, without mention of complication
8831	Open wound of fingers, complicated
8832	Open wound of fingers, with tendon involvement
8840	Multiple and unspecified open wound of upper limb, without mention of complication
8841	Multiple and unspecified open wound of upper limb, complicated
8842	Multiple and unspecified open wound of upper limb, with tendon involvement
8850	Traumatic amputation of thumb (complete) (partial), without mention of complication
8851	Traumatic amputation of thumb (complete) (partial), complicated
8860	Traumatic amputation of other finger(s) (complete) (partial), without mention of complication
8861	Traumatic amputation of other finger(s) (complete) (partial), complicated
8870	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, without mention of complication
8871	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated
8872	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication
8873	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated
8874	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, without mention of complication
8875	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated

Diagnosis Code	Description
8876	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), without mention of complication
8877	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated
8900	Open wound of hip and thigh, without mention of complication
8901	Open wound of hip and thigh, complicated
8902	Open wound of hip and thigh, with tendon involvement
8910	Open wound of knee, leg (except thigh), and ankle, without mention of complication
8911	Open wound of knee, leg (except thigh), and ankle, complicated
8912	Open wound of knee, leg (except thigh), and ankle, with tendon involvement
8920	Open wound of foot except toe(s) alone, without mention of complication
8921	Open wound of foot except toe(s) alone, complicated
8922	Open wound of foot except toe(s) alone, with tendon involvement
8930	Open wound of toe(s), without mention of complication
8931	Open wound of toe(s), complicated
8932	Open wound of toe(s), with tendon involvement
8940	Multiple and unspecified open wound of lower limb, without mention of complication
8941	Multiple and unspecified open wound of lower limb, complicated
8942	Multiple and unspecified open wound of lower limb, with tendon involvement
8950	Traumatic amputation of toe(s) (complete) (partial), without mention of complication
8951	Traumatic amputation of toe(s) (complete) (partial), complicated
8960	Traumatic amputation of foot (complete) (partial), unilateral, without mention of complication
8961	Traumatic amputation of foot (complete) (partial), unilateral, complicated
8962	Traumatic amputation of foot (complete) (partial), bilateral, without mention of complication
8963	Traumatic amputation of foot (complete) (partial), bilateral, complicated
8970	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, without mention of complication

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Diagnosis Code	Description
8971	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, complicated
8972	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, without mention of complication
8973	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, complicated
8974	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, without mention of complication
8975	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, complicated
8976	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), without mention of complication
8977	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), complicated
90000	Injury to carotid artery, unspecified
90001	Injury to common carotid artery
90002	Injury to external carotid artery
90003	Injury to internal carotid artery
9001	Injury to internal jugular vein
90081	Injury to external jugular vein
90082	Injury to multiple blood vessels of head and neck
90089	Injury to other specified blood vessels of head and neck
9009	Injury to unspecified blood vessel of head and neck
9010	Injury to thoracic aorta
9011	Injury to innominate and subclavian arteries
9012	Injury to superior vena cava
9013	Injury to innominate and subclavian veins
90140	Injury to pulmonary vessel(s), unspecified
90141	Injury to pulmonary artery
90142	Injury to pulmonary vein
90181	Injury to intercostal artery or vein
90182	Injury to internal mammary artery or vein
90183	Injury to multiple blood vessels of thorax
90189	Injury to other specified blood vessels of thorax
9019	Injury to unspecified blood vessel of thorax
9020	Injury to abdominal aorta
90210	Injury to inferior vena cava, unspecified
90211	Injury to hepatic veins
90219	Injury to other specified branches of inferior vena cava
90220	Injury to celiac and mesenteric arteries, unspecified
90221	Injury to gastric artery
90222	Injury to hepatic artery
90223	Injury to splenic artery
90224	Injury to other specified branches of celiac axis
90225	Injury to superior mesenteric artery (trunk)
90226	Injury to primary branches of superior mesenteric artery
90227	Injury to inferior mesenteric artery
90229	Injury to other celiac and mesenteric arteries
90231	Injury to superior mesenteric vein and primary subdivisions
90232	Injury to inferior mesenteric vein
90233	Injury to portal vein
90234	Injury to splenic vein
90239	Injury to other portal and splenic veins
90240	Injury to renal vessel(s), unspecified
90241	Injury to renal artery
90242	Injury to renal vein
90249	Injury to other renal blood vessels
90250	Injury to iliac vessel(s), unspecified
90251	Injury to hypogastric artery
90252	Injury hypogastric vein
90253	Injury to iliac artery
90254	Injury to iliac vein
90255	Injury to uterine artery
90256	Injury to uterine vein
90259	Injury to other iliac blood vessels
90281	Injury to ovarian artery
90282	Injury to ovarian vein
90287	Injury to multiple blood vessels of abdomen and pelvis
90289	Injury to other specified blood vessels of abdomen and pelvis
9029	Injury to unspecified blood vessel of abdomen and pelvis
90300	Injury to axillary vessel(s), unspecified
90301	Injury to axillary artery
90302	Injury to axillary vein
9031	Injury to brachial blood vessels
9032	Injury to radial blood vessels

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Diagnosis Code	Description
9033	Injury to ulnar blood vessels
9034	Injury to palmar artery
9035	Injury to digital blood vessels
9038	Injury to other specified blood vessels of upper extremity
9039	Injury to unspecified blood vessel of upper extremity
9040	Injury to common femoral artery
9041	Injury to superficial femoral artery
9042	Injury to femoral veins
9043	Injury to saphenous veins
90440	Injury to popliteal vessel(s), unspecified
90441	Injury to popliteal vessel(s), unspecified
90442	Injury to popliteal vein
90450	Injury to tibial vessel(s), unspecified
90451	Injury to anterior tibial artery
90452	Injury to anterior tibial vein
90453	Injury to posterior tibial artery
90454	Injury to posterior tibial vein
9046	Injury to deep plantar blood vessels
9047	Injury to other specified blood vessels of lower extremity
9048	Injury to unspecified blood vessel of lower extremity
9049	Injury to blood vessels of unspecified site
9050	Late effect of fracture of skull and face bones
9051	Late effect of fracture of spine and trunk without mention of spinal cord lesion
9052	Late effect of fracture of upper extremities
9053	Late effect of fracture of neck of femur
9054	Late effect of fracture of lower extremities
9055	Late effect of fracture of multiple and unspecified bones
9056	Late effect of dislocation
9057	Late effect of sprain and strain without mention of tendon injury
9058	Late effect of tendon injury
9059	Late effect of traumatic amputation
9060	Late effect of open wound of head, neck, and trunk
9061	Late effect of open wound of extremities without mention of tendon injury
9062	Late effect of superficial injury
9063	Late effect of contusion
9064	Late effect of crushing

Diagnosis Code	Description
9065	Late effect of burn of eye, face, head, and neck
9066	Late effect of burn of wrist and hand
9067	Late effect of burn of other extremities
9068	Late effect of burns of other specified sites
9069	Late effect of burn of unspecified site
9070	Late effect of intracranial injury without mention of skull fracture
9071	Late effect of injury to cranial nerve
9072	Late effect of spinal cord injury
9073	Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk
9074	Late effect of injury to peripheral nerve of shoulder girdle and upper limb
9075	Late effect of injury to peripheral nerve of pelvic girdle and lower limb
9079	Late effect of injury to other and unspecified nerve
9080	Late effect of internal injury to chest
9081	Late effect of internal injury to intra-abdominal organs
9082	Late effect of internal injury to other internal organs
9083	Late effect of injury to blood vessel of head, neck, and extremities
9084	Late effect of injury to blood vessel of thorax, abdomen, and pelvis
9085	Late effect of foreign body in orifice
9086	Late effect of certain complications of trauma
9089	Late effect of unspecified injury
9090	Late effect of poisoning due to drug, medicinal or biological substance
9091	Late effect of toxic effects of nonmedical substances
9092	Late effect of radiation
9093	Late effect of complications of surgical and medical care
9094	Late effect of certain other external causes
9095	Late effect of adverse effect of drug, medicinal or biological substance
9099	Late effect of other and unspecified external causes
9100	Abrasion or friction burn of face, neck, and scalp except eye, without mention of infection
9101	Abrasion or friction burn of face, neck, and scalp except eye, infected

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Diagnosis Code	Description
9102	Blister of face, neck, and scalp except eye, without mention of infection
9103	Blister of face, neck, and scalp except eye, infected
9104	Insect bite, nonvenomous of face, neck, and scalp except eye, without mention of infection
9105	Insect bite, nonvenomous of face, neck, and scalp except eye, infected
9106	Superficial foreign body (splinter) of face, neck, and scalp except eye, without major open wound and without mention of infection
9107	Superficial foreign body (splinter) of face, neck, and scalp except eye, without major open wound, infected
9108	Other and unspecified superficial injury of face, neck, and scalp, without mention of infection
9109	Other and unspecified superficial injury of face, neck, and scalp, infected
9110	Abrasion or friction burn of trunk, without mention of infection
9111	Abrasion or friction burn of trunk, infected
9112	Blister of trunk, without mention of infection
9113	Blister of trunk, infected
9114	Insect bite, nonvenomous of trunk, without mention of infection
9115	Insect bite, nonvenomous of trunk, infected
9116	Superficial foreign body (splinter) of trunk, without major open wound and without mention of infection
9117	Superficial foreign body (splinter) of trunk, without major open wound, infected
9118	Other and unspecified superficial injury of trunk, without mention of infection
9119	Other and unspecified superficial injury of trunk, infected
9120	Abrasion or friction burn of shoulder and upper arm, without mention of infection
9121	Abrasion or friction burn of shoulder and upper arm, infected
9122	Blister of shoulder and upper arm, without mention of infection
9123	Blister of shoulder and upper arm, infected
9124	Insect bite, nonvenomous of shoulder and upper arm, without mention of infection
9125	Insect bite, nonvenomous of shoulder and upper arm, infected

Diagnosis Code	Description
9126	Superficial foreign body (splinter) of shoulder and upper arm, without major open wound and without mention of infection
9127	Superficial foreign body (splinter) of shoulder and upper arm, without major open wound, infected
9128	Other and unspecified superficial injury of shoulder and upper arm, without mention of infection
9129	Other and unspecified superficial injury of shoulder and upper arm, infected
9130	Abrasion or friction burn of elbow, forearm, and wrist, without mention of infection
9131	Abrasion or friction burn of elbow, forearm, and wrist, infected
9132	Blister of elbow, forearm, and wrist, without mention of infection
9133	Blister of elbow, forearm, and wrist, infected
9134	Insect bite, nonvenomous of elbow, forearm, and wrist, without mention of infection
9135	Insect bite, nonvenomous, of elbow, forearm, and wrist, infected
9136	Superficial foreign body (splinter) of elbow, forearm, and wrist, without major open wound and without mention of infection
9137	Superficial foreign body (splinter) of elbow, forearm, and wrist, without major open wound, infected
9138	Other and unspecified superficial injury of elbow, forearm, and wrist, without mention of infection
9139	Other and unspecified superficial injury of elbow, forearm, and wrist, infected
9140	Abrasion or friction burn of hand(s) except finger(s) alone, without mention of infection
9141	Abrasion or friction burn of hand(s) except finger(s) alone, infected
9142	Blister of hand(s) except finger(s) alone, without mention of infection
9143	Blister of hand(s) except finger(s) alone, infected
9144	Insect bite, nonvenomous, of hand(s) except finger(s) alone, without mention of infection
9145	Insect bite, nonvenomous, of hand(s) except finger(s) alone, infected
9146	Superficial foreign body (splinter) of hand(s) except finger(s) alone, without major open wound and without mention of infection

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Diagnosis Code	Description
9147	Superficial foreign body (splinter) of hand(s) except finger(s) alone, without major open wound, infected
9148	Other and unspecified superficial injury of hand(s) except finger(s) alone, without mention of infection
9149	Other and unspecified superficial injury of hand(s) except finger(s) alone, infected
9150	Abrasion or friction burn of fingers, without mention of infection
9151	Abrasion or friction burn of fingers, infected
9152	Blister of fingers, without mention of infection
9153	Blister of fingers, infected
9154	Insect bite, nonvenomous, of fingers, without mention of infection
9155	Insect bite, nonvenomous of fingers, infected
9156	Superficial foreign body (splinter) of fingers, without major open wound and without mention of infection
9157	Superficial foreign body (splinter) of fingers, without major open wound, infected
9158	Other and unspecified superficial injury of fingers without mention of infection
9159	Other and unspecified superficial injury of fingers, infected
9160	Abrasion or friction burn of hip, thigh, leg, and ankle, without mention of infection
9161	Abrasion or friction burn of hip, thigh, leg, and ankle, infected
9162	Blister of hip, thigh, leg, and ankle, without mention of infection
9163	Blister of hip, thigh, leg, and ankle, infected
9164	Insect bite, nonvenomous, of hip, thigh, leg, and ankle, without mention of infection
9165	Insect bite, nonvenomous of hip, thigh, leg, and ankle, infected
9166	Superficial foreign body (splinter) of hip, thigh, leg, and ankle, without major open wound and without mention of infection
9167	Superficial foreign body (splinter) of hip, thigh, leg, and ankle, without major open wound, infected
9168	Other and unspecified superficial injury of hip, thigh, leg, and ankle, without mention of infection
9169	Other and unspecified superficial injury of hip, thigh, leg, and ankle, infected
9170	Abrasion or friction burn of foot and toe(s), without mention of infection

Diagnosis Code	Description
9172	Blister of foot and toe(s), without mention of infection
9173	Blister of foot and toe(s), infected
9174	Insect bite, nonvenomous, of foot and toe(s), without mention of infection
9175	Insect bite, nonvenomous, of foot and toe(s), infected
9176	Superficial foreign body (splinter) of foot and toe(s), without major open wound and without mention of infection
9177	Superficial foreign body (splinter) of foot and toe(s), without major open wound, infected
9178	Other and unspecified superficial injury of foot and toes, without mention of infection
9179	Other and unspecified superficial injury of foot and toes, infected
9180	Superficial injury of eyelids and periocular area
9181	Superficial injury of cornea
9182	Superficial injury of conjunctiva
9189	Other and unspecified superficial injuries of eye
9190	Abrasion or friction burn of other, multiple, and unspecified sites, without mention of infection
9191	Abrasion or friction burn of other, multiple, and unspecified sites, infected
9192	Blister of other, multiple, and unspecified sites, without mention of infection
9193	Blister of other, multiple, and unspecified sites, infected
9194	Insect bite, nonvenomous, of other, multiple, and unspecified sites, without mention of infection
9195	Insect bite, nonvenomous, of other, multiple, and unspecified sites, infected
9196	Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound and without mention of infection
9197	Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound, infected
9198	Other and unspecified superficial injury of other, multiple, and unspecified sites, without mention of infection
9199	Other and unspecified superficial injury of other, multiple, and unspecified sites, infected

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Diagnosis Code	Description
920	Contusion of face, scalp, and neck except eye(s)
9210	Black eye, not otherwise specified
9211	Contusion of eyelids and periocular area
9212	Contusion of orbital tissues
9213	Contusion of eyeball
9219	Unspecified contusion of eye
9220	Contusion of breast
9221	Contusion of chest wall
9222	Contusion of abdominal wall
92231	Contusion of back
92232	Contusion of buttock
92233	Contusion of interscapular region
9224	Contusion of genital organs
9228	Contusion of multiple sites of trunk
9229	Contusion of unspecified part of trunk
92300	Contusion of shoulder region
92301	Contusion of scapular region
92302	Contusion of axillary region
92303	Contusion of upper arm
92309	Contusion of multiple sites of shoulder and upper arm
92310	Contusion of forearm
92311	Contusion of elbow
92320	Contusion of hand(s)
92321	Contusion of wrist
9233	Contusion of finger
9238	Contusion of multiple sites of upper limb
9239	Contusion of unspecified part of upper limb
92400	Contusion of thigh
92401	Contusion of hip
92410	Contusion of lower leg
92411	Contusion of knee
92420	Contusion of foot
92421	Contusion of ankle
9243	Contusion of toe
9244	Contusion of multiple sites of lower limb
9245	Contusion of unspecified part of lower limb
9248	Contusion of multiple sites, not elsewhere classified
9249	Contusion of unspecified site
9251	Crushing injury of face and scalp
9252	Crushing injury of neck
9260	Crushing injury of external genitalia

Diagnosis Code	Description
92611	Crushing injury of back
92612	Crushing injury of buttock
92619	Crushing injury of other specified sites of trunk
9268	Crushing injury of multiple sites of trunk
9269	Crushing injury of unspecified site of trunk
92700	Crushing injury of shoulder region
92701	Crushing injury of scapular region
92702	Crushing injury of axillary region
92703	Crushing injury of upper arm
92709	Crushing injury of multiple sites of upper arm
92710	Crushing injury of forearm
92711	Crushing injury of elbow
92720	Crushing injury of hand(s)
92721	Crushing injury of wrist
9273	Crushing injury of finger(s)
9278	Crushing injury of multiple sites of upper limb
9279	Crushing injury of unspecified site of upper limb
92800	Crushing injury of thigh
92801	Crushing injury of hip
92810	Crushing injury of lower leg
92811	Crushing injury of knee
92820	Crushing injury of foot
92821	Crushing injury of ankle
9283	Crushing injury of toe(s)
9288	Crushing injury of multiple sites of lower limb
9289	Crushing injury of unspecified site of lower limb
9290	Crushing injury of multiple sites, not elsewhere classified
9299	Crushing injury of unspecified site
9300	Corneal foreign body
9301	Foreign body in conjunctival sac
9302	Foreign body in lacrimal punctum
9308	Foreign body in other and combined sites on external eye
9309	Foreign body in unspecified site on external eye
931	Foreign body in ear
932	Foreign body in nose
9330	Foreign body in pharynx
9331	Foreign body in larynx

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Diagnosis Code	Description
9340	Foreign body in trachea
9341	Foreign body in main bronchus
9348	Foreign body in other specified parts bronchus and lung
9349	Foreign body in respiratory tree, unspecified
9350	Foreign body in mouth
9351	Foreign body in esophagus
9352	Foreign body in stomach
936	Foreign body in intestine and colon
937	Foreign body in anus and rectum
938	Foreign body in digestive system, unspecified
9390	Foreign body in bladder and urethra
9391	Foreign body in uterus, any part
9392	Foreign body in vulva and vagina
9393	Foreign body in penis
9399	Foreign body in unspecified site in genitourinary tract
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa
94100	Burn of unspecified degree of unspecified site of face and head
94101	Burn of unspecified degree of ear (any part)
94102	Burn of unspecified degree of eye (with other parts of face, head, and neck)
94103	Burn of unspecified degree of lip(s)
94104	Burn of unspecified degree of chin
94105	Burn of unspecified degree of nose (septum)
94106	Burn of unspecified degree of scalp (any part)
94107	Burn of unspecified degree of forehead and cheek
94108	Burn of unspecified degree of neck
94109	Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck
94110	Erythema due to burn (first degree) of unspecified site of face and head
94111	Erythema due to burn (first degree) of ear (any part)
94112	Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
94113	Erythema due to burn (first degree) of lip(s)
94114	Erythema due to burn (first degree) of chin
94115	Erythema due to burn (first degree) of nose (septum)
94116	Erythema due to burn (first degree) of scalp (any part)
94117	Erythema due to burn (first degree) of forehead and cheek
94118	Erythema due to burn (first degree) of neck
94119	Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck
94120	Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site
94121	Blisters, with epidermal loss due to burn (second degree) of ear (any part)
94122	Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)
94123	Blisters, with epidermal loss due to burn (second degree) of lip(s)
94124	Blisters, with epidermal loss due to burn (second degree) of chin
94125	Blisters, with epidermal loss due to burn (second degree) of nose (septum)
94126	Blisters, with epidermal loss due to burn (second degree) of scalp (any part)
94127	Blisters, with epidermal loss due to burn (second degree) of forehead and cheek
94128	Blisters, with epidermal loss due to burn (second degree) of neck
94129	Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck
94130	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
94131	Full-thickness skin loss due to burn (third degree NOS) of ear (any part)
94132	Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
94133	Full-thickness skin loss due to burn (third degree NOS) of lip(s)
94134	Full-thickness skin loss due to burn (third degree NOS) of chin

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Diagnosis Code	Description
94135	Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
94136	Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
94137	Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
94138	Full-thickness skin loss due to burn (third degree NOS) of neck
94139	Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear

Diagnosis Code	Description
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part
94200	Burn of unspecified degree of unspecified site of trunk
94201	Burn of unspecified degree of breast
94202	Burn of unspecified degree of chest wall, excluding breast and nipple
94203	Burn of unspecified degree of abdominal wall
94204	Burn of unspecified degree of back (any part)
94205	Burn of unspecified degree of genitalia
94209	Burn of unspecified degree of other and multiple sites of trunk
94210	Erythema due to burn (first degree) of unspecified site of trunk
94211	Erythema due to burn (first degree) of breast
94212	Erythema due to burn (first degree) of chest wall, excluding breast and nipple
94213	Erythema due to burn (first degree) of abdominal wall
94214	Erythema due to burn (first degree) of back (any part)
94215	Erythema due to burn (first degree) of genitalia
94219	Erythema due to burn (first degree) of other and multiple sites of trunk

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Diagnosis Code	Description
94220	Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk
94221	Blisters with epidermal loss due to burn (second degree) of breast
94222	Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
94223	Blisters with epidermal loss due to burn (second degree) of abdominal wall
94224	Blisters with epidermal loss due to burn (second degree) of back (any part)
94225	Blisters with epidermal loss due to burn (second degree) of genitalia
94229	Blisters with epidermal loss due to burn (second degree) of other and multiple sites of trunk
94230	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk
94231	Full-thickness skin loss due to burn (third degree NOS) of breast
94232	Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple
94233	Full-thickness skin loss due to burn (third degree NOS) of abdominal wall
94234	Full-thickness skin loss due to burn (third degree NOS) of back (any part)
94235	Full-thickness skin loss due to burn (third degree NOS) of genitalia
94239	Full-thickness skin loss due to burn (third degree NOS) of other and multiple sites of trunk
94240	Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part
94241	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast
94242	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall
94243	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall
94244	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back
94245	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia

Diagnosis Code	Description
94249	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part
94250	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part
94251	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast
94252	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall
94253	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall
94254	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back
94255	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia
94259	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part
94300	Burn of unspecified degree of unspecified site of upper limb
94301	Burn of unspecified degree of forearm
94302	Burn of unspecified degree of elbow
94303	Burn of unspecified degree of upper arm
94304	Burn of unspecified degree of axilla
94305	Burn of unspecified degree of shoulder
94306	Burn of unspecified degree of scapular region
94309	Burn of unspecified degree multiple sites of upper limb, except wrist and hand
94310	Erythema due to burn (first degree) of unspecified site of upper limb
94311	Erythema due to burn (first degree) of forearm
94312	Erythema due to burn (first degree) of elbow
94313	Erythema due to burn (first degree) of upper arm
94314	Erythema due to burn (first degree) of axilla
94315	Erythema due to burn (first degree) of shoulder
94316	Erythema due to burn (first degree) of scapular region

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Diagnosis Code	Description
94319	Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand
94320	Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb
94321	Blisters with epidermal loss due to burn (second degree) of forearm
94322	Blisters with epidermal loss due to burn (second degree) of elbow
94323	Blisters with epidermal loss due to burn (second degree) of upper arm
94324	Blisters with epidermal loss due to burn (second degree) of axilla
94325	Blisters with epidermal loss due to burn (second degree) of shoulder
94326	Blisters with epidermal loss due to burn (second degree) of scapular region
94329	Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand
94330	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb
94331	Full-thickness skin loss due to burn (third degree NOS) of forearm
94332	Full-thickness skin loss due to burn (third degree NOS) of elbow
94333	Full-thickness skin loss due to burn (third degree NOS) of upper arm
94334	Full-thickness skin loss due to burn (third degree NOS) of axilla
94335	Full-thickness skin loss due to burn (third degree NOS) of shoulder
94336	Full-thickness skin loss due to burn (third degree NOS) of scapular region
94339	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand
94340	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part
94341	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm
94342	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow
94343	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm
94344	Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla
94345	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder
94346	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula
94349	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb
94350	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part
94351	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm
94352	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow
94353	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm
94354	Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla
94355	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder
94356	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula
94359	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb
94400	Burn of unspecified degree of unspecified site of hand
94401	Burn of unspecified degree of single digit (finger (nail) other than thumb
94402	Burn of unspecified degree of thumb (nail)
94403	Burn of unspecified degree of two or more digits of hand, not including thumb
94404	Burn of unspecified degree of two or more digits of hand, including thumb
94405	Burn of unspecified degree of palm of hand
94406	Burn of unspecified degree of back of hand
94407	Burn of unspecified degree of wrist
94408	Burn of unspecified degree of multiple sites of wrist(s) and hand(s)

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Diagnosis Code	Description
94410	Erythema due to burn (first degree) of unspecified site of hand
94411	Erythema due to burn (first degree) of single digit (finger [nail]) other than thumb
94412	Erythema due to burn (first degree) of thumb (nail)
94413	Erythema due to burn (first degree) of two or more digits of hand, not including thumb
94414	Erythema due to burn (first degree) of two or more digits of hand including thumb
94415	Erythema due to burn (first degree) of palm of hand
94416	Erythema due to burn (first degree) of back of hand
94417	Erythema due to burn (first degree) of wrist
94418	Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)
94420	Blisters with epidermal loss due to burn (second degree) of unspecified site of hand
94421	Blisters with epidermal loss due to burn (second degree) of single digit (finger [nail]) other than thumb
94422	Blisters with epidermal loss due to burn of (second degree) of thumb (nail)
94423	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb
94424	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand including thumb
94425	Blisters with epidermal loss due to burn (second degree) of palm of hand
94426	Blisters with epidermal loss due to burn (second degree) of back of hand
94427	Blisters with epidermal loss due to burn (second degree) of wrist
94428	Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)
94430	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand
94431	Full-thickness skin loss due to burn (third degree NOS) of single digit (finger [nail]) other than thumb
94432	Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)
94433	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb
94434	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb
94435	Full-thickness skin loss due to burn (third degree NOS) of palm of hand
94436	Full-thickness skin loss due to burn (third degree NOS) of back of hand
94437	Full-thickness skin loss due to burn (third degree NOS) of wrist
94438	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)
94440	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand
94441	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, without mention of loss of finger
94442	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb
94443	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers
94444	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers
94445	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm
94446	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand
94447	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist
94448	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), without mention of loss of a body part
94450	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand
94451	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, with loss of finger
94452	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb

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Diagnosis Code	Description
94453	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers
94454	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers
94455	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand
94456	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand
94457	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist
94458	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part
94500	Burn of unspecified degree of unspecified site of lower limb (leg)
94501	Burn of unspecified degree of toe(s) (nail)
94502	Burn of unspecified degree of foot
94503	Burn of unspecified degree of ankle
94504	Burn of unspecified degree of lower leg
94505	Burn of unspecified degree of knee
94506	Burn of unspecified degree of thigh (any part)
94509	Burn of unspecified degree of multiple sites of lower limb(s)
94510	Erythema due to burn (first degree) of unspecified site of lower limb (leg)
94511	Erythema due to burn (first degree) of toe(s) (nail)
94512	Erythema due to burn (first degree) of foot
94513	Erythema due to burn (first degree) of ankle
94514	Erythema due to burn (first degree) of lower leg
94515	Erythema due to burn (first degree) of knee
94516	Erythema due to burn (first degree) of thigh (any part)
94519	Erythema due to burn (first degree) of multiple sites of lower limb(s)
94520	Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)
94521	Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)
94522	Blisters with epidermal loss due to burn (second degree) of foot

Diagnosis Code	Description
94523	Blisters with epidermal loss due to burn (second degree) of ankle
94524	Blisters with epidermal loss due to burn (second degree) of lower leg
94525	Blisters with epidermal loss due to burn (second degree) of knee
94526	Blisters with epidermal loss due to burn (second degree) of thigh (any part)
94529	Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)
94530	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb
94531	Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)
94532	Full-thickness skin loss due to burn (third degree NOS) of foot
94533	Full-thickness skin loss due to burn (third degree NOS) of ankle
94534	Full-thickness skin loss due to burn (third degree NOS) of lower leg
94535	Full-thickness skin loss due to burn (third degree NOS) of knee
94536	Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)
94539	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)
94540	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part
94541	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)
94542	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot
94543	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle
94544	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg
94545	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee
94546	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh

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Diagnosis Code	Description
94549	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part
94550	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part
94551	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)
94552	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot
94553	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle
94554	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg
94555	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee
94556	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh
94559	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part
9460	Burns of multiple specified sites, unspecified degree
9461	Erythema due to burn (first degree) of multiple specified sites
9462	Blisters with epidermal loss due to burn (second degree) of multiple specified sites
9463	Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites
9464	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part
9465	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part
9470	Burn of mouth and pharynx
9471	Burn of larynx, trachea, and lung
9472	Burn of esophagus
9473	Burn of gastrointestinal tract
9474	Burn of vagina and uterus
9478	Burn of other specified sites of internal organs
9479	Burn of internal organs, unspecified site

Diagnosis Code	Description
94800	Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94810	Burn (any degree) involving 10-19 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94811	Burn (any degree) involving 10-19 percent of body surface with third degree burn of 10-19 percent
94820	Burn (any degree) involving 20-29 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94821	Burn (any degree) involving 20-29 percent of body surface with third degree burn of 10-19 percent
94822	Burn (any degree) involving 20-29 percent of body surface with third degree burn of 20-29 percent
94830	Burn (any degree) involving 30-39 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94831	Burn (any degree) involving 30-39 percent of body surface with third degree burn of 10-19 percent
94832	Burn (any degree) involving 30-39 percent of body surface with third degree burn of 20-29 percent
94833	Burn (any degree) involving 30-39 percent of body surface with third degree burn of 30-39 percent
94840	Burn (any degree) involving 40-49 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94841	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 10-19 percent
94842	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 20-29 percent
94843	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 30-39 percent
94844	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 40-49 percent
94850	Burn (any degree) involving 50-59 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94851	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 10-19 percent

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Diagnosis Code	Description
94852	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 20-29 percent
94853	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 30-39 percent
94854	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 40-49 percent
94855	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 50-59 percent
94860	Burn (any degree) involving 60-69 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94861	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 10-19 percent
94862	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 20-29 percent
94863	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 30-39 percent
94864	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 40-49 percent
94865	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 50-59 percent
94866	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 60-69 percent
94870	Burn (any degree) involving 70-79 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94871	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 10-19 percent
94872	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 20-29 percent
94873	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 30-39 percent
94874	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 40-49 percent
94875	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 50-59 percent

Diagnosis Code	Description
94876	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 60-69 percent
94877	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 70-79 percent
94880	Burn (any degree) involving 80-89 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94881	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 10-19 percent
94882	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 20-29 percent
94883	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 30-39 percent
94884	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 40-49 percent
94885	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 50-59 percent
94886	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 60-69 percent
94887	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 70-79 percent
94888	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 80-89 percent
94890	Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount
94891	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10-19 percent
94892	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20-29 percent
94893	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30-39 percent
94894	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40-49 percent
94895	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50-59 percent

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Diagnosis Code	Description
94896	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60-69 percent
94897	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70-79 percent
94898	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80-89 percent
94899	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface
9490	Burn of unspecified site, unspecified degree
9491	Erythema due to burn (first degree), unspecified site
9492	Blisters with epidermal loss due to burn (second degree), unspecified site
9493	Full-thickness skin loss due to burn (third degree NOS), unspecified site
9494	Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part
9495	Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part
9500	Optic nerve injury
9501	Injury to optic chiasm
9502	Injury to optic pathways
9503	Injury to visual cortex
9509	Injury to unspecified optic nerve and pathways
9510	Injury to oculomotor nerve
9511	Injury to trochlear nerve
9512	Injury to trigeminal nerve
9513	Injury to abducens nerve
9514	Injury to facial nerve
9515	Injury to acoustic nerve
9516	Injury to accessory nerve
9517	Injury to hypoglossal nerve
9518	Injury to other specified cranial nerves
9519	Injury to unspecified cranial nerve
95200	C1-C4 level spinal cord injury, unspecified
95201	C1-C4 level with complete lesion of spinal cord
95202	C1-C4 level with anterior cord syndrome
95203	C1-C4 level with central cord syndrome
95204	C1-C4 level with other specified spinal cord injury
95205	C5-C7 level spinal cord injury, unspecified
95206	C5-C7 level with complete lesion of spinal cord
95207	C5-C7 level with anterior cord syndrome
95208	C5-C7 level with central cord syndrome
95209	C5-C7 level with other specified spinal cord injury
95210	T1-T6 level spinal cord injury, unspecified
95211	T1-T6 level with complete lesion of spinal cord
95212	T1-T6 level with anterior cord syndrome
95213	T1-T6 level with central cord syndrome
95214	T1-T6 level with other specified spinal cord injury
95215	T7-T12 level spinal cord injury, unspecified
95216	T7-T12 level with complete lesion of spinal cord
95217	T7-T12 level with anterior cord syndrome
95218	T7-T12 level with central cord syndrome
95219	T7-T12 level with other specified spinal cord injury
9522	Lumbar spinal cord injury without spinal bone injury
9523	Sacral spinal cord injury without spinal bone injury
9524	Cauda equina spinal cord injury without spinal bone injury
9528	Multiple sites of spinal cord injury without spinal bone injury
9529	Unspecified site of spinal cord injury without spinal bone injury
9530	Injury to cervical nerve root
9531	Injury to dorsal nerve root
9532	Injury to lumbar nerve root
9533	Injury to sacral nerve root
9534	Injury to brachial plexus
9535	Injury to lumbosacral plexus
9538	Injury to multiple sites of nerve roots and spinal plexus
9539	Injury to unspecified site of nerve roots and spinal plexus
9540	Injury to cervical sympathetic nerve, excluding shoulder and pelvic girdles
9541	Injury to other sympathetic nerve, excluding shoulder and pelvic girdles
9548	Injury to other specified nerve(s) of trunk, excluding shoulder and pelvic girdles

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Diagnosis Code	Description
9549	Injury to unspecified nerve of trunk, excluding shoulder and pelvic girdles
9550	Injury to axillary nerve
9551	Injury to median nerve
9552	Injury to ulnar nerve
9553	Injury to radial nerve
9554	Injury to musculocutaneous nerve
9555	Injury to cutaneous sensory nerve, upper limb
9556	Injury to digital nerve, upper limb
9557	Injury to other specified nerve(s) of shoulder girdle and upper limb
9558	Injury to multiple nerves of shoulder girdle and upper limb
9559	Injury to unspecified nerve of shoulder girdle and upper limb
9560	Injury to sciatic nerve
9561	Injury to femoral nerve
9562	Injury to posterior tibial nerve
9563	Injury to peroneal nerve
9564	Injury to cutaneous sensory nerve, lower limb
9565	Injury to other specified nerve(s) of pelvic girdle and lower limb
9568	Injury to multiple nerves of pelvic girdle and lower limb
9569	Injury to unspecified nerve of pelvic girdle and lower limb
9570	Injury to superficial nerves of head and neck
9571	Injury to other specified nerve(s)
9578	Injury to multiple nerves in several parts
9579	Injury to nerves, unspecified site
9580	Air embolism as an early complication of trauma
9581	Fat embolism as an early complication of trauma
9582	Secondary and recurrent hemorrhage as an early complication of trauma
9583	Posttraumatic wound infection not elsewhere classified
9584	Traumatic shock
9585	Traumatic anuria
9586	Volkmann's ischemic contracture
9587	Traumatic subcutaneous emphysema
9588	Other early complications of trauma
95901	Other and unspecified injury to head
95909	Other and unspecified injury to face and neck
95911	Other injury of chest wall
95912	Other injury of abdomen
95913	Fracture of corpus cavernosum penis
95914	Other injury of external genitals
95919	Other injury of other sites of trunk
9592	Other and unspecified injury to shoulder and upper arm
9593	Other and unspecified injury to elbow, forearm, and wrist
9594	Other and unspecified injury to hand, except finger
9595	Other and unspecified injury to finger
9596	Other and unspecified injury to hip and thigh
9597	Other and unspecified injury to knee, leg, ankle, and foot
9598	Other and unspecified injury to other specified sites, including multiple
9599	Other and unspecified injury to unspecified site

The following diagnosis codes are payable for Tetanus, injections, acute care:

Diagnosis Code	Description
85011	Concussion, with loss of consciousness of 30 minutes or less
85012	Concussion, with loss of consciousness from 31 to 59 minutes

25.3.3.10 Deep Brain Stimulators

Implantation of neurostimulator electrodes for the treatment of intractable tremors, diagnosis code 3320, idiopathic Parkinson's Disease, and diagnosis code 3331, Essential tremor, are payable benefits. One of these diagnoses must appear on the claim for reimbursement to be considered. The actual deep brain stimulator device is payable only under the DRG or ASC/HASC reimbursement rate. No separate payment outside of the DRG or ASC/HASC reimbursement rate will be made for the device.

When billing for procedures related to the implantation of a deep brain stimulator, use the following codes. The types of service for which these codes are payable are listed with each code. TOS F should be used by the ASC/HASC.

Professional services for these codes are:

- Payable in the inpatient and outpatient settings
- Subject to the global surgical fee policy, with three weeks precare and six weeks postcare days assigned

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- Subject to multiple surgery guidelines

Procedure Codes	Types of Service
F-61880	2, 8
F-61885	2
F-61888	2, 8

The following procedure codes are payable without prior authorization for the electronic analysis of the implanted neurostimulator pulse generator:

Procedure Codes			
5-95970	5-95971	5-95972	5-95973
5-95974	5-95975	5-95978	5-95979

25.3.3.11 Hospital Laboratory Services

The American Medical Association (AMA) has discontinued the following general multichannel automated panel codes:

Discontinued Panel Codes			
5-80002	5-80003	5-80004	5-80005
5-80006	5-80007	5-80008	5-80009
5-80010	5-80011	5-80012	5-80013
5-80014	5-80015	5-80016	5-80017
5-80018	5-80019	5-G0058	5-G0059
5-G0060			

These panel codes are being discontinued because the panel does not define exactly what tests are performed.

The new organ and disease panel codes 5-80048, 5-80051, 5-80053, 5-80069, and 5-80076 must be used instead of the general multichannel automated panel codes in the table above.

The CPT codes in the table above should not be used as billing codes, but the payment amounts associated with pricing of these automated profiles will continue.

For example, if two automated profile tests are performed, the individual codes for the two automated tests must be billed instead of code 5-80002. For pricing, count the number of automated profile tests billed, and payment will be at the same rate as the former code 5-80002. CMS continues to provide updated pricing for the deleted profiles of automated tests.

The new organ or disease panels include the following codes:

5-80048 - Basic metabolic panel includes:			
5-82310	5-82374	5-82435	5-82565
5-82947	5-84132	5-84295	5-84520

5-80050 - General health panel includes:		
5-80053	5-85027 or 5-85025	5-84443

5-80051 - Electrolyte panel includes:			
5-82374	5-82435	5-84132	5-84295

5-80053 - Comprehensive metabolic panel includes:			
5-82040	5-82247	5-82310	5-82374
5-82435	5-82565	5-82947	5-84075
5-84132	5-84155	5-84295	5-84450
5-84460	5-84520		

5-80055 - Obstetric panel includes:			
5-85025	5-86592	5-86762	5-86850
5-86900	5-86901	5-87340	

5-80061 - Lipid panel includes:			
5-80069	5-82465	5-83718	5-84478

5-80069 - Renal function panel includes:			
5-82040	5-82310	5-82374	5-82435
5-82565	5-82947	5-84100	5-84132
5-84295	5-84520		

5-80074 - Acute hepatitis panel includes:			
5-86705	5-86709	5-86803	5-87340

5-80076 - Hepatic function panel includes:			
5-82040	5-82247	5-82248	5-84075
5-84155	5-84450	5-84460	

5-80090 - TORCH antibody panel includes:			
5-86644	5-86694	5-86762	5-86777

Outpatient and inpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: *Hospital laboratories may bill for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.*

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 84 of the HCFA-1450 (UB-92) claim form and must enter the performing laboratory's nine-digit provider identifier next to the service provided by the performing laboratory.

Hospitals may bill a handling fee procedure code (1-99001) for collecting and forwarding a specimen to a referral laboratory if the specimen is collected by venipuncture or catheterization. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Laboratory tests generally performed as a panel (chemistries, CBC, urinalyses) must be billed with the appropriate HCPCS panel code. The policy applies to laboratory tests performed by a hospital laboratory.

Modifier 91

Modifier 91 should be used for *repeat* clinical diagnostic tests as follows:

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- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the clinical diagnostic retest.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 91, the claim or detail is denied.
- If a clinical diagnostic retest is performed by the same provider on the same day and is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/ services must be documented on appeal.
- Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Modifier 76

The use of modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure, it must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/ services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 76 auditing for dates of service on or after April 3, 1998. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile, [e.g., brucella, francisella, murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims for that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for the 76 modifier.

When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Refer to: "Laboratory Paneling" on page 26-5 for more information about laboratory paneling procedures.

25.3.3.12 Helicobacter Pylori (H. Pylori)

The following procedure codes are covered services: 5-83013, 5-83014, 5-78338, and 5-87339.

These codes are considered to be clinical lab services and must be billed using TOS 5. The interpretation/professional component TOS I is not separately reimbursed.

Refer to: "Helicobacter Pylori (H. Pylori)" on page 36-58 for more information.

25.3.3.13 Colorectal Cancer Screening

The following procedure codes are covered services:

Procedure Codes		
2/F-G0104	2/F-G0105	2-G0121
4/I/T-G0106	4/I/T-G0120	5-G0107

Procedure code 2-G0121 is limited to diagnosis code V7651, Special screening for malignant neoplasms-colon. Procedure codes G0104, G0105, G0106, and G0120 are no longer limited for diagnosis codes 5582, Toxic gastroenteritis), and 5583, Allergic gastroenteritis and colitis. Procedure codes G0104 and G0106 are a benefit when billed with diagnosis code V7651 (limited to once every 5 years). Procedure code 4/I/T-G0122 is *not* covered by Medicaid.

Refer to: "Cancer Screening, Colorectal" on page 36-28 for more information.

25.3.3.14 Pap Smears

Pap or estrogen smears are benefits of the Texas Medicaid Program. Pap smears completed for family planning purposes in the outpatient department should be billed using diagnosis code V2509, Encounter for other contraceptive management. If a specimen is sent to an outside laboratory for processing, the outside laboratory must bill for the test. The hospital is not reimbursed for a collection or handling fee.

Refer to: "Cytopathology Studies – Gynecological, Pap Smears" on page 36-35 for more information on Pap smears.

25.3.3.15 Nonstress Testing and Contraction Stress Test

The following diagnosis codes are payable for *both* nonstress and contraction stress testing:

Diagnosis Code	Description
30393	Other and unspecified alcohol dependence, in remission
30403	Opioid type dependence, in remission
30420	Cocaine dependence, unspecified use
30421	Cocaine dependence, continuous use
30422	Cocaine dependence, episodic use
30423	Cocaine dependence, in remission

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Diagnosis Code	Description
30430	Cannabis dependence, unspecified use
30431	Cannabis dependence, continuous use
30432	Cannabis dependence, episodic use
30433	Cannabis dependence, in remission
30440	Amphetamine and other psychostimulant dependence, unspecified use
30441	Amphetamine and other psychostimulant dependence, continuous use
30442	Amphetamine and other psychostimulant dependence, episodic use
30443	Amphetamine and other psychostimulant dependence, in remission
30450	Hallucinogen dependence, unspecified use
30451	Hallucinogen dependence, continuous use
30452	Hallucinogen dependence, episodic use
30453	Hallucinogen dependence, in remission
30460	Other specified drug dependence, unspecified use
30461	Other specified drug dependence, continuous use
30462	Other specified drug dependence, episodic use
30463	Other specified drug dependence, in remission
30470	Combinations of opioid type drug with any other drug dependence, unspecified use
30471	Combinations of opioid type drug with any other drug dependence, continuous use
30472	Combinations of opioid type drug with any other drug dependence, episodic use
30473	Combinations of opioid type drug with any other drug dependence, in remission
30480	Combinations of drug dependence excluding opioid type drug, unspecified use
30481	Combinations of drug dependence excluding opioid type drug, continuous use
30482	Combinations of drug dependence excluding opioid type drug, episodic use
30483	Combinations of drug dependence excluding opioid type drug, in remission
30490	Unspecified drug dependence, unspecified use
30491	Unspecified drug dependence, continuous use
30492	Unspecified drug dependence, episodic use
30493	Unspecified drug dependence, in remission
5851	Chronic kidney disease, stage I
5852	Chronic kidney disease, stage II (mild)
5853	Chronic kidney disease, stage III (moderate)
5854	Chronic kidney disease, stage IV (severe)
5855	Chronic kidney disease, stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
64210	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64211	Hypertension secondary to renal disease, with delivery
64212	Hypertension secondary to renal disease, with delivery, with mention of postpartum complication
64213	Hypertension secondary to renal disease, antepartum
64214	Hypertension secondary to renal disease, postpartum
64220	Other pre-existing hypertension complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64221	Other pre-existing hypertension, with delivery
64222	Other pre-existing hypertension, with delivery, with mention of postpartum complication
64223	Other pre-existing hypertension, antepartum
64224	Other pre-existing hypertension, postpartum
64230	Transient hypertension of pregnancy, unspecified as to episode of care
64231	Transient hypertension of pregnancy, with delivery
64232	Transient hypertension of pregnancy, with delivery, with mention of postpartum complication
64233	Antepartum transient hypertension
64240	Mild or unspecified pre-eclampsia, unspecified as to episode of care
64241	Mild or unspecified pre-eclampsia, with delivery
64242	Mild or unspecified pre-eclampsia, with delivery, with mention of postpartum complication
64243	Mild or unspecified pre-eclampsia, antepartum
64244	Mild or unspecified pre-eclampsia, postpartum
64250	Severe pre-eclampsia, unspecified as to episode of care

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Diagnosis Code	Description
64251	Severe pre-eclampsia, with delivery
64252	Severe pre-eclampsia, with delivery, with mention of postpartum complication
64253	Severe pre-eclampsia, antepartum
64254	Severe pre-eclampsia, postpartum
64260	Eclampsia complicating pregnancy, child-birth or the puerperium, unspecified as to episode of care
64261	Eclampsia, with delivery
64262	Eclampsia, with delivery, with mention of postpartum complication
64263	Eclampsia, antepartum
64264	Eclampsia, postpartum
64270	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64271	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery
64272	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery, with mention of postpartum complication
64273	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, antepartum
64400	Threatened premature labor, unspecified as to episode of care
64403	Threatened premature labor, antepartum
64410	Other threatened labor, unspecified as to episode of care
64413	Other threatened labor, antepartum
64510	Post term pregnancy, unspecified episode of care
64513	Post term pregnancy, antepartum condition or complication
64520	Prolonged pregnancy, unspecified episode of care
64523	Prolonged pregnancy, antepartum condition or complication
64700	Syphilis of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64701	Syphilis of mother, complicating pregnancy, with delivery
64702	Syphilis of mother, complicating pregnancy, with delivery, with mention of postpartum complication
64703	Antepartum syphilis
64704	Postpartum syphilis

Diagnosis Code	Description
64710	Gonorrhea of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64711	Gonorrhea of mother, with delivery
64712	Gonorrhea of mother, with delivery, with mention of postpartum complication
64713	Antepartum gonorrhea
64714	Postpartum gonorrhea
64720	Other venereal diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64721	Other venereal diseases of mother, with delivery
64722	Other venereal diseases of mother, with delivery, with mention of postpartum complication
64723	Other antepartum venereal diseases
64724	Other postpartum venereal diseases
64730	Tuberculosis of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64731	Tuberculosis of mother, with delivery
64732	Tuberculosis of mother, with delivery, with mention of postpartum complication
64733	Antepartum tuberculosis
64734	Postpartum tuberculosis
64740	Malaria of mother, complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care
64741	Malaria of mother, with delivery
64742	Malaria of mother, with delivery, with mention of postpartum complication
64743	Antepartum malaria
64744	Postpartum malaria
64750	Rubella of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64751	Rubella of mother, with delivery
64752	Rubella of mother, with delivery, with mention of postpartum complication
64753	Antepartum rubella
64754	Postpartum rubella
64760	Other viral diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64761	Other viral diseases of mother, with delivery

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Diagnosis Code	Description
64762	Other viral diseases of mother, with delivery, with mention of postpartum complication
64763	Other antepartum viral diseases
64764	Other postpartum viral diseases
64780	Other specified infectious and parasitic diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64781	Other specified infectious and parasitic diseases of mother, with delivery
64782	Other specified infectious and parasitic diseases of mother, with delivery, with mention of postpartum complication
64783	Other specified infectious and parasitic diseases of mother, antepartum
64800	Diabetes mellitus of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64801	Diabetes mellitus of mother, with delivery
64802	Diabetes mellitus of mother, with delivery, with mention of postpartum complication
64803	Antepartum diabetes mellitus
65130	Twin pregnancy with fetal loss and retention of one fetus, unspecified as to episode of care or not applicable
65131	Twin pregnancy with fetal loss and retention of one fetus, delivered, with or without mention of antepartum condition
65133	Twin pregnancy with fetal loss and retention of one fetus, antepartum condition or complication
65140	Triplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable
65141	Triplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65143	Triplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65150	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable
65151	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65153	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65160	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care
65161	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65163	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65633	Fetal distress, affecting management of mother, antepartum
65650	Poor fetal growth, affecting management of mother, unspecified as to episode of care
65651	Poor fetal growth, affecting management of mother, delivered
65653	Poor fetal growth, affecting management of mother, antepartum condition or complication
65660	Excessive fetal growth, affecting management of mother, unspecified as to episode of care
65661	Excessive fetal growth, affecting management of mother, delivered
65663	Excessive fetal growth, affecting management of mother, antepartum
65840	Infection of amniotic cavity, unspecified as to episode of care
65841	Infection of amniotic cavity, delivered
65843	Infection of amniotic cavity, antepartum
V231	Supervision of high-risk pregnancy with history of tropho blastic disease
V232	Supervision of high-risk pregnancy with history of abortion
V233	Supervision of high-risk pregnancy with grand multiparity
V235	Supervision of high-risk pregnancy with other poor reproductive history
V237	Supervision of high-risk pregnancy with insufficient prenatal care
V2381	Supervision of high-risk pregnancy with elderly primigravida
V2382	Supervision of high-risk pregnancy with elderly multigravida
V2383	Supervision of high-risk pregnancy with young primigravida
V2384	Supervision of high-risk pregnancy with young multigravida
V2389	Supervision of other high-risk pregnancy
V239	Supervision of unspecified high-risk pregnancy

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Nonstress testing is a form of fetal monitoring in which transducers are applied to the mother's abdomen to monitor fetal heart rate. Tracings of this activity may be obtained from the fetoscope.

Nonstress testing conducted in the outpatient setting should be billed with revenue code B-729.

This revenue code is denied if it is billed more than once per day with the same provider. The provider must appeal with documentation supporting the performance of the test more than once on the same day/same provider.

Revenue code B-729 is payable for outpatient (POS 5) hospital settings and to hospital-based rural health clinics only. The inpatient hospital stay is payable under the hospital's reimbursement methodology.

The following diagnosis codes are payable only for nonstress testing (B-729):

Diagnosis Code	Description
64110	Hemorrhage from placenta previa, unspecified as to episode of care
64111	Hemorrhage from placenta previa, with delivery
64113	Hemorrhage from placenta previa, antepartum
64120	Premature separation of placenta, unspecified as to episode of care
64121	Premature separation of placenta, with delivery
64123	Premature separation of placenta, antepartum
64130	Antepartum hemorrhage associated with coagulation defects, unspecified as to episode of care
64131	Antepartum hemorrhage associated with coagulation defects, with delivery
64133	Antepartum hemorrhage associated with coagulation defects
64180	Other antepartum hemorrhage, unspecified as to episode of care
64181	Other antepartum hemorrhage, with delivery
64183	Other antepartum hemorrhage
64190	Unspecified antepartum hemorrhage, unspecified as to episode of care
64191	Unspecified antepartum hemorrhage, with delivery
64193	Unspecified antepartum hemorrhage
65420	Previous cesarean delivery, unspecified as to episode of care in pregnancy
65421	Previous cesarean delivery, with or without mention of antepartum condition
65423	Previous cesarean delivery, antepartum condition or complication
65570	Decreased fetal movements, affecting management of mother, unspecified as to episode of care
65571	Decreased fetal movements, affecting management of mother, delivered
65573	Decreased fetal movements, affecting management of mother, antepartum condition or complication

Revenue code B-729, Fetal monitoring (external) –labor room/delivery–other and fetal stress testing, is payable for the following diagnosis codes:

Diagnosis Codes			
V2381	V2382	V2383	V2384
V2389	V239		

The contraction stress test is performed to assess the condition of the fetus in utero. This test is done by monitoring the fetus' response to the stress of uterine contractions. Baseline recordings of the fetal heart rate are made by an electronic devise such as a Doppler. IV oxytocin is administered to produce uterine contractions. Fetal heart rate is measured during the contractions. Sustained alterations of the heart rate beyond the contractions may indicate fetal distress and the need for further intervention.

Contraction stress testing conducted in the outpatient setting should be billed with revenue code B-729, Fetal stress testing.

Revenue code B-729 (facility services) is reimbursed on the same day/different provider, without appeal. This procedure code is denied if it is billed more than once per day with the same provider. The provider must appeal with documentation supporting the performance of the test more than once on the same day/same provider.

Revenue code B-729 (facility services) is payable for outpatient hospital stays and to hospital-based rural health clinics only. The inpatient hospital stay is reimbursed under the hospital's DRG.

The following diagnosis codes are payable only for contraction stress testing (B-729):

Diagnosis Code	Description
2825	Sickle-cell trait
28263	Sickle-cell/HB-C disease without crisis
65613	Rhesus isoimmunization, affecting management of mother, antepartum condition
65623	Isoimmunization from other and unspecified blood-group incompatibility, affecting management of mother, antepartum
65803	Oligohydramnios, antepartum

Refer to: "Nonstress Testing, Contraction Stress Testing" on page 36-197 for related physician services.

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25.3.3.16 Hospital Radiology Services

CPT codes T-93005 and T-93041 are payable for diagnosis codes 3373, 78071, and 78079.

Effective for dates of service on or after April 1, 2004, the following diagnosis codes will be payable for electrocardiograms:

Diagnosis Code	Description
03282	Diptheritic myocarditis
0362	Meningococcemia
03640	Meningococcal carditis, unspecified
03641	Meningococcal pericarditis
03642	Meningococcal endocarditis
03643	Meningococcal myocarditis
07420	Coxsackie carditis, unspecified
07421	Coxsackie pericarditis
07422	Coxsackie endocarditis
07423	Coxsackie myocarditis
0860	Chagas' disease with heart involvement
08881	Lyme disease
0930	Aneurysm of aorta, specified as syphilitic
0931	Syphilitic aortitis
09320	Syphilitic endocarditis of valve, unspecified
09321	Syphilitic endocarditis of mitral valve
09322	Syphilitic endocarditis of aortic valve
09323	Syphilitic endocarditis of tricuspid valve
09324	Syphilitic endocarditis of pulmonary valve
0938	Other specified cardiovascular syphilis
09381	Syphilitic pericarditis
09382	Syphilitic myocarditis
09389	Other specific cardiovascular syphilis
09883	Gonococcal pericarditis
09884	Gonococcal endocarditis
09885	Other gonococcal heart disease
11281	Candidal endocarditis
11503	Histoplasma capsulatum pericarditis
11504	Histoplasma capsulatum endocarditis
11513	Histoplasma duboisii pericarditis
11514	Histoplasma duboisii endocarditis
11593	Histoplasmosis pericarditis, unspecified
11594	Histoplasmosis endocarditis
124	Trichinosis
1303	Myocarditis due to toxoplasmosis
135	Sarcoidosis
1640	Malignant neoplasm of thymus
1641	Malignant neoplasm of heart
1642	Malignant neoplasm of anterior mediastinum
1643	Malignant neoplasm of posterior mediastinum
1648	Malignant neoplasm of other parts of mediastinum
1649	Malignant neoplasm of mediastinum, part unspecified
19889	Secondary malignant neoplasm of other specified sites
2127	Benign neoplasm of heart
25000	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
25001	Diabetes mellitus without mention of complication, type I (juvenile type), not stated as uncontrolled
25002	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
25003	Diabetes mellitus without mention of complication, type I (juvenile type), uncontrolled
2501	Diabetes with ketoacidosis
25010	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
25011	Diabetes with ketoacidosis, type I (juvenile type), not stated as uncontrolled
25012	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled
25013	Diabetes with ketoacidosis, type I (juvenile type), uncontrolled
2502	Diabetes with hyperosmolarity
25020	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled
25021	Diabetes with hyperosmolarity, type I (juvenile type), not stated as uncontrolled
25022	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled
25023	Diabetes with hyperosmolarity, type I (juvenile type), uncontrolled
2503	Diabetes with other coma
25030	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled
25031	Diabetes with other coma, type I (juvenile type), not stated as uncontrolled
25032	Diabetes with other coma, type II or unspecified type, uncontrolled
25033	Diabetes with other coma, type I (juvenile type), uncontrolled

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Diagnosis Code	Description
2504	Diabetes with renal manifestations
25040	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled
25041	Diabetes with renal manifestations, type I (juvenile type), not stated as uncontrolled
25042	Diabetes with renal manifestations, type II or unspecified type, uncontrolled
25043	Diabetes with renal manifestations, type I (juvenile type), uncontrolled
2505	Diabetes with ophthalmic manifestations
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled
2506	Diabetes with neurological manifestations
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations, type I (juvenile type), not stated as uncontrolled
25062	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations, type I (juvenile type), uncontrolled
2507	Diabetes with peripheral circulatory disorders
25070	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
25071	Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled
25072	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
25073	Diabetes with peripheral circulatory disorders, type I (juvenile type), uncontrolled
2508	Diabetes with other specified manifestations
25080	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled

Diagnosis Code	Description
25081	Diabetes with other specified manifestations, type I (juvenile type), not stated as uncontrolled
25082	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
25083	Diabetes with other specified manifestations, type I (juvenile type), uncontrolled
2509	Diabetes with unspecified complication
25090	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled
25091	Diabetes with unspecified complication, type I (juvenile type), not stated as uncontrolled
25092	Diabetes with unspecified complication, type II or unspecified type, uncontrolled
25093	Diabetes with unspecified complication, type I (juvenile type), uncontrolled
2512	Hypoglycemia, unspecified
2720	Pure hypercholesterolemia
2721	Pure hyperglyceridemia
2722	Mixed hyperlipidemia
2723	Hyperchylomicronemia
2724	Other and unspecified hyperlipidemia
2725	Lipoprotein deficiencies
2726	Lipodystrophy
2727	Lipidoses
2728	Other disorders of lipoid metabolism
2750	Disorders of iron metabolism
2752	Disorders of magnesium metabolism
2753	Disorders of phosphorus metabolism
27541	Hypocalcemia
27542	Hypercalcemia
2760	Hyperosmolality and/or hypernatremia
2761	Hyposmolality and/or hyponatremia
2762	Acidosis
2763	Alkalosis
2764	Mixed acid-base balance disorder
2765	Volume depletion disorder
27650	Volume depletion, unspecified
27651	Dehydration
27652	Hypovolemia
2766	Fluid overload disorder
2767	Hyperpotassemia
2768	Hypopotassemia

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Diagnosis Code	Description
27730	Amyloidosis, unspecified
27739	Other amyloidosis
3062	Cardiovascular malfunction arising from mental factors
3373	Autonomic dysreflexia
390	Rheumatic fever without mention of heart involvement
391	Rheumatic fever with heart involvement
3910	Acute rheumatic pericarditis
3911	Acute rheumatic endocarditis
3912	Acute rheumatic myocarditis
3918	Other acute rheumatic heart disease
3919	Acute rheumatic heart disease, unspecified
392	Rheumatic chorea
3920	Rheumatic chorea with heart involvement
3929	Rheumatic chorea without mention of heart involvement
393	Chronic rheumatic pericarditis
394	Diseases of mitral valve
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
395	Diseases of aortic valve
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
397	Diseases of other endocardial structures
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve unspecified

Diagnosis Code	Description
398	Other rheumatic heart disease
3980	Rheumatic myocarditis
3989	Other and unspecified rheumatic heart diseases
39890	Rheumatic heart disease, unspecified
39891	Rheumatic heart failure (congestive)
39899	Other rheumatic heart diseases
401	Essential hypertension
4010	Malignant essential hypertension
4011	Benign essential hypertension
4019	Unspecified essential hypertension
4020	Malignant hypertensive heart disease
40200	Malignant hypertensive heart disease without congestive heart failure
40201	Malignant hypertensive heart disease with congestive heart failure
4021	Benign hypertensive heart disease
40210	Benign hypertensive heart disease without congestive heart failure
40211	Benign hypertensive heart disease with congestive heart failure
4029	Unspecified hypertensive heart disease
40290	Unspecified hypertensive heart disease without congestive heart failure
40291	Unspecified hypertensive heart disease with congestive heart failure
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
40400	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified

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Diagnosis Code	Description
40401	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
40410	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40411	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40490	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40491	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
40501	Malignant renovascular hypertension
40509	Other malignant secondary hypertension
40511	Benign renovascular hypertension
40519	Other benign secondary hypertension
41000	Acute myocardial infarction of anterolateral wall, episode of care unspecified
41001	Acute myocardial infarction of anterolateral wall, initial episode of care

Diagnosis Code	Description
41002	Acute myocardial infarction of anterolateral wall, subsequent episode of care
4101	Acute myocardial infarction of other anterior wall
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care
41012	Acute myocardial infarction of other anterior wall, subsequent episode of care
4102	Acute myocardial infarction of inferolateral wall
41020	Acute myocardial infarction of inferolateral wall, episode of care unspecified
41021	Acute myocardial infarction of inferolateral wall, initial episode of care
41022	Acute myocardial infarction of inferolateral wall, subsequent episode of care
4103	Acute myocardial infarction of inferopos-terior wall
41030	Acute myocardial infarction of inferopos-terior wall, episode of care unspecified
41031	Acute myocardial infarction of inferopos-terior wall, initial episode of care
41032	Acute myocardial infarction of inferopos-terior wall, subsequent episode of care
4104	Acute myocardial infarction of other inferior wall
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41042	Acute myocardial infarction of other inferior wall, subsequent episode of care
4105	Acute myocardial infarction of other lateral wall
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41052	Acute myocardial infarction of other lateral wall, subsequent episode of care
4106	True posterior wall infarction
41060	True posterior wall infarction, episode of care unspecified
41061	True posterior wall infarction, initial episode of care
41062	True posterior wall infarction, subsequent episode of care
4107	Subendocardial infarction

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Diagnosis Code	Description
41070	Subendocardial infarction, episode of care unspecified
41071	Subendocardial infarction, initial episode of care
41072	Subendocardial infarction, subsequent episode of care
4108	Acute myocardial infarction of other specified sites
41080	Acute myocardial infarction of other specified sites, episode of care unspecified
41081	Acute myocardial infarction of other specified sites, initial episode of care
41082	Acute myocardial infarction of other specified sites, subsequent episode of care
4109	Acute myocardial infarction of unspecified site
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41092	Acute myocardial infarction of unspecified site, subsequent episode of care
411	Other acute and subacute forms of ischemic heart disease
4110	Postmyocardial infarction syndrome
4111	Intermediate coronary syndrome
4118	Other acute and subacute forms of ischemic heart disease
41181	Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction
41189	Other acute and subacute forms of ischemic heart disease, other
412	Old myocardial infarction
413	Angina pectoris
4130	Angina decubitus
4131	Prinzmetal angina
4139	Other and unspecified angina pectoris
414	Other forms of chronic ischemic heart disease
4140	Coronary atherosclerosis
41400	Coronary atherosclerosis of unspecified type of vessel, native or graft
41401	Coronary atherosclerosis of native coronary artery
41402	Coronary atherosclerosis of autologous vein bypass graft
41403	Coronary atherosclerosis of nonautologous biological bypass graft

Diagnosis Code	Description
41404	Coronary atherosclerosis of artery bypass graft
41405	Coronary atherosclerosis of unspecified bypass graft
41406	Coronary atherosclerosis of native coronary artery of transplanted heart
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
4141	Aneurysm of heart
41410	Aneurysm of heart (wall)
41411	Aneurysm of coronary vessels
41412	Dissection of coronary artery
41419	Other aneurysm of heart
4148	Other specified forms of chronic ischemic heart disease
4149	Chronic ischemic heart disease, unspecified
415	Acute pulmonary heart disease
4150	Acute cor pulmonale
4151	Pulmonary embolism and infarction
41511	Iatrogenic pulmonary embolism and infarction
41519	Other pulmonary embolism and infarction
416	Chronic pulmonary heart disease
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4168	Other chronic pulmonary heart diseases
4169	Chronic pulmonary heart disease, unspecified
417	Other diseases of pulmonary circulation
4170	Arteriovenous fistula of pulmonary vessels
4171	Aneurysm of pulmonary artery
4178	Other specified diseases of pulmonary circulation
4179	Unspecified disease of pulmonary circulation
420	Acute pericarditis
4200	Acute pericarditis in diseases classified elsewhere
4209	Other and unspecified acute pericarditis
42090	Acute pericarditis, unspecified
42091	Acute idiopathic pericarditis
42099	Other acute pericarditis
421	Acute and subacute endocarditis
4210	Acute and subacute bacterial endocarditis
4211	Acute and subacute infective endocarditis in diseases classified elsewhere

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Diagnosis Code	Description
4219	Acute endocarditis, unspecified
4220	Acute myocarditis in diseases classified elsewhere
4229	Other and unspecified acute myocarditis
42290	Acute myocarditis, unspecified
42291	Idiopathic myocarditis
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Other acute myocarditis
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4238	Other specified diseases of pericardium
4239	Unspecified disease of pericardium
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4255	Alcoholic cardiomyopathy
4257	Nutritional and metabolic cardiomyopathy
4258	Cardiomyopathy in other diseases classified elsewhere
4259	Secondary cardiomyopathy, unspecified
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block

Diagnosis Code	Description
42652	Right bundle branch block and left anterior fascicular block
42653	Other bilateral bundle branch block
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-ganong-levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
42731	Atrial fibrillation
42732	Atrial flutter
42741	Ventricular fibrillation
42742	Ventricular flutter
4275	Cardiac arrest
42760	Premature beats, unspecified
42761	Supraventricular premature beats
42769	Other premature beats
42781	Sinoatrial node dysfunction
42789	Other specified cardiac dysrhythmias
4279	Cardiac dysrhythmia, unspecified
4280	Congestive heart failure
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
4290	Myocarditis, unspecified
4291	Myocardial degeneration

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Diagnosis Code	Description
4292	Cardiovascular disease, unspecified
4293	Cardiomegaly
4294	Functional disturbances following cardiac surgery
4295	Rupture of chordae tendineae
4296	Rupture of papillary muscle
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other
42981	Other disorders of papillary muscle
42982	Hyperkinetic heart disease
42983	Takotsubo syndrome
42989	Other ill-defined heart diseases
4299	Heart disease, unspecified
43300	Occlusion and stenosis of basilar artery without mention of cerebral infarction
43301	Occlusion and stenosis of basilar artery with cerebral infarction
43310	Occlusion and stenosis of carotid artery without mention of cerebral infarction
43311	Occlusion and stenosis of carotid artery with cerebral infarction
43390	Occlusion and stenosis of unspecified precerebral artery without mention of cerebral infarction
43391	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction
43490	Cerebral artery occlusion, unspecified without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
4359	Unspecified transient cerebral ischemia
4372	Hypertensive encephalopathy
44100	Dissection of aorta, unspecified site
44101	Dissection of aorta, thoracic
44103	Dissection of aorta, thoracoabdominal
4411	Thoracic aneurysm, ruptured
4412	Thoracic aneurysm without mention of rupture
4416	Thoracoabdominal aneurysm, ruptured
4417	Thoracoabdominal aneurysm, without mention of rupture
4439	Peripheral vascular disease, unspecified
4440	Embolism and thrombosis of abdominal aorta
4441	Embolism and thrombosis of thoracic aorta
44421	Arterial embolism and thrombosis of upper extremity
44422	Arterial embolism and thrombosis of lower extremity
4460	Polyarteritis nodosa
4467	Takayasu’s disease
4580	Orthostatic hypotension
45821	Hypotension of hemodialysis
4589	Hypotension, unspecified
4590	Hemorrhage, unspecified
496	Chronic airway obstruction, not elsewhere classified
514	Pulmonary congestion and hypostasis
5173	Acute chest syndrome
5184	Acute edema of lung, unspecified
5185	Pulmonary insufficiency following trauma and surgery
51882	Other pulmonary insufficiency, not elsewhere classified
51884	Acute and chronic respiratory failure
51919	Other diseases of trachea and bronchus
53081	Esophageal reflux
57410	Calculus of gallbladder with other cholecystitis, without mention of obstruction
64201	Benign essential hypertension with delivery
64202	Benign essential hypertension, with delivery, with mention of postpartum complication
64203	Antepartum benign essential hypertension
64204	Postpartum benign essential hypertension
64251	Severe pre-eclampsia, with delivery
64252	Severe pre-eclampsia, with delivery, with mention of postpartum complication
64253	Severe pre-eclampsia, antepartum
64254	Severe pre-eclampsia, postpartum
64850	Congenital cardiovascular disorders of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64851	Congenital cardiovascular disorders of mother, with delivery

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Diagnosis Code	Description
64852	Congenital cardiovascular disorders of mother, with delivery, with mention of postpartum complication
64853	Congenital cardiovascular disorders of mother, antepartum
64854	Congenital cardiovascular disorders of mother, postpartum
65420	Previous cesarean delivery, unspecified as to episode of care in pregnancy
65423	Previous cesarean delivery, antepartum condition or complication
66810	Cardiac complications of anesthesia or other sedation in labor and delivery, unspecified as to episode of care
66811	Cardiac complications of anesthesia or other sedation in labor and delivery, delivered
66812	Cardiac complications of anesthesia or other sedation in labor and delivery, delivered, with mention of postpartum complication
66813	Cardiac complications of anesthesia or other sedation in labor and delivery, antepartum
66814	Cardiac complications of anesthesia or other sedation in labor and delivery, postpartum
66971	Cesarean delivery, without mention of indication, delivered, with or without mention of antepartum condition
67450	Peripartum cardiomyopathy, unspecified as to episode of care or not applicable
67451	Peripartum cardiomyopathy, delivered, with or without mention of antepartum condition
67452	Peripartum cardiomyopathy, delivered, with mention of postpartum condition
67453	Peripartum cardiomyopathy, antepartum condition or complication
67454	Peripartum cardiomyopathy, postpartum condition or complication
7100	Systemic lupus erythematosus
7142	Other rheumatoid arthritis with visceral or systemic involvement
71941	Pain in joint involving shoulder region
7200	Ankylosing spondylitis
7231	Cervicalgia
7295	Pain in limb
7336	Tietze's disease
7450	Common truncus
7451	Transposition of great vessels

Diagnosis Code	Description
74510	Complete transposition of great vessels
74511	Double outlet right ventricle
74512	Corrected transposition of great vessels
74519	Other transposition of great vessels
7452	Tetralogy of fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
7456	Endocardial cushion defects
74560	Endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other endocardial cushion defects
7457	Cor biloculare
7458	Other bulbus cordis anomalies and anomalies of cardiac septal closure
7459	Unspecified defect of septal closure
746	Other congenital anomalies of heart
7460	Anomolies of pulmonary valve, congenital
74600	Congenital pulmonary valve anomaly, unspecified
74601	Atresia of pulmonary valve, congenital
74602	Stenosis of pulmonary valve, congenital
74609	Other congenital anomalies of pulmonary valve
7461	Tricuspid atresia and stenosis, congenital
7462	Ebstein's anomaly
7463	Congenital stenosis of aortic valve
7464	Congenital insufficiency of aortic valve
7465	Congenital mitral stenosis
7466	Congenital mitral insufficiency
7467	Hypoplastic left heart syndrome
7468	Other specified congenital anomalies of heart
74681	Subaortic stenosis, congenital
74682	Cor triatriatum
74683	Infundibular pulmonic stenosis, congenital
74684	Congenital obstructive anomalies of heart, not elsewhere classified
74685	Coronary artery anomaly, congenital
74686	Congenital heart block
74687	Malposition of heart and cardiac apex
74689	Other specified congenital anomalies of heart
7469	Unspecified congenital anomaly of heart

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Diagnosis Code	Description
747	Other congenital anomalies of circulatory system
7470	Patent ductus arteriosus
7471	Coarctation of aorta
74710	Coarctation of aorta (preductal) (postductal)
74711	Interruption of aortic arch
7472	Other congenital anomalies of aorta
74720	Congenital anomaly of aorta, unspecified
74721	Congenital anomalies of aortic arch
74722	Congenital atresia and stenosis of aorta
74729	Other congenital anomalies of aorta
7473	Congenital anomalies of pulmonary artery
7474	Congenital anomaly of great veins
74740	Congenital anomaly of great veins, unspecified
74741	Total anomalous pulmonary venous connection
74742	Partial anomalous pulmonary venous connection
74749	Other anomalies of great veins
7580	Down's syndrome
7593	Situs inversus
75982	Marfan syndrome
78001	Coma
78002	Transient alteration of awareness
78003	Persistent vegetative state
78009	Alterations of consciousness, other
7802	Syncope and collapse
7804	Dizziness and giddiness
78079	Other malaise and fatigue
7808	Generalized hyperhidrosis
7815	Clubbing of fingers
7823	Edema
7825	Cyanosis
7850	Tachycardia, unspecified
7851	Palpitations
7852	Undiagnosed cardiac murmurs
7853	Other abnormal heart sounds
78550	Shock, unspecified
78551	Cardiogenic shock
78552	Septic shock
78559	Other shock without mention of trauma
78600	Respiratory abnormality, unspecified
78602	Orthopnea
78605	Shortness of breath

Diagnosis Code	Description
78609	Respiratory distress
78650	Unspecified chest pain
78651	Precordial pain
78652	Painful respiration
78659	Other chest pain
78701	Nausea with vomiting
78702	Nausea alone
78703	Vomiting alone
7871	Heartburn
78900	Abdominal pain, unspecified site
78907	Abdominal pain, generalized
78960	Abdominal tenderness, unspecified site
79001	Precipitous drop in hematocrit
7904	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase (ldh)
7905	Other nonspecific abnormal serum enzyme levels
7906	Other abnormal blood chemistry
7932	Nonspecific abnormal findings on radiological and other examination of other intrathoracic organs
79430	Unspecified abnormal function study of cardiovascular system
79431	Nonspecific abnormal electrocardiogram (ECG) (EKG)
79439	Other nonspecific abnormal function study of cardiovascular system
7944	Nonspecific abnormal results of function study of kidney
7945	Nonspecific abnormal results of function study of thyroid
7946	Nonspecific abnormal results of other endocrine function study
7947	Nonspecific abnormal results of function study of basal metabolism
7948	Nonspecific abnormal results of function study of liver
7949	Nonspecific abnormal results of other specified function study
7991	Respiratory arrest
8072	Closed fracture of sternum
8073	Open fracture of sternum
8074	Flail chest
8600	Traumatic pneumothorax without mention of open wound into thorax
8601	Traumatic pneumothorax with open wound into thorax

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Diagnosis Code	Description
8602	Traumatic hemothorax without mention of open wound into thorax
8603	Traumatic hemothorax with open wound into thorax
8604	Traumatic pneumohemothorax without mention of open wound into thorax
8605	Traumatic pneumohemothorax with open wound into thorax
86100	Unspecified injury of heart without mention of open wound into thorax
86101	Contusion of heart without mention of open wound into thorax
86102	Laceration of heart without penetration of heart chambers or open wound into thorax
86103	Laceration of heart with penetration of heart chambers, without mention of open wound into thorax
8611	Heart injury with open wound into thorax
86110	Unspecified injury of heart with open wound into thorax
86111	Contusion of heart with open wound into thorax
86112	Laceration of heart without penetration of heart chambers, with open wound into thorax
86113	Laceration of heart with penetration of heart chambers and open wound into thorax
8628	Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity
8629	Injury to multiple and unspecified intrathoracic organs with open wound into cavity
9000	Injury to carotid artery
90000	Injury to carotid artery, unspecified
90001	Injury to common carotid artery
90002	Injury to external carotid artery
90003	Injury to internal carotid artery
9001	Injury to internal jugular vein
9010	Injury to thoracic aorta
9011	Injury to innominate and subclavian arteries
9012	Injury to superior vena cava
9013	Injury to innominate and subclavian veins
9014	Injury to pulmonary blood vessels
90140	Injury to pulmonary vessel(s), unspecified
90141	Injury to pulmonary artery
90142	Injury to pulmonary vein
90181	Injury to intercostal artery or vein
90182	Injury to internal mammary artery or vein

Diagnosis Code	Description
90183	Injury to multiple blood vessels of thorax
9221	Contusion of chest wall
9584	Traumatic shock
9607	Poisoning by antineoplastic antibiotics
9631	Poisoning by antineoplastic and immunosuppressive drugs
96509	Poisoning by other opiates and related narcotics
9720	Poisoning by cardiac rhythm regulators
9721	Poisoning by cardiotonic glycosides and drugs of similar action
9722	Poisoning by antilipemic and antiarteriosclerotic drugs
9723	Poisoning by ganglion-blocking agents
9724	Poisoning by coronary vasodilators
9725	Poisoning by other vasodilators
9726	Poisoning by other antihypertensive agents
9727	Poisoning by antivaricose drugs, including sclerosing agents
9728	Poisoning by capillary-active drugs
9729	Poisoning by other and unspecified agents primarily affecting the cardiovascular system
9779	Poisoning by unspecified drug or medicinal substance
986	Toxic effect of carbon monoxide
9893	Toxic effect of organophosphate and carbamate
9894	Toxic effect of other pesticides, not elsewhere classified
9895	Toxic effect of venom
9920	Heat stroke and sunstroke
9921	Heat syncope
9940	Effect of lightning
9941	Drowning and nonfatal submersion
9947	Asphyxiation and strangulation
9948	Electrocution and nonfatal effects of electrical current
9950	Other anaphylactic shock, not elsewhere classified
99522	Unspecified adverse effect of anesthesia
99523	Unspecified adverse effect of insulin
99527	Other drug allergy
99600	Mechanical complications of unspecified cardiac device, implant, and graft
99601	Mechanical complication due to cardiac pacemaker (electrode)

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Diagnosis Code	Description
99602	Mechanical complication due to heart valve prosthesis
99603	Mechanical complication due to coronary bypass graft
99604	Mechanical complication of automatic implantable cardiac defibrillator
99609	Other mechanical complication of cardiac device, implant, and graft
99661	Infection and inflammatory reaction due to cardiac device, implant, and graft
99671	Other complications due to heart valve prosthesis
99672	Other complications due to other cardiac device, implant, and graft
99683	Complications of transplanted heart
9971	Cardiac complications, not elsewhere classified
9980	Postoperative shock, not elsewhere classified
9993	Other infection due to medical care, not elsewhere classified
9994	Anaphylactic shock due to serum, not elsewhere classified
V151	Personal history of surgery to heart and great vessels, presenting hazards to health
V252	Sterilization
V421	Heart replaced by transplant
V422	Heart valve replaced by transplant
V426	Lung replaced by transplant
V4321	Organ or tissue replaced by other means, heart assist device
V433	Organ or tissue replaced by other means, fully implantable artificial heart
V4500	Unspecified cardiac device in situ
V4501	Cardiac pacemaker in situ
V4502	Automatic implantable cardiac defibrillator in situ
V4509	Other specified cardiac device in situ
V4581	Postsurgical aortocoronary bypass status
V4582	Percutaneous transluminal coronary angio-plasty status
V472	Other cardiorespiratory problems
V4983	Other cardiorespiratory problems
V5331	Fitting and adjustment of cardiac pacemaker
V5332	Fitting and adjustment of automatic implantable cardiac defibrillator
V5339	Fitting and adjustment of other cardiac device
V5844	Aftercare following organ transplant
V5869	Long-term (current) use of other medications
V717	Observation for suspected cardiovascular disease
V7281	Pre-operative cardiovascular examination
V7284	Pre-operative examination, unspecified

All medically necessary radiology services provided to hospital clients must be ordered by the client's attending or consulting physician. These services must be documented in the client's medical record.

The diagnoses submitted on the claim form should reflect the medical necessity of services rendered. If a diagnosis is not available, TMHP accepts signs and symptoms. TMHP monitors the diagnoses indicated for the following procedures:

- Ambulatory electroencephalograms (A/EEG)
- EKG
- Arteriography
- Venography
- Radiation therapy
- Cardiac blood pool imaging
- Chest X-rays
- Computerized axial tomography (CAT) scans
- Echography
- Magnetic Resonance Angiogram (MRA)
- Mammography
- Magnetic Resonance Imaging (MRI) mammography
- Polysomnography

Repeat Procedures/Modifier 76

The use of modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/ services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (e.g., disposable diapers or sterile saline).

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When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Certain procedure codes have been removed from modifier 76 auditing. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for the modifier 76.

25.3.3.17 Computerized Tomography

Scout views and reconstruction are considered part of any CT procedure and are not reimbursed in addition to any other CT. Procedure codes 4-76375 and 4-76380, are denied when billed on the same day as any other CT. Procedure codes 4-76375 and 4-76380 are paid if billed as an independent procedure.

25.3.3.18 Technetium TC 99M Tetrofosmin

Procedure code 9-A9502 is a benefit without age restriction. It is payable in the office, inpatient, and outpatient settings. Payable providers are physicians, radiation treatment centers, and hospitals.

Inpatient settings are reimbursed under their DRG. Services provided in the outpatient hospital setting are paid at the Texas Medicaid Reimbursement Methodology (TMRM). Radiation treatment centers are reimbursed at a maximum fee of $112.46.

Low Osmolar (Nonionic) Contrast Material (LOCM)

LOCM used with intrathecal, intra-arterial, and/or intravenous radiological procedures may be reimbursed separately when medically indicated for clients with but not limited to the following high-risk conditions:

- History of allergic reaction to contrast material with the exception of a heat or flushing sensation or a single episode of nausea or vomiting
- History of asthma
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension
- Generalized severe debilitation
- Sickle cell disease

The LOCM is reimbursed as a drug furnished as incidental to a physician's service. Payment is limited to services performed in the office (POS 1), freestanding radiation centers (POS 6), and outpatient facilities (POS 5). LOCM used on clients in the inpatient hospital setting of a DRG reimbursed hospital is included in the DRG payment and no additional payment is made.

Radiological procedures that specify with contrast include payment for *high* osmolar contrast material and no additional payment is made for *low* osmolar contrast material. When using low osmolar contrast material for procedures, bill the codes that specify without contrast. The low osmolar contrast material should be billed separately.

MRI procedures that specify with contrast include payment for para-magnetic contrast; therefore, *low* osmolar contrast material is not reimbursed separately.

Cardiac blood pool imaging (procedure codes 4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a covered benefit for the following diagnosis codes:

Diagnosis Code	Description
3526	Multiple cranial nerve palsies
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve unspecified
41000	Acute myocardial infarction of anterolateral wall, episode of care unspecified
41001	Acute myocardial infarction of anterolateral wall, initial episode of care
41002	Acute myocardial infarction of anterolateral wall, subsequent episode of care
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care

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Diagnosis Code	Description
41012	Acute myocardial infarction of other anterior wall, subsequent episode of care
41020	Acute myocardial infarction of inferolateral wall, episode of care unspecified
41021	Acute myocardial infarction of inferolateral wall, initial episode of care
41022	Acute myocardial infarction of inferolateral wall, subsequent episode of care
41030	Acute myocardial infarction of inferoposterior wall, episode of care unspecified
41031	Acute myocardial infarction of inferoposterior wall, initial episode of care
41032	Acute myocardial infarction of inferoposterior wall, subsequent episode of care
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41042	Acute myocardial infarction of other inferior wall, subsequent episode of care
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41052	Acute myocardial infarction of other lateral wall, subsequent episode of care
41060	True posterior wall infarction, episode of care unspecified
41061	True posterior wall infarction, initial episode of care
41062	True posterior wall infarction, subsequent episode of care
41070	Subendocardial infarction, episode of care unspecified
41071	Subendocardial infarction, initial episode of care
41072	Subendocardial infarction, subsequent episode of care
41080	Acute myocardial infarction of other specified sites, episode of care unspecified
41081	Acute myocardial infarction of other specified sites, initial episode of care
41082	Acute myocardial infarction of other specified sites, subsequent episode of care
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41092	Acute myocardial infarction of unspecified site, subsequent episode of care

Diagnosis Code	Description
4110	Postmyocardial infarction syndrome
4111	Intermediate coronary syndrome
41181	Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction
41189	Other acute and subacute forms of ischemic heart disease, other
412	Old myocardial infarction
4130	Angina decubitus
4131	Prinzmetal angina
4139	Other and unspecified angina pectoris
41400	Coronary atherosclerosis of unspecified type of vessel, native or graft
41401	Coronary atherosclerosis of native coronary artery
41402	Coronary atherosclerosis of autologous vein bypass graft
41403	Coronary atherosclerosis of nonautologous biological bypass graft
41404	Coronary atherosclerosis of artery bypass graft
41405	Coronary atherosclerosis of unspecified bypass graft
41406	Coronary atherosclerosis of native coronary artery of transplanted heart
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
41410	Aneurysm of heart (wall)
41411	Aneurysm of coronary vessels
41412	Dissection of coronary artery
41419	Other aneurysm of heart
4148	Other specified forms of chronic ischemic heart disease
4149	Chronic ischemic heart disease, unspecified
4150	Acute cor pulmonale
41511	Iatrogenic pulmonary embolism and infarction
41519	Other pulmonary embolism and infarction
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4168	Other chronic pulmonary heart diseases
4169	Chronic pulmonary heart disease, unspecified
4170	Arteriovenous fistula of pulmonary vessels
4171	Aneurysm of pulmonary artery
4178	Other specified diseases of pulmonary circulation

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Diagnosis Code	Description
4179	Unspecified disease of pulmonary circulation
4200	Acute pericarditis in diseases classified elsewhere
42090	Acute pericarditis, unspecified
42091	Acute idiopathic pericarditis
42099	Other acute pericarditis
4210	Acute and subacute bacterial endocarditis
4211	Acute and subacute infective endocarditis in diseases classified elsewhere
4219	Acute endocarditis, unspecified
4220	Acute myocarditis in diseases classified elsewhere
42290	Acute myocarditis, unspecified
42291	Idiopathic myocarditis
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Other acute myocarditis
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4238	Other specified diseases of pericardium
4239	Unspecified disease of pericardium
4240	Mitral valve disorders
4241	Aortic valve disorder
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4255	Alcoholic cardiomyopathy
4257	Nutritional and metabolic cardiomyopathy
4258	Cardiomyopathy in other diseases classified elsewhere
4259	Secondary cardiomyopathy, unspecified
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block

Diagnosis Code	Description
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block
42652	Right bundle branch block and left anterior fascicular block
42653	Other bilateral bundle branch block
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-ganong-levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
42731	Atrial fibrillation
42732	Atrial flutter
42741	Ventricular fibrillation
42742	Ventricular flutter
4275	Cardiac arrest
42760	Premature beats, unspecified
42761	Supraventricular premature beats
42769	Other premature beats
42781	Sinoatrial node dysfunction
42789	Other specified cardiac dysrhythmias
4279	Cardiac dysrhythmia, unspecified
4280	Congestive heart failure
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure

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Diagnosis Code	Description
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
4290	Myocarditis, unspecified
4291	Myocardial degeneration
4292	Cardiovascular disease, unspecified
4293	Cardiomegaly
4294	Functional disturbances following cardiac surgery
4295	Rupture of chordae tendineae
4296	Rupture of papillary muscle
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other
42981	Other disorders of papillary muscle
42982	Hyperkinetic heart disease
42989	Other ill-defined heart diseases
4299	Heart disease, unspecified
7813	Lack of coordination
78650	Unspecified chest pain
78651	Precordial pain
78652	Painful respiration
78659	Other chest pain
7991	Respiratory arrest
V4321	Organ or tissue replaced by other means, heart assist device
V4581	Postsurgical aortocoronary bypass status

MRI—Additional High Dose Injection of Contrast Material

MRI, additional high dose injection of contrast material, (for example, procedure code 9-A4643, is a benefit of the Texas Medicaid Program).

A diagnostic technique has been developed in which an MRI of the central nervous system is first performed without contrast material; a second is performed with a standard dosage of contrast material; and a third is performed with a double dose of contrast material. Procedure code 9-A4643 is used for only the high dose injection given for the third MRI. The third MRI itself is not covered. Payment of high dose contrast material is limited to procedure codes 4-70553, 4-72156, 4-72157, and 4-72158. High dose contrast material administered in the inpatient setting (POS 3) is included in the DRG reimbursement, and no separate payment is made.

When submitting a claim for procedure code 9-A4643, the name of the drug and the number of cc or mL used must be indicated. If not, it will deny.

25.3.3.19 Gamma Knife Radiosurgery

The following diagnosis codes are payable for F-61793:

Diagnosis Code	Description
1700	Malignant neoplasm of bones of skull and face, except mandible
1701	Malignant neoplasm of mandible
1702	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
1703	Malignant neoplasm of ribs, sternum, and clavicle
1704	Malignant neoplasm of scapula and long bones of upper limb
1705	Malignant neoplasm of short bones of upper limb
1706	Malignant neoplasm of pelvic bones, sacrum, and coccyx
1707	Malignant neoplasm of long bones of lower limb
1708	Malignant neoplasm of short bones of lower limb
1709	Malignant neoplasm of bone and articular cartilage, site unspecified
1710	Malignant neoplasm of connective and other soft tissue of head, face, and neck
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe
1912	Malignant neoplasm of temporal lobe
1913	Malignant neoplasm of parietal lobe
1914	Malignant neoplasm of occipital lobe
1915	Malignant neoplasm of ventricles
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1944	Malignant neoplasm of pineal gland
1983	Secondary malignant neoplasm of brain and spinal cord
2251	Benign neoplasm of cranial nerves
2252	Benign neoplasm of cerebral meninges
2254	Benign neoplasm of spinal meninges

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Diagnosis Code	Description
2273	Benign neoplasm of pituitary gland and craniopharyngeal duct
2370	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
2371	Neoplasm of uncertain behavior of pineal gland
2530	Acromegaly and gigantism
2531	Other and unspecified anterior pituitary hyperfunction
2550	Cushing's syndrome
25511	Glucocorticoid-remediable aldosteronism
25512	Conn's syndrome
25513	Bartter's syndrome
25514	Other secondary aldosteronism
3501	Trigeminal neuralgia
74760	Anomaly of the peripheral vascular system, unspecified site
74781	Congenital anomalies of cerebrovascular system

25.3.3.20 Hospital Radiation Therapy Services

Outpatient radiation therapy is limited to a maximum of five facility services every seven days beginning with the first date of service.

Important: *Take-home drugs given during the course of therapy can be reimbursed separately through the Vendor Drug Program.*

Freestanding radiation therapy facilities (specialty 98) and outpatient hospitals are reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the services listed in the following procedure code tables.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services: therapeutic radiation treatment planning, therapeutic radiology simulation-aided field setting, teletherapy, brachytherapy isodose calculation, treatment devices, proton beam delivery/treatment, intracavity radiation source application, interstitial radiation source application, remote afterloading high intensity brachytherapy, radiation treatment delivery, localization, and radioisotope therapy.

Clinical Treatment Planning

Procedure Codes			
T-77280	T-77285	T-77290	T-77295
T-77299			

Refer to: "Physician" on page 36-1 for further radiation therapy guidelines.

Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

Procedure Codes			
T-77300	T-77305	T-77310	T-77315
T-77326	T-77327	T-77328	T-77332
T-77333	T-77334	T-77399	

Clinical Brachytherapy

Procedure Codes			
T-77781	T-77782	T-77783	T-77784
T-77789	T-77799		

Radiation Treatment Delivery/Port Films

Procedure Codes			
T-77401	T-77402	T-77403	T-77404
T-77406	T-77407	T-77408	T-77409
T-77411	T-77412	T-77413	T-77414
T-77416	T- 77417	T-77421	T-77422
T-77423			

Contrast Materials/Radiopharmaceuticals

Reimbursement for radiological procedures, such as MRI or CT, with descriptions that specify with contrast, include payment for high osmolar, LOCM and paramagnetic contrast materials. These contrast materials will not be reimbursed separately.

Radiopharmaceuticals, when used for therapeutic treatment, may be considered for separate reimbursement.

The following procedure codes may be billed for therapeutic radiopharmaceuticals:

Procedure Codes			
4-79403	9-A9517	9-A9530	9-A9532
9-A9543	9-A9545	9-A9699	

The following services are *not* benefits of the Texas Medicaid Program:

Procedure Codes			
6-77321	6-77331	6-77336	6-77370
6-77470	6–77600	6-77620	6-77790

Procedure code T-77295, is payable to freestanding therapy facilities (specialty 98) and outpatient hospital setting (POS 5). Reimbursement for freestanding radiation treatment centers is at 28.32 relative value units (RVUs). Services provided in the outpatient hospital setting are paid at the TMRM. This code is payable on Medicare crossover claims. Procedure code T-77295 is payable once per day. Procedure codes T-77305, T-77310, and T-77315, are denied when billed on the same day as procedure code T-77295.

Texas Medicaid Program benefits include payment for the technical portion of radiation therapy services provided in an inpatient setting. Covered services include clinical

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treatment planning and management and clinical brachytherapy. Hospitals use revenue code B-333, Radiation therapy, on the HCFA-1450 (UB-92) claim form when submitting charges for these services.

25.3.3.21 Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy is a type of therapy that is intended to increase the environmental oxygen pressure to promote the movement of oxygen from the environment into the body tissues by means of pressurization that is greater than atmospheric pressure. Such treatment is performed in specially constructed hyperbaric chambers, which may hold one or several patients.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, etc., or applied topically is not considered hyperbaric treatment in itself.*

Hyperbaric oxygen therapy will be limited to one session per day, any provider using procedure code 1-99183.

Outpatient hospital clinics and hospital-based rural health centers must use revenue code B-413, Respiratory services, hyperbaric oxygen therapy, (quantity of one) for reimbursement of the technical component.

The FDA-approved indications for the hyperbaric oxygen chamber (therapy) in accordance with the guidelines established by the Undersea and Hyperbaric Medical Society are as follows:

- Air or gas embolism
- Carbon monoxide/smoke inhalation
- Compromised skin grafts and flaps
- Crush injuries/acute traumatic ischemias
- Decompression sickness
- Enhanced healing in selected problem wounds
- Exceptional blood loss (anemia)
- Gas gangrene (clostridial myonecrosis)
- Intracranial abscess
- Necrotizing soft tissue infections
- Radiation tissue damage (osteoradionecrosis)
- Refractory osteomyelitis
- Thermal burns

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *air or gas embolism* the following diagnosis codes should be used:

Diagnosis Code	Description
6396	Embolism following abortion or ectopic and molar pregnancies
67300	Obstetrical air embolism, unspecified as to episode of care
9580	Air embolism as an early complication of trauma
9991	Air embolism as a complication of medical care, not elsewhere classified

Effective for dates of service on or after April 1, 2004, diagnosis code 78552, Septic shock, will be payable for hyperbaric oxygen therapy.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *carbon monoxide/smoke inhalation* use diagnosis code 986, Carbon monoxide poisoning and smoke inhalation.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *compromised skin grafts and flaps* the following diagnosis codes should be used:

Diagnosis Code	Description
99652	Mechanical complication of prosthetic graft of other tissue, not elsewhere classified
99660	Infection and inflammatory reaction due to unspecified device, implant, and graft
99661	Infection and inflammatory reaction due to cardiac device, implant, and graft
99662	Infection and inflammatory reaction due to other vascular device, implant, and graft
99663	Infection and inflammatory reaction due to nervous system device, implant, and graft
99664	Infection and inflammatory reaction due to indwelling urinary catheter
99665	Infection and inflammatory reaction due to other genitourinary device, implant, and graft
99666	Infection and inflammatory reaction due to internal joint prosthesis
99667	Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft
99668	Infection and inflammatory reaction due to peritoneal dialysis catheter
99669	Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft
99670	Other complications due to unspecified device, implant, and graft
99671	Other complications due to heart valve prosthesis
99672	Other complications due to other cardiac device, implant, and graft
99673	Other complications due to renal dialysis device, implant, and graft
99674	Other complications due to other vascular device, implant, and graft

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Diagnosis Code	Description
99675	Other complications due to nervous system device, implant, and graft
99676	Other complications due to genitourinary device, implant, and graft
99677	Other complications due to internal joint prosthesis
99678	Other complications due to other internal orthopedic device, implant, and graft
99679	Other complications due to other internal prosthetic device, implant, and graft
V423	Skin replaced by transplant

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *crush injuries/acute traumatic ischemias* the following diagnosis codes should be used:

Diagnosis Code	Description
8690	Internal injury to unspecified or ill-defined organs without mention of open wound into cavity
8691	Internal injury to unspecified or ill-defined organs with open wound into cavity
8871	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated
8873	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated
8875	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated
8877	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated
8971	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, complicated
8973	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, complicated
8975	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, complicated
8977	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), complicated
9251	Crushing injury of face and scalp
9252	Crushing injury of neck
9260	Crushing injury of external genitalia
92611	Crushing injury of back
92612	Crushing injury of buttock
92619	Crushing injury of other specified sites of trunk
9268	Crushing injury of multiple sites of trunk
9269	Crushing injury of unspecified site of trunk
92700	Crushing injury of shoulder region
92701	Crushing injury of scapular region
92702	Crushing injury of axillary region
92703	Crushing injury of upper arm
92709	Crushing injury of multiple sites of upper arm
92710	Crushing injury of forearm
92711	Crushing injury of elbow
92720	Crushing injury of hand(s)
92721	Crushing injury of wrist
9273	Crushing injury of finger(s)
9278	Crushing injury of multiple sites of upper limb
9279	Crushing injury of unspecified site of upper limb
92800	Crushing injury of thigh
92801	Crushing injury of hip
92810	Crushing injury of lower leg
92811	Crushing injury of knee
92820	Crushing injury of foot
92821	Crushing injury of ankle
9283	Crushing injury of toe(s)
9288	Crushing injury of multiple sites of lower limb
9289	Crushing injury of unspecified site of lower limb
9290	Crushing injury of multiple sites, not elsewhere classified
9299	Crushing injury of unspecified site
99690	Complications of unspecified reattached extremity
99691	Complications of reattached forearm
99692	Complications of reattached hand
99693	Complications of reattached finger(s)
99694	Complications of reattached upper extremity, other and unspecified
99695	Complication of reattached foot and toe(s)
99696	Complication of reattached lower extremity, other and unspecified
99699	Complication of other specified reattached body part

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When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *decompression sickness* use diagnosis code 9933, Caisson disease.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *enhanced healing in selected problem wounds* the following diagnosis codes should be used:

Diagnosis Code	Description
25070	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
25071	Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled
25072	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
25073	Diabetes with peripheral circulatory disorders, type I (juvenile type), uncontrolled
44023	Atherosclerosis of native arteries of the extremities with ulceration
44024	Atherosclerosis of native arteries of the extremities with gangrene
44381	Peripheral angiopathy in diseases classified elsewhere
44382	Erythromelalgia
44389	Other peripheral vascular disease
4439	Peripheral vascular disease, unspecified
4540	Varicose veins of lower extremities with ulcer
4542	Varicose veins of lower extremities with ulcer and inflammation
68600	Pyoderma, unspecified
68601	Pyoderma gangrenosum
68609	Other pyoderma
70700	Decubitus ulcer, unspecified site
70701	Decubitus ulcer, elbow
70702	Decubitus ulcer, upper back
70703	Decubitus ulcer, lower back
70704	Decubitus ulcer, hip
70705	Decubitus ulcer, buttock
70706	Decubitus ulcer, ankle
70707	Decubitus ulcer, heel
70709	Decubitis ulcer, other site
70710	Unspecified ulcer of lower limb
70711	Ulcer of thigh
70712	Ulcer of calf
70713	Ulcer of ankle
70714	Ulcer of heel & midfoot
70715	Ulcer other part of foot
70719	Ulcer oth part low limb
7078	Chronic ulcer of other specified sites
7079	Chronic ulcer of unspecified site
9895	Toxic effect of venom
99859	Other postoperative infection

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *exceptional blood loss (anemia)* the following diagnosis codes should be used:

Diagnosis Code	Description
2851	Acute post hemorrhagic anemia
78559	Other shock without mention of trauma
9584	Traumatic shock
9980	Postoperative shock, not elsewhere classified

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *gas gangrene (clostridial myonecrosis)* the following diagnosis codes should be used:

Diagnosis Code	Description
0383	Septicemia due to anaerobes
0400	Gas gangrene

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *necrotizing soft tissue infections* the following diagnosis codes should be used:

Diagnosis Code	Description
72886	Necrotizing fasciitis
7854	Gangrene

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *radiation tissue damage (osteoradionecrisis)* the following diagnosis codes should be used:

Diagnosis Code	Description
73010	Chronic osteomyelitis, site unspecified
73011	Chronic osteomyelitis involving shoulder region
73012	Chronic osteomyelitis involving upper arm
73013	Chronic osteomyelitis involving forearm
73014	Chronic osteomyelitis involving hand
73015	Chronic osteomyelitis involving pelvic region and thigh
73016	Chronic osteomyelitis involving lower leg

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Diagnosis Code	Description
73017	Chronic osteomyelitis involving ankle and foot
73018	Chronic osteomyelitis involving other specified sites
73019	Chronic osteomyelitis involving multiple sites
7854	Gangrene
9092	Late effect of radiation
990	Effects of radiation, unspecified

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *refractory osteomyelitis* the following diagnosis codes should be used:

Diagnosis Code	Description
73000	Acute osteomyelitis, site unspecified
73001	Acute osteomyelitis involving shoulder region
73002	Acute osteomyelitis involving upper arm
73003	Acute osteomyelitis involving forearm
73004	Acute osteomyelitis involving hand
73005	Acute osteomyelitis involving pelvic region and thigh
73006	Acute osteomyelitis involving lower leg
73007	Acute osteomyelitis involving ankle and foot
73008	Acute osteomyelitis involving other specified sites
73009	Acute osteomyelitis involving multiple sites
73010	Chronic osteomyelitis, site unspecified
73011	Chronic osteomyelitis involving shoulder region
73012	Chronic osteomyelitis involving upper arm
73013	Chronic osteomyelitis involving forearm
73014	Chronic osteomyelitis involving hand
73015	Chronic osteomyelitis involving pelvic region and thigh
73016	Chronic osteomyelitis involving lower leg
73017	Chronic osteomyelitis involving ankle and foot
73018	Chronic osteomyelitis involving other specified sites
73019	Chronic osteomyelitis involving multiple sites
73020	Unspecified osteomyelitis, site unspecified

Osteomyelitis, periotitis, and other infections involving bone.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *thermal burns* the following diagnosis codes should be used:

Diagnosis Code	Description
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa
94100	Burn of unspecified degree of unspecified site of face and head
94101	Burn of unspecified degree of ear (any part)
94102	Burn of unspecified degree of eye (with other parts of face, head, and neck)
94103	Burn of unspecified degree of lip(s)
94104	Burn of unspecified degree of chin
94105	Burn of unspecified degree of nose (septum)
94106	Burn of unspecified degree of scalp (any part)
94107	Burn of unspecified degree of forehead and cheek
94108	Burn of unspecified degree of neck
94109	Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck
94110	Erythema due to burn (first degree) of unspecified site of face and head
94111	Erythema due to burn (first degree) of ear (any part)
94112	Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
94113	Erythema due to burn (first degree) of lip(s)
94114	Erythema due to burn (first degree) of chin
94115	Erythema due to burn (first degree) of nose (septum)
94116	Erythema due to burn (first degree) of scalp (any part)
94117	Erythema due to burn (first degree) of forehead and cheek
94118	Erythema due to burn (first degree) of neck
94119	Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck

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Diagnosis Code	Description
94120	Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site
94121	Blisters, with epidermal loss due to burn (second degree) of ear (any part)
94122	Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)
94123	Blisters, with epidermal loss due to burn (second degree) of lip(s)
94124	Blisters, with epidermal loss due to burn (second degree) of chin
94125	Blisters, with epidermal loss due to burn (second degree) of nose (septum)
94126	Blisters, with epidermal loss due to burn (second degree) of scalp (any part)
94127	Blisters, with epidermal loss due to burn (second degree) of forehead and cheek
94128	Blisters, with epidermal loss due to burn (second degree) of neck
94129	Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck
94130	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
94131	Full-thickness skin loss due to burn (third degree NOS) of ear (any part)
94132	Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
94133	Full-thickness skin loss due to burn (third degree NOS) of lip(s)
94134	Full-thickness skin loss due to burn (third degree NOS) of chin
94135	Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
94136	Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
94137	Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
94138	Full-thickness skin loss due to burn (third degree NOS) of neck
94139	Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part

Diagnosis Code	Description
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp

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Diagnosis Code	Description
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part
94200	Burn of unspecified degree of unspecified site of trunk
94201	Burn of unspecified degree of breast
94202	Burn of unspecified degree of chest wall, excluding breast and nipple
94203	Burn of unspecified degree of abdominal wall
94204	Burn of unspecified degree of back (any part)
94205	Burn of unspecified degree of genitalia
94209	Burn of unspecified degree of other and multiple sites of trunk
94210	Erythema due to burn (first degree) of unspecified site of trunk
94211	Erythema due to burn (first degree) of breast
94212	Erythema due to burn (first degree) of chest wall, excluding breast and nipple
94213	Erythema due to burn (first degree) of abdominal wall
94214	Erythema due to burn (first degree) of back (any part)
94215	Erythema due to burn (first degree) of genitalia
94219	Erythema due to burn (first degree) of other and multiple sites of trunk
94220	Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk
94221	Blisters with epidermal loss due to burn (second degree) of breast
94222	Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
94223	Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
94224	Blisters with epidermal loss due to burn (second degree) of back (any part)
94225	Blisters with epidermal loss due to burn (second degree) of genitalia

Diagnosis Code	Description
94229	Blisters with epidermal loss due to burn (second degree) of other and multiple sites of trunk
94230	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk
94231	Full-thickness skin loss due to burn (third degree NOS) of breast
94232	Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple
94233	Full-thickness skin loss due to burn (third degree NOS) of abdominal wall
94234	Full-thickness skin loss due to burn (third degree NOS) of back (any part)
94235	Full-thickness skin loss due to burn (third degree NOS) of genitalia
94239	Full-thickness skin loss due to burn (third degree NOS) of other and multiple sites of trunk
94240	Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part
94241	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast
94242	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall
94243	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall
94244	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back
94245	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia
94249	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part
94250	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part
94251	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast
94252	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall

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Diagnosis Code	Description
94253	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall
94254	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back
94255	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia
94259	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part
94300	Burn of unspecified degree of unspecified site of upper limb
94301	Burn of unspecified degree of forearm
94302	Burn of unspecified degree of elbow
94303	Burn of unspecified degree of upper arm
94304	Burn of unspecified degree of axilla
94305	Burn of unspecified degree of shoulder
94306	Burn of unspecified degree of scapular region
94309	Burn of unspecified degree multiple sites of upper limb, except wrist and hand
94310	Erythema due to burn (first degree) of unspecified site of upper limb
94311	Erythema due to burn (first degree) of forearm
94312	Erythema due to burn (first degree) of elbow
94313	Erythema due to burn (first degree) of upper arm
94314	Erythema due to burn (first degree) of axilla
94315	Erythema due to burn (first degree) of shoulder
94316	Erythema due to burn (first degree) of scapular region
94319	Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand
94320	Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb
94321	Blisters with epidermal loss due to burn (second degree) of forearm
94322	Blisters with epidermal loss due to burn (second degree) of elbow
94323	Blisters with epidermal loss due to burn (second degree) of upper arm
94324	Blisters with epidermal loss due to burn (second degree) of axilla

Diagnosis Code	Description
94325	Blisters with epidermal loss due to burn (second degree) of shoulder
94326	Blisters with epidermal loss due to burn (second degree) of scapular region
94329	Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand
94330	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb
94331	Full-thickness skin loss due to burn (third degree NOS) of forearm
94332	Full-thickness skin loss due to burn (third degree NOS) of elbow
94333	Full-thickness skin loss due to burn (third degree NOS) of upper arm
94334	Full-thickness skin loss due to burn (third degree NOS) of axilla
94335	Full-thickness skin loss due to burn (third degree NOS) of shoulder
94336	Full-thickness skin loss due to burn (third degree NOS) of scapular region
94339	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand
94340	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part
94341	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm
94342	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow
94343	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm
94344	Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla
94345	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder
94346	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula
94349	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb

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Diagnosis Code	Description
94350	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part
94351	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm
94352	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow
94353	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm
94354	Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla
94355	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder
94356	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula
94359	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb
94400	Burn of unspecified degree of unspecified site of hand
94401	Burn of unspecified degree of single digit (finger [nail]) other than thumb
94402	Burn of unspecified degree of thumb (nail)
94403	Burn of unspecified degree of two or more digits of hand, not including thumb
94404	Burn of unspecified degree of two or more digits of hand, including thumb
94405	Burn of unspecified degree of palm of hand
94406	Burn of unspecified degree of back of hand
94407	Burn of unspecified degree of wrist
94408	Burn of unspecified degree of multiple sites of wrist(s) and hand(s)
94410	Erythema due to burn (first degree) of unspecified site of hand
94411	Erythema due to burn (first degree) of single digit (finger [nail]) other than thumb
94412	Erythema due to burn (first degree) of thumb (nail)
94413	Erythema due to burn (first degree) of two or more digits of hand, not including thumb
94414	Erythema due to burn (first degree) of two or more digits of hand including thumb
94415	Erythema due to burn (first degree) of palm of hand
94416	Erythema due to burn (first degree) of back of hand
94417	Erythema due to burn (first degree) of wrist
94418	Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)
94420	Blisters with epidermal loss due to burn (second degree) of unspecified site of hand
94421	Blisters with epidermal loss due to burn (second degree) of single digit (finger [nail]) other than thumb
94422	Blisters with epidermal loss due to burn of (second degree) of thumb (nail)
94423	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb
94424	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand including thumb
94425	Blisters with epidermal loss due to burn (second degree) of palm of hand
94426	Blisters with epidermal loss due to burn (second degree) of back of hand
94427	Blisters with epidermal loss due to burn (second degree) of wrist
94428	Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)
94430	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand
94431	Full-thickness skin loss due to burn (third degree NOS) of single digit (finger [nail]) other than thumb
94432	Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)
94433	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb
94434	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb
94435	Full-thickness skin loss due to burn (third degree NOS) of palm of hand
94436	Full-thickness skin loss due to burn (third degree NOS) of back of hand
94437	Full-thickness skin loss due to burn (third degree NOS) of wrist
94438	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)

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Diagnosis Code	Description
94440	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand
94441	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, without mention of loss of finger
94442	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb
94443	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers
94444	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers
94445	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm
94446	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand
94447	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist
94448	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist
94450	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand
94451	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, with loss of finger
94452	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb
94453	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers
94454	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers
94455	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand
94456	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand

Diagnosis Code	Description
94457	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist
94458	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part
94500	Burn of unspecified degree of unspecified site of lower limb (leg)
94501	Burn of unspecified degree of toe(s) (nail)
94502	Burn of unspecified degree of foot
94503	Burn of unspecified degree of ankle
94504	Burn of unspecified degree of lower leg
94505	Burn of unspecified degree of knee
94506	Burn of unspecified degree of thigh (any part)
94509	Burn of unspecified degree of multiple sites of lower limb(s)
94510	Erythema due to burn (first degree) of unspecified site of lower limb (leg)
94511	Erythema due to burn (first degree) of toe(s) (nail)
94512	Erythema due to burn (first degree) of foot
94513	Erythema due to burn (first degree) of ankle
94514	Erythema due to burn (first degree) of lower leg
94515	Erythema due to burn (first degree) of knee
94516	Erythema due to burn (first degree) of thigh (any part)
94519	Erythema due to burn (first degree) of multiple sites of lower limb(s)
94520	Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)
94521	Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)
94522	Blisters with epidermal loss due to burn (second degree) of foot
94523	Blisters with epidermal loss due to burn (second degree) of ankle
94524	Blisters with epidermal loss due to burn (second degree) of lower leg
94525	Blisters with epidermal loss due to burn (second degree) of knee
94526	Blisters with epidermal loss due to burn (second degree) of thigh (any part)
94529	Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)
94530	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb

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Diagnosis Code	Description
94531	Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)
94532	Full-thickness skin loss due to burn (third degree NOS) of foot
94533	Full-thickness skin loss due to burn (third degree NOS) of ankle
94534	Full-thickness skin loss due to burn (third degree NOS) of lower leg
94535	Full-thickness skin loss due to burn (third degree NOS) of knee
94536	Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)
94539	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)
94540	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part
94541	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)
94542	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot
94543	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle
94544	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg
94545	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee
94546	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh
94549	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part
94550	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part
94551	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)
94552	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot
94553	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle

Diagnosis Code	Description
94554	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg
94555	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee
94556	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh
94559	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part
9460	Burns of multiple specified sites, unspecified degree
9461	Erythema due to burn (first degree) of multiple specified sites
9462	Blisters with epidermal loss due to burn (second degree) of multiple specified sites
9463	Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites
9464	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part
9465	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part
9470	Burn of mouth and pharynx
9471	Burn of larynx, trachea, and lung
9472	Burn of esophagus
9473	Burn of gastrointestinal tract
9474	Burn of vagina and uterus
9478	Burn of other specified sites of internal organs
9479	Burn of internal organs, unspecified site
94800	Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94810	Burn (any degree) involving 10-19 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94811	Burn (any degree) involving 10-19 percent of body surface with third degree burn of 10-19 percent
94820	Burn (any degree) involving 20-29 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94821	Burn (any degree) involving 20-29 percent of body surface with third degree burn of 10-19 percent

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Diagnosis Code	Description
94822	Burn (any degree) involving 20-29 percent of body surface with third degree burn of 20-29 percent
94830	Burn (any degree) involving 30-39 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94831	Burn (any degree) involving 30-39 percent of body surface with third degree burn of 10-19 percent
94832	Burn (any degree) involving 30-39 percent of body surface with third degree burn of 20-29 percent
94833	Burn (any degree) involving 30-39 percent of body surface with third degree burn of 30-39 percent
94840	Burn (any degree) involving 40-49 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94841	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 10-19 percent
94842	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 20-29 percent
94843	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 30-39 percent
94844	Burn (any degree) involving 40-49 percent of body surface with third degree burn of 40-49 percent
94850	Burn (any degree) involving 50-59 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94851	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 10-19 percent
94852	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 20-29 percent
94853	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 30-39 percent
94854	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 40-49 percent
94855	Burn (any degree) involving 50-59 percent of body surface with third degree burn of 50-59 percent
94860	Burn (any degree) involving 60-69 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94861	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 10-19 percent
94862	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 20-29 percent
94863	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 30-39 percent
94864	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 40-49 percent
94865	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 50-59 percent
94866	Burn (any degree) involving 60-69 percent of body surface with third degree burn of 60-69 percent
94870	Burn (any degree) involving 70-79 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94871	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 10-19 percent
94872	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 20-29 percent
94873	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 30-39 percent
94874	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 40-49 percent
94875	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 50-59 percent
94876	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 60-69 percent
94877	Burn (any degree) involving 70-79 percent of body surface with third degree burn of 70-79 percent
94880	Burn (any degree) involving 80-89 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94881	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 10-19 percent
94882	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 20-29 percent

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Diagnosis Code	Description
94883	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 30-39 percent
94884	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 40-49 percent
94885	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 50-59 percent
94886	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 60-69 percent
94887	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 70-79 percent
94888	Burn (any degree) involving 80-89 percent of body surface with third degree burn of 80-89 percent
94890	Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount
94891	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10-19 percent
94892	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20-29 percent
94893	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30-39 percent
94894	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40-49 percent
94895	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50-59 percent
94896	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60-69 percent
94897	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70-79 percent
94898	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80-89 percent
94899	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface
9490	Burn of unspecified site, unspecified degree
9491	Erythema due to burn (first degree), unspecified site
9492	Blisters with epidermal loss due to burn (second degree), unspecified site
9493	Full-thickness skin loss due to burn (third degree NOS), unspecified site
9494	Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part
9495	Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part

Hyperbaric oxygen therapy that exceeds one session per day, any provider will be denied.

25.3.3.22 Implantable Contraceptive Capsules

ASCs and HASCs billing for removal of implantable contraceptive capsules should use procedure code F-11975, F-11976, and F-11977.

25.3.3.23 Occupational and Physical Therapy Services

Occupational and Physical Therapy Procedure Codes and Limitations

Occupational and physical therapy are benefits of the Medicaid program as outlined in the following sections. Specific codes to occupational and physical therapy as well as information about benefits can be found in these sections.

Occupational and physical therapy procedure codes are listed in the following table:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97020	1-97022	1-97024	1-97026
1-97028	1-97032	1-97033	1-97034
1-97035	1-97036	1-97039	1-97110
1-97112	1-97113	1-97116	1-97124
1-97139	1-97140	1-97150	1-97520
1-97530	1-97750	1-97799	

The following occupational and physical therapy procedure codes are a benefit for *THSteps-CCP clients only*:

Procedure Codes			
1-97504	1-97535	1-97537	1-97542
1-97703			

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The following procedure codes are limited to one per day:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97022	1-97024	1-97026	1-97028
1-97150			

The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes			
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140	1-97504	1-97520	1-97530
1-97535	1-97537		

Procedure code 1-97010, is not a benefit of the Texas Medicaid Program.

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure codes 1-97703 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit will be denied as part of another procedure billed the same day. Procedure code 1-97703 is only payable for clients younger than 21 years of age.

Occupational Therapy Services

Occupational therapy is a payable benefit to physicians and hospitals. Occupational therapy must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. Occupational therapy is to be billed with the following CPT procedure codes as applicable:

Procedure Codes			
1-97003	1-97004	1-97012	1-97014
1-97016	1-97018	1-97022	1-97024
1-97026	1-97028	1-97032	1-97033
1-97034	1-97035	1-97036	1-97039
1-97110	1-97112	1-97113	1-97116
1-97124	1-97139	1-97140	1-97150
1-97530	1-97535	1-97537	1-97542
1-97750	1-97760	1-97761	1-97762
1-97799			

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy.

If a condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Occupational therapy prescribed primarily as an adjunct to psychotherapy is not a benefit.

Procedure codes 1-97003 and 1-97004 are for occupational therapy only.

Procedure code 1-97003, is payable once per six months, any provider, same facility. Procedure code 1-97004, is payable one time per month, any provider, same facility. These codes are not payable on the same day as the following codes:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97022	1-97024	1-97026	1-97028
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140	1-97150	1-97504	1-97520
1-97530	1-97750	1-97760	1-97761
1-97762			

Refer to: "Physician" on page 36-1 for more guidelines.

Physical Therapy Services

Physical therapy is the use of physical agents such as heat, massage, electricity, traction, or exercises in the treatment of disease. Payments for physical therapy are limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical medicine to restore function.

Physical therapy, including functional evaluations, must be provided according to the current written orders of a physician (written within 60 days) and based on medical necessity. It may be performed by auxilliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

The acute modifier AT must be billed for payment to be made. The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy.

Example: *The following may be considered acute: a new injury, therapy before or after surgery, acute exacerbations of conditions, such as rheumatoid arthritis, and interventions such as a newly implanted intrathecal pump to decrease spasticity or Botulinum Toxin Type A injections.*

If a condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic, and the

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client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Payment cannot be made to a physician or an independently practicing physical therapist who provides physical therapy to a resident of a nursing facility. These services must be made available to nursing facility residents on an as-needed basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

Procedure codes 1-97001 and 1-97002 are for physical therapy only.

Procedure code 1-97001 is payable once per six months, any provider, same facility. Procedure code 1-97002, is payable once per month, any provider, same facility. Procedure codes 1-97001 and 1-97002 are not payable on the same day as the following codes:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97022	1-97024	1-97026	1-97028
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97150	1-97504	1-97520	1-97530
1-97750	1-97760	1-97761	1-97762

The following procedure codes are limited to once per day:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97022	1-97024	1-97026	1-97028
1-97150			

The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes			
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140			

Procedure code 1-97010 is not a benefit of the Texas Medicaid Program.

Procedure codes 1-97703 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit will be denied as part of another procedure billed the same day. Procedure code 1-97703 is only payable for clients younger than 21 years of age.

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Refer to: “Claim Filing Resources” on page 24-61.

“THSteps Medical and Dental Administrative Information” on page 43-5 for authorization requirements and coverage or noncoverage of the above physical therapy and rehabilitation codes.

25.3.3.24 Osteopathic Manipulation Treatments (OMT)

OMT is a covered benefit of the Texas Medicaid Program for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury including acute musculoskeletal injury with a neurological component. The acute modifier AT must be submitted with the claim for payment to be made.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Use procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions.

When multiples of procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 are billed on the same day by the same provider, the most inclusive code is paid and the others denied.

Procedure code 1-97140 will deny as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

25.3.3.25 Psychiatric Services

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) is also limited to a combined total of 12 hours. MDs and DOs who delegate and providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day.

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Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped. Documentation requirements for all services billed are listed for each individual specialty in this manual.

Outpatient behavioral health services without prior authorization are limited to 30 encounters/visits per client per calendar year. An encounter/visit is defined as any and all outpatient behavioral health services rendered per hour by any provider, in the office, outpatient, nursing home, and home settings. This limitation includes encounters/visits by all practitioners.

The following services are not counted towards the 30 encounter/visit limitation:

- School Health and Related Services (SHARS) behavioral health rehab services
- Mental Health and Mental Retardation (MHMR) services
- Laboratory and radiology services
- Pharmacological management (1-90862)

Services that exceed 30 encounters/visits per calendar year per client must be prior authorized. Prior authorization must be obtained before providing the 25th service in a calendar year. Prior authorization requests in increments of up to 10 additional encounters/visits may be considered. If the client changes providers during the year and the new provider is unable to obtain complete information on the client, prior authorization may be made when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the 25th encounter/visit and before rendering services. This information must be submitted in addition to the usual medical necessity information.

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was unable to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to 10 encounters/visits per request, and must be submitted on the Extended Outpatient/ Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number and type of services requested and the dates (based on the frequency of visits) that the services will be provided
- All areas of the request must be completed with the information required on the form. If additional room is needed providers may state "see attached." The attachment must contain the specific information required in that section of the form

Prior authorization is not granted to providers who have seen a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits* must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these *additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts for court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

The following psychiatric services are not covered by the Texas Medicaid Program:

- The services of a licensed chemical dependency counselor (LCDC), psychological associate (masters level psychologist), psychiatric nurse, or behavioral health worker
- Psychiatric daycare
- Recreational therapy
- Biofeedback
- Music/dance
- Thermogenic therapy

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Outpatient psychiatric services for the diagnosis or treatment of a mental, psychoneurotic, or personality disorder are reimbursed at the hospital's designated reimbursement rate as determined by the annual cost settlement.

Note: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists that provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR BHOs.*

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-81.

"Medicaid Managed Care" on page 7-4 for more information or contact the client's BHO.

25.3.3.26 Psychological and Neuropsychological Testing

Psychological or neuropsychological testing will be limited to a total of four hours per day per client, any provider. Documentation of medical necessity must be maintained in the client's chart. Each hour of therapy, psychological and/or neuropsychological testing counts as one of the 30-encounter/visit limit.

Refer to: "Psychological and Neuropsychological Testing" on page 38-3 for information on outpatient psychological and neuropsychological testing, including procedure codes and diagnosis code restrictions.

25.3.3.27 Sterilization Services

The Texas Medicaid Program benefits include payment for elective sterilization (performed solely for the purpose of rendering the individual incapable of bearing or fathering children) of eligible clients when providers comply with HHS regulations (42 CFR 441.250, Subpart F).

Payment of elective sterilization is *not* made if the client is:

- Younger than 21 years of age at the time the consent form is signed
- Declared mentally incompetent for the purpose of sterilization (the individual may be adjudicated competent for the purpose of sterilization)
- Institutionalized in a correctional facility, mental hospital, or other rehabilitative facility
- Giving consent during labor or childbirth, under the influence of alcohol or other drugs, or while seeking or obtaining an abortion

Important: *If a client eligible for Medicaid decides not to be sterilized after entering the hospital, the hospital may be reimbursed for its services. The hospital must submit a valid consent form signed by the client. The physician's signature is not required.*

TMHP must have a signed, valid sterilization consent form on file to reimburse elective sterilization procedures. Typewritten, blocked, or facsimile stamped signatures are not acceptable for signature requirements. When TMHP receives a valid consent form, the client's eligibility file is updated to reflect receipt. Subsequent claims received by TMHP for the sterilization covered by the consent are referenced to the valid consent and reimbursed even if they are not accompanied by a valid consent. It is to the provider's benefit to submit a consent form with claims for sterilization rather than relying on a fellow provider. A legible valid copy of the consent is acceptable.

The "Sterilization Consent Form Instructions (2 Pages)" on page B-92 and the HHS-approved form (supplied by TMHP) are the only acceptable forms. Providers may use their own consent form as long as the form has the HHS-approved language and required fields. The only exception is if the provider obtains prior approval from HHS.

Refer to: "Elective Sterilization Services" on page 36-68.

"Sterilization and Sterilization-Related Procedures" on page 20-14 for elective sterilization services requirements and instructions.

25.3.4 Utilization Review

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Utilization review activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the *Social Security Act*, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of the Texas Medicaid Program.

Utilization review may also occur by an examination of particular claims or services not within the usual screening review when a specific utilization review is requested by HHSC or the Texas Attorney General's Office.

25.3.4.1 Responsibilities

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate billing patterns by outpatient hospitals and HASCs. All providers are subject to TMHP's utilization review monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid Program compliance. An analysis of utilization review data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider's practice and billing patterns are incon-

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sistent with the federal requirements and the Texas Medicaid Program's scope of benefits, a TMHP representative contacts the provider. The purpose of the contact is to discuss appropriate billing guidelines and to assist the provider in resolving the inappropriate billing patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician
- Billed in the quantities ordered and documented as provided
- Program benefits
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim
- Billed to Medicaid only after other medical insurance resources have been exhausted

Refer to: "Medicaid Identification (Form H3087)" on page 4-9.

- Indicated by the documentation in the medical record.

The determination of TMHP's utilization review process may result in the following:

- Educational letters/visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, ASC/HASC, or inpatient records *not* reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
- Recoupment
- Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

25.3.5 Claims Information

Providers must submit all required claim information on the face of the HCFA-1450 (UB-92) claim form. TMHP no longer accepts the required information on an attachment to the claim (for example, itemized statements). Identification of outpatient charges must be in Block 43, if submitting by narrative description or in Block 44, if submitting by HCPCS code. The Texas Medicaid Program recommends the use of specific HCPCS codes for claim submission. Do *not* use the revenue code description in Block 43. The HCPCS narrative description must be identified on the claim. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (for example, gait training).

Charges on claims must be itemized on the face of the HCFA-1450 (UB-92) claim form instead of submitting attachments or charge tickets. If a claim contains more than 23 line items, continue the claim on additional UB-92s. Total each HCFA-1450 (UB-92) claim form as a stand-alone claim. If you do not total each page, your claim may be denied with EOB 472 (No more than 27 details allowed per claim). Resubmit with 27 or less details and ensure HCFA-1450 (UB-92) claim form and attached statement totals agree. Refer to Provider Manual." TMHP uses information attached to the claim for clarification purposes only.

Providers must purchase HCFA-1450 claim form from the vendor of their choice; TMHP does not supply them.

Refer to: "HCFA-1450 (UB-92) Claim Filing Instructions" on page 5-32 for claims completion instructions.

25.3.5.1 Claim Filing Resources

Refer to the following sections and/or forms on the page numbers listed below when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
HCFA-1450 (UB-92) Claim Filing Instructions	5-32
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Hospital Audits Request for Claims Summary	B-54
Hospital Report (Newborn Child or Children) HHSC Form 7484	B-51
Sterilization Consent Form (English)	B-92
Sterilization Consent Form (Spanish)	B-94
Sterilization Consent Form Instructions	B-96
Hospital-Based ASC Claim Example	D-17
Hospital Inpatient Claim Example	D-18
Hospital Outpatient Claim Example	D-18
Acronym Dictionary	F-1

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Section

26

Independent Laboratory

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26.1 Enrollment

To enroll in the Texas Medicaid Program, the independent (freestanding) laboratory must do the following:

- Be independent from a physician's office or hospital
- Meet staff, equipment, and testing capability standards for certification by HHSC
- Have Medicare certification
- Submit a current copy of the medical director's physician license, if the lab has physician involvement

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

26.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

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

26.2 Clinical Laboratory Improvement Amendments (CLIA)

26.2.1 CLIA Requirements

To be eligible for reimbursement by Medicare and Medicaid, all providers performing laboratory tests must:

- Pay a fee to the Centers for Medicare & Medicaid Services (CMS)
- Contact HHSC at 1-512-834-6650 to receive a Clinical Laboratory Improvement Amendments (CLIA) registration and/or certification number. Submit CLIA applications to the following address:

  Health Facility Licensing and Certification Division
  HHSC
  1100 West 49th Street
  Austin, TX 78756

- Notify TMHP of the assigned CLIA number at the following address:

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

Important: *TMHP monitors claims submitted by clinical laboratories for CLIA numbers. Without a CLIA number on file with TMHP, claims for laboratory services will be denied.*

26.2.2 CLIA Regulations

Effective for dates of service on or after September 1, 1992, CMS implemented CLIA rules and regulations. The CLIA regulations were published in the February 28, 1992, *Federal Register* and have been amended several times since. The regulations are found at Title 42 *Code of Federal Regulations*, Part 493.

The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA regulations set standards designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing (PT). These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratories (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet standards based on the complexity of the test(s) they perform.

26.2.3 Limits of Waiver and Physician-Performed Microscopy Procedure (PPMP) CLIA Certificates

CLIA certificates may limit the holder to performing only certain tests. Medicaid bills must accurately reflect those services authorized by the CLIA program and no other procedures. Two types of certificates limit holders to only certain test procedures: *Waiver* and *PPMP* certificates. A list of those test procedures follows.

26.2.3.1 Waiver Certificate

Providers holding waiver CLIA certificates are authorized to perform only the following tests. The following tests granted waiver status under CLIA were updated beginning September 27, 2002. The QW modifier is a CLIA requirement for specific codes based on their complexity and must be included or claims will be denied.

Procedure Codes		
5-80061-QW	5-80101-QW	5-81002
5-81003-QW	5-81025	5-82010-QW
5-82044-QW	5-82055-QW	5-82120-QW
5-82270	5-82274-QW	5-82465-QW
5-82523-QW	5-82570-QW	5-82679-QW
5-82947-QW	5-82950-QW	5-82951-QW
5-82952-QW	5-82985-QW	5-83001-QW
5-83002-QW	5-83026	5-83036-QW
5-83518-QW	5-83605-QW	5-83718-QW
5-83880-QW	5-83986-QW	5-84450-QW
5-84460-QW	5-84478-QW	5-84703-QW
5-85013	5-85014-QW	5-85018-QW
5-85576-QW	5-85610-QW	5-85651
5-86294-QW	5-86308-QW	5-86318-QW
5-86618-QW	5-86701-QW	5-87077-QW
5-87210-QW	5-87449-QW	5-87804-QW
5-87880-QW	5-G0107	

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26.2.3.2 PPMP Certificates

Holders of PPMP certificates are authorized to perform all the procedures listed for waiver certificate in addition to the following tests:

Procedure Codes		
5-81000	5-81001	5-81015
5-81020	5-89190	5-Q0111
5-Q0112	5-Q0113	5-Q0115

26.3 Reimbursement

Medicaid pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider. Providers who perform the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component; those who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied. Claims are paid based on the order they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical and/or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

The Medicaid rates for independent laboratories are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8081 and §355.8610, and the *Deficit Reduction Act* (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982, independent laboratories are not directly reimbursed by Texas Medicaid when providing tests to clients registered as hospital inpatients. Reimbursement must be obtained from the hospital.

These services cannot be billed to the client.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

26.3.1 Texas Health Steps (THSteps) Outpatient Laboratory Services

The Medicaid service, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), is known in Texas as Texas Health Steps (THSteps).

Refer to: "Eligibility for a Medical Checkup" on page 43-7.

Important: *All required THSteps laboratory work is to be performed by the Department of State Health Services (DSHS) Bureau of Laboratories. DSHS makes these services available free to all enrolled THSteps medical providers for THSteps-eligible children. THSteps services provided in a private laboratory will not be reimbursed. The Bureau of Laboratories is reimbursed at its cost for performing these tests.*

Except for Pap smears, all required THSteps laboratory work must be sent to the DSHS Bureau of Laboratories at the following address:

DSHS Bureau of Laboratories
1100 West 49th Street
Austin, TX 78756-3199
1-512-458-7661

Pap smear specimens must be sent to the following address:

Women's Health Laboratories
Attn: Kathy Allen, Cytology Laboratory
2303 SE Military Drive
San Antonio TX 78223
1-210-534-8857, Ext. 2357
Toll-free: 1-888-440-5002
E-mail: Kathleen.Allen@dshs.state.tx.us

Claims for tests listed in the following table submitted by a THSteps medical provider or an outside laboratory for the same date of service as a THSteps medical checkup will be denied and are subject to retrospective review:

Procedure Codes		
5-80061	5-82465	5-83020
5-83021	5-83655	5-83718
5-84203	5-84478	5-85013
5-85014	5-85018	5-86403
5-86580	5-86592	5-86689
5-86701	5-87490	5-87590
5-88142	5-88147	5-88150
5-88164		

26.4 Benefits and Limitations

The Texas Medicaid Program only covers professional and technical services that an independent laboratory is certified by Medicare to perform.

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26.4.1 Reference Labs and Lab Handling Fees

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may *not* bill for any laboratory tests. An independent laboratory may only bill Medicaid for tests referred to another laboratory (independent or hospital) if it performs at least one test (that is Medicare-certified to perform) and forwards a portion of the same specimen to another laboratory (reference laboratory) to have one or more tests performed.

In this instance, the referring laboratory may bill for tests it has performed and *all* tests it is to perform on the specimen. When billing, the *Yes* box in Block 20 of the CMS-1500 claim form must be marked, the name and provider identifier of the *reference lab* to where the specimens have been forwarded must be indicated in Block 32, and the provider identifier of the *reference lab* must be indicated in Block 24-K next to each procedure to be performed by the *reference lab*.

Important: *Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.*

An independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (1-99001) for collecting and forwarding the specimen to the other laboratory if the specimen is collected by routine venipuncture or catheterization. Routine venipunctures or finger, heel, and ear sticks for collection of specimen(s) (2/5-36415) are not a Medicaid benefit. Family planning agencies must use code 1-99000 with modifier FP to bill their laboratory handling charges for laboratory specimens sent out. As with the physician code 1-99000, only one handling fee may be charged for each laboratory to the agency that sends specimens, regardless of the number of specimens taken.

When family planning test specimens such as Pap smears are collected, providers must direct the laboratory to indicate the claim for the test is to be billed as a family planning service.

If personnel from the independent laboratory are sent to a nursing facility to collect a blood specimen from a client eligible for Medicaid, procedure code 36415 may be billed. When billing on paper, the claim must document the name and address or the nine-digit provider identifier of the nursing facility in Block 32 of the CMS-1500 claim form. If billing electronically, the information must be in the appropriate field.

26.4.2 Repeated Procedures

26.4.2.1 Modifier 91

Effective for dates of service on or after May 5, 2004, modifier 91 should be used for repeat clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

For dates of service on or after April 3, 1998, certain procedure codes have been removed from modifier 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 91 will continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

26.4.2.2 Modifier 76

Modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (e.g., disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 76 auditing for dates of service on or after April 3, 1998. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have

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been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for modifier 76.

When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

26.4.3 Laboratory Paneling

A *panel* is defined as a group of tests that were performed together or in combination. Chemistry tests, urinalysis, and CBC must be billed as a panel.

When paneling codes, the charge for the panel must reflect the total charge for the laboratory services.

26.4.3.1 Chemistry Tests

Laboratory Paneling

Medicare policy pertaining to laboratory paneling procedures was implemented by the Texas Medicaid Program. Organ and disease panel codes 5-80048, 5-80051, and 5-80053 must be used instead of the general multichannel automated panel codes.

Procedure code 5-84078 is considered a component of the multiple chemistry panels. Procedure code 5-85595 is considered a component of any hemogram with a platelet panel. Hemogram or CBC with platelet panel codes 5-85025 to 5-85027 must be billed when two or more components of a CBC and a platelet count are performed. When two or more components of a CBC and a platelet count are billed separately on the same day, all components are denied with Explanation of Benefits (EOB) 00559, "*These tests must be combined and billed as a CBC/panel. Resubmit with signed claim copy, R&S report copy, and appropriate code (5-85025 and 5-85027)*."

The following chemistry tests must be billed individually unless a complete panel is performed on the same day:

Procedure Codes		
5-82040	5-82150	5-82247
5-82248	5-82310	5-82373
5-82374	5-82435	5-82465
5-82550	5-82565	5-82945
5-82947	5-82948	5-82977
5-83090	5-83615	5-83663
5-83664	5-83690	5-83735
5-83921	5-84075	5-84078
5-84100	5-84132	5-84152
5-84155	5-84160	5-84295
5-84450	5-84460	5-84478
5-84520	5-84550	5-84591

26.4.3.2 Urinalysis

Procedure codes 5-82009, 5-82947, and 5-83986 are payable when billed on the same day as a urinalysis. If procedure code 5-84578 and 5-84583 are billed on the same day as any of the following urinalysis procedure codes, procedure codes 5-84578 and 5-84583 will be denied as part of the urinalysis:

Procedure Codes		
5-81000	5-81001	5-81002
5-81003	5-81005	5-81020

If procedure code 5-81015 is billed in addition to routine urinalysis codes 5-81000 or 5-81001, procedure code 5-81015 will be denied as part of 5-81000 or 5-81001. If procedure code 5-81015 is billed with urinalysis codes 5-81002 or 5-81003, both codes will be denied requiring paneling into either 5-81000 or 5-81001.

When performing bacterial urine culture with antibiotic sensitivities, use procedure code 5-87086.

26.4.4 Cancer Screening, Colorectal

The following procedure codes are covered services:

Procedure Codes		
5–G0103	2/F-G0104	2/F-G0105
4/I/T-G0106	5-G0107	4/I/T-G0120

Procedure code 4/I/T-G0122 is *not* covered by Medicaid.

Screening intervals are recommended once every 48 months for individuals 50 years of age and older. The screening colonoscopy is recommended once every 24 months for individuals at high risk for colorectal cancer.

High-risk individuals include people with one or more of the following:

- Close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyposis
- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of colorectal cancer
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis

A screening colonoscopy may be covered for the following diagnoses:

26.4.4.1 History

Diagnosis Code	Description
V1005	Personal history of malignant neoplasm of the large intestine
V1006	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

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Diagnosis Code	Description
V160	Family history of malignant neoplasm of gastrointestinal tract
V1851	Family history, colonic polyps

26.4.4.2 Chronic Digestive Disease Condition

Diagnosis Code	Description
5550	Regional enteritis of small intestine
5551	Regional enteritis of large intestine
5552	Regional enteritis of small intestine with large intestine
5559	Regional enteritis of unspecified site
5560	Ulcerative (chronic) enterocolitis
5561	Ulcerative (chronic) ileocolitis
5562	Ulcerative (chronic) proctitis
5563	Ulcerative (chronic) protosigmoiditis
5568	Other ulcerative colitis
5569	Ulcerative colitis, unspecified

26.4.4.3 Inflammatory Bowel

Diagnosis Code	Description
5582	Toxic gastroenteritis and colitis
5583	Allergic gastroenteritis and colitis
5589	Other and unspecified noninfectious gastroenteritis and colitis

26.4.4.4 Complete Blood Count (CBC)

A CBC is a comprehensive service that includes components. A CBC is billed with procedure code 85025, 85027, or 85032.

The components of a CBC are listed in the following table. Any of these procedure codes billed for the same date of service as a CBC procedure code will deny as part of another service.

Procedure Codes		
85007	85008	85009
85013	85014	85018
85041	85048	85049

Procedure code 85049 may be reimbursed separately. If this procedure code is billed for the same date of service as procedure codes 85004, 85007, 85008, 85009, or 85027, it will deny as part of another service.

Reticulocyte procedure codes 85044, 85045, and 85046 may be reimbursed in addition to a CBC.

26.4.5 Helicobacter Pylori (H. Pylori)

Procedure codes 5-83013, 5-83014, 5-87338, and 5-87339 are covered services.

These codes are considered to be clinical lab services and must be billed using type of service (TOS) 5. The interpretation/professional component TOS I is not separately reimbursed.

Procedure codes 5-87338 and/or 5-87339 are not payable on the same date of service to the same provider as procedure codes 5-83013 and/or 5-83014. If a gastrointestinal endoscopy is performed within 90 days of the H. pylori test, procedure codes 2-43200, 2-43202, 2-43234, 2-43235, and 2-43239 will be denied.

These services can be appealed with submission of medical documentation that supports performance of a gastrointestinal endoscopy. The following diagnoses are covered for procedure code 5-87338:

Diagnosis Code	Description
53100	Acute gastric ulcer with hemorrhage, without mention of obstruction
53101	Acute gastric ulcer with hemorrhage, with obstruction
53110	Acute gastric ulcer with perforation, without mention of obstruction
53111	Acute gastric ulcer with perforation, with obstruction
53120	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction
53121	Acute gastric ulcer with hemorrhage and perforation, with obstruction
53130	Acute gastric ulcer without mention of hemorrhage or perforation, without mention of obstruction
53131	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction
53140	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction
53141	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction
53150	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction
53151	Chronic or unspecified gastric ulcer with perforation, with obstruction
53160	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction
53161	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction
53170	Chronic gastric ulcer without mention of hemorrhage or perforation, without mention of obstruction

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Diagnosis Code	Description
53171	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction
53190	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, without mention of obstruction
53191	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
53200	Acute duodenal ulcer with hemorrhage, without mention of obstruction
53201	Acute duodenal ulcer with hemorrhage, with obstruction
53210	Acute duodenal ulcer with perforation, without mention of obstruction
53211	Acute duodenal ulcer with perforation, with obstruction
53220	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction
53221	Acute duodenal ulcer with hemorrhage and perforation, with obstruction
53230	Acute duodenal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53231	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction
53240	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction
53241	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction
53250	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction
53251	Chronic or unspecified duodenal ulcer with perforation, with obstruction
53260	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction
53261	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction

Diagnosis Code	Description
53270	Chronic duodenal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53271	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction
53290	Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation, without mention of obstruction
53291	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
53400	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction
53401	Acute gastrojejunal ulcer, with hemorrhage, with obstruction
53410	Acute gastrojejunal ulcer with perforation, without mention of obstruction
53411	Acute gastrojejunal ulcer with perforation, with obstruction
53420	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction
53421	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction
53430	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53431	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction
53440	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction
53441	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction
53450	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction
53451	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction
53460	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction

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Diagnosis Code	Description
53461	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction
53470	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53471	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction
53490	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, without mention of obstruction
53491	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
53500	Acute gastritis (without mention of hemorrhage)
53501	Acute gastritis with hemorrhage
53510	Atrophic gastritis (without mention of hemorrhage)
53511	Atrophic gastritis with hemorrhage
53550	Unspecified gastritis and gastroduodenitis (without mention of hemorrhage)
53551	Unspecified gastritis and gastroduodenitis with hemorrhage
53560	Duodenitis (without mention of hemorrhage)
53561	Duodenitis with hemorrhage
5368	Dyspepsia and other specified disorders of function of stomach
78901	Abdominal pain, right upper quadrant
78902	Abdominal pain, left upper quadrant
78906	Abdominal pain, epigastric

Refer to: "Helicobacter Pylori (H. Pylori)" on page 36-58 for more information.

26.4.6 Microquantitative Sweat Test

Procedure code 89230 is a procedure used to diagnose cystic fibrosis (27700 and 27701). Effective for dates of service on or after February 1, 2000, procedure code 89230 is not restricted by diagnosis.

26.4.7 Organ or Disease Panels

Organ panels are specific laboratory studies that have been combined under a problem-oriented classification as an approach to diagnosis. The following list of panels includes all components that must be included to report the panel code.

Individual laboratory studies considered a part of a specific panel are denied when billed on the same day as the panel code by the same provider.

26.4.7.1 Basic Metabolic Panel (5-80048)

This panel must include the following:

5-80048—Basic metabolic panel includes:		
5-82310	5-82374	5-82435
5-82565	5-82947	5-84132
5-84295	5-84520	

5-80050—General health panel includes:		
5-80053	5-85025	5-85027
5-84443		

5-80051—Electrolyte panel includes:		
5-82374	5-82435	5-84132
5-84295		

5-80053—Comprehensive metabolic panel includes:		
5-82040	5-82247	5-82310
5-82374	5-82435	5-82565
5-82947	5-84075	5-84132
5-84155	5-84295	5-84450
5-84460	5-84520	

5-80055—Obstetric panel includes:		
5-85025	5-85027	5-86592
5-86762	5-86850	5-86900
5-86901	5-87340	

5-80061—Lipid panel includes:		
5-80069	5-82465	5-83718
5-84478		

5-80069—Renal function panel includes:		
5-82040	5-82310	5-82374
5-82435	5-82565	5-82947
5-84100	5-84132	5-84295
5-84520		

5-80074—Acute hepatitis panel includes:		
5-86709	5-86705	5-87340
5-86803		

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5-80076—Hepatic function panel includes:		
5-82040	5-82247	5-82248
5-84075	5-84155	5-84460
5-84450		

5-80090—TORCH Antibody panel includes:		
5-86644	5-86694	5-86762
5-86777		

26.4.8 Ferritin and Iron Studies

Procedure codes 5-82728, 5-83540, 5-83550, 5-84466, and 5-85536, are payable for the following diagnoses:

Diagnosis Code	Description
2750	Disorders of iron metabolism
2800	Iron deficiency anemias, secondary to blood loss (chronic)
2801	Iron deficiency anemias, secondary to inadequate dietary iron intake
2808	Other specified iron deficiency anemias
2809	Iron deficiency anemia, unspecified
2810	Pernicious anemia
2811	Other vitamin B-12 deficiency anemia
2812	Folate-deficiency anemia
2819	Unspecified deficiency anemia
28241	Sickle-cell thalassemia without crisis
28242	Sickle-cell thalassemia with crisis
28249	Other thalassemia
28264	Sickle-cell/Hb-C disease with crisis
28268	Other sickle-cell disease without crisis
2828	Other specified hereditary hemolytic anemias
2829	Hereditary hemolytic anemia, unspecified
2839	Acquired hemolytic anemia, unspecified
2850	Sideroblastic anemia
28521	Anemia in chronic kidney disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic disease
2859	Anemia, unspecified
5360	Achlorhydria
5728	Other sequelae of chronic liver disease
5738	Other specified disorders of liver
5739	Unspecified disorder of liver
5793	Other and unspecified postsurgical nonabsorption
5798	Other specified intestinal malabsorption
5799	Unspecified intestinal malabsorption
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
586	Renal failure, unspecified
64820	Anemia of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64821	Anemia of mother, with delivery
64822	Anemia of mother, with delivery, with mention of postpartum complication
64823	Antepartum anemia
64824	Postpartum anemia
70900	Dyschromia, unspecified
V560	Aftercare involving extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V568	Aftercare involving other dialysis

Effective for dates of service on or after April 1, 2004, diagnosis code 2824, thalassemias, is no longer payable for ferritin and iron studies. The following new diagnosis codes are payable for ferritin and iron studies: 28241, 28242, 28249, 28264, and 28268.

If a ferritin and an iron study are billed on the same day, procedure code 5-82728 will be denied and procedure code 5-83540 will be paid. Ferritin and iron studies will be payable on the same day with the diagnosis of 2750, Disorders of iron metabolism.

Effective for dates of service on or after August 1, 2002, procedure codes 5-82728 and 5-83540 are payable on the same day, same provider, with the following diagnoses:

Diagnosis Code	Description
28521	Anemia in chronic kidney disease
5851	Chronic kidney disease, Stage I

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Diagnosis Code	Description
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified

26.4.9 Laboratory Services for Clients on Dialysis

The Texas Medicaid Program provides reimbursement for laboratory services performed for clients on dialysis.

Charges for routine laboratory tests performed according to the established frequencies are included in the facility's dialysis charge billed to Medicaid regardless of where the tests were performed. Routine laboratory services performed by an outside laboratory are billed to the facility.

Nonroutine laboratory services for clients dialyzing in a facility and all lab work for clients on continuous ambulatory peritoneal dialysis (CAPD) may be billed separately from the dialysis charge. These services and recommended frequencies are listed in "Laboratory and Radiology Services" on page 40-4.

26.4.10 Transfusion Medicine

Procedure code 5-86890 is denied when billed by any provider for the same client for dates of service in excess of two times within four days. The use of modifier 76 does not prevent claim denials. Documentation may be submitted on appeal that supports the medical necessity and appropriateness of more than two predeposited autologous donations in four days.

26.4.11 Diagnosis Requirements

Independent laboratories and pathologists do not have to supply Medicaid with a diagnosis except when billing the following procedures:

Procedure Codes		
5-82728	5-83540	5-84233
5-86950	5-88230	5-88237
5-88239	5-88261	5-88262
5-89230	5-95950	5-95951
5-95953	5-95956	

Claims submitted for the above procedures without a diagnosis are denied. *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) evaluation and management (E/M) codes must not be used as the primary diagnosis.

All *V* codes except those listed under "Coding" on page 5-12 may be used as a primary diagnosis if appropriate. Additionally, any laboratory services provided to clients eligible for emergency services only must have a diagnosis on the claim to ensure accurate claims processing.

26.5 Claims Information

When family planning test specimens such as Pap smears are collected, providers must direct the laboratory to indicate the claim for the test is to be billed as a family planning service using diagnosis code V2509.

Independent laboratory services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

26.5.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6 and the billing provider identifier belongs to a laboratory, there is no need to submit the same provider identifier in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim.

For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

26.5.2 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
AIS (Automated Inquiry System)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Independent Laboratory Claim Example	D-19
Acronym Dictionary	F-1

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Section

27

In-Home Total Parenteral Hyperalimentation Supplier

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27.1 Enrollment

To enroll in the Texas Medicaid Program, providers of in-home total parenteral hyperalimentation must be enrolled in Medicare (the intermediary is Palmetto) as in-home total parenteral hyperalimentation supplier providers.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

27.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

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

27.2 Reimbursement

In-home total parenteral hyperalimentation suppliers are reimbursed the lesser of the provider's billed charges or the rate calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8087, which is a global fee for a package of services of $145 per day, with an annual maximum of $53,000. This rate applies to procedure codes 1-S9364, 1-S9365, 1-S9366, 1-S9367, and 1-S9368.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

27.3 Benefits and Limitations

In-home total parenteral hyperalimentation is a covered benefit for eligible clients who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Texas Health Steps (THSteps)-Comprehensive Care Program (CCP) clients younger than 21 years of age with diagnoses other than those mentioned above require prior authorization through CCP. Covered services must be reasonable, medically necessary, appropriate, and prescribed by a physician. Hyperalimentation is not available through the traditional Medicaid program when oral intake will maintain adequate nutrition.

All requests for in-home total parenteral hyperalimentation need to include the prescription for what is actually going to be administered to the client. TMHP must ensure that amino acids and lipids are being prescribed to the client, thus making this in-home total parenteral hyperalimentation rather than the administration of IV fluids and electrolytes, which cannot be billed as in-home total parenteral hyperalimentation. A prescription must accompany a request for prior authorization for all total parenteral hyperalimentation.

Hyperalimentation *must* be prior authorized by TMHP's Medical Director. The request for prior authorization must be submitted by the physician prescribing the treatment and must include the following information:

- Documented diagnosis
- Supplier's name and Medicaid provider identifier
- Client's name and Medicaid number
- Start date of total parenteral hyperalimentation
- Estimated period of time total parenteral hyperalimentation is needed
- Documentation to support the medical necessity of the hyperalimentation, including:
    - A completed letter of medical necessity, signed and dated by the physician
    - A clear copy of the most recent laboratory results (to include potassium, calcium, albumin, and liver function studies)
    - A clear copy of the total parenteral nutrition (TPN) formula/prescription, including amino acids and lipids, signed and dated by the physician. The administration of intravenous fluids and electrolytes cannot be billed as in-home total parenteral hyperalimentation

Requests must include all pertinent medical records as required by HHSC or TMHP to indicate the medical necessity of the long-term total parenteral hyperalimentation. Prior authorization may be given for up to one year, subject to renewal every year with the submission of a supplemental report documenting continued medical necessity for the treatment.

Covered services include, but are not necessarily limited to, the following:

- Parenteral hyperalimentation solutions and additives as ordered by the client's physician
- Supplies and equipment, including refrigeration (if necessary), that are required for the administration of prescribed solutions and additives
- Education of the client and/or caregivers regarding the in-home administration of total parenteral hyperalimentation before administration initially begins. Education must include the use and maintenance of required supplies and equipment
- Visits by a registered nurse appropriately trained in the administration of hyperalimentation. The nurse must visit the client at least once per month to monitor the client's status and to provide ongoing education to the client and/or family members/support people about the administration of hyperalimentation
- Customary and routine laboratory work required to monitor the client's status
- Enteral supplies and equipment, if medically necessary, in *conjunction* with total parenteral hyperalimentation

Important: *Hospitals administering total parenteral hyperalimentation in the hospital outpatient department*

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should refer to "Hospital (Medical/Surgical Acute Care Facility)" on page 25-1 for the policies and billing instructions.

Total parenteral hyperalimentation is payable only once per day, per client. No more than a one week supply of solutions and additives will be reimbursed if the solutions and additives are shipped and not used because of the client's loss of eligibility, change in treatment, or inpatient hospitalization. Any days that the client is an inpatient in a hospital or other medical facility or institution must be excluded from the daily billing. Payment for partial months will be prorated based on actual days of administration.

Use the following procedure codes for billing hyperalimentation supplies:

Procedure Codes		
1-S9364	1-S9365	1-S9366
1-S9367	1-S9368	9-B4185

Lipids (9-B4185) will be denied if billed on the same date of service as any other TPN procedure code (1-S9364, 1-S9365, 1-S9366, 1-S9367, or 1-S9368).

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

27.4 Claims Information

In-home total parenteral hyperalimentation services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

Reminder: *Claims for total parenteral hyperalimentation must contain the nine-character prior authorization number in Block 23. Providers must consult with their vendor for the location of this field in the electronic claims format. The prescribing physician name and provider identifier must be in Block 17 and 17a or in the appropriate field of the provider's electronic software.*

27.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
In-Home Total Parenteral Hyperalimentation Supplier Claim Example	D-1
Acronym Dictionary	F-1

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Section

28

Licensed Clinical Social Worker (LCSW)

28.1 Enrollment 28-2
    28.1.1 Medicaid Managed Care Enrollment 28-2
28.2 Reimbursement 28-2
28.3 Benefits and Limitations 28-2
28.4 Documentation Requirements 28-3
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28.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, a licensed clinical social worker (LCSW) must be licensed by the Texas State Board of Social Worker Examiners. LCSWs must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based LCSW is enrolling as part of a Medicare-enrolled group, then the LCSW must also be enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in the Texas Medicaid Program.

A licensed clinical social worker (LCSW) cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

28.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Managed Care clients. Contact the individual health plan for enrollment information.

Important: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. LCSWs who practice in the Dallas service area must be enrolled in the NorthSTAR Behavioral Health Organization to provide services to NorthSTAR clients. Providers must not bill TMHP for services rendered to NorthSTAR clients.*

Refer to: "Managed Care" on page 7-1 for more information.

28.2 Reimbursement

According to Title 1 *Texas Administrative Code* (TAC) §355.8091, the Texas Medicaid Program rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

Under 1 TAC §355.8261, a federally qualified health center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LCSW services.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

28.3 Benefits and Limitations

LCSW counseling services are a benefit for clients suffering from a mental, psychoneurotic, or personality disorder, when performed in the office (place of service [POS] 1), home (POS 2), skilled nursing facility (SNF) (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other location (POS 9). When billing for contracted LCSW counseling services provided to Texas Medicaid Program clients who are younger than 21 years of age and reside in a residential treatment facility, providers should use POS 9 (other location).

LCSWs must not bill for services provided by people under their supervision; only the licensed LCSW and Medicaid enrolled practitioner providing the service may bill the Texas Medicaid Program. LCSWs who are employed by or remunerated by another provider may not bill the Texas Medicaid Program directly for counseling services if that billing would result in duplicate payment for the same services.

The following procedure codes are allowable for services provided by an LCSW on an hourly basis:

Procedure Code	Maximum Fee
1-90806	$53.86
1-90847	$53.84*
1-90853	$13.47 per client

* When billing or providing family counseling services, note the following requirements for Medicaid reimbursement:

- The client must be present when family counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes bills as 0.5 hour
- 60 minutes bills as 1 hour
- 90 minutes bills as 1.5 hours
- 120 minutes bills as 2 hours

The time indicated on the claim form must be the time actually spent with the client.

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a doctor of medicine (MD) or doctor of osteopathy (DO) is also limited to a combined total of 12 hours. Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day. Retrospective review may occur for both the total hours of services performed

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per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped.

Outpatient behavioral health services are limited per client to 30 encounters/visits per calendar year (January 1 through December 31), regardless of provider unless prior authorized. *This limitation includes encounters/visits by all practitioners.* Laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Texas Medicaid Program client is limited to 30 encounters/visits per calendar year (January 1 through December 31).

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, will be adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to ten encounters/visits per request and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including specific symptoms and response to past treatment, treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided
- All areas of request must be completed with the information required by the form. If additional room is needed providers may state "see attached," but the attachment must contain the specific information required in that section of the form

Prior authorization will not be granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. *It is recommended that a request for extension of outpatient behavioral health services be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided*.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

The following services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Music or dance therapy
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or a psychologist assistant
- Thermogenic therapy, recreational therapy, psychiatric daycare, and biofeedback
- Hypnosis
- *Adult activity* and *individual activity* (these types of services would be payable only if guidelines of group therapy are met and are termed group therapy)

Refer to: "Managed Care" on page 7-1 for more information, or contact the client's BHO. Do not bill TMHP for services rendered to NorthSTAR clients.

28.4 Documentation Requirements

Those services not supported by required documentation in the client's record will be subject to recoupment.

Each client for whom services are billed must have the following documentation included in their records, and the documentation must comply with the standards indicated (below) in the first listed item:

- All entries must be documented clearly, legible to individuals other than the author, dated (month/day/year), and signed by the performing provider

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- Notations of the beginning and ending session times
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Diagnosis (background, symptoms, impression)
  - Behavioral observations during the session
  - Narrative description of the counseling session
  - Narrative description of the assessment, treatment plan, and recommendations

28.5 Claims Information

Submit all claims for LCSW services to the Texas Medicaid Program. Services provided by LCSWs must be submitted in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them.

Providers must bill Medicare before Medicaid when clients are eligible for services under both programs. Medicaid's responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing the Texas Medicaid Program. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. The Texas Medicaid Program is responsible for the coinsurance and deductible of Medicare-allowed services on a crossover basis only.

Refer to: "Part B" on page 2-8.

"Medicare Part B Crossovers" on page 4-12.

28.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Medicaid Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Request for Extended Outpatient Psychotherapy/Counseling Form	B-81
Licensed Clinical Social Worker (LCSW) Claim Example	D-20
Acronym Dictionary	F-1

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Section

29

Licensed Marriage and Family Therapist (LMFT)

29.1 Enrollment 29-2
29.1.1 Medicaid Managed Care Enrollment 29-2
29.2 Reimbursement 29-2
29.3 Benefits and Limitations 29-2
29.4 Documentation Requirements 29-3
29.5 Claims Information 29-4
29.5.1 Claim Filing Resources 29-4

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29.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, a licensed marriage and family therapist (LMFT) must be licensed by the Texas State Board of Examiners of Licensed Marriage and Family Therapists. LMFTs are covered as Medicaid-only providers. Therefore, enrollment in Medicare is not a requirement. LMFTs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in the Texas Medicaid Program.

LMFTs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

29.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Important: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. LMFTs practicing in the Dallas service area must be enrolled in the NorthSTAR Behavioral Health Organization to provide services to NorthSTAR clients. Providers must not bill TMHP for services rendered to NorthSTAR clients.*

Refer to: "Managed Care" on page 7-1 for more information.

29.2 Reimbursement

According to Title 1 *Texas Administrative Code* (TAC) §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.

According to 1 TAC §355.8261, a federally qualified health center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LMFT counseling services.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

29.3 Benefits and Limitations

LMFT counseling services are a benefit for clients suffering from a mental, psychoneurotic, or personality disorder when provided in the office, (place of service [POS] 1), the home (POS 2), skilled nursing facility (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other locations (POS 9). When billing for contracted LMFT counseling services provided to Medicaid clients younger than 21 years of age residing in a residential treatment facility, providers should use POS 9 (other location).

LMFTs must not bill for services provided by people under their supervision; only the licensed LMFT and Medicaid enrolled practitioner providing the services may bill Medicaid. LMFTs employed or remunerated by another provider may not bill Medicaid directly for counseling service if the billing results in duplicate payment for the same services.

The following procedure codes are allowable for services provided by an LMFT on an hourly basis:

Procedure Code	Maximum Fee
1-90806	$53.86
1-90847	$53.84*
1-90853	$13.47 per client

* When billing or providing family/counseling services, note the following requirements for Medicaid reimbursement:

- The client must be present when family/counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of children with Temporary Assistance for Needy Families. The following specific relatives are included in family counseling services:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes bills as 0.5 hour
- 60 minutes bills as 1 hour
- 90 minutes bills as 1.5 hours
- 120 minutes bills as 2 hours

The time indicated on the claim form must be the time actually spent with the client.

LMFTs must use modifier U8, to identify the provider of the service as an LMFT.

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by an MD or DO is also limited to a combined total of 12 hours. Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day. Retrospective review may occur for both the total hours of services

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performed per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped.

Outpatient behavioral health services are limited per client to 30 encounters/visits per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. *This limitation includes encounters/visits by all practitioners.* Laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year (January 1 through December 31).

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, will be adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that there are times when a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services, when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to ten encounters/visits per request and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including specific symptoms and response to past treatment
- Treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided

All areas of request must be completed with the required information. If additional room is needed, providers may state "see attached," but the attachment must contain the specific information required in that section of the form.

Prior authorization will not be granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

The following services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Music or dance therapy
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or psychologist assistant
- Thermogenic therapy, recreational therapy, psychiatric day care, and biofeedback
- Hypnosis
- Adult activity and individual activity (these types of services would be payable only if guidelines of group therapy are met and are termed *group therapy*)

29.4 Documentation Requirements

Those services not supported by required documentation in the client's record will be subject to recoupment.

Each client for whom services are billed must have the following documentation (which meets the standards indicated) included in their records:

- All entries are documented clearly and are legible to individuals other than the author, dated (month/day/year), and signed by the performing provider
- Notations of the beginning and ending session times
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:

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- Diagnosis
- Behavioral observations during the session
- Narrative description of the counseling session
- Narrative description of the assessment, treatment plan, and recommendations

29.5 Claims Information

Services provided by LMFTs must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form available from the vendor of their choice. TMHP does not supply the forms.

29.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Medicaid Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Request for Extended Outpatient Psychotherapy/Counseling Form	B-81
Licensed Marriage and Family Therapist (LMFT) Claim Example	D-21
Acronym Dictionary	F-1

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Section

30

Licensed Professional Counselor (LPC)

30.1 Enrollment 30-2
30.1.1 Medicaid Managed Care Enrollment 30-2
30.2 Reimbursement 30-2
30.3 Benefits and Limitations 30-2
30.4 Documentation Requirements 30-3
30.5 Claims Information 30-4
30.6 Claim Filing Resources 30-4

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30.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, a licensed professional counselor (LPC) must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LPCs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in the Texas Medicaid Program.

LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

30.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Important: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. LPCs who practice in the Dallas service area must be enrolled in the NorthSTAR Behavioral Health Organization to provide services to NorthSTAR clients. Providers must not bill TMHP for services rendered to NorthSTAR clients.*

Refer to: "Managed Care" on page 7-1 for more information.

30.2 Reimbursement

According to Title 1 *Texas Administrative Code* (TAC) §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service under 1 TAC §355.8085.

Under 1 TAC §355.8261 a federally qualified health center (FQHC) is reimbursed according to its specific prospective payment system (PPS) rate per visit for LPC services provided by an LPC.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

30.3 Benefits and Limitations

LPC services are a benefit to clients of any age when performed in the office (place of service [POS] 1), home (POS 2), skilled nursing facility (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other location (POS 9) for clients suffering from a mental, psychoneurotic, or personality disorder. When billing for contracted LPC counseling services provided to Medicaid clients who are younger than 21 years of age and reside in a residential treatment facility, providers should use other location (POS 9). LPCs must not bill for services provided by people under their supervision; only the licensed LPC and Medicaid enrolled practitioner providing the service may bill Medicaid. LPCs may only bill for services that they provide to Medicaid clients. LPCs who are employed by or remunerated by another provider may not bill Medicaid directly for counseling services if that billing would result in duplicate payment for the same services.

The following procedure codes are allowable for services provided by an LPC on an hourly basis:

Procedure Code	Maximum Fee
1-90806	$53.86
1-90847	$53.84*
1-90853	$13.47 per client

*When billing or providing family counseling services, note the following requirements for Medicaid reimbursement:

- The client must be present when family counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in the supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes bills as 0.5 hour
- 60 minutes bills as 1 hour
- 90 minutes bills as 1.5 hours
- 120 minutes bills as 2 hours

The time indicated on the claim form must be the time actually spent with the client.

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) is also limited to a combined total of 12 hours. Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day. Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped.

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Outpatient behavioral health services are limited per client to 30 encounters/visits per calendar year (January 1 through December 31), regardless of provider, unless prior authorized. *This limitation includes encounters/visits by all practitioners. Laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation.* An encounter is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider.

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, will be adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to ten encounters/visits per request, and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency encounters/visits)
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided

All areas of request must be completed with the information required by the form. If additional room is needed providers may state "see attached," but the attachment must contain the specific information required in that section of the form

Prior authorization will not be granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits*. Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

The following services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Music or dance therapy
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or psychologist assistant
- Thermogenic therapy, recreational therapy, psychiatric day care, and biofeedback
- Hypnosis
- *Adult activity and individual activity* (These types of services would be payable only if guidelines of group therapy are met and are termed group therapy)

30.4 Documentation Requirements

Those services not supported by required documentation in the client's record will be subject to recoupment.

Each client for whom services are billed must have documentation that meets the following guidelines included in their records:

- All entries must be documented clearly and legible to individuals that meet the following guidelines than the author, dated (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times.
- All pertinent information regarding the client's condition to substantiate the need for services, including, but not limited to the following:
    - Diagnosis (background, symptoms, impression)
    - Behavioral observations during the session
    - Narrative description of the counseling session
    - Narrative description of the assessment, treatment plan, and recommendations

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30.5 Claims Information

Submit all claims for LPC services to the Texas Medicaid Program. Services provided by LPCs must be submitted in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them.

30.6 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Medicaid Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Request for Extended Outpatient Psychotherapy/Counseling Form	B-81
Licensed Professional Counselor (LPC) Claim Example	D-21
Acronym Dictionary	F-1

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Section

31

Maternity Service Clinic (MSC)

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31.1 Enrollment

To enroll in the Texas Medicaid Program, maternity service clinics (MSCs) must ensure that the provider providing the services is employed by or has a contractual agreement or formal arrangement with the clinic to assume professional responsibility for the services provided to clinic clients. To meet this requirement, a provider must see the client at least once, prescribe the type of care provided, and if the services are not limited by the prescription, periodically review the need for continued care. Medicare certification is not a prerequisite for MSC enrollment. A current copy of the supervising practitioner's physician license must be submitted at the time of enrollment.

An MSC must be a facility that is:

- Not an administrative, organizational, or financial part of a hospital.
- Organized and operated to provide maternity services to outpatients.
- Compliant with all applicable federal, state, and local laws and regulations.

An MSC wanting to bill and receive reimbursement for case management services to high-risk pregnant adolescents, women, and infants must meet the eligibility criteria specified in "Case Management for Children and Pregnant Women (CPW)" on page 12-1.

To bill and receive reimbursement for family planning services, family planning agencies, providers, advanced practice nurses (APNs), or physicians assistants (PAs) must use their provider identifier.

To bill and receive reimbursement for laboratory procedures, an MSC must meet the requirements for an independent laboratory.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Independent Laboratory" on page 26-1.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

31.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

31.2 Reimbursement

The Medicaid rates for maternity service clinics for procedure codes 1-99201-TH, 1-99202-TH, 1-99203-TH, 1-99204-TH, 1-99205-TH, 2-59430, 1-99211-TH, 1-99212-TH, 1-99213-TH, 1-99214-TH, and 1-99215-TH for antepartum and postpartum care visits are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8201. The applicable rates are reported in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com, or by calling the TMHP Contact Center at 1-800-925-9126 to request a copy.

Refer to: "Reimbursement" on page 2-2 for more information on reimbursement.

31.3 Benefits and Limitations

MSCs are those medical services provided by registered nurses (RNs) and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do *not* include deliveries.

Covered clinic services include, but are not necessarily limited to: risk assessment, medical services, specific laboratory or screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and client education about maternal and child health.

Medical services must be furnished on an outpatient basis by the physician, nurse practitioner, physician's assistant, or licensed professional nurse under the physician's supervision, and must be within the staff's scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic, and ensure through approval of the plan of care (POC) that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

The physician must see each client as soon as possible after she enters the MSC care and prescribe or approve the POC. The POC must be based on a risk assessment completed by the physician or licensed, professional clinic staff. MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

A minimum level of service must be provided by enrolled MSC providers to all Texas Medicaid clients as follows.

31.3.1 Initial Antepartum Care Visit Components

The following initial antepartum care visit components should be done as early as possible in the client's pregnancy.

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31.3.1.1 History

History includes obstetric and gynecological, present pregnancy, medical/surgical, substance use, environmental, nutritional, psychosocial (including violence), and family/support system.

31.3.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

31.3.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

Important: *The laboratory services listed may not be billed using the MSC provider identifier. They may be ordered by MSC personnel and provided by a reference laboratory.*

MSCs referring laboratory work are required to supply the reference laboratory with the client's Medicaid number, as well as the MSC provider identifier for laboratory work including but not limited to:

- Hemoglobin or hematocrit, or CBC
- Urinalysis
- Blood type and Rh
- Antibody screen
- Rubella antibody titer
- Serology for syphilis
- Hepatitis B Surface Antigen
- Cervical cytology
- Other laboratory tests

The following tests may be performed at the initial antepartum care, as indicated:

- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test
- Human Immunodeficiency Virus (HIV) antibody screen
- Chlamydia test

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

31.3.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

31.3.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

31.3.1.6 Education/Counseling

Education/counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health.

The complete physical examination may be completed at the second visit if the MSC's routine involves a two-stage initial evaluation.

31.3.2 Subsequent Antepartum Care Visits

The following is a recommended guide for the frequency of subsequent antepartum visits for a regular pregnancy:

- One visit every four weeks for the first 28 weeks of pregnancy
- One visit every two to three weeks from 28 to 36 weeks of pregnancy
- One visit per week from 36 weeks to delivery

More frequent visits may be medically necessary. Physicians, certified nurse midwives (CNM), and MSCs are limited to 20 antepartum care visits per pregnancy and two postpartum care visits per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

Interim History

- Problems
- Maternal status
- Fetal status

Physical Examination

- Weight, blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

Laboratory Tests

- Urinalysis for protein and glucose every visit

Important: *The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.*

- Hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeat antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Screen for gestational diabetes at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load
- Other laboratory tests as indicated by the medical condition of the client

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31.3.3 Risk Assessment

A systematic assessment of factors that may compromise the health outcome for the pregnant adolescent or woman, or the fetus must be performed for all prenatal clients at the initial visit. The risk assessment must be ongoing and modified as necessary.

The level of services provided to the client must be appropriate for the risk assessment. Services must be available on-site or through a referral. If the maternity clinic refers the client to a physician, CNM, and/or hospital that does not participate in the Texas Medicaid Program, the maternity clinic must inform the client in advance of the client's potential financial responsibility, according to the requirements of the Texas Medicaid Program.

31.3.3.1 Classification of Risk

Low risk

A client with a normal evaluation without substantial risk factors at the initial examination and each subsequent examination is low risk. The number of antepartum care visits does not usually exceed 20 and the number of usual postpartum visits is two.

High risk

A client with an identified complication or risk factor that might adversely affect the mother or fetus is high risk. Examples of common high-risk pregnancy factors are listed in the following table with the appropriate diagnosis code, but not all high-risk factors are listed. Providers submitting charges for high-risk antepartum care must document the high-risk diagnosis on the claim form.

- Maternal client is younger than 17 years of age or older than 35 years of age (V2381, V2382, V2383, V2384)
- Nutritional problems
  - Underweight—30 percent underweight before pregnancy (V2389). Calculations of weight are based on actual weight compared to the standard height/weight charts nationally
  - Failure to gain weight appropriately (64680)
  - Weight loss greater than 10 pounds during pregnancy (V2389, 64890)

Diagnosis Code	Description
30300	Acute alcoholic intoxication in alcoholism, unspecified drinking behavior
30390	Other and unspecified alcohol dependence, unspecified drinking behavior
30400	Opioid type dependence, unspecified use
30410	Sedative, hypnotic or anxiolytic dependence, unspecified
30420	Cocaine dependence, unspecified use
30430	Cannabis dependence, unspecified use
30440	Amphetamine and other psychostimulant dependence, unspecified use
30450	Hallucinogen dependence, unspecified use
30500	Nondependent alcohol abuse, unspecified drinking behavior
3180	Moderate mental retardation
3181	Severe mental retardation
3182	Profound mental retardation
59010	Acute pyelonephritis without lesion of renal medullary necrosis
59011	Acute pyelonephritis with lesion of renal medullary necrosis
630	Hydatidiform mole
64110	Hemorrhage from placenta previa, unspecified as to episode of care
64120	Premature separation of placenta, unspecified as to episode of care
64180	Other antepartum hemorrhage, unspecified as to episode of care
64190	Unspecified antepartum hemorrhage, unspecified as to episode of care
64200	Benign essential hypertension complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64210	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64220	Other pre-existing hypertension complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64230	Transient hypertension of pregnancy, unspecified as to episode of care
64250	Severe pre-eclampsia, unspecified as to episode of care
64260	Eclampsia complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care
64290	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64310	Hyperemesis gravidarum with metabolic disturbance, unspecified as to episode of care
64420	Early onset of delivery, unspecified as to episode of care

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Diagnosis Code	Description
64510	Post term pregnancy, unspecified episode of care
64520	Prolonged pregnancy, unspecified episode of care
64630	Habitual aborter, currently pregnant, unspecified as to episode of care
64700	Syphilis of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64710	Gonorrhea of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64720	Other venereal diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64830	Drug dependence of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64880	Abnormal glucose tolerance of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
65100	Twin pregnancy, unspecified as to episode of care
65101	Twin pregnancy, delivered
65103	Twin pregnancy, antepartum condition or complication
65110	Triplet pregnancy, unspecified as to episode of care
65113	Triplet pregnancy, antepartum condition or complication
65120	Quadruplet pregnancy, unspecified as to episode of care
65121	Quadruplet pregnancy, delivered
65123	Quadruplet pregnancy, antepartum condition or complication
65130	Twin pregnancy with fetal loss and retention of one fetus, unspecified as to episode of care or not applicable
65131	Twin pregnancy with fetal loss and retention of one fetus, delivered, with or without mention of antepartum condition
65133	Twin pregnancy with fetal loss and retention of one fetus, antepartum condition or complication

Diagnosis Code	Description
65140	Triplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable
65141	Triplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65143	Triplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65150	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable
65151	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65153	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65160	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care
65161	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65163	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65170	Multiple gestation following (elective) fetal reduction, unspecified as to episode of care or not applicable
65171	Multiple gestation following (elective) fetal reduction,delivered, with or without mention of antepartum condition
65173	Multiple gestation following (elective) fetal reduction, antepartum condition or complication
65180	Other specified multiple gestation, unspecified as to episode of care
65181	Other specified multiple gestation, delivered
65183	Other specified multiple gestation, antepartum condition or complication

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Diagnosis Code	Description
65190	Unspecified multiple gestation, unspecified as to episode of care
65300	Major abnormality of bony pelvis, not further specified, unspecified as to episode of care
65301	Major abnormality of bony pelvis, not further specified, delivered
65303	Major abnormality of bony pelvis, not further specified, antepartum
65310	Generally contracted pelvis, unspecified as to episode of care in pregnancy
65311	Generally contracted pelvis, delivered
65313	Generally contracted pelvis, antepartum
65320	Inlet contraction of pelvis, unspecified as to episode of care in pregnancy
65321	Inlet contraction of pelvis, delivered
65323	Inlet contraction of pelvis, antepartum
65330	Outlet contraction of pelvis, unspecified as to episode of care in pregnancy
65350	Unusually large fetus causing disproportion, unspecified as to episode of care
65360	Hydrocephalic fetus causing disproportion, unspecified as to episode of care
65370	Other fetal abnormality causing disproportion, unspecified as to episode of care
65420	Previous cesarean delivery, unspecified as to episode of care in pregnancy
65450	Cervical incompetence, unspecified as to episode of care in pregnancy
65520	Hereditary disease in family possibly affecting fetus, affecting management of mother, unspecified as to episode of care in pregnancy
65650	Poor fetal growth, affecting management of mother, unspecified as to episode of care
65700	Polyhydramnios, unspecified as to episode of care
65800	Oligohydramnios, unspecified as to episode of care
V231	Supervision of high-risk pregnancy with history of tropho blastic disease
V233	Supervision of high-risk pregnancy with grand multiparity
V234	Supervision of high-risk pregnancy with other poor obstetric history
V235	Supervision of high-risk pregnancy with other poor reproductive history
V2389	Supervision of other high-risk pregnancy

31.3.4 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 2-59430. A maximum of two postpartum visits are allowed within 60 days postpartum period for those clients without documentation or a diagnosis of complication of pregnancy. However, it is preferable for the MSC to enroll as a family planning agency and bill the postpartum visits as family planning services.

31.3.5 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by Health and Human Services Commission (HHSC) or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client's 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

31.4 Claims Information

MSCs must submit claims to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice since TMHP does not supply them. Services other than antepartum and postpartum visits will be denied.

Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for antepartum care. The urinalysis for protein and glucose, Hemoglobin, and Hematocrit is included in the visit fee and is not separately reimbursable to MSCs.

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31.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Maternity Service Clinic (MSC) Claim Example	D-22
Acronym Dictionary	F-1

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Section

32

Mental Health (MH) Mental Retardation (MR)

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32.1 Enrollment

To enroll in the Texas Medicaid Program, Mental Health (MH) providers must contact the Texas Department of State Health Services (DSHS) at 1-512-206-4830. Mental Retardation (MR) providers must contact the Texas Department of Aging and Disability Services (DADS) at 1-512-438-3011 to be approved.

Local MR providers are eligible to enroll, with the approval of DADS, for MR service coordination. Local MH providers are eligible to enroll, with the approval of DSHS, for MH case management and MH rehabilitative services.

Community mental health centers (CMHC) can enroll in the Texas Medicaid Program without the approval of DADS, but must be enrolled in Medicare.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

32.1.1 Medicaid Managed Care Enrollment

MR service coordination, MH case management, and MH rehabilitative services providers are not required to enroll with Medicaid Managed Care. Claims for MR services are submitted to TMHP for all Medicaid clients including Medicaid Managed Care clients. MH services are submitted to DSHS for all Medicaid clients including Medicaid Managed Care clients.

Note: *File all claims for MR service coordination with TMHP, including those for* Medicaid Managed Care clients*. File all claims for MH case management and rehabilitative services with DSHS, including those for Medicaid Managed Care clients.*

Exception: *MH providers in the Dallas service area must join the NorthSTAR Behavioral Health Organizations (BHO) to provide services to NorthSTAR clients.*

Important: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. MH providers who provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR BHOs.*

32.2 Reimbursement

Services are reimbursed according to a maximum allowable fee established by HHSC. Reimbursement is limited to the federal matching percentage of the maximum allowable fee and is subject to adjustment annually.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement and the federal matching percentage.

32.3 Benefits and Limitations

32.3.1 Service Coordination and Case Management

The Texas Medicaid Program provides the following service coordination and case management services:

- Service coordination for people with mental retardation or related condition (adult or child) per consumer, per month
- Case management for people with serious emotional disturbance (child, 3–17 years of age)
- Case management for people with severe and persistent mental illness (adult, 18 years of age and older)

Service	Procedure Code	Modifier	Limitations
Individual Community Support Services			
Service Coordination for people with mental retardation or related condition (adult or child)	G9012		Once per calendar month

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Service	Procedure Code	Modifier	Limitations
Routine case management (adult)	T1017	TF	32 units (8 hours) per calendar day for people 18 years of age or older.
Routine case management (child and adolescent)	T1017	TF and HA	32 units (8 hours) per calendar day for people less than 18 years of age.
Intensive case management (child and adolescent)	T1017	TG and HA	

An MR service coordination reimbursable *contact* is the provision of a service coordination activity by an authorized service coordinator during a face-to-face meeting with an individual eligible for service coordination. To bill and be paid for one unit of service coordination per month, at least one face-to-face meeting between the service coordinator and the eligible individual must occur during the month billed.

An MH case management reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact.

Service coordination and case management services are not reimbursable when provided to a client eligible for Medicaid and receiving services through the Home and Community-Based Services (HCS) waiver. These services are included in the waiver. Claims submitted to TMHP for people receiving services under the HCS waiver are identified quarterly by DADS and payments are recouped.

The Texas Medicaid Program must *not* be billed for service coordination or case management services provided to people who are residents or inpatients of:

- Nursing facilities (for people not mandated by the Omnibus Budget Reconciliation Act [OBRA] of 1987)*
- Intermediate care facilities for mental retardation (ICF_MR)*
- State mental retardation facilities*
- State mental health facilities
- Title XIX participating hospitals including general medical hospitals
- Private psychiatric hospitals
- Medicaid-certified residence not already specified
- Institutions for mental diseases such as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of people with mental diseases including medical attention, nursing care, and related services
- Jail or public institution

*A contact by the service coordinator to assist in discharge planning from some of the above may be reimbursed, if provided within 180 days before discharge. Service coordination services provided to people who are on predischarge furlough to the community from a nursing facility, intermediate care facility, or state mental retardation facility may be reimbursed. Service coordination services provided to people who are on trial placement from a state mental retardation facility to the community may be reimbursed if the person remains eligible for Medicaid upon release from the facility and receives regular Medicaid coverage.

The Texas Medicaid Program must *not* be billed for MH case management services provided before the establishment of a diagnosis of mental illness and authorization of services.

Refer to: "Managed Care" on page 7-1 for more information or contact the client's BHO. Do not bill TMHP for MH case management services rendered to NorthSTAR clients.

32.3.2 Mental Health Rehabilitative Services

The following rehabilitative services may be provided to individuals who satisfy the criteria of the mental health priority population and who are determined to need rehabilitative services. These services may be provided to a person with a single severe mental disorder (excluding mental retardation, pervasive

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developmental disorder, or substance use disorder) or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*:

Service	Procedure Code	Modifier	Limitations
Day program for acute needs	G0177		6 units (4.5 to 6 hours) per calendar day, in any combination, for people 18 years of age or older
Day program for acute needs, Assertive Community Treatment (ACT), or ACT alternative client	G0177	HK	
Medication training and support, adult, individual	H0034		8 units (2 hours) per calendar day in any combination, for people 18 years of age or older.
Medication training and support, adult, ACT or ACT alternative client, individual	H0034	HK	
Medication training and support, adult, group	H0034	HQ	
Medication training and support, adult, ACT or ACT alternative client, group	H0034	HK and HQ	
Medication training and support, child and adolescent, Individual	H0034	HA	8 units (2 hours) per calendar day in any combination, for people less than 18 years of age.
Medication training and support, child and adolescent with other individual	H0034	HA and HR or UK	
Medication training and support, child and adolescent, group	H0034	HA and HQ	
Medication training and support, child and adolescent with other group	H0034	HA and HQ and HR or UK	
Crisis intervention services, adult	H2011		96 units (24 hours) per calendar day in any combination
Crisis intervention services, adult, ACT or ACT alternative client	H2011	HK	
Crisis intervention services, child and adolescent	H2011	HA	
Skills training and development, adult, individual	H2014		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Skills training and development, adult, group	H2014	HQ	
Skills training and development, child and adolescent, individual	H2014	HA	16 units (4 hours) per calendar day, in any combination, for people less than 18 years of age
Skills training and development, child and adolescent, with other, individual	H2014	HA and HR or UK	

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Service	Procedure Code	Modifier	Limitations
Psychosocial rehabilitative services, individual	H2017		16 units (4 hours) per calendar day, in any combination, for people 18 years of age or older
Psychosocial rehabilitative services, ACT or ACT alternative client, individual	H2017	HK	
Psychosocial rehabilitative services, by RN, individual	H2017	TD	
Psychosocial rehabilitative services ACT or ACT alternative client, by registered nurse (RN), individual	H2017	HK and TD	
Psychosocial rehabilitative services, group	H2017	HQ	
Psychosocial rehabilitative services, ACT or ACT alternative client, group	H2017	HQ and HK	
Psychosocial rehabilitative services, by RN, group	H2017	HQ and TD	
Psychosocial rehabilitative services, ACT or ACT alternative client, by RN, group	H2017	HQ and HK and TD	
Psychosocial rehabilitative services, Individual, crisis	H2017	ET	96 units (24 hours) per calendar day, in any combination
Psychosocial rehabilitative services, ACT or ACT alternative client, Individual, crisis	H2017	HK and ET	

32.3.2.1 Rehabilitative Services Limitations

The Texas Medicaid Program must *not* be billed for rehabilitative services provided before the establishment of a diagnosis of mental illness and authorization of services; rehabilitative services provided to individuals who reside in an institution for mental diseases; rehabilitative services provided to general acute care hospital inpatients; vocational services; educational services; nursing facility residents who are not mandated to need services by OBRA of 1987; and services provided to individuals in jail or a public institution.

Refer to: Title 25 *Texas Administrative Code* (TAC), Part I, Chapter 419, Subchapter L and the Medicaid MH Rehabilitative Billing Guidelines for more information.

32.3.2.2 Billing Units

All claims for reimbursement for rehabilitative services are based on the actual amount of time the eligible individual or primary caregiver/legal guardian of an eligible individual is engaged in face-to-face contact with a service provider. The billable units are: individual, group (15 continuous minutes); day programs (45-60 continuous minutes).

32.4 Claims Information

Submit MR service coordination services to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

Submit MH case management and rehabilitative services to the DSHS Resiliency and Disease Management (RDM) translator in the approved formats.

Refer to: RDM Medicaid Claims Billing Process for Mental Health Rehabilitative and Case Management Services.

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32.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Mental Health Case Management Claim Example	D-22
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Section

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Military Hospital

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33.1 Enrollment

To enroll in the Texas Medicaid Program, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

33.1.1 Medicaid Managed Care Enrollment

Medicaid Managed Care health plans must reimburse military hospital providers for emergency services.

Refer to: "Managed Care" on page 7-1 for more information.

33.2 Reimbursement

Reimbursement is limited to claims submitted for emergency inpatient care only.

Allowed inpatient hospital stays are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. The Texas Medicaid Program requires that one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing. Providers should submit only one claim per inpatient stay to Medicaid, regardless of the diagnosis, to ensure accurate payment. The DRG reimbursement includes all facility services that were provided to the client while registered as an inpatient.

Reimbursement to hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). This limitation does not apply to services related to certain organ transplants, services to clients younger than 21 years of age and covered by the Comprehensive Care Program (CCP), or to services for certain clients enrolled in Medicaid Managed Care.

Military hospitals should keep a Medicaid client as an inpatient only for the length of time necessary to stabilize that client. The Medicaid client, once stabilized, should be transferred to the nearest Medicaid acute care hospital facility for further treatment.

When more than one hospital provides care for the same client, the hospital that furnishes the most significant amount of care receives consideration for a full DRG payment.

The other hospital is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the Remittance and Status (R&S) report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Medicaid does not recognize specialty units as separate entities; therefore, these transfers should be billed as *one* admission under the provider identifier. Admissions billed inappropriately are identified and denied during the utilization review process and may result in intensified review.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine if the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

The inpatient DRG reimbursement includes payment for all radiology and laboratory services, including those sent to referral laboratories.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

"THSteps-Comprehensive Care Program (CCP)" on page 43-33.

33.3 Benefits and Limitations

33.3.1 Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to the Medicaid "spell of illness." The *spell of illness* is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively." After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. Exceptions are made in the following instances:

- Texas Health Steps (THSteps)-eligible clients do not have a 30-day spell of illness limitation, if medically necessary conditions exist (covered under THSteps-CCP).
- Some Medicaid Managed Care clients do not have a 30-day spell of illness limitation.

Refer to: "Managed Care" on page 7-1 for more information.

Hospitals may submit *information only* claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.

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- Payment that has been made by a third party resource/other insurance exceeds the Medicaid allowed amount.

Important: *For clients older than 21 years of age and not enrolled in Medicaid Managed Care, an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31) exists. Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.*

Important: *If type of bill (TOB) 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with Explanation of Benefit (EOB) 217, "Payment reduced through hospital action."*

It is appropriate to submit *information only* claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of the Texas Medicaid Program. Medicaid reimbursement for services cannot exceed the limitations of the Texas Medicaid Program.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. The authorized signature in Block 85 of the HCFA-1450 (UB-92) claim form certifies that the billing hospital has a record on file that the services provided were ordered by a physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 84 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items, except when received by prescription through the Vendor Drug Program.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

33.3.2 Outpatient/Physician Services

Although Medicare reimburses for emergency outpatient and inpatient services, Medicaid does not reimburse for either outpatient or physician services. Military hospitals are not reimbursed for outpatient day surgery.

33.4 Utilization Review

For information about hospital utilization review procedures, refer to "Utilization Review Process" on page 25-12.

33.5 Claims Information

Submit claims for emergency hospital services to TMHP in an approved electronic format or on a HCFA-1450 (UB-92) paper claim form. Providers must purchase HCFA-1450 (UB-92) claim forms from the vendor of their choice. TMHP does not supply them.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes.

Refer to: "Military Hospital (Emergency Inpatient)" on page D-23.

33.5.1 Claim Filing Resources

Refer to the following sections and/or forms when claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
HCFA-1450 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Military Hospital (Emergency Inpatient) Claim Example	D-23
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Section

34

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

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34.1 Enrollment

To enroll in the Texas Medicaid Program, a Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) must be licensed as a registered nurse and recognized as an APN by the Board of Nurse Examiners (BNE) for the State of Texas. A registered nurse under the multi-state licensure compact can be licensed in another state but certified as an APN by the BNE for the State of Texas. The Texas Medicaid Program accepts a signed letter of certification from the BNE as acceptable documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA are not reimbursed for laboratory services.

All APNs (including certified nurse-midwife [CNM], certified registered nurse anesthetist [CRNA], clinical nurse specialist [CNS], and nurse practitioner [NP]) are enrolled within the categories of practice as determined by the BNE. CNSs and NPs must enroll as an APN; CNMs and CRNAs are allowed to enroll using their specific titles. Specific CNM and CRNA enrollment information may be found in the CNM and CRNA sections of this manual.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"CLIA Requirements" on page 26-2.

"Enrollment" on page 14-2 for more information on certified nurse midwife enrollment.

"Enrollment" on page 15-2 for more information on certified registered nurse anesthetist enrollment.

34.1.1 Enrollment in Texas Health Steps

Family and pediatric nurse practitioners are allowed to enroll in the Texas Health Steps (THSteps) Program to provide medical checkups. Women's health care nurse practitioners can enroll as THSteps providers for adolescents. Specific information is found in the THSteps section of this manual.

Refer to: "Provider Enrollment" on page 43-5 for more information on enrollment procedures.

34.1.2 Medicaid Managed Care Enrollment

NPs and CNSs may be eligible to enroll with Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

34.2 Reimbursement

According to Title 1 *Texas Administrative Code* (TAC) §355.8281, the Medicaid rate for APNs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current fee schedule is available on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "Provider Enrollment" on page 1-2 for more information.

"Reimbursement Methodology" on page 2-2 for more information.

"TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on how to obtain electronic fee schedules from the TMHP website.

34.3 Benefits and Limitations

Services performed by NPs and CNSs are covered if the services meet the following criteria:

- Are within the scope of practice for APNs, as defined by Texas state law
- Are consistent with rules and regulations promulgated by the BNE for the State of Texas or other appropriate state licensing authority
- Are covered by the Texas Medicaid Program when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medicaid Program for their services if the billing results in duplicate payment for the same services.

Benefit limitation information for services can be found in the physician services, Texas Health Steps medical (includes newborn exams), and family planning sections of this manual.

Note: *Payment to physicians for supplies is not a benefit of the Texas Medicaid Program. Costs of supplies are included in the reimbursement for office visits.*

Important: *Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and received within 95 days from the date of service.*

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Procedures billed by an NP or CNS are reviewed retrospectively for appropriateness. Independently enrolled NPs and CNSs with a valid Medicare provider number are eligible to receive payment of deductible and coinsurance amounts as appropriate on Medicare crossover claims.

Refer to: "Family Planning Services" on page 20-1 for more information.

"Physician" on page 36-1 for more information.

"THSteps Medical Checkup Facilities" on page 43-11 for more information on THSteps services.

34.4 Claims Information

Providers must submit APN services in an approved electronic format or on a CMS-1500 paper claim form.

Refer to: "Claims Filing Instructions" on page 5-23 for paper claims completion instructions.

34.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
Use of the Family Planning 2017 Claim Form	20-5
Communication Guide	A-1
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Section

35

Physical Therapists/Independent Practitioners

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35.1 Enrollment

To enroll in the Texas Medicaid Program, licensed physical therapists must be enrolled in Medicare.

Providers cannot be enrolled if their license is due to expire within 30 days of application. A current license must be submitted.

The Medicare enrollment requirement is waived for therapists that only provide services to Texas Health Steps (THSteps)-eligible clients who are younger than 21 years of age and who do not receive Medicare benefits. These therapists must enroll as individuals. If providers are currently enrolled with the Texas Medicaid Program or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in the THSteps-Comprehensive Care Program (CCP) is not necessary. All non-CCP physical therapy services must be billed with the current provider identifier.

Refer to: “Provider Enrollment” on page 1-2 for more information about enrollment procedures.

“THSteps-CCP Overview” on page 43-33 for more information about providing services to Medicaid/THSteps clients.

“Texas Medicaid (Title XIX) Home Health Services” on page 24-1 for more information about providing services to clients in the home setting.

35.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: “Managed Care” on page 7-1 for more information.

35.2 Reimbursement

The Medicaid rates for physical therapists and independent practitioners are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8081 and §355.8085. The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com. To request a copy, call the TMHP Contact Center at 1-800-925-9126.

Refer to: “Reimbursement Methodology” on page 2-2 for more information.

35.2.1 Benefits and Limitations

Physical therapy is the use of physical agents such as heat, massage, electricity, traction, or exercises in the treatment of disease. Payments for physical therapy will be limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical therapy to restore function. The acute modifier AT must be billed for payment to be made. The AT modifier represents treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is defined as the point that maximum improvement has been documented and more improvement ceases.

Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions such as rheumatoid arthritis
- Interventions such as a newly implanted intrathecal pump to decrease spasticity or Botulinum Toxin Type A injections.

Physical therapy, including functional evaluations, must be provided according to the current written orders of a physician (within 60 days) and based on medical necessity. It may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

Payment cannot be made to a provider or an independently practicing physical therapist who provides physical medicine to a resident of a nursing facility. These services must be made available to nursing facility residents on an *as needed* basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing facilities must refrain from admitting clients who need goal-directed therapy, if the facility is unable to provide these services.

The following procedure codes are limited to once per day:

Procedure Codes				
1-97012	1-97014	1-97016	1-97018	1-97022
1-97024	1-97028	1-97150		

The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes				
1-97032	1-97033	1-97034	1-97035	1-97036
1-97039	1-97110	1-97112	1-97113	1-97116
1-97124	1-97139	1-97140	1-97530	1-97535
1-97537	1-97760	1-97761		

Procedure codes 1-97535, 1-97537, and 1-97760 are only payable for clients younger than 21 years of age.

Procedure codes 1-97010, 1-97265, 1-97545, 1-97546, 1-97770, 1-97780, and 1-97781 are not a benefit.

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Procedure codes 1-97750 and 1-97762 are comprehensive codes and include an office visit. If an office visit is billed for the same day by the same provider, the office visit will be denied as part of another procedure billed for the same day. Procedure code 1-97762 is only payable for clients younger than 21 years of age.

Procedure code 1-97001 is payable once per six months, any provider, same facility. Procedure code 1-97002, is payable once per month, any provider, same facility. Procedure codes 1-97001 and 1-97002 are not payable on the same day as the following procedure codes:

Procedure Codes				
1-97012	1-97014	1-97016	1-97018	1-97022
1-97024	1-97028	1-97032	1-97033	1-97034
1-97035	1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139	1-97140
1-97150	1-97530	1-97750	1-97760	1-97761
1-97762				

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Physical therapy (PT) services that are not benefits of the regular Texas Medicaid Program may be benefits under THSteps-CCP when they are provided to clients with musculoskeletal or neuromusculoskeletal conditions.

Important: *CCP is for Medicaid THSteps-eligible clients who are younger than 21 years of age. CCP eligibility ends on the day of the client's twenty-first birthday.*

Refer to: "Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for information about authorization requirements and coverage or noncoverage of physical medicine and rehabilitation codes in the home.

35.2.2 Physical Therapy Documentation Requirements

Authorization is not required for therapy services delivered to clients younger than 21 years of age, although authorization is recommended through THSteps-CCP for services delivered in the home. Clients 21 years of age and older receive PT through Home Health Services.

Submit the following documentation for claims payment:

- A physician's prescription:
  - Clients younger than 21 years of age who receive PT services often have chronic conditions that require ongoing medical supervision.
  - The prescription must address medical necessity.
  - A new prescription is required at least every six months.
- Therapy treatment plan:
  - The initial THSteps-CCP treatment plan must include a copy of a current evaluation and documentation of the treatment goals and anticipated measurable progress.
  - Renewal of THSteps-CCP therapy services requires a summary statement of the measurable progress during the previous treatment period and documentation of new treatment goals with anticipated measurable progress for the renewal period.
  - A treatment plan is valid for up to six months.

Refer to: "Home Health Services" on page 24-6 for information about physical therapy services provided in the home setting.

"THSteps-Comprehensive Care Program (CCP)" on page 43-33 for information about PT, occupational therapy (OT), and speech language-pathology (SLP) services.

35.2.2.1 Provisions for Therapy Services Provided Through ECI Programs

Because the state Early Childhood Intervention (ECI) Program requires local ECI providers to follow quality assurance procedures and develop Individualized Family Service Plans (IFSP) for each child, THSteps-CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. (Providers may request copies of the ECI Request for Initial/Renewal Outpatient Therapy form from TMHP.) However, the prescription requirements as stated above must be followed by ECI providers.

35.2.3 Rehabilitative Services

Rehabilitative Services is a program administered by HHSC to nursing facility clients who need rehabilitation. These services must be *prior authorized* before the therapy is provided and paid by HHSC. Covered services include OT, PT, and SLP to clients who are eligible for Medicaid, with an acute onset of an illness or injury, with the expectation that function will be improved measurably. For all rehabilitative services inquiries, call Rehabilitative Services at 1-800-792-1109.

35.3 Claims Information

Submit services provided by an independently practicing physical therapist to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number (PAN) is reflected in the equivalent electronic field.

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35.3.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Physical Therapist Claim Example	D-26
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Acronym Dictionary	F-1

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Section

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Physician

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36.1 Enrollment

36.1.1 Physicians and Doctors

To enroll in the Texas Medicaid Program to provide medical services, physicians (doctor of medicine [MD] and doctor of osteopathy [DO]) and doctors (dental medical doctor [DMD], doctor of dental surgery [DDS], doctor of optometry [OD], doctor of podiatric medicine [DPM], and doctor of chiropractic medicine [DC]) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.*

All physicians except gynecologists, pediatricians, pediatric sub-specialists, pediatric psychiatrists and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before Medicaid enrollment. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

Refer to: "Provider Enrollment" on page 1-2 for more information.

36.1.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information on Medicaid Managed Care programs.

Important: *North State of Texas Access Reform (NorthSTAR) is a pilot managed care program in the Dallas service area that covers behavioral health services. Physicians that provide behavioral health services to clients in NorthSTAR must be a network provider of the NorthSTAR Behavioral Health Organization (BHO) to provide services to NorthSTAR clients.*

36.1.3 Comprehensive Health Centers (CHC)

CHCs and/or physician-operated clinics are funded by federal grants. To apply for participation in the Texas Medicaid Program, they must be certified and participate as a health center under Medicare (Title XVIII).

CHC claims are paid according to each center's encounter rates as established by CMS. Medicaid payment to CHCs is limited to the Medicare deductible and/or coinsurance.

All providers supplying laboratory services in an office setting must be certified and registered with the U.S. Food and Drug Administration (FDA) in accordance with Clinical Laboratory Improvement Amendments (CLIA).

Providers who do not comply with CLIA cannot be reimbursed for laboratory services.

Refer to: "CLIA Requirements" on page 26-2 and "Provider Enrollment" on page 1-2 for more information.

36.2 Reimbursement

The Medicaid rates for physicians and certain other practitioners are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8085. The current physician fee schedule is available at www.tmhp.com. See Section 3.1.1.1, "Physician Services in Outpatient Hospital Setting" on page 2-5.

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

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

These procedures are designated with note code "1" in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60 percent limitation:

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

Because of TEFRA, Medicaid reimbursement for a payable nonemergency office service performed in the outpatient department of a hospital is limited to 60 percent of the

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Medicaid rate for that service. If the condition qualifies as an emergency, the 60 percent professional service reimbursement limit does not apply.

Note: *STAR, STAR+PLUS, and NorthSTAR programs may follow a different reimbursement methodology. Providers should check each plan's reimbursement policies.*

Refer to: "Reimbursement" on page 2-2 for more information.

"Anesthesia" on page 36-24 for information on anesthesia services that are reimbursed according to relative value units.

"TMHP Website" on page 3-2 for more information on obtaining fee schedules.

36.2.1 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under the Texas Medicaid Program. All supplies, including anesthetizing agents such as Xylocaine, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If physicians bill separately for any of these items, they are denied as included in the surgical fee. If billed in any other place of service (POS), these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a covered benefit for home use.

36.2.2 Prior Authorization

Prior authorization may be required on several Medicaid benefits. For more information, call the TMHP Contact Center at 1-800-925-9126 with questions.

36.3 Benefits and Limitations

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) *Current Procedural Terminology* (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

To receive reimbursement, providers must document the service, the date rendered, pertinent information about the client's condition supporting the need for service, and the care given in the client's medical record.

Important: *If a provider bills for an office visit, documentation must appear in the client's medical record for that date of service (DOS).*

36.3.1 Supervision

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physicians' personal supervision that are within the scope of practice of their profession as defined by state law. For each encounter, unless an explicit exception is provided, the teaching/supervising physician must:

- Examine the patient.
- Confirm or revise the diagnosis of record.
- Confirm or revise a plan of care.
- Document these tasks in the appropriate medical records for the client before submitting claims.

If such documentation is not present in the appropriate medical record, then any payment made may be recouped. The services are covered if provided in the office, client's home, hospital, nursing facility, or elsewhere.

To be payable by Medicaid, physician services must be performed by the teaching or supervising physician personally, or the person to whom the physician has delegated responsibility. The following describes the level of supervision required may be direct or personal.

Indicate services provided by a physician assistant (PA) and/or an advanced practice nurse (APN) being billed as physician or facility services with the modifiers U7 and SA. The use of modifiers identifies if a PA or an APN performed the service.

36.3.1.1 Definition

Administrative Supervision

The supervision of a PA or an APN must be delivered according to protocols developed jointly with the physician and must be in accordance with the scope of practice and state law governing PAs and APNs. Personal supervision is no longer required.

Resident Physician

The physician is enrolled in good standing in an accredited graduate medical education (GME) program and possesses all appropriate licensure.

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Teaching Attending Physician and Resident Physician

The roles of the teaching attending physician and resident physician occur in the context of an accredited GME training program.

This policy pertains to the prerequisites necessary for consideration of reimbursement when the teaching attending physician submits claims for Medicaid-covered services that were performed, in whole or in part, by the resident physician. For the purposes of this policy, *attending physician* means the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being claimed. Reimbursement may be reduced, denied or recouped if compliance with the criteria of this policy is not documented in the medical record.

In all cases, the medical record must clearly document that the teaching attending physician provided identifiable supervision of the resident. As defined below, that supervision must be direct, personal or on-call, depending upon the setting and the clinical circumstances. When not otherwise feasible to provide during the normally scheduled medical service operations of the GME program, the needed level of supervision must be available *on-call*, as defined below.

Personal supervision means that the teaching attending physician must be in the building of the office or facility when and where the service is provided.

Direct supervision means that the teaching attending physician must be physically present in the room when and where the service is being provided.

The teaching attending physician must provide direct supervision during all medically complex situations, dangerous procedures, or major surgery. A service or procedure is complex or dangerous if deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable and immediate risk to the patient's life or health. This criterion applies regardless of the place or setting of care.

The teaching attending physician must provide medically appropriate, identifiable personal or on-call supervision for all other services that do not require direct supervision.

On-call means the teaching attending physician is able to provide the appropriate level of personal or direct resident supervision on a prompt, seamless, 24 hours per day, and 7 days per week basis.

Services Provided In An Outpatient Setting

For services provided in an outpatient setting, the teaching attending physician must demonstrate and document that personal and identifiable direction was provided by:

- Reviewing the patient's history and physical examination;
- Confirming or revising the patient's diagnosis;
- Determining the course of treatment to be followed;
- Ensuring that any supervision needed by the interns or residents is provided, and;
- Making appropriate documentation in the patient's medical record of the tasks identified in paragraphs (1)–(4) of this subsection before submitting the claim for payment to the department or its designee. The documentation is made in the same manner as required by federal regulations under Medicare.

Exception for Evaluation & Management Services Furnished in Certain Primary Care Centers

Teaching attending physicians that meet the primary care exception under Medicare, are allowed to bill for low-level and mid-level E/M services for residents. Facilities that meet the primary care exception under Medicare, can bill the Texas Medicaid Program, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for:

- New patient services procedure codes: 1-99201, 1-99202, and 1-99203
- Established patient services: 1-99211, 1-99212, and 1-99213

Note: *All services provided in an outpatient setting that do not qualify for the exception above require that the attending teaching physician personally examine the patient.*

Services Provided In An Inpatient Setting

For services provided in an inpatient setting, the teaching attending physician must demonstrate and document that medically appropriate identifiable personal or direct supervision was provided by:

- Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period of time after the patient's admission and before the patient's discharge;
- Confirming or revising the patient's diagnosis;
- Determining the course of treatment to be followed;
- Ensuring that any supervision needed by the interns or residents is provided; and
- Making appropriate documentation in the patient's medical record of the tasks identified in paragraphs (1)–(4) of this subsection before submitting the claim for payment to the department or its designee. The documentation is made in the same manner as required by federal regulations under Medicare.

Surgical Services and Procedures

The teaching attending surgeon is responsible for the beneficiary's preoperative, operative, and postoperative care. The teaching attending physician must demonstrate that personal and identifiable supervision was provided by:

- Reviewing the patient's history and physical examination by personally examining the patient within a reasonable period of time after the patient's inpatient admission and before the patient's discharge, and by examining the patient during all outpatient encounters;
- Confirming or revising the client's diagnosis;
- Determining the course of treatment to be followed;

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- Ensuring that any supervision needed by the interns or residents is provided; and
- Making appropriate documentation of the above tasks in the patient's medical record before submitting the claim for payment to the department.

Documentation

The teaching attending physician must document his presence and participation in the major surgical or other complex and dangerous procedure or situation.

36.3.1.2 Benefit Limitations

Effective for dates of service on or after September 1, 2003, the following outpatient professional E/M services changes are in place:

- Procedure code 5-94760 is denied as part of another procedure when billed on the same day by the same provider as an office (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215) or outpatient consultation visit (3-99241, 3-99242, 3-99243, 3-99244, or 3-99245).
- Procedure codes 1-99050 and 1-99056 are reimbursed only once per day when billed by the same provider.
- Procedure codes 1-99354 and 1-99355 are denied within precare days when billed by the same provider.
- Procedure codes 1-99354 and 1-99355 are denied within extended postcare days with a related diagnosis when billed by the same provider.
- Procedure codes 1-99354 and 1-99355 are denied with 90 days of surgery for a related diagnosis when billed by a different provider unless billed with modifier 55.
- Procedure codes 1-99050, 1-99056, 1-99354, and 1-99355 are denied within six weeks following surgery for the same diagnosis when billed by the same provider.
- Procedure codes 1-99050, 1-99056, 1-99354, and 1-99355 are denied within six weeks following anesthesia service for a related diagnosis billed by the same provider.

36.3.2 Substitute Physician

Physicians may bill for the service of a substitute physician who sees clients in the billing physician's practice under either an informal arrangement of less than 14 days or a formal renewable arrangement of up to 90 days.

The name, address, and Medicaid provider identifier in Block 33 of the claim form must be the billing provider's, not the substituting physician's.

The substitute physician is not required to enroll with Medicaid. The substitute physician's name and address must be documented on the claim.

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.

When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24K.

36.3.3 Physician Assistants (PAs)

PAs are eligible to enroll and bill as individual providers for services provided with dates of service on or after July 1, 2006. Enrollment as an individual provider is not mandatory.

Refer to: "Physician Assistant (PA)" on page 37-1, for additional information.

PAs currently treating clients and billing under the supervising physician's number can continue this billing arrangement. Effective for dates of service on or after March 1, 1999, the Texas Medicaid Program will reimburse Medicaid-enrolled physicians or RHCs for services performed by the PA without the physician's personal supervision. These services must be billed using the physician's or RHC's provider identifier. The PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

Note: *Personal supervision previously required that the physician be in the building or facility when and where the service is provided; however, with the March 1, 1999, revision, the supervising physician is no longer required to be in the building at the time services are performed.*

Services performed by a PA and billed under a physician's or RHC's provider identifier are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM) for physician services. Services provided to Medicaid clients must be documented in the client's medical record to include:

- Services provided
- DOS
- Pertinent information about the client's condition supporting the need for service
- The individual practitioner of the service

Effective on or after December 1, 2002, services provided by a PA being billed as physician or facility services should be indicated with modifier U7, Medicaid level of care 7, as defined by each state (PA services for other than assistant-at-surgery).

The use of modifiers will identify if a PA performed the service.

Claims Information

Claims must be filed to the Texas Medicaid Program according to the policies and procedures described in this manual. Services provided by a PA must be submitted with the modifier U7.

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36.3.4 Visits

36.3.4.1 Claims Filing Deadlines

Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days from *each* date of service, *not 95 days from the discharge date.*

Reminder: *Inpatient claims must indicate the facility's nine-digit provider identifier in Block 32 or in the appropriate field of electronic software.*

36.3.4.2 Concurrent Hospital Care

Concurrent hospital care is defined as daily hospital care of a client provided and billed by more than one physician (regardless of specialty). Concurrent care is payable if the client's condition indicates the need for continuing care of more than one physician. Generally, concurrent care is appropriate when major multiple organ failure requires the skills of different specialties concurrently on a daily basis to manage the client to a successful outcome.

Important: *Diagnoses are considered related when the first three digits match the primary International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code.*

Claims for concurrent care are denied when billed by the same or different specialties for the same or related diagnoses. Claims denied for concurrent care are considered on an appeal basis when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Explanation of the medical necessity for the services of physicians providing care and treatment
- Diagnosis and an indication of the severity of the client's condition; whether the condition is acute or critical
- Physician's role in the care of the client including the name of the admitting physician
- Specialty and/or subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above are denied.

Important: *If the attending physician requests only a consultation, the request must be clearly stated in the orders.*

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and should include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician
- The name of the requesting physician by the physician rendering concurrent care

36.3.4.3 Consultations

A *consultation* is defined as rendering an opinion or advice for diagnosis and/or treatment of a client. Office or other outpatient consultations (3-99241, 3-99242, 3-99243, 3-99244, or 3-99245) are payable in the office, (POS 1) or outpatient (POS 5) setting (including emergency department) only. Office or outpatient consultations are limited to one consultation per provider, per client, per six-month period. All other consultations during this period are changed to the appropriate outpatient or office visit code. Claims for consultation services must indicate the referring physician in Block 17 or 17a.

The following information from the attending physician must be documented in the client's medical record and communicated to the requesting physician:

- The request for consultation
- The need for a consultation
- The consultant's opinion
- Any ordered services

Inpatient consultations are provided to hospital inpatients or residents of nursing facilities, and are payable in hospital and nursing facilities (POS 3, 4, or 8) only.

If an emergency department visit and a consultation are billed for the same client by the same physician on the same day, the emergency department visit is paid and the consultation is denied.

Consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting are billed using the following procedure codes:

Procedure Codes		
1-99251	1-99252	1-99253
1-99254	1-99255	

Any E/M visit billed with any consultation on the same day by the same provider is denied with explanation of benefit (EOB) 00117. This procedure is part of another procedure billed on the same day.

An initial psychiatric examination performed within 30 days of any consultation by the same provider is changed to a subsequent consultation (3-99241), regardless of the diagnosis.

Refer to: "Surgeons and Surgery" on page 36-327 for information about consultations and the global fee concept.

36.3.4.4 Home Services

Home services are those services that are provided in a private residence. Providers may utilize the following procedure codes when billing for these services:

New Patient Visits

Procedure Codes		
1-99341	1-99342	1-99343
1-99344	1-99345	

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Established Visits

Procedure Codes		
1-99347	1-99348	1-99349
1-99350		

New patient visits are limited to one code per day, per provider and will be denied if billed on the same day by the same provider as procedures 1-99281, 1-99282, 1-99283, 1-99284, or 1-99285.

Established patient visits will be denied if billed on the same day by the same provider as a new patient visit.

36.3.4.5 Hospital-Based Emergency Department

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who require immediate medical attention. The facility must be available to provide services 24 hours per day, 7 days a week.

According to federal legislation (*Emergency Medical Transportation and Labor Act*), if any individual arrives at the hospital emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists. The following definitions were developed to be consistent with the CMS:

- *Antidumping Statute.* A hospital must provide to any person who seeks emergency services an appropriate medical screening examination sufficient to determine whether he or she has an emergency medical condition.
- *Emergency Behavioral Health Condition.* Any condition, without regard to the nature or cause of the condition which, in the opinion of a prudent layperson possessing an average knowledge of health and medicine, requires immediate intervention and/or medical attention without which the patient would present an immediate danger to himself or others or that renders the patient incapable of controlling, knowing, or understanding the consequences of his or her actions.
- *Emergency Medical Condition.* A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical care could result in one of the following circumstances:
    - Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
    - Causing serious impairment to bodily functions
    - Causing serious dysfunction of any bodily organ or part
- *Emergency Services.* Covered hospital-based emergency department services needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition.
- *Medical Screening Examination.* The process required to determine, with reasonable clinical confidence, that an emergency medical condition or an emergency behavioral health condition exists. Depending on the patient's presenting symptoms, the medical screening examination ranges from a brief history and physical examination to performing ancillary studies and procedures (such as, but not limited to, lumbar punctures, clinical laboratory tests, and computer-aided tomography [CT] scans). A medical screening examination is not an isolated event, it is an ongoing process. The medical records must reflect continued monitoring according to the patient's needs and must continue until he is stabilized or appropriately transferred. There should be evidence of whether the patient is stable or unstable.
- *No Prior Authorization Before Screening or Stabilization.* It is not appropriate for a hospital to request or a health plan to require prior authorization before the patient has received a medical screening examination to determine the presence or absence of an emergency medical condition or before the patient's emergency condition is stabilized.
- *Post-Stabilization Services.* In the case of an emergency medical condition or emergency behavioral health condition, post-stabilization services begin once the patient has been determined stable by the emergency department physician or discharged, transferred, or admitted to the hospital.
- *Prudent Layperson Definition of an Emergency.* A person presenting himself or herself as an emergency onsite in an emergency department, could reasonably expect that the absence of immediate medical attention would result in placing his or her health in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
- *Routine Condition.* A health condition, including a behavioral health situation, that can be addressed by a routine office visit within the next several days.
- *Stabilization Services.* In the case of an emergency medical condition or an emergency behavioral health condition, to stabilize is to provide medical services to assure within reasonable medical probability that no deterioration of the condition is likely to result from or occur during discharge, transfer, or admission of the patient from the emergency department.
- *Triage.* The evaluation, by a nurse(s), of people presenting for health care to a medical facility that allows treatment of the most serious cases first.
- *Urgent Behavioral Health Situations.* Conditions that require attention and assessment within 24 hours but that do not place the patient in immediate danger to themselves or others, and the patient is able to cooperate with treatment.

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- *Urgent Condition.* A health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson possessing the average knowledge of medicine to believe the patient's condition requires medical treatment, evaluation, or treatment within 24 hours by a physician to prevent serious deterioration of the patient's condition or health.

Hospital-based emergency department services are divided as:

- Emergency department services by physicians
- Emergency department services by facilities (room and ancillary)

Refer to: "Hospital (Medical/Surgical Acute Care Facility)" on page 25-1.

Emergency department attending physicians may use procedure codes 1-99281, 1-99282, 1-99283, 1-99284, or 1-99285 when billing for services provided in the hospital-based emergency department (POS 5).

Office-based physicians may use procedure codes 1-99201, 1-99202, 1-99203, 1-99204, or 1-99205 for new patients, and procedure codes 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215 for established patients, when billing for services provided in the office or hospital-based emergency department (POS 5).

Office-based physicians may bill an additional charge (procedure codes 1-99050, 1-99056, or 1-99060) for providing services after routine office hours in the office or the hospital-based emergency department. This charge is in addition to the charge for the office visit or hospital-based emergency department visit, and should be billed separately.

Refer to: Section 36.3.4.7, "Services Outside of Business Hours" on page 36-15 for more information.

Additional charges for after hours (1-99050, 1-99056, or 1-99060) by *emergency department-based physicians or emergency department groups* are denied.

Consulting physicians may use procedure codes 3-99241, 3-99242, 3-99243, 3-99244, or 3-99245 when billing for services provided in the office or hospital-based emergency department (POS 5).

Consulting physicians may bill for critical care services (1-99291 or 1-99292) when provided in the hospital-based emergency department (POS 5). The quantity for procedure code 1-99292 must reflect the number of 30-minute units provided. If the number of units is not on the claim, a quantity of 1 is paid.

The facility may bill separately for the emergency department treatment room, minor surgery room, or observation room. The physician may bill separately for diagnostic procedures performed on the same day as a hospital-based emergency visit using the appropriate procedure codes from the CPT manual.

Emergency department visits are inclusive of 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 is provided.

Multiple emergency department visits on the same day, billed by the same provider, must have the times for each visit documented on separate forms, or more than one visit on the same day can be indicated by adding modifier 76 to the claim form.

Emergency department visits may be paid to different providers on the same day, when medically necessary, regardless of specialty and diagnosis.

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 for payment to be considered.

If an emergency department visit is billed on the same day as an initial hospital visit by the same provider, the emergency department visit is denied. Providers may submit documentation of medical necessity on an appeal basis.

If an emergency department visit or an emergency department visit after-hours charge is billed together with a consultation or critical care service on the same day, by the same provider, then the emergency department visit and/or the emergency department visit after-hours charge is paid and the consultation/critical care service is denied.

Other services billed the same day as an emergency department visit (1-99281, 1-99282, 1-99283, 1-99284, or 1-99285), office visit (1-99201, 1-99202, 1-99203, 1-99204, or 1-99205), or consultation (3-99241, 3-99242, 3-99243, 3-99244, or 3-99245), such as 1-99058 and 1-92504, are denied as part of another procedure the same day.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for those physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The diagnoses list of emergent conditions is used to determine the appropriate reimbursement for these services. The reimbursement for each service is determined by establishing a charge base for each professional service and multiplying the charge base by 60 percent.

36.3.4.6 Hospital Visits

Nonintensive Care

Hospital visits are limited to one per day for the same provider. Prolonged physician service and physician standby service without face-to-face contact, procedure codes 1-99358, 1-99359, 1-99360, are not benefits of the Texas Medicaid Program.

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Only one initial hospital care visit may be paid to the same provider within a 30-day period regardless of diagnosis. Additional hospital visits within the 30 days are paid as subsequent care visits.

Any visit, irrespective of the POS, billed on the same day by the same provider, as an initial hospital care code is denied. An initial hospital visit (1-99221, 1-99222, or 1-99223) or a subsequent hospital visit (1-99231, 99232, or 1-99233) may *not* be paid on the same day to the same provider as visits to the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit (NICU), or the emergency care facility.

An initial hospital care visit billed within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or similar diagnosis billed by the same provider, should be billed as a subsequent care visit.

Subsequent hospital visit codes (1-99231, 99232, or 1-99233) billed on the same day as hospital discharge day management (1-99234, 1-99235, 1-99236, 1-99238, or 1-99239) are denied as part of another procedure billed on the same day.

Subsequent daily hospital care is payable once per day, and if procedure code 1-99234, 1-99235, 1-99236, 1-99238, or 1-99239 is billed on the same day as a subsequent visit (1-99231, 99232, or 1-99233), the subsequent visit is denied.

Refer to: “Prolonged Physician Services” on page 36-17.

Critical Care

Critical care includes the care of critically ill patients who require constant attention of the physician. Critical care is usually given in a critical care area such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

Use procedure code 1-99291 for the first 30 to 74 minutes of critical care. Use procedure code 1-99292 for each additional 30 minutes beyond the first 74 minutes of critical care for up to six units (or three hours) per day. The quantity for procedure code 1-99292 must reflect the number of 30-minute units provided. If the number of units is not on the claim, a quantity of 1 is paid.

Critical care codes 1-99291 and 1-99292 are denied when billed by the same/different provider on the same day as neonatal intensive care codes 1-99295, 1-99296, 1-99298, 1-99299, or 1-99300.

Initial hospital visits (1-99221, 1-99222, or 1-99223), billed on the same day as critical care by the same provider, are reimbursed as a subsequent hospital visit (1-99231, 99232, or 1-99233).

Use subsequent hospital care codes (1-99231, 1-99232, or 1-99233) for services to a client who is not critically ill but is in the critical care unit.

The following procedures, when billed on the same day by the same provider, may be paid at full reimbursement in addition to critical care:

Procedure Codes		
2-31500	2-32000	2-32020
2-36620	2-92950	2-92960

The following services are denied as part of another procedure when billed on the same day as hospital critical care codes 1-99291, 1-99292, 1-99354, 1-99355, 1-99356, 1-99357, or 1-99440 by the same provider:

Procedure Codes		
2-36000	2-36410	2-36600
I-71010	I-71020	1-91105
5-93561	5-93562	

Neonatal Intensive Care

Neonatal intensive care should be billed using procedure code 1-99295 for the initial day of neonatal intensive care, irrespective of the time the physician spends with the critically ill neonate or infant that is 30 days of age or less. Procedure code 1-99296 should be billed for subsequent neonatal critical care per day, irrespective of the time that the physician spends with the critically ill neonate or infant that is 30 days of age or less. Procedure codes 1-99298,1-99299, or 1-99300 should be billed for subsequent neonatal intensive care per day, irrespective of the time that the physician spends with the critically ill neonate or infant, as appropriate for the present body weight and intensity of service required by the neonate or infant.

Procedure codes 1-99295, 1-99296, 1-99298, 1-99299, and 1-99300 are limited to one code for payment per day, per provider. Procedure codes 1-99299 and 1-99300 will be denied if billed on the same day by the same provider as procedure codes 1-99295 or 1-99296.

Physicians who provide care to high-risk newborns should use procedure code 1-99440. Initial hospital care codes (1-99221, 1-99222, or 1-99223) billed in addition to 1-99440 on the same day, by the same provider, are reimbursed as a subsequent care code (1-99231, 1-99232, or 1-99233). If the anesthesiologist is required to resuscitate the baby at the same time he or she administers anesthesia for the mother, he or she is to be paid for both services. Newborn resuscitation must be billed only on the baby’s claim.

Prolonged physician service (1-99354, 1-99355, 1-99356, or 1-99357) may be paid when billed on the same day as initial neonatal intensive care (1-99295). Resuscitation of newborn (1-99440) and prolonged physician service (1-99354, 1-99355, 1-99356, or 1-99357) are denied when billed on the same day as neonatal intensive care (1-99291 and 1-99292) by the same provider.

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When billed on the same day by the same provider, the following procedures may be paid at full reimbursement in addition to neonatal intensive care:

Procedure Codes		
2-32000	2-32020	2-36450
2-36455	2-49080	2-49081
2-61000	2-61001	

Services that deny as part of the neonatal intensive care visit include, but are not limited to, the following procedure codes:

Procedure Codes		
2-31500	2-31502	2-31720
2-31730	2-36400	2-36405
2-36406	2-36420	2-36430
2-36440	2-36510	2-36620
2-36625	2-36640	2-36660
2-51000	2-51005	2-51010
2-62270	2-62272	1-90760
1-94640	1-94656	1-94657
1-S9364	1-S9365	1-S9366
1-S9367	1-S9368	

Pediatric critical care should be used by the physician who provides care to the critically ill pediatric client using procedure codes 1-99293, 1-99294, and 1-99299.

36.3.4.7 Services Outside of Business Hours

Texas Medicaid limits reimbursement to office-based providers providing services after routine hours in the office or emergency department.

An office-based provider may bill a charge in addition to an office or consultation visit for providing services after routine office hours. A provider's routine office hours are those hours posted at the physician's office as the usual office hours. Provider billing practices are reviewed routinely for the appropriate use of these codes. Misuse results in recoupment and/or other administrative sanctions.

Important: *Inconvenience charges are paid in addition to the appropriate E/M visit code in the office (POS 1) or the emergency room (POS 5). Inconvenience charges are not paid in any other POS (for example, inpatient hospital, SNF, or nursing facility [NF]).*

Medicaid reimburses *office-based* physicians an inconvenience charge or after-hours charge when either of the following conditions 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

Use the following procedure codes when billing an inconvenience fee for services in the office (POS 1) or emergency room (POS 5):

Procedure Codes		
1-99050	1-99056	1-99060
The codes listed above are subject to the pre- and post-care global surgical fee limitations. **These codes are denied in addition to hospital or observation room visits.**		

Additional charges for after hours (1-99050, 1-99056, or 1-99560) by *emergency department-based physicians or emergency department groups* are denied.

36.3.4.8 Inpatient Hospital Visits

Refer to: "Hospital Visits" on page 36-13.

36.3.4.9 New Patient Visits

A new patient is defined as a patient who is new to the physician's practice and whose medical and administrative records need to be established. An established patient is defined as a patient whose medical and administrative records are available to the physician.

Refer to: "Texas Health Steps (THSteps)" on page 43-1 for information on checkup visits for clients younger than 21 years of age.

A new patient visit is limited to one every two years, per patient, per provider. A new patient visit in the office (POS 1), home (POS 2), or nursing facility (POS 8) is reimbursed as an established patient visit if history shows that the same physician has furnished a medical service (Type of Service [TOS] 1, excluding routine newborn care and the lab handling fee), a surgical service (TOS 2), or a consultation (TOS 3) within two years. Services coded as new patient visits in excess of this limitation are changed and reimbursed as follows:

If billed as:	Change to:
1-99201 (office)	1-99211
1-99202 (office)	1-99212
1-99203 (office)	1-99213
1-99204 (office)	1-99214
1-99205 (office)	1-99215
1-99341 (home)	1-99347
1-99342 (home)	1-99348
1-99343 (home)	1-99349
1-99344 (home)	1-99349
1-99345 (home)	1-99350

Established patient visits billed on the same day as a new patient visit in POS 1, 2, and 8, by the same provider, for any diagnosis, are denied as part of another procedure on the same day. Established patient care visits are also limited to one per day for the same provider regardless of diagnosis.

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36.3.4.10 Observation Room Services and Discharge Day Management

Physician outpatient hospital observation room services are professional services provided for a period of more than six hours but less than 24 hours, regardless of the hour of the initial contact, and regardless of whether or not the patient remains under physician care past midnight.

Reminder: *Physicians may bill codes 1-99218, 1-99219, or 1-99220 for the outpatient observation period of less than 24 hours.*

Emergency department visits (1-99281, 1-99282, 1-99283, 1-99284, or 1-99285) and emergency department/office additional charges (1-99056 and 1-99060) are denied the same day as physician outpatient hospital observation room service (1-99218, 1-99219, or 1-99220), when billed by the same provider.

Physicians may use procedure code 1-99217 to report all services provided to patients on discharge from observation status if the discharge is other than the initial date of admission to observation. Procedure code 1-99217 is denied when billed on the same day as initial observation care (1-99218, 1-99219, or 1-99220), when billed by the same provider.

36.3.4.11 Observation Care Codes

The following limitations apply to procedure codes 1-99234, 1-99235, or 1-99236:

- If 1-99234, 1-99235, or 1-99236 are billed on the same day by the same provider as initial observation care codes (1-99218, 1-99219, or 1-99220), procedure codes 1-99234, 1-99235, or 1-99236 are denied.
- If a hospital admission (1-99221, 1-99222, or 1-99223) is billed on the same day by the same provider as outpatient hospital observation (1-99234, 1-99235, or 1-99236), the observation is denied.
- If 1-99234, 1-99235, or 1-99236 are billed on the same day as a subsequent hospital visit (1-99231, 1-99232, or 1-99233), the subsequent visit is denied.
- If 1-99234, 1-99235, or 1-99236 are billed on the same day by the same provider as a consultation, the consultation is denied.
- Code 1-99217 is not payable on the same day as codes 1-99234, 1-99235, 1-99236, 1-99238, or 1-99239.
- Codes 1-99234, 1-99235, or 1-99236 are subject to the global surgical fee pre- and post-care days assigned to certain surgical procedures.

Refer to: "Inpatient Hospital Visits" on page 36-15 for more information.

36.3.4.12 Initial Visits

Physicians may use procedure codes 1-99201, 1-99202, 1-99203, 1-99204, or 1-99205 when billing for new patient services provided in the office (POS 1), or in an outpatient or other ambulatory facility (POS 5).

Established Visits

Physicians may use procedure codes 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215 when billing for established patient services provided in the office (POS 1), or in an outpatient or other ambulatory facility (POS 5).

Preventive Care Visits

With adequate documentation, a preventive care visit may be billed on the same day, by the same provider, as an office or outpatient consultation visit. For example, a physician sees a child for a THSteps visit and the child is wheezing.

Office/Outpatient Consultation Visits

Physicians may use procedure codes 3-99241, 3-99242, 3-99243, 3-99244, or 3-99245 when billing for new or established patient consultation provided in the office (POS 1), or in an outpatient or other ambulatory facility (POS 5).

Procedure codes 1-92504, 5-94760, and 1-99058 are denied as part of another procedure when billed on the same day, by the same provider, using the following codes as an office visit or as an outpatient consultation:

Office Visits

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215		

Outpatient Consultation

Procedure Codes		
3-99241	3-99242	3-99243
3-99244	3-99245	

Prolonged Physician Service Visits

Prolonged physician services provided in the office (POS 1) or in an outpatient setting (POS 5) involving direct (face-to-face) patient contact, that is beyond the usual service, may be paid on the same day as an E/M visit using the following procedure codes:

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215	3-99241	3-99242
3-99243	3-99244	3-99245

Use procedure code 1-99354 to report the *first hour* of prolonged service; it is *limited to one per day*.

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Procedure code 1-99354 may be used to report a total duration of prolonged service of 30–60 minutes on a given date. Prolonged service of less than 30 minutes of total duration is not separately reported.

Use procedure code 1-99355 to report *each additional 30 minutes; it is limited to a quantity of three* units or 1.5 hours per day.

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.

36.3.4.13 Outpatient Professional Evaluation and Management Services

Outpatient services are defined as conditions, including routine, urgent, or emergent, that are evaluated and managed at physicians' offices, freestanding emergency centers, hospital outpatient clinics, or multispecialty clinics.

These are locations other than hospital-based emergency departments and, therefore, are not governed by hospital antidumping legislation.

Outpatient Professional Evaluation and Management Services Limitations

Office visits are limited to one per day for the same provider, regardless of diagnosis, using the following procedure codes:

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215		

If an office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215) is billed on the same day, by the same physician as a minor procedure, the office visit is paid and the minor procedure is denied, if the following office visit procedure codes are used:

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215		

If an office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215) is billed on the same day, by the same physician as a more extensive procedure, the procedure is paid and the office visit is denied, if the following office visit procedure codes are used:

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215		

If an initial hospital visit following admission is billed on the same day by the same provider as an emergency department visit (1-99281, 1-99282, 1-99283, 1-99284, or 1-99285), office visit (1-99201 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215), or outpatient consultation (3-99241, 3-99242, 3-99243, 3-99244, or 3-99245), the initial hospital visit is paid and the other visits are denied.

After-hours visits (1-99050, 1-99056, or 1-99060) are reimbursed only once per day when billed by the same provider.

36.3.4.14 Prolonged Physician Services

Physicians may bill for prolonged physician services when a patient requires the presence of the physician. When billing for prolonged physician services, the following procedure codes should be billed:

- Procedure codes 1-99354, 1-99355, 1-99356, or 1-99357 are reported when a physician provides prolonged service involving direct (face-to-face) patient contact beyond the usual service in the appropriate office, outpatient, or inpatient setting.
- Procedure codes 1-99354 and 1-99356 must be used to report the first hour of prolonged service and are limited to one per day. Either code may be used to report a total duration of prolonged service of 30–60 minutes on a given date. Prolonged service of less than 30 minutes total duration is not separately reported.
- Procedure codes 1-99355 and 1-99357 are used to report each additional 30 minutes and are limited to three units or 1.5 hours per day. Prolonged services of less than 15 minutes duration should not be reported separately.
- Procedure codes 1-99354 or 1-99355 are limited to the office (POS 1) and outpatient (POS 5) settings. E/M services performed in the office (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215) may be reported in addition to prolonged physician services.
- Physician outpatient hospital observation (1-99217, 1-99218, 1-99219, 1-99220, 1-99234, 1-99235, or 1-99236) billed on the same day as a prolonged service (1-99354 or 1-99355) by the same provider is denied as part of another procedure on the same day. Prolonged physician services billed on the same day, same provider, as critical care (1-99291 and 1-99292) are denied.
- Procedure codes 1-99356 and 1-99357 are limited to the inpatient (POS 3) setting. Prolonged service may be paid on the same day as an initial hospital visit (1-99221, 1-99222, or 1-99223), subsequent hospital visit (1-99231, 1-99232, or 1-99233), or initial

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neonatal intensive care visit (1-99295) when the physician is present for the delivery or newborn resuscitation is required.

- Prolonged services and resuscitation of newborn (1-99440) are denied when billed on the same day as subsequent neonatal intensive care (1-99296, 1-99298, or 1-99299) by the same provider. Procedure codes 1-99356 and 1-99357 are denied when billed on the same day as critical care services (1-99291 or 1-99292) by the same provider.

Prolonged physician service *without* direct (face-to-face) patient contact (1-99358 or 1-99359) and physician standby service (1-99360) are not benefits of the Texas Medicaid Program.

36.3.4.15 Referrals

A *referral* is defined as the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. These services should be billed using the appropriate E/M visit code.

When a Medicaid provider refers a Medicaid client to another provider for additional treatment or services, the provider must forward notification of the client's eligibility and nine-digit provider identifier. The referred provider must advise the client whether the provider accepts Medicaid. Some clients not eligible for Medicaid are eligible for family planning through Titles V and XX. These clients should be referred to contracted agency providers for family planning services.

Referral Requirements for Children with Disabilities

All health care professionals are required by state and federal legislation to refer children younger than 3 years of age with developmental delays to early childhood intervention services provided under the authority of the Department of Assistive and Rehabilitative Services (DARS). Referrals must take place within two business days of identifying a delay in development.

DARS is a coordinated system of services available in every Texas county for children from birth to 3 years of age with developmental delays. DARS has served more than 27,000 children younger than 3 years of age through 70 local programs.

Referrals may be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

On referral, DARS programs determine eligibility based on screening and assessments. Children are eligible if they meet at least one of the following criteria:

- A delay in one or more areas of development
- *Atypical development*. Children who perform within their appropriate age range on test instruments, but whose patterns of development are different from their peers
- *A medically diagnosed condition*. Children who have a medically diagnosed condition with a high probability of resulting in developmental delay

Families and professionals work together to plan appropriate services based on the unique needs of the child and the child's family.

Services that are provided at no cost to families may include:

- Physical, occupational, speech, and language therapy
- Service coordination
- Vision services
- Special instruction
- Nutrition services
- Family counseling and education
- Assistive technology (service and devices)

Providers can refer families for services by calling the local DARS program or the statewide DARS Care Line at 1-800-250-2246. Providers can also obtain brochures or more information by calling the DARS Care Line or visiting the DARS website at www.dars.state.tx.us.

36.3.5 Physician Services in a Long Term Care (LTC) Nursing Facility

The Department of Aging and Disability Services (DADS) requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician's office or the nursing facility.

The *Omnibus Budget Reconciliation Act* (OBRA) of 1987 included legislation on Preadmission Screening and Resident Review (PASARR). PASARR requires that *all admissions to a Medicaid-certified distinct part of a nursing facility* be screened for mental illness, mental retardation, or a related condition. This screening prevents inappropriate placement of clients in Medicaid-certified nursing facility beds.

DADS uses the Client Assessment Review and Evaluation (CARE) Form 3652-A to satisfy PASARR screening requirements. All individuals must have a preadmission screening completed before admission to the nursing facility. The screening is performed by the hospital or the nursing facility completing a CARE Form 3652-A with a purpose code *P*. Individuals whose CARE Forms have a *Y* checked in Item 34 must have a Level II screening conducted by DADS.

Physicians and hospitals may obtain written instructions on the completion and processing of the CARE form by visiting the following website at www.dads.state.tx.us/handbooks/instr/3000/F3652-A/.

If the attending physician delegates health care tasks to a qualified PA in an intermediate care/SNF, the physician services are covered if the supervision or delegation is consistent with the Texas Medical Board's rules and regulations. Services provided by PAs in intermediate care/skilled nursing facilities must be consistent with the

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requirements of DADS agency rules [§§16.1906, 16.1912, 16.3017(c), and 16.3207(a)] as they relate to operating policies and procedures, client-patient care policies, conformance with physician orders, and drug orders. If the supervision of the delegated task is not appropriately documented in the patient's chart, any payment for services may be recouped.

Rehabilitation services (for example, physical therapy [PT], occupational therapy [OT], and speech-language pathology [SLP]) must be made available to nursing facility residents on an as-needed basis as ordered by the attending physician, and must be provided by the nursing facility staff or furnished by the facility through arrangements with outside qualified resources. Clients who need these services cannot be admitted to the nursing facility if the facility is unable to provide these services as needed. Payment for these services is included in the reimbursement made to the nursing facility; they may not be billed to TMHP. If these services cannot be furnished by the extended care facility, it is the facility's responsibility to provide transportation for the client to a provider to render these services. The Texas Medicaid Program must not be billed for the rehabilitation services or the transportation charges in these situations.

36.3.5.1 Long Term Care—Nursing Facilities Discharge Day Management

Procedure codes 1-99315 and 1-99316 are payable to physicians when discharging a client from a nursing home (POS 8) or specialized nursing home (POS 4). Codes 1-99315 and 1-99316 are not both payable on the same day, for the same client. If a subsequent nursing facility visit (code 1-99307, 1-99308, 1-99309, or 1-99310) is billed on the same day by the same provider as 1-99315 or 1-99316, the subsequent visit is denied. If 1-99315 or 1-99316 is billed on the same day by the same provider as an initial hospital care visit (codes 1-99221, 1-99222, or 1-99223), the nursing facility discharge day management is denied.

Physician visits to Medicaid patients confined in an extended care facility are not limited when they are seen for a diagnosis of illness or injury. The CMS-1500 claim form must document the medical necessity of the visit by listing the specific diagnosis in Block 21 or the appropriate electronic field.

36.3.5.2 Physician Nursing Facility Visits

The following visit codes are a benefit when performed in a nursing home or specialized nursing home setting:

Initial Care	Subsequent Care
1-99304	1-99307
1-99305	1-99308
1-99306	1-99309
	1-99310

In addition to the listed codes above, the following codes are also a benefit when performed in a nursing home or specialized nursing home setting:

Procedure Codes		
1-99318	1-99324	1-99325
1-99326	1-99327	1-99328
1-99335	1-99336	1-99337

Procedure codes 1-99339 and 1-99340 are a benefit when performed in the home, nursing home, or specialized nursing home setting.

Procedure codes 1-99304, 1-99305, and 1-99306 are limited to one every six months, per client, per provider. Other encounters billed on the same day as 1-99304, 1-99305, or 1-99306 are denied. Nursing facility visit codes are limited to one per day, regardless of diagnosis.

Procedure codes 1-99304, 1-99305, 1-99306, 1-99307, 1-99308, 1-99309, 1-99310, 1-99315, or 1-99316 billed on the same day as 1-99221, 1-99222, or 1-99223 by the same provider are denied as part of another procedure billed on the same day.

36.3.5.3 Telemedicine Services

Telemedicine is a reimbursable service of Texas Medicaid. Telemedicine is defined as a method of health care service delivery used to facilitate medical consultations by physicians to health care providers in rural or medically underserved areas (MUAs) for purposes of patient diagnosis or treatment that requires advanced telecommunications technologies, including interactive video consultation, teleradiology, and telepathology.

A *rural area* is defined as a county with a population of less than 50,000 people.

An *underserved area* is one that meets the definition of a MUA or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).

No separate reimbursement is made for the cost of telemedicine hardware and/or equipment, videotapes, and transmissions. Telephone conversations, chart reviews, email messages, and faxes alone do not constitute a telemedicine interactive video consultation and, therefore, are not reimbursed. Only those services that involve direct *face-to-face* interactive video communication with the client, remote, and hub site providers are reimbursed; unless the service may currently be reimbursed using telemedicine, without face-to-face contact, i.e., teleradiology and telepathology.

Telemedicine services are reimbursed only when provided through systems meeting minimum technical specification standards, as identified by the Texas Health and Human Services Commission (HHSC), such as those of the Telecommunications Infrastructure Fund Board (TIFB), or as otherwise authorized.

In both the traditional and managed care systems, THSteps (Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]) visits will not be reimbursed if performed using telemedicine services. In the managed

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care system, THSteps visits, well child checkups, and adult preventive visits will not be reimbursed if performed using telemedicine services. Care provided for abnormalities identified during these preventive health visits may be reimbursed if the care is provided by using telemedicine services.

Information about the diagnosis, evaluation, or treatment of a client with Medicaid coverage by a person licensed or certified to perform the diagnosis, evaluation, or treatment of drug abuse or any medical or emotional disorder is confidential information that the provider may disclose only to authorized people. Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other aspects. The signed consent form or documentation of consent for release of information is to become part of the medical records at the remote site.

Reimbursement for telemedicine services is made only when *both* the hub site provider and remote site provider are acceptable Medicaid provider types for telemedicine services.

Reimbursement for the telemedicine services is made only to the following Texas Medicaid enrolled primary care provider using the GT (telemedicine) modifier with the appropriate E/M code. RHCs and federally qualified health center (FQHC) providers must use encounter codes with modifiers AM (Physician), SA (APN/Certified nurse-midwives [CNM]), and U7 (PA) in addition to the GT modifier (refer to the following):

- Physicians (MDs/DOs)
- PA
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- CNM

Hub site providers are limited to:

- Physician (MD), provider type 20
- Physician (DO), provider type 19

Remote site providers are limited to:

- Physician (MD), provider type 20
- Physician (DO), provider type 19
- NP, CNS, PA, provider type 10
- CNM, provider type 33
- FQHC, provider type 46
- RHC, provider types 78 and 79

The Healthcare Common Procedure Coding System (HCPCS) modifier code GQ (via asynchronous telecommunications system) is not appropriate for the Texas Medicaid telemedicine program, and should not be used.

The remote and hub site providers are to be reimbursed for telemedicine services. Reimbursement for telemedicine services is made at current TMRM for CPT E/M codes and encounter rates for RHCs and FQHCs.

Providers billing for teleradiology and telepathology services are to use the appropriate CPT code and the modifier GT.

The use of these modifiers by providers certifies they have met the criteria set forth by HHSC and that they understand claims data may be monitored for program integrity and provider compliance. Visits, consultations, and encounters are reimbursed based on individual policy guidelines; for example, global fee policy, consultation policy, and so forth (including payable provider types and places of service [POS]). Office or outpatient consultations are limited to one consultation per six-month period, same provider. All other consultations during the period are changed to the appropriate outpatient or office E/M code.

Telemedicine services are reimbursable only in the following places of service:

- Practitioner's office (Hub site)
- Practitioner's office (Remote site)
- RHC
- FQHC
- Inpatient hospital
- Outpatient hospital
- Emergency room
- ICF-MR state schools

Nursing facilities, skilled nursing facilities, and client homes *are not* approved places of service.

Use of telemedicine services in ICF-MR state schools is subject to policies established by HHSC and DADS.

36.3.5.4 Hub Site Provider

A hub site provider must be a physician at an accredited medical or osteopathic school located in Texas, or a physician at one of the following entities affiliated through a written contract or agreement with an accredited medical or osteopathic school located in Texas:

- Hospitals
- Teaching hospitals
- Tertiary centers
- Health clinics

The hub site physician provides consultation and the diagnosis, as well as develops the patient's plan of care and treatment.

Hub site providers may be reimbursed only for consultations via interactive video using procedure codes 3-99241, 3-99242, 3-99243, 3-99244, 3-99245, 3-99251, 3-99252, 3-99253, 3-99254, or 3-99255 billed with the GT modifier.

The hub site physician's findings must be documented in writing in the client's medical records at the remote site. The client's medical records may be faxed to the remote site provider.

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More than one medically necessary telemedicine consultation may be paid on the same day/time, same POS, if the consultations are billed by physicians of different specialties.

36.3.5.5 Remote Site Provider

Remote site providers must be primary care providers, such as physicians, PAs, NPs, CNSs, or CNMs, who provide visits/encounters in their offices, RHCs, or FQHCs and are able to bill the Texas Medicaid Program independently. Remote site providers must be located in rural or underserved areas. The remote site provider is responsible for carrying out or coordinating the plan of care and treatment after consulting with the hub site provider. Because the office visit or encounter must be through interactive video, the remote site provider must be present with the client during the performance of the interactive video telemedicine consultation. The signed consent form or documentation of consent for release of information must remain in the medical records at the remote site.

Remote site providers may be reimbursed for an office visit (POS 1) using codes 1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, 1-99215 or encounter code 1-T1015 (FQHC, RHC) in POS 1 or 5, as applicable.

FQHC and RHC telemedicine encounter providers must submit their claims using the following modifiers. Use modifier AM, U7, or SA *in the first modifier field* on the claim form together with the modifier GT *in the second field* on the claim form.

If prolonged physician services 1-99354, 1-99355 or special services 1-99050 are provided in addition to a telemedicine office visit (1-99201, 1-99202, 1-99203, 1-99204, 1-99205, 1-99211, 1-99212, 1-99213, 1-99214, 1-99215), these services should also be billed with modifier GT.

36.3.6 Orthognathic Surgery

Orthognathic surgery is a covered benefit only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program.

Treatment of malocculsion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is covered when it is necessary as part of an approved dental benefit.

Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction.
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies.
- Facial skeletal discrepancies associated with documented speech impairments.
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies.

Orthognathic surgery may be considered for reimbursement if the surgical service is required in order for the client to access a dental service.

Orthognathic surgery is administered and reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

Prior Authorization

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons when mandatory prior authorization is received from the TMHP Medical Director or designee. A narrative explaining medical necessity must be provided with the authorization request.

Procedure Codes		
2/F-21010	2-21031	2-21032
2/8/F-21050	2/8/F-21060	2/F-21100
2-21110	2/8-21120	2/8/F-21121
2/8/F-21122	2/8/F-21123	2/8-21125
2/8/F-21127	2/8-21137	2/8-21138
2/8-21139	2/8-21145	2/8-21146
2/8-21147	2/8-21150	2/8-21151
2/8-21154	2/8-21155	2/8-21159
2/8-21160	2/8-21172	2/8-21175
2/8-21179	2/8-21180	2/8/F-21181
2/8-21182	2/8-21183	2/8-21184
2/8-21188	2/8-21193	2/8-21194
2/8-21195	2/8-21196	2/8-21198
2/8-21199	2/8/F-21206	2/F-21208
2/8/F-21209	2/8/F-21210	2/F-21215
2/8/F-21230	2/F-21235	2/8/F-21240
2/8/F-21242	2/8/F-21243	2/8/F-21244
2/F-21245	2/F-21246	2/8-21247
2/8-21255	2/8-21256	2/8-21260
2/8-21261	2/8-21263	2/8/F-21267
2/8-21268	2/F-21270	2/8/f-21275
2/F-21280	2/F-21282	2/F-21295
2/F-21296	2/8/F-21299	2/F-29800
2/F-29804	2/F-40840	2/F-40842
2/F-40843	2/F-40844	2/F-40845

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36.4 Procedures and Services

36.4.1 Aerosol Treatment

Aerosol treatments including vaporizers, humidifiers, nebulizers, and inhalers are appropriate methods of treatment for certain *acute* medical problems and should be coded 1-94640 and revenue code B-412.

Payment for professional services for aerosol therapy is limited to the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
0796	Respiratory syncytial virus (RSV)
1363	Pneumocystosis
46400	Acute laryngitis, without mention of obstruction
46401	Acute laryngitis, with obstruction
46410	Acute tracheitis, without mention of obstruction
46411	Acute tracheitis, with obstruction
46420	Acute laryngotracheitis, without mention of obstruction
46421	Acute laryngotracheitis, with obstruction
46430	Acute epiglottitis, without mention of obstruction
46431	Acute epiglottitis, with obstruction
4644	Croup
46450	Unspecified supraglottitis, without mention of obstruction
46451	Unspecified supraglottitis, with obstruction
4660	Acute bronchitis
46611	Acute bronchiolitis due to RSV
46619	Acute bronchiolitis due to other infectious organisms
4786	Edema of larynx
47875	Laryngeal spasm
4788	Upper respiratory tract hypersensitivity reaction, site unspecified
4803	Pneumonia due to SARS-associated coronavirus
48284	Legionnaires' disease
490	Bronchitis, not specified as acute or chronic
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis
49120	Obstructive chronic bronchitis, without mention of acute exacerbation
49121	Obstructive chronic bronchitis, with acute exacerbation
49122	Obstructive chronic bronchitis with acute bronchitis
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysematous bleb
4928	Other emphysema
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma with acute exacerbation
49310	Intrinsic asthma without mention of status asthmaticus or acute exacerbation or unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma with acute exacerbation
49320	Chronic obstructive asthma without mention of status asthmaticus or acute exacerbation or unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma with acute exacerbation
49390	Asthma, unspecified without mention of status asthmaticus or acute exacerbation or unspecified
49391	Asthma, unspecified with status asthmaticus
49392	Asthma, unspecified with acute exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmer's lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	Ventilation pneumonitis
4958	Other specified allergic alveolitis and pneumonitis

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Diagnosis Code	Description
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction, not elsewhere classified
5173	Acute chest syndrome
5184	Acute edema of lung, unspecified
5186	Allergic bronchopulmonary aspergillosis
51911	Acute bronchospasm
51919	Other diseases of trachea and bronchus
99527	Other drug allergy

Medications used in aerosol therapy are reimbursed separately and should be billed using the appropriate HCPCS procedure code. A separate charge for saline used in aerosol therapy is denied as part of the aerosol therapy.

Procedure code 5-94664 is generally performed for chronic conditions and is *not a benefit* of the Texas Medicaid Program when billed by a physician or outpatient hospital.

36.4.2 Allergy Services

The Texas Medicaid Program uses the following guidelines for reimbursement of allergy services.

Reminder: *Procedure codes 1-95120, 1-95125, 1-95130, 1-95131, 1-95132, 1-95133, 1-95134 are no longer payable.*

36.4.2.1 Allergy Injections, Vials

A physician may prepare an allergy vial or extract for administration to the patient by another physician or by the patient. An allergy injection is a covered service if the physician who prepares the allergy extract has examined the patient at some time and determined the plan of treatment and dosage regimen. The physician who prepares the allergy extract and provides the vials to the client to self-administer or for another physician to administer may be paid for the extract and preparation. Physicians must use procedure codes 1-95145, 1-95146, 1-95147, 1-95148, 1-95149, 1-95165, or 1-95170 to document the service rendered. Each procedure code must be given a *quantity* to reflect the total volume of the vial (such as the number of cc in the vial). When the number of cc is not stated on the claim, a *quantity of one* is reimbursed.

Use the following procedure codes when a physician administers allergy serum prepared by another physician: 1-95115 and 1-95117.

The physician may bill the antigen vial using procedure codes 1-95145, 1-95146, 1-95147, 1-95148, 1-95149, 1-95165, or 1-95170 with the total number of cc specified and the administration-only code 1-95115 or 1-95117 each time an injection is given from a vial.

Established patient office visits on the same day for the same diagnosis as an antigen or vial are denied unless the claim indicates the visit was for re-evaluation of the patient's condition. If the provider documents that the office visit was for a diagnosis completely unrelated to the allergy diagnosis or re-evaluation of the patient's condition, the claim is considered for payment.

Sublingual antigens are not a benefit of the Texas Medicaid Program. Single-dose vials are not a benefit of the Texas Medicaid Program. Antigen injections are payable to physicians only in POS 1 (office).

36.4.2.2 Allergy Testing

Allergy testing is a benefit of the Texas Medicaid Program. The following procedure codes may be used for allergy testing:

Procedure Codes		
1-95004	1-95010	1-95015
1-95024	1-95028	1-95044
1-95052	1-95056	1-95060
1-95065	1-95070	1-95071
5-86003	5-86005	

The following procedure codes should be billed with the type and *actual number* of allergy tests performed. The quantity listed on the claim must indicate the number of tests performed to ensure proper reimbursement.

Procedure Codes		
1-95004	1-95010	1-95015
1-95024	1-95028	1-95044
1-95052	1-95056	1-95060
1-95065	1-95070	1-95071

The following allergy tests are not benefits of the Texas Medicaid Program and are denied: procedure codes 1-95027, 1-95078, and 1-95199.

Use the following codes for the billing of patch and photo patch allergy tests:

- 1-95044 (specify number of tests) for patch or application tests
- 1-95052 (specify number of tests) for photo patch tests

The type and number of allergy tests performed should be indicated on the claim. When the number of tests is not specified, it is paid as a quantity of one.

Radioallergosorbent tests (R.A.S.T.) and multiple antigen simultaneous tests (M.A.S.T.) are benefits of the Texas Medicaid Program. R.A.S.T. testing is a radioimmuno assay of the blood serum used to detect specific allergens. M.A.S.T. is a R.A.S.T.-type test using an enzyme rather than a radioactive marker. R.A.S.T.and M.A.S.T. testing is usually performed by an independent lab; however, some physicians have the capability to perform these tests in their offices. Physicians who bill R.A.S.T./M.A.S.T. tests in their offices must indicate this

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by the use of the modifier SU for payment to be allowed. Without the use of the modifier SU, R.A.S.T., and M.A.S.T. testing billed in the office (POS 1) is denied with EOB 00216, "Laboratory or X-ray performed outside your office must be billed by the performing facility."

Use the following codes for the billing of R.A.S.T. and M.A.S.T. testing: 5-86003 and 5-86005.

Procedure code 5-86003 may be used to bill each individual allergen, which is limited to 12 per year per provider. Procedure code 5-86005 should be billed as a quantity of 1 and is limited to four per year per provider. An allergy injection (1-95115, 1-95117, 1-95145, 1-95146, 1-95147, 1-95148, 1-95149, 1-95165, and 1-95170) may be paid in addition to R.A.S.T. and M.A.S.T. testing on the same day. Allergy injections are denied when billed on the same day as any other allergy testing.

An initial evaluation of a new patient is payable in addition to allergy testing on the same day. Established patient visits are not payable in addition to allergy testing on the same day unless documentation is submitted stating the visit was necessary for re-evaluation of the patient's condition or for an unrelated diagnosis. The allergy testing is paid and the visits are denied with the EOB 00117, "This procedure is part of another procedure billed on the same day."

36.4.3 Anesthesia

36.4.3.1 Anesthesia for Abortion

Use the procedure code 7-01965 for abortions.

36.4.3.2 Anesthesia for Sterilization

Use modifier FP, Family Planning, when reporting anesthesia services for a sterilization procedure.

The following procedure codes require modifier FP, in addition to the regular anesthesia modifier, if the service is sterilization:

CPT Anesthesia Codes		
7-00840	7-00920	7-00940
7-00851	7-00922	7-00950

36.4.3.3 Anesthesia for Labor and Delivery

Epidural Anesthesia by the Delivering Obstetrician

The Texas Medicaid Program reimburses the anesthesia services and the delivery at full allowance when provided by the delivering obstetrician. Procedure codes 2-62311 and 2-62319 are reimbursed according to the TMRM fee.

For continuous epidural analgesia, the Texas Medicaid Program reimburses for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences. Claims for procedure codes 7-01967, 7-01968, and 7-01969 must indicate the time spent administering the epidural, as well as the actual time spent with the client. Insertion and injection of the epidural are not reimbursed separately.

Refer to the following procedure codes:

Procedure Codes		
2-59410	2-59515	2-59614
2/8-59622	2-62311	2-62319
7-01960	7-01961	7-01963
7-01967	7-01968	7-01969

Procedure code 1-99140 is not reimbursed for diagnosis codes 650, Normal delivery, or 66970 and 66971, Cesarean delivery, when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition.

Epidural Anesthesia by a Provider other than the Delivering Obstetrician

The following procedure codes must be used for epidural anesthesia when provided by a provider other than the delivering obstetrician or surgeon. Procedure codes 2-62311 and 2-62319 must be used when the anesthesiologist or certified registered nurse anesthetists (CRNA) provides the epidural anesthesia during labor only. Procedure codes 2-62311 and 2-62319 are reimbursed according to the TMRM fee.

An anesthesia provider who administers epidural anesthesiology and remains with the client throughout labor and delivery or Cesarean section should combine all charges with the appropriate CPT anesthesia code (7-01967 for vaginal delivery or 7-01968 for Cesarean section). The claim must reflect the actual time spent administering the epidural and the *actual* time spent with the client in the delivery and/or operating room. If the anesthesiologist administers the epidural and leaves the client to return at a later time for the delivery or Cesarean section, the time not spent with the client is not reimbursable. For continuous epidural analgesia, the Texas Medicaid Program reimburses for the time when the anesthesia provider is physically present and monitoring the continuous epidural.

Note: *The anesthesia provider must be physically present in the room to bill for actual time spent with the client.*

Claims for procedure codes 7-01968 and 7-01967 are inclusive codes for labor and delivery anesthesia services. The labor and delivery minutes will be combined and paid on the higher relative value unit (RVU) detail. The provider must document the actual minutes spent administering the epidural as well as time spent with the client. Insertion and injection of the epidural are not reimbursed separately when billed with the CPT anesthesia delivery codes.

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Refer to the following procedure codes:

Procedure Codes		
2-62311	2-62319	7-01960
7-01961	7-01963	7-01967
7-01968	7-01969	

Procedure code 1-99140 is not reimbursed for diagnosis codes 650, Normal delivery, or 66970 and 66971, Cesarean delivery, when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition.

36.4.3.4 Anesthesia Provided by the Surgeon (Other than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. According to the Texas Medicaid Program, the anesthesia service is included in the global surgical fee.

36.4.3.5 Base Units

Base units are the relative value units (RVUs) assigned by Texas Medicaid to each anesthesia service billed.

36.4.3.6 Central Lines

Placement (insertion) of a central venous catheter is denied as part of another procedure when procedure 2-33970 is billed on the same day. Separate payment for the *insertion* of monitoring lines is not available. Reimbursement for the *insertion* of monitoring lines is included in the anesthesia fee when the time units are calculated.

Total units (as determined by the above guidelines) are multiplied by the Texas Medicaid conversion factor of $15.55. The following procedure codes have a conversion factor of $18.21:

Procedure Codes		
7-01960	7-01961	7-01963
7-01967	7-01968	7-01969
7-00851		

Providers must code the procedures in Block 24D of the CMS-1500 paper claim form with a valid CPT anesthesia code preceded by TOS indicator 7 for anesthesia.

36.4.3.7 Claim Filing

The Texas Medicaid Program reimburses anesthesiologists based on TEFRA. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 claim form)
- Person (physician or CRNA) administering anesthesia (modifiers must be used to designate this provider type)
- Time in minutes
- Any other appropriate modifier (refer to “Modifiers” on page 5-21 for a complete listing)

36.4.3.8 Complicated Anesthesia

The following procedure codes are payable in addition to an anesthesia procedure or service: 1-99100, 1-99116, 1-99135, and 1-99140.

Procedure code 1-99140 is not reimbursed for diagnosis codes 650, Normal delivery, or 66970, Cesarean delivery without mention of indication, when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

36.4.3.9 Pain Management

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent, often lasting more than six months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

Epidural and Subarachnoid Infusion (not including Labor and Delivery)

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management. Procedure code 1-01996 should be reported as a type of service (TOS) 1 (medical) instead of a TOS 7 (anesthesia).

Procedure code 1-01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure (TOS 2, 7, and 8). Procedure code 1-01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 1-01996 is payable to the following providers:

- Independent CRNA
- Independent CRNA group
- Family nurse practitioner/pediatric nurse practitioner (FNP/PNP)
- DO
- MD
- Physician group, DO

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- Physician group, MD

Intrathecal Morphine Pumps

Treatment of intractable pain with an intrathecal morphine pump is a benefit with prior authorization. However, prior authorization is *not* required if used for the treatment of intractable cancer pain.

The request for prior authorization must include required information. The use of the Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section I form is not mandatory; however, the information requested on both pages of the form is required.

Providers are to mail or fax prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Pain management is a benefit of the Texas Medicaid Program. Prior authorization is required for procedure codes 2-62350, 2-62360, 2-62361, and 2-62362 unless used for the treatment of intractable cancer pain.

Procedure codes 2-62350, 2-62351, 2-62355, 2-62360, 2-62361, 2-62362, and 2-62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 2-62350, 2-62351, 2-62355, 2-62360, 2-62361, 2-62362, and 2-62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.

Use the following codes when billing for the implantation/revision/replacement of the pump/catheter:

Procedure Codes		
2-62350	2-62351	2-62355
2-62360	2-62361	2-62362
2-62365		

Procedure codes I-62367 and I-62368 do not require prior authorization and are payable for the professional component (TOS I) only, with no payment allowed for the technical component.

Refer to: "Chemotherapy" on page 36-29 for more information about implanted pumps.

"Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section I" on page B-102

36.4.3.10 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items. Multiple surgical procedures billed on the same day by the same provider are subject to the multiple surgery guidelines.

When billing for multiple anesthesia services, TOS 7, performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for *all* anesthesia services rendered on the a higher RVU code.

36.4.3.11 Reimbursement Methodology

Reimbursement for anesthesia services is determined by a calculation using the relative value units for a particular anesthesia procedure (Base Units) plus the quantity billed (anesthesia *Time Units* divided by 15) multiplied by the TMRM conversion factor for physicians. The formula is Base Unit + Time Units x TMRM. The following is an example of physician pricing:

Provider Type Description–Physician Pricing Example				
Modifier	=	120/15	=	8 (quantity billed)
Procedure Code	=	7-00851 (6 RVUs) 6.00 + 8	=	14.00
Time	=	14.00 x 18.21	=	$254.94 (physician reimbursement)

36.4.3.12 Services Incidental to Surgery and/or Anesthesia

Certain services that are performed in conjunction with surgical or anesthesia procedures are considered incidental to the surgery or anesthesia and will be denied as included in the surgical/anesthesia fee. The following table includes, but may not be limited to, services that are incidental to surgery or anesthesia:

Procedure Codes		
1-90760	1-90761	1-90765
1-90766	1-90767	1-90768
1-94656	1-94657	1-96521
1-96522	1-96523	1-99231
1-99232	1-99291	1-99292
1-99233	2-36010	2-36420
2-36425	2-36430	2-36440
2-36620	2-3662	5-82800
5-82803	5-82805	5-82810
5-82820	5/I/T-93561	5/I/T-93562
5/I-94010	5/I-94060	5/I-94680
5/I-94681	5/I-94690	5-94760

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Procedure Codes		
5-94761	5/I-94770	T-93005
T-93017	T-93041	

Separate payment for the insertion of monitoring lines is not allowed in addition to the anesthesia fee. Separate charges for insertion of monitoring lines (i.e., central venous pressure lines, arterial lines and Swan-Ganz catheters) will be denied as included in the anesthesia fee, as the reimbursement of monitoring lines is considered to be included in the anesthesia time. The following table includes, but may not be limited to, services that are incidental to the anesthesia fee:

Procedure Codes		
2-33967	2-33970	2-36013
2-36014	2-93503	2-36555
2-36556	2-36568	2-36569

Should the need arise for the insertion of a monitoring line due to a separate incident not related to the original surgery after the postoperative recovery period, reimbursement may be considered on appeal with appropriate documentation. Reimbursement for monitoring lines billed as the sole procedure performed will be allowed.

36.4.3.13 Supervision of Concurrent Anesthesia Procedures

Physicians must supply information on the number of anesthetists being concurrently supervised through the use of the appropriate modifier. The name of each nurse anesthetist supervised and all concurrent procedures performed *do not* have to be submitted on the claim form. Physicians are responsible for maintaining the information that is subject to retrospective review.

The percentage of reduction for each modifier is shown in the following table:

Modifier	Description	Time Divided By	RVU Reduction
AA	Anesthesia services performed personally by the anesthesiologist [RVU + (Minutes/15)] X Conversion Factor = Allowed Amount	15 minutes	0 percent
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures. The AD modifier is also used when a modifier is not submitted on the claim.	NA. Total time units for claim are set to one unit.	0 percent
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals [RVU + (Minutes/30)] X Conversion Factor = Allowed Amount	30 minutes	10 percent
QS	Monitored services. This informational modifier can be billed by a CRNA or physician and must have a pricing modifier billed with it for processing.	NA	NA
QY*	Medical direction of one CRNA by an anesthesiologist [RVU + (Minutes/15)] X Conversion Factor = Allowed Amount	15 minutes	0 percent
*** = Providers should continue to use the AA modifier until further notice.**			

36.4.3.14 Supervision of Anesthesiologist Assistant

For claims to be considered for payment, providers should bill with the appropriate anesthesia procedure code for the service performed and a primary/pricing modifier.

Anesthesiologists must be Board-certified to supervise anesthesiologist assistants, and may medically direct no more than two concurrent sessions including anesthesi-

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ology assistants. The anesthesiologist will not perform a personal separate anesthesia service while supervising the anesthesiologist assistant(s).

36.4.3.15 Supervision of CRNA

TMHP reimburses an anesthesiologist for supervision of a CRNA. The services of the CRNA must be billed using a CRNA provider identifier.

In situations where the anesthesiologist supervises the CRNA and no concurrent procedures occur, the anesthesiologist or the CRNA should bill for the administration of anesthesia. Payment is not made to both providers when the modifier AA is used by the physician anesthesiologist.

CRNA services are reimbursed the lesser of the actual charge or 92 percent of the rate reimbursed to a physician anesthesiologist for the same service for covered procedures.

Time Units

Time Units is based on the time in minutes indicated on the claim by the provider. It is the result of the following calculation:

- Time in minutes as indicated on the claim by the provider
- Divided by 15-minute or 30-minute increments

The resulting *Time Units* value is added to the *Base Units* value to get the *Total Units* value.

The modifier indicated on the claim determines which time increment is used to divide the total anesthesia time billed.

Providers billing anesthesia time must refer to the CPT manual definition of time. The definition is provided under the title *Time Reporting*:

> "Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under the postoperative supervision."

Refer to: "Supervision of Concurrent Anesthesia Procedures" on page 36-27.

36.4.3.16 Anesthesia (General) for THSteps Dental Restoration

Anesthesia services for THSteps dental procedures must be billed using procedure code 7-00170 with modifier EP and diagnosis code 52100 in Block 21 of the CMS-1500 paper claim form.

Note: *Except for Primary Care Case Management (PCCM), THSteps Dental anesthesia services for clients in the STAR and STAR+PLUS health plans must be billed to the appropriate health plan, not to TMHP. PCCM providers submit claims to TMHP.*

36.4.4 Assessment of Higher Cerebral Function Testing

Physician Payment Reform has grouped assessment of higher cerebral function testing, procedure codes 5-96105, 5-96110, and 5-96111 into the payment for primary services; therefore, no separate payment is made for this testing.

Aphasia, developmental, and cognitive testing must be billed using the appropriate E/M or outpatient code. Procedure codes 5-96105, 5-96110, and 5-96111 are denied as part of the patient's evaluation, whether billed in conjunction with an E/M or outpatient code or as an independent procedure(s).

Assessment of higher cerebral function testing is *not* reimbursed under the Comprehensive Care Program (CCP) because it is part of the patient's evaluation.

36.4.5 Cancer

36.4.5.1 Cancer Screening, Colorectal

The following procedure codes are covered services: 2/F-G0104, 2/F-G0105, 5-G0107, 4/I/T-G0106, and 4/I/T-G0120

Procedure code 4/I/T-G0122 is not covered by Medicaid.

Screening intervals are recommended once every 48 months for individuals 50 years of age and older. The screening colonoscopy is recommended once every 24 months for individuals at high risk for colorectal cancer. High-risk individuals include people with one more of the following factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyposis
- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of colorectal cancer
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis

A screening colonoscopy may be covered for the following diagnosis codes:

Diagnosis Code	Description
5550	Regional enteritis of small intestine
5551	Regional enteritis of large intestine
5552	Regional enteritis of small intestine with large intestine
5559	Regional enteritis of unspecified site
5560	Ulcerative (chronic) enterocolitis
5561	Ulcerative ileocolitis
5562	Ulcerative (chronic) proctitis
5563	Ulcerative (chronic) proctosigmoiditis
5568	Other ulcerative colitis
* Payable as secondary diagnosis	

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Diagnosis Code	Description
5569	Ulcerative colitis, unspecified
5589	Other and unspecified noninfectious gastroenteritis and colitis
V1005	Personal history of malignant neoplasm of the large intestine
V1006	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
V160	Family history of malignant neoplasm of gastrointestinal tract
V1851*	Family history, Colonic polyps
* Payable as secondary diagnosis	

In addition to the above listed diagnosis codes, procedure codes 2/F-G0104 and 4/I/T-G0106, which are limited to once every five years, are a benefit when billed with diagnosis code V7651 (Special screening for malignant neoplasms, colon). The procedure code 2-G0121 is a covered service when billed with diagnosis code V7651.

36.4.5.2 Chemotherapy

Chemotherapy infusion procedure codes listed in the following table are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents either by or under the supervision of the physician, but do not include the provision of the chemotherapeutic agents:

Procedure Codes		
1-96402	1-96405	1-96406
1-96409	1-96413	1-96420
1-96422	1-96521	1-96522
1-96542	1-96549	

Chemotherapeutic infusion procedure codes are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents under the physician's direct supervision, but do not include the provision of chemotherapeutic agents. These procedure codes also include the appropriate invasive surgical procedure. As a result, a thoracentesis billed with 1-96440 is denied as part of 1-96440; a paracentesis billed with 1-96445 is denied as part of 1-96445; and a lumbar puncture billed with 1-96450 is denied as part of 1-96450.

These codes (1-96440, 1-96445, and 1-96450) may be paid in addition to E/M codes billed on the same day, regardless of the POS billed.

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be billed separately and reimbursed using the appropriate procedure code(s).

Chemotherapeutic codes may be paid in addition to E/M codes provided on the same day if the services occur in a sequential manner in POS 1, 2, or 5 for the following:

Procedure Codes		
1-96401	1-96402	1-96405
1-96406	1-96409	1-96413
1-96420	1-96422	1-96521
1-96522	1-96523	1-96542
1-96549		

If the patient is hospitalized (POS 3), the physician should use the appropriate E/M codes. These chemotherapeutic codes are denied as part of the daily hospital management codes in POS 3. If chemotherapy administration is the only service billed in POS 3, it is reimbursed.

Chemotherapy planning may be considered for reimbursement as a physician service.

When a chemotherapy planning program is billed by the same provider on the same date of service with office visits, consultations, hospital visits, and emergency room visits, the chemotherapy planning is reimbursed, and the visits will deny as part of the chemotherapy planning.

Factors considered for planning chemotherapy treatment include, but are not limited to:

- The type of cancer.
- Where the cancer is located in the body
- Whether the cancer has spread
- Where the cancer has spread (if it has)
- The age and general health of the client
- The frequency of chemotherapy treatment, and how long the treatment lasts, depending on factors that include, but are not limited to:
  - Type of cancer
  - Drugs used
  - How the cancer cells respond to the drugs
  - Any side effects from the drugs.

Procedure code 2-51720 is used for Treatment of bladder lesion.

Chemotherapy Procedure Codes

When billing the following codes to facilitate the administration of chemotherapy, prior authorization is *not* required:

Procedure Codes		
2-61210	2-61215	2-62350
2-62360	2-62361	2-62362

However, if these codes are billed for services provided in treating chronic spasticity with intrathecal baclofen, they *do* require prior authorization.

Prolonged infusion of chemotherapeutic agents is reimbursed as follows: procedure codes 1-96413 and 1-96422.

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The following procedure codes are not payable: 1-96415, 1-96423, and 1-96425.

Chemotherapy administration by push technique (1-96409 and 1-96420) and by infusion technique (1-96413 and 1-96422) is reimbursed when billed for the same date of service.

Only one 1-96409 and one 1-96420 are allowed per day, regardless of whether separate drugs are given.

The following codes are valid for any date of service:

Procedure Codes		
1-J9062	1-J9080	1-J9090
1-J9091	1-J9092	1-J9094
1-J9095	1-J9096	1-J9097
1-J9110	1-J9140	1-J9182
1-J9250	1-J9290	1-J9291
1-J9375	1-J9380	

Refer to: "Baclofen (Lioresal), Trial Injection and Pump Implantation/Catheter Insertion/Revision/Replacement" on page 36-89.

36.4.5.3 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

Bacillus Calmette-Guérin (BCG) intravesical, instillation (1-J9031) and for bladder cancer, live, for intravesical use (1-90586) are covered benefits of the Texas Medicaid Program for the following diagnosis codes:

Diagnosis Code	Description
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
2337	Carcinoma in situ of the bladder

BCG intravesical vaccines will autodeny for all other diagnosis codes. Bladder instillation of anticarcinogenic agent (2-51720) may be reimbursed separately when billed separately.

36.4.6 Casting, Splinting, and Strapping

When a casting, splinting, strapping, or traction device is billed on the same day as surgery, the surgery will be paid and the casting, splinting, strapping, or traction device will deny as part of another procedure billed on the same day if the following procedure codes are used:

Procedure Codes		
29000	29010	29015
29020	29025	29035
29040	29044	29046
29049	29055	29058
29065	29075	29085
29086	29105	29125
29126	29130	29131
29200	29220	29240
29260	29280	29305
29325	29345	29355
29358	29365	29405
29425	29435	29440
29445	29450	29505
29515	29520	29530
29540	29550	29580
29590		

The replacement of a cast, splint, or strapping, using the procedure codes in the table above, is not included in the original surgical fee and may be paid separately.

Payment for cast removal or repair will be denied if billed within six weeks of the initial cast application, splinting, or strapping by the same provider. The procedure codes for cast removal listed in the table below may be paid to a provider other than the provider who applied the initial cast, splint, or strap.

Procedure Codes		
2-29700	2-29705	2-29710
2-29715	2-29720	2-29730
2-29740	2-29750	2-29799

When casting, splinting, strapping, or wedging is performed without surgery and the appropriate E/M code is billed, both may be paid using the following procedure codes:

Procedure Codes		
2-29000	2-29010	2-29015
2-29020	2-29025	2-29035
2-29040	2-29044	2-29046
2-29049	2-29055	2-29058
2-29065	2-29075	2-29085
2-29086	2-29105	2-29125
2-29126	2-29130	2-29131

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Procedure Codes		
2-29200	2-29220	2-29240
2-29260	2-29280	2-29305
2-29325	2-29345	2-29355
2-29358	2-29365	2-29405
2-29425	2-29435	2-29440
2-29445	2-29450	2-29505
2-29515	2-29520	2-29530
2-29540	2-29550	2-29580
2-29590	2-29750	

Supplies are not separately payable. This includes the procedure code 9-99070.

36.4.7 Neurostimulators

36.4.7.1 Central Nervous System Stimulators

The implantation of central nervous system electrical nerve stimulators is a benefit of the Texas Medicaid Program with documentation of medical necessity. It may be covered for the relief of chronic intractable pain. Conditions that may indicate chronic intractable pain include, but are not limited to:

- Amputation *ghost* pain

Diagnosis Code	Description
7092	Scar conditions and fibrosis of skin
7295	Pain in limb
V493	Sensory problems with limbs

- Cancer with bone metastasis (too numerous to list)
- Causalgia of upper/lower limb

Diagnosis Code	Description
3544	Causalgia of upper limb
35571	Causalgia of lower limb

- Herniated disc

Diagnosis Code	Description
7220	Displacement of cervical intervertebral disc without myelopathy
72210	Displacement of lumbar intervertebral disc without myelopathy
72211	Displacement of thoracic intervertebral disc without myelopathy
7222	Displacement of intervertebral disc, site unspecified, without myelopathy
72230	Schmorl's nodes of unspecified region
72231	Schmorl's nodes of thoracic region
72232	Schmorl's nodes of lumbar region
72239	Schmorl's nodes of other spinal region
7224	Degeneration of cervical intervertebral disc
72251	Degeneration of thoracic or thoracolumbar intervertebral disc
72252	Degeneration of lumbar or lumbosacral intervertebral disc
7226	Degeneration of intervertebral disc, site unspecified
72270	Intervertebral disc disorder with myelopathy, unspecified region
72271	Intervertebral disc disorder with myelopathy, cervical region
72272	Intervertebral disc disorder with myelopathy, thoracic region

- Radiculitis

Diagnosis Code	Description
7234	Brachial neuritis or radiculitis NOS
7292	Neuralgia, neuritis, and radiculitis, unspecified
09489	Other specified neurosyphilis

- Spinal stenosis

Diagnosis Code	Description
7230	Spinal stenosis in cervical region
7231	Cervicalgia
7232	Cervicocranial syndrome
7233	Cervicobrachial syndrome (diffuse)
7234	Brachial neuritis or radiculitis NOS
7235	Torticollis, unspecified
7236	Panniculitis specified as affecting neck
7237	Ossification of posterior longitudinal ligament in cervical region
7238	Other syndromes affecting cervical region
7239	Unspecified musculoskeletal disorders and symptoms referable to neck
72400	Spinal stenosis of unspecified region
72401	Spinal stenosis of thoracic region
72402	Spinal stenosis of lumbar region
72409	Spinal stenosis of other region

- Spinal surgery, using the following procedure codes:

Procedure Codes		
2-63001	2-63003	2-63005
2-63011	2-63012	2-63015

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Procedure Codes		
2-63016	2-63017	2-63020
2-63030	2-63035	2-63040
2-63041	2-63042	2-63043
2-63044	2-63045	2-63046
2-63047	2-63048	2-63050
2-63051	2-63055	2-63056
2-63057	2-63064	2-63066
2-63075	2-63076	2-63077
2-63078	2-63081	2-63082
2-63085	2-63086	2-63087
2-63088	2-63090	2-63091
2-63101	2-63102	2-63103
2-63170	2-63172	2-63173
2-63180	2-63182	2-63185
2-63190	2-63191	2-63194
2-63195	2-63196	2-63197
2-63198	2-63199	2-63200
2-63250	2-63251	2-63252
2-63265	2-63266	2-63267
2-63268	2-63270	2-63271
2-63272	2-63273	2-63275
2-63276	2-63277	2-63278
2-63280	2-63281	2-63282
2-63283	2-63285	2-63286
2-63287	2-63290	2-63295
2-63300	2-63301	2-63302
2-63303	2-63304	2-63305
2-63306	2-63307	2-63308

- Tic douloureux (Trigeminal neuralgia)

Diagnosis Code	Description
3501	Trigeminal neuralgia
3502	Atypical face pain
05312	Postherpetic trigeminal neuralgia
05313	Postherpetic polyneuropathy

The following types of central nervous system stimulators are covered:

- Dorsal column (spinal cord) (2/F-63650, 2/8-63655, 2/F-63660, 2/F-63685, and 2/F-63688)
- Intracranial (2-61850, 2-61860, 2-61863, 2-61864, 2-61867, 2-61868, 2-61870, 2-61875, 2/8/F-61880, 2/F-61885, 2-61886, and 2/F-61888)

Documentation of the following must be submitted with claims for payment of the implantation of a *dorsal column stimulator:*

- Implantation of the stimulator is a last resort in a patient with chronic intractable pain. Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and been shown to be unsatisfactory, unsuitable, or contraindicated for the patient.
- The patient has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team before implantation. This screening should include psychological as well as physical evaluation.
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and follow-up of the patient are available.
- Demonstration of pain relief with a temporarily implanted electrode preceded permanent implantation.

Separate payment for the device is not covered for the physician or hospital. It is included in the hospital or facility global payment group. Separate charges for the rental or purchase of the stimulator device (dorsal column, intracranial, deep brain, or vagal) are denied as not a benefit of Medicaid.

The *implantation of intracranial neurostimulators* is payable *only* for the following diagnoses and is subject to multiple surgery audit guidelines. When billing for intracranial neurostimulator implantation (2/F-61850, 2-61860, 2-61863, 2-61864, 2-61867, 2-61868, 2-61870, 2-61875, 2/8/F-61880, 2/F-61885, 2-61886, and 2/F-61888), the documentation required for dorsal column stimulators does *not* need to be submitted. When billing the following codes pertaining to the treatment of intractable pain with a dorsal column stimulator, prior authorization is not required: 2/F-63685 and 2/F-63688.

Documentation must be included in the client's records and is subject to retrospective review.

The following codes are payable through the Texas Medicaid Program without prior authorization for the electronic analysis of an implanted neurostimulator:

Procedure Codes		
5-95970	5-95971	5-95972
5-95973	5-95974	5-95975
5-95978	5-95979	

Payment will not be made for the implantation of CNS stimulators to treat motor function disorders such as multiple sclerosis. However, the implantation, revision, and removal of deep brain stimulators is a payable benefit for the treatment of intractable tremors because of diagnosis code 3320, Paralysis Agitans, or diagnosis code 3331, Essential and other specified forms of tremor.

However, if codes 2/F-63685 or 2/F-63688 are billed for services provided in treating intractable seizures with a vagal nerve stimulator, they *do* require prior authorization.

Refer to: "Deep Brain Stimulators" on page 36-33 for more information about prior authorization.

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36.4.7.2 Deep Brain Stimulators

Implantation of neurostimulator electrodes for the treatment of intractable tremors, diagnosis codes 3320, Paralysis agitans, and 3331, Tremor NEC, are payable benefits. One of these diagnoses must appear on the claim for reimbursement to be considered. The actual deep brain stimulator device is payable only under the DRG or ASC/HASC reimbursement rate. *No separate payment outside of the DRG or ASC/HASC reimbursement rate is made for the device.*

Procedure codes 2/8/F-61880, 2/F-61885, and 2/8/F-61888 are:

- Payable in the inpatient and outpatient settings
- Subject to the global surgical fee policy, with three-day pre-care and six week post-care periods assigned
- Subject to multiple surgery guidelines

36.4.7.3 Percutaneous/Transcutaneous Nerve Stimulators

Application of a surface (transcutaneous) neurostimulator is *not a benefit* of the Medicaid program. Implantation of percutaneous peripheral nerve stimulators and electrodes are *not a benefit* of the Medicaid program.

Purchase or rental of electrical nerve stimulators and associated supplies, such as leads/electrodes, rechargeable transcutaneous electrical nerve stimulator (TENS) battery packs, and form-fitting conductive garments, are *not a benefit* of the Medicaid program. Additionally, diagnostic assessments for use of a TENS or percutaneous electrical nerve stimulator (PENS) are not a benefit of the Medicaid program.

36.4.7.4 Sacral Nerve Stimulators

Sacral nerve stimulators are *not a benefit* of the Texas Medicaid Program.

36.4.7.5 Vagal Nerve Stimulators

The implantation, revision, programming/reprogramming, and removal of the vagal nerve stimulator device is a payable benefit for Texas Medicaid clients with medically intractable partial onset seizures.

These procedures are payable for inpatient, ASC, and HASC. If performed in an ASC or HASC, the maximum reimbursement is determined by the payment grouping.

No separate payment for the device is made to either the hospital or the physician. Reimbursement for the device is included in the facility payment.

The following procedure codes are payable for the incision, implantation, revision, or removal of the vagal nerve stimulator: 2/F-61885, 2/F-64573, 2/F-64585, and 2/F-61888.

The following diagnosis codes must be billed for procedure codes 2/F-61885 and 2/F-61888 when requesting the vagal nerve stimulator:

Diagnosis Code	Description
34511	Generalized convulsive epilepsy, with intractable epilepsy
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy

The following procedure codes are payable in an outpatient setting or physician office for the electronic analysis and programming/reprogramming of the implanted neurostimulator: 5-95970, 5-95971, 5-95972, 5-95973, 5-95974, and 5-95975. These procedure codes do not require prior authorization.

Clients with diagnoses with ominous prognoses or other limiting factors would not be considered appropriate candidates for the implantation of the vagal nerve stimulator (for example, clients with an absent left vagus nerve, severe mental retardation, cerebral palsy, stroke, progressive fatal neurologic diseases, or progressive fatal medical diseases).

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for children younger than 21 years of age.

36.4.8 Cochlear Implants

A cochlear implant, when medically indicated, is a payable benefit of the Texas Medicaid Program. Reimbursement is provided only for those patients who meet all the following criteria:

- Diagnosis of total bilateral sensorineural deafness that cannot be mitigated by use of a hearing aid in clients whose auditory cranial nerve is able to be stimulated
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation
- Post-lingual deafness or pre-lingual deafness
- Clients 18 months of age or older
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- No contraindications to surgery

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The payment for cochlear implant is limited to the following diagnosis codes:

Diagnosis Code	Description
38910	Sensorineural hearing loss, unspecified
38911	Sensory hearing loss, bilateral
38912	Neural hearing loss, bilateral
38914	Central hearing loss, bilateral
38915	Sensorineural hearing loss, unilateral
38916	Sensorineural hearing loss, asymmetrical
38918	Sensorineural hearing loss of combined types, bilateral
3892	Mixed conductive and sensorineural hearing loss

Prior authorization is not required for these diagnosis codes.

Diagnostic analysis of the cochlear implant in the event of malfunction may be considered for reimbursement using the following procedure codes: 1-92601, 1-92602, 1-92603, and 1-92604.

36.4.9 Diagnostic Tests

36.4.9.1 Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring is a covered benefit for patients when hypertension is suspected but not defined by history or physical. Ambulatory blood pressure monitoring has been shown to be effective when used in the differential diagnosis of hypertension not elucidated by conventional studies.

The monitoring unit is 24 hours. Benefits are limited to the following medical necessities:

- Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
- At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
- There is no evidence of end-organ damage. Indications for the use of this monitoring are for diagnostic purposes only and should not be used for maintenance monitoring.

Use procedure codes 5-93784, 5-93786, 5-93788, 5-93790 to bill for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is a benefit when submitted with diagnosis code 7962 (Elevated blood pressure reading without diagnosis of hypertension).

Other diagnoses may be considered on appeal with supporting medical documentation submitted to the TMHP Medical Director.

36.4.9.2 Ambulatory Electroencephalogram (A/EEG)

Ambulatory electroencephalographic monitoring (A/EEG) or 24-hour ambulatory monitoring is a covered benefit for patients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG where A/EEG has been shown to be effective when used in the differential diagnosis of syncope and transient cerebral ischemic attacks not elucidated by the conventional studies.

The monitoring unit is 24 hours. Benefits are limited to two units (each unit 24 hours) for each physician for the same client per six months when medically necessary.

Use the following procedure codes to bill A/EEG: 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, and 5/I/T-95956.

Procedure codes 5-95950, 5-95951, 5-95953, and 5-95956 are related. When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied.

Procedure codes 5-95950, 5-95951, 5-95953, and 5-95956 are payable when billed with the following diagnosis codes:

Diagnosis Code	Description
2930	Acute delirium, epileptic; confusional state
2948	Other persistent mental disorders due to conditions classified elsewhere
3332	Myoclonus
34500	Generalized nonconvulsive epilepsy, without mention of intractable epilepsy
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy
34510	Generalized convulsive epilepsy, without mention of intractable epilepsy
34511	Generalized convulsive epilepsy, with intractable epilepsy
3452	Petit mal status, epileptic
3453	Grand mal status, epileptic
34540	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy

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Diagnosis Code	Description
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
34560	Infantile spasms, without mention of intractable epilepsy
34561	Infantile spasms, with intractable epilepsy
34570	Epilepsia partialis continua, without mention of intractable epilepsy
34571	Epilepsia partialis continua, with intractable epilepsy
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
34590	Epilepsy, unspecified, without mention of intractable epilepsy
34591	Epilepsy, unspecified, with intractable epilepsy
64940	Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
64941	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
64942	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
64943	Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
64944	Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
7790	Convulsions in newborn
7797	Preventricular leukomalacia
78031	Febrile convulsions (simple), unspecified
78032	Complex febrile convulsions
78039	Other convulsions
78097	Altered mental status

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

36.4.9.3 Bone Marrow Aspiration, Biopsy

Procedure code 2-20220 is for bone biopsy and is inappropriate for billing of bone marrow aspiration or bone marrow biopsy.

Physicians may bill procedure code I-85097 if interpretation is for smear interpretation, or 5/I/T-88305 if interpretation is for preparation and interpretation of cell block. If both 5-85097 and 5-88305 are billed, 5-88305 is paid and 5-85097 is denied.

Physicians may bill procedure code 5-85097 or 5-88305 for preparation and interpretation of the specimen.

36.4.9.4 Computerized Axial Tomography (CAT) Scan

Freestanding facilities may bill for CAT scans using the TOS T for the technical component only. The radiologist or neurologist who reads the scan may bill using the TOS I for interpretation only. Additionally, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill using the TOS I for interpretation.

Scout views and reconstruction are considered part of any CAT scan procedure and are not reimbursed in addition to any other CAT scan.

36.4.9.5 Cytopathology Studies – Gynecological, Pap Smears

Pap smears are a benefit of the Texas Medicaid Program for early detection of cancer. Family planning clients are eligible for annual Pap smears.

Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

Procedure Codes		
I-88141	5-88142	5-88143
5-88147	5-88148	5-88150
5-88151	5-88152	5-88153
5-88154	5-88155	5-88164
5-88165	5-88166	5-88167
5-88174	5-88175	

These procedure codes are payable in the POS where the Pap smear is interpreted: POS 1 (office), POS 3 (inpatient), POS 5 (outpatient), or POS 6 (independent laboratory).

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The interpretation portion of any gynecological cytopathology test must be reported using procedure code I-88141. It is inappropriate to use the following procedure codes to bill for the interpretation:

Procedure Codes		
I-88142	I-88143	I-88147
I-88148	I-88150	I-88151
I-88152	I-88153	I-88154
I-88155	I-88164	I-88165
I-88166	I-88167	I-88174
I-88175		

Procedure code I-88141 remains a benefit. Its reimbursement is restricted to laboratories and pathologists. It is reimbursed in addition to the technical component. The following procedure codes are payable for TOS 5 only:

Procedure Codes		
5-88142	5-88143	5-88147
5-88148	5-88150	5-88152
5-88153	5-88154	5-88164
5-88165	5-88166	5-88167
5-88174	5-88175	

Procedure code 5-88155 is a benefit but is not reimbursed when billed in addition to the following cytopathology procedure codes:

Procedure Codes		
5-88142	5-88143	5-88147
5-88148	5-88150	5-88151
5-88152	5-88153	5-88154
5-88155	5-88164	5-88165
5-88166	5-88167	5-88174
5-88175		

Procedure code 5-88144 is not a benefit because the procedure it describes has not been FDA-approved.

36.4.9.6 Cytopathology Studies – Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client's E/M and will not be reimbursed separately.

Procedure codes 5/I/T-88160, 5/I/T-88161, and 5/I/T-88162 are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists). These procedure codes are reimbursed according to the POS where the cytopathology smear is interpreted.

The following procedures are payable in the office (POS 1), outpatient setting (POS 5), or independent laboratory (POS 6): 5-88160, 5-88161, and 5-88162.

The following procedures are payable to a pathologist in the outpatient (POS 5) and inpatient (POS 3) hospital: I-88160, I-88161, and I-88162.

- Procedure codes 5/I-88160 and/or 5/I-88161 are denied as part of 5/I-88162.
- Procedure code 5/I-88160 is denied as part of procedure code 5/I-88161.

36.4.9.7 Echoencephalography

Echoencephalography (4/I/T-76506) is medically indicated for the following conditions or diagnosis codes:

Diagnosis Code	Description
01300	Tuberculous meningitis, unspecified examination
01301	Tuberculous meningitis, bacteriological or histological examination not done
01302	Tuberculous meningitis, bacteriological or histological examination results unknown (at present)
01303	Tuberculous meningitis, tubercle bacilli found (in sputum) by microscopy
01304	Tuberculous meningitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01305	Tuberculous meningitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01306	Tuberculous meningitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01310	Tuberculoma of meninges, unspecified examination
01311	Tuberculoma of meninges, bacteriological or histological examination not done
01312	Tuberculoma of meninges, bacteriological or histological examination results unknown (at present)
01313	Tuberculoma of meninges, tubercle bacilli found (in sputum) by microscopy
01314	Tuberculoma of meninges, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01315	Tuberculoma of meninges, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically

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Diagnosis Code	Description
01316	Tuberculoma of meninges, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01320	Tuberculoma of brain, unspecified examination
01321	Tuberculoma of brain, bacteriological or histological examination not done
01322	Tuberculoma of brain, bacteriological or histological examination results unknown (at present)
01323	Tuberculoma of brain, tubercle bacilli found (in sputum) by microscopy
01324	Tuberculoma of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01325	Tuberculoma of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01326	Tuberculoma of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01330	Tuberculous abscess of brain, unspecified examination
01331	Tuberculous abscess of brain, bacteriological or histological examination not done
01332	Tuberculous abscess of brain, bacteriological or histological examination results unknown (at present)
01333	Tuberculous abscess of brain, tubercle bacilli found (in sputum) by microscopy
01334	Tuberculous abscess of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01335	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01336	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01340	Tuberculoma of spinal cord, unspecified examination
01341	Tuberculoma of spinal cord, bacteriological or histological examination not done
01342	Tuberculoma of spinal cord, bacteriological or histological examination results unknown (at present)
01343	Tuberculoma of spinal cord, tubercle bacilli found (in sputum) by microscopy
01344	Tuberculoma of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01345	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01346	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01350	Tuberculous abscess of spinal cord, unspecified examination
01351	Tuberculous abscess of spinal cord, bacteriological or histological examination not done
01352	Tuberculous abscess of spinal cord, bacteriological or histological examination results unknown (at present)
01353	Tuberculous abscess of spinal cord, tubercle bacilli found (in sputum) by microscopy
01354	Tuberculous abscess of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01355	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01356	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01360	Tuberculous encephalitis or myelitis, unspecified examination
01361	Tuberculous encephalitis or myelitis, bacteriological or histological examination not done
01362	Tuberculous encephalitis or myelitis, bacteriological or histological examination results unknown (at present)

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Diagnosis Code	Description
01363	Tuberculous encephalitis or myelitis, tubercle bacilli found (in sputum) by microscopy
01364	Tuberculous encephalitis or myelitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01365	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacterio-logical examination, but tuberculosis confirmed histologically
01366	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacterio-logical or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01380	Other specified tuberculosis of central nervous system, unspecified examination
01381	Other specified tuberculosis of central nervous system, bacteriological or histological examination not done
01382	Other specified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present)
01383	Other specified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy
01384	Other specified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01385	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01386	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inocu-lation of animals)
1700	Malignant neoplasm of bone and articular cartilage; bones of skull and face, except mandible
1901	Malignant neoplasm of eye; orbit
1910	Malignant neoplasm of brain; cerebrum, except lobes and ventricles
1911	Malignant neoplasm of brain; frontal lobe
1912	Malignant neoplasm of brain; temporal lobe
1913	Malignant neoplasm of brain; parietal lobe
1914	Malignant neoplasm of brain; occipital lobe
1915	Malignant neoplasm of brain; ventricles
1916	Malignant neoplasm of brain; cerebellum NOS
1917	Malignant neoplasm of brain; brain stem
1918	Malignant neoplasm of brain; other parts of brain
1919	Malignant neoplasm of brain; unspecified
1920	Malignant neoplasm of other and unspecified parts of nervous system; cranial nerves
1921	Malignant neoplasm of other and unspecified parts of nervous system; cerebral meninges
1943	Malignant neoplasm of other endocrine glands and related struc-tures; pituitary gland and craniopharyngeal duct
1983	Secondary malignant neoplasm of other specified sites; brain and spinal cord
1984	Secondary malignant neoplasm of other specified sites; other parts of nervous system
1985	Secondary malignant neoplasm of other specified sites; bone and bone marrow
19889	Secondary malignant neoplasm of other specified sites; other
2130	Benign neoplasm of bone and articular cartilage; bones of skull and face
2241	Benign neoplasm of eye; orbit
2250	Benign neoplasm of brain and other parts of nervous system; brain
2251	Benign neoplasm of brain and other parts of nervous system; cranial nerves
2252	Benign neoplasm of brain and other parts of nervous system; cerebral meninges
2270	Benign neoplasm of other endocrine glands and related structures; adrenal gland
2340	Carcinoma in situ of other and unspecified sites; eye

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Diagnosis Code	Description
2348	Carcinoma in situ of other and unspecified sites; other specified sites
2375	Neoplasm of uncertain behavior of endocrine glands and nervous system; brain and spinal cord
2376	Neoplasm of uncertain behavior of endocrine glands and nervous system; meninges
2379	Neoplasm of uncertain behavior of endocrine glands and nervous system; other and unspecified parts of nervous system
2380	Neoplasm of uncertain behavior of other and unspecified sites and tissues; bone and articular cartilage
2388	Neoplasm of uncertain behavior of other and unspecified sites and tissues; other specified sites
2392	Neoplasms of unspecified nature; bone, soft tissue, and skin
2396	Neoplasms of unspecified nature; brain
2397	Neoplasms of unspecified nature; endocrine glands and other parts of nervous system
2398	Neoplasms of unspecified nature; other specified sites
29010	Presenile dementia, uncomplicated
3240	Intracranial abscess
3249	Intracranial and intraspinal abscess; of unspecified site
325	Phlebitis and thrombophlebitis of intracranial venous sinuses
3310	Alzheimer's disease
33111	Pick's disease
33119	Other frontotemporal dementia
3312	Senile degeneration of brain
3313	Communicating hydrocephalus
3314	Obstructive hydrocephalus
3317	Cerebral degeneration in diseases classified elsewhere (manifestation code; code first the underlying disease)
33181	Reye's syndrome
33182	Dementia with lewy bodies
33189	Other cerebral degeneration
3319	Cerebral degeneration, unspecified
3480	Cerebral cysts
3482	Benign intracranial hypertension

Diagnosis Code	Description
34830	Encephalopathy, unspecified
34831	Metabolic encephalopathy
34839	Other encephalopathy
3484	Compression of brain
3485	Cerebral edema
37700	Papilledema NOS
37701	Papilledema associated with increased intracranial pressure
37702	Papilledema associated with decreased ocular pressure
37703	Papilledema associated with retinal disorder
37704	Foster-kennedy syndrome
37710	Optic atrophy NOS
37711	Primary optic atrophy
37712	Postinflammatory optic atrophy
37713	Optic atrophy associated with retinal dystrophies
37714	Glaucomatous atrophy (cupping) of optic disc
37715	Partial optic atrophy
37716	Hereditary optic atrophy
37721	Drusen of optic disc
37722	Crater-like holes of optic disc
37723	Coloboma of optic disc
37724	Pseudopapilledema
37730	Optic neuritis, unspecified
37731	Optic papillitis
37732	Retrobulbar neuritis
37733	Nutritional optic neuropathy
37734	Toxic optic neuropathy
37739	Optic neuritis NEC
37741	Ischemic optic neuropthy
37742	Hemorrhage in optic nerve sheaths
37749	Other disorders of optic nerve
37751	Disorders of optic chiasm associated with pituitary neoplasms and disorders
37752	Disorders of optic chiasm associated with other neoplasms
37753	Disorders of optic chiasm associated with vascular disorders
37754	Disorders of optic chiasm associated with inflammatory disorders
37761	Disorders of other visual pathways associated with neoplasms

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Diagnosis Code	Description
37762	Disorders of other visual pathways associated with vascular disorders
37763	Disorders of other visual pathways associated with inflammatory disorders
37771	Disorders of visual cortex associated with neoplasms
37772	Disorders of visual cortex associated with vascular disorders
37773	Disorders of visual cortex associated with inflammatory disorders
37775	Cortical blindness
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
4320	Nontraumatic extradural hemorrhage
4321	Subdural hemorrhage
4329	Unspecified intracranial hemorrahge
43400	Cerebral thrombosis; without mention of cerebral infarction
43401	Cerebral thrombosis; with cerebral infarction
43410	Cerebral embolism; without mention of cerebral infarction
43411	Cerebral embolism; with cerebral infarction
43490	Cerebral artery occlusion, unspecified; without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified; with cerebral infarction
436	Acute, but ill-defined, cerebrovascular disease
4371	Other generalized ischemic cerebrovascular disease
4373	Cerebral aneurysm, nonruptured
0065	Amebic brain abscess
67400	Cerebrovascular disorders in the puerperium; unspecified as to episode of care or not applicable
67401	Cerebrovascular disorders in the puerperium; delivered, with or without mention of antepartum condition
67402	Cerebrovascular disorders in the puerperium; delivered, with mention of postpartum complication
67403	Cerebrovascular disorders in the puerperium; antepartum condition or complication
67404	Cerebrovascular disorders in the puerperium; postpartum condition or complication

Diagnosis Code	Description
74100	Spina bifida; with hydrocephalus, unspecified region
74101	Spina bifida; with hydrocephalus, cervical region
74102	Spina bifida; with hydrocephalus, dorsal (thoracic) region
74103	Spina bifida; with hydrocephalus, lumbar region
7420	Other congenital anomalies of nervous system; encephalocele
7421	Other congenital anomalies of nervous system; microcephalus
7422	Other congenital anomalies of nervous system; reduction deformities of brain
7423	Other congenital anomalies of nervous system; congenital hydrocephalus
7424	Other congenital anomalies of nervous system; other specified anomalies of brain
74781	Anomalies of cerebrovascular system
76500	Disorders relating to extreme immaturity of infant unspecified weight
76501	Disorders relating to extreme immaturity of infant less than 500 grams
76502	Disorders relating to extreme immaturity of infant 500–749 grams
76503	Disorders relating to extreme immaturity of infant 750–999 grams
76504	Disorders relating to extreme immaturity of infant 1,000–1,249 grams
76505	Disorders relating to extreme immaturity of infant 1,250–1,499 grams
76506	Disorders relating to extreme immaturity of infant 1,500–1,749 grams
76507	Disorders relating to extreme immaturity of infant 1,750–1,999 grams
76510	Disorders relating to other preterm infants unspecified weight
76511	Disorders relating to other preterm infants less than 500 grams
76512	Disorders relating to other preterm infants 500–749 grams
76513	Disorders relating to other preterm infants 750–999 grams

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Diagnosis Code	Description
76514	Disorders relating to other preterm infants 1,000–1,249 grams
76515	Disorders relating to other preterm infants 1,250–1,499 grams
76516	Disorders relating to other preterm infants 1,500–1,749 grams
76517	Disorders relating to other preterm infants 1,750–1,999 grams
7670	Birth trauma; subdural and cerebral hemorrhage
76711	Epicranial subaponeurotic hemor-rhage (massive)
76719	Other injuries to scalp
7678	Other specified birth trauma
7712	Infections specific to the perinatal period; other congenital infections
77210	Intraventricular hemorrhage, unspec-ified grade
77211	Intraventricular hemorrhage, Grade I
77212	Intraventricular hemorrhage, Grade II
77213	Intraventricular hemorrhage, Grade III
77214	Intraventricular hemorrhage, Grade IV
7722	Fetal and neonatal hemorrhage; subarachnoid hemorrhage
7790	Convulsions in newborn
7797	Periventricular leukomalacia
78031	Febrile convulsions (simple), unspecified
78039	Other convulsions
7842	Swelling, mass, or lump in head and neck
8500	Concussion with no loss of consciousness
85011	Concussion, with loss of consciousness of 30 minutes or less
85012	Concussion, with loss of consciousness from 31 minutes to 59 minutes
8502	Concussion with moderate loss of consciousness
8503	Concussion with prolonged loss of consciousness and return to pre-existing conscious level
8504	Concussion with prolonged loss of consciousness, without return to pre-existing conscious level
8505	Concussion with loss of consciousness of unspecified duration
8509	Concussion, unspecified

Diagnosis Code	Description
85100	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified
85101	Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspec-ified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified
85110	ortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration
85119	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified
85120	Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified
85121	Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness
85122	Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85123	Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85124	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85129	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified
85130	Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified
85131	Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified
85140	Cerebellar or brain stem contusion without mention of open intracranial wound, with state of consciousness unspecified
85141	Cerebellar or brain stem contusion without mention of open intracranial wound, with no loss of consciousness
85142	Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85149	Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified
85150	Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified
85151	Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness

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Diagnosis Code	Description
85152	Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85153	Cerebellar or brain stem contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85155	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration
85159	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration

Diagnosis Code	Description
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified
85170	Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified
85171	Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness
85172	Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85230	Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85231	Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness

Diagnosis Code	Description
85232	Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85233	Subdural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85236	Subdural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85239	Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified 8525,Extradural hemorrhage following injury with open intracranial wound
85250	Extradural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85251	Extradural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85252	Extradural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85253	Extradural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85255	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85256	Extradural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85400	Intracranial injury of other and unspecified nature without mention of open intracranial wound
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with concussion, unspecified
85410	Intracranial injury of other and unspecified nature, with open intracranial wound, with state of consciousness unspecific

Diagnosis Code	Description
85411	Intracranial injury of other and unspecified nature, with open intracranial wound, with no loss of consciousness
85412	Intracranial injury of other and unspecified nature, with open intracranial wound, with brief (less than one hour) loss of consciousness
85413	Intracranial injury of other and unspecified nature, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85414	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85415	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85416	Intracranial injury of other and unspecified nature, with open intracranial wound, with loss of consciousness of unspecified duration
85419	Intracranial injury of other and unspecified nature, with open intracranial wound, with concussion, unspecified
95901	Other and unspecified injury to head

36.4.9.8 Intraoperative Echography

Procedure code 4/I/T-76986 is no longer denied as service not a benefit. The code is part of a surgical procedure and is denied as this charge is included in the surgical/anesthesia fee.

36.4.9.9 Electrocardiogram (EKG)

An electrocardiogram (EKG) is a recording of the heart's electrical activity. The EKG provides important information about the spread of excitation to the different chambers of the heart and helps diagnose cases of abnormal cardiac rhythm and myocardial damage.

EKG procedure codes T-93005 and T-93041 are payable for the following diagnosis codes:

Diagnosis Code	Description
03282	Diphtheritic myocarditis
0362	Meningococcemia
03640	Meningococcal carditis, unspecified
03641	Meningococcal pericarditis
03642	Meningococcal endocarditis
03643	Meningococcal myocarditis
07420	Coxsackie carditis, unspecified

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Diagnosis Code	Description
07421	Coxsackie pericarditis
07422	Coxsackie endocarditis
07423	Coxsackie myocarditis
0860	Chagas' disease with heart involvement
08881	Lyme disease
0930	Aneurysm of aorta, specified as syphilitic
0931	Syphilitic aortitis
09320	Contusion of chest wall
09321	Syphilitic endocarditis of mitral valve
09322	Syphilitic endocarditis of aortic valve
09323	Syphilitic endocarditis of tricuspid valve
09324	Syphilitic endocarditis of pulmonary valve
09381	Syphilitic pericarditis
09382	Syphilitic myocarditis
09389	Other specified cardiovascular syphilis
09883	Gonococcal pericarditis
09884	Gonococcal endocarditis
09885	Other gonococcal heart disease
11281	Candidal endocarditis
11503	Histoplasma capsulatum pericarditis
11504	Histoplasma capsulatum endocarditis
11513	Histoplasma duboisii pericarditis
11514	Histoplasma duboisii endocarditis
11593	Histoplasmosis pericarditis, unspecified
11594	Histoplasmosis endocarditis
124	Trichinosis
1303	Myocarditis due to toxoplasmosis
135	Sarcoidosis
1640	Malignant neoplasm of thymus
1641	Malignant neoplasm of heart
1642	Malignant neoplasm of anterior mediastinum
1643	Malignant neoplasm of posterior mediastinum
1648	Malignant neoplasm of other parts of mediastinum
1649	Malignant neoplasm of mediastinum, part unspecified
19889	Secondary malignant neoplasm of other specified sites
2127	Benign neoplasm of heart

Diagnosis Code	Description
25000	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
25001	Diabetes mellitus without mention of complication, type I (juvenile type), not stated as uncontrolled
25002	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
25003	Diabetes mellitus without mention of complication, type I (juvenile type), uncontrolled
25010	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled
25011	Diabetes with ketoacidosis, type I (juvenile type), not stated as uncontrolled
25012	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled
25013	Diabetes with ketoacidosis, type I (juvenile type), uncontrolled
25020	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled
25021	Diabetes with hyperosmolarity, type I (juvenile type), not stated as uncontrolled
25022	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled
25023	Diabetes with hyperosmolarity, type I (juvenile type), uncontrolled
25030	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled
25031	Diabetes with other coma, type I (juvenile type), not stated as uncontrolled
25032	Diabetes with other coma, type II or unspecified type, uncontrolled
25033	Diabetes with other coma, type I (juvenile type), uncontrolled
25040	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled
25041	Diabetes with renal manifestations, type I (juvenile type), not stated as uncontrolled
25042	Diabetes with renal manifestations, type II or unspecified type, uncontrolled
25043	Diabetes with renal manifestations, type I (juvenile type), uncontrolled

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Diagnosis Code	Description
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations, type I (juvenile type), not stated as uncontrolled
25062	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations, type I (juvenile type), uncontrolled
25070	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
25071	Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled
25072	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
25073	Diabetes with peripheral circulatory disorders, type I (juvenile type), uncontrolled
25080	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled
25081	Diabetes with other specified manifestations, type I (juvenile type), not stated as uncontrolled
25082	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled
25083	Diabetes with other specified manifestations, type I (juvenile type), uncontrolled
25090	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled
25091	Diabetes with unspecified complication, type I (juvenile type), not stated as uncontrolled

Diagnosis Code	Description
25092	Diabetes with unspecified complication, type II or unspecified type, uncontrolled
25093	Diabetes with unspecified complication, type I (juvenile type), uncontrolled
2512	Hypoglycemia, unspecified
2720	Pure hypercholesterolemia
2721	Pure hyperglyceridemia
2722	Mixed hyperlipidemia
2723	Hyperchylomicronemia
2724	Other and unspecified hyperlipidemia
2725	Lipoprotein deficiencies
2726	Lipodystrophy
2727	Lipidoses
2728	Other disorders of lipoid metabolism
2750	Disorders of iron metabolism
2752	Disorders of magnesium metabolism
2753	Disorders of phosphorus metabolism
27541	Hypocalcemia
27542	Hypercalcemia
2760	Hyperosmolality and/or hypernatremia
2761	Hyposmolality and/or hyponatremi
2762	Acidosis
2763	Alkalosis
2764	Mixed acid-base balance disorder
27651	Dehydration
27652	Hypovolemia
2766	Fluid overload disorder
2767	Hyperpotassemia
2768	Hypopotassemia
27730	Amyloidosis, unspecified
27739	Other amyloidosis
3062	Cardiovascular malfunction arising from mental factors
3373	Autonomic dysreflexia
3889	Unspecified disorder of ear
390	Rheumatic fever without mention of heart involvement
3910	Acute rheumatic pericarditis
3911	Acute rheumatic endocarditis
3912	Acute rheumatic myocarditis
3918	Other acute rheumatic heart disease
3919	Acute rheumatic heart disease, unspecified

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Diagnosis Code	Description
3920	Rheumatic chorea with heart involvement
3929	Rheumatic chorea without mention of heart involvement
393	Chronic rheumatic pericarditis
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve unspecified
3980	Rheumatic myocarditis
39891	Rheumatic heart failure (congestive)
39899	Other rheumatic heart diseases
4010	Malignant essential hypertension
4011	Benign essential hypertension
4019	Unspecified essential hypertension
40200	Malignant hypertensive heart disease without congestive heart failure
40201	Malignant hypertensive heart disease with congestive heart failure
40210	Benign hypertensive heart disease without congestive heart failure
40211	Benign hypertensive heart disease with congestive heart failure

Diagnosis Code	Description
40290	Unspecified hypertensive heart disease without congestive heart failure
40291	Unspecified hypertensive heart disease with congestive heart failure
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
4039	Unspecified hypertensive renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
40400	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40401	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
40410	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40411	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified

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Diagnosis Code	Description
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40490	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40491	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
40501	Malignant renovascular hypertension
40509	Other malignant secondary hypertension
40511	Benign renovascular hypertension
40519	Other benign secondary hypertension
41000	Acute myocardial infarction of antero-lateral wall, episode of care unspecified
41001	Acute myocardial infarction of antero-lateral wall, initial episode of care
41002	Acute myocardial infarction of antero-lateral wall, subsequent episode of care
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care
41012	Acute myocardial infarction of other anterior wall, subsequent episode of care
41020	Acute myocardial infarction of infero-lateral wall, episode of care unspecified
41021	Acute myocardial infarction of infero-lateral wall, initial episode of care

Diagnosis Code	Description
41022	Acute myocardial infarction of infero-lateral wall, subsequent episode of care
41030	Acute myocardial infarction of infero-posterior wall, episode of care unspecified
41031	Acute myocardial infarction of infero-posterior wall, initial episode of care
41032	Acute myocardial infarction of infero-posterior wall, subsequent episode of care
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41042	Acute myocardial infarction of other inferior wall, subsequent episode of care
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41052	Acute myocardial infarction of other lateral wall, subsequent episode of care
41060	True posterior wall infarction, episode of care unspecified
41061	True posterior wall infarction, initial episode of care
41062	True posterior wall infarction, subsequent episode of care
41070	Subendocardial infarction, episode of care unspecified
41071	Subendocardial infarction, initial episode of care
41072	Subendocardial infarction, subsequent episode of care
41081	Acute myocardial infarction of other specified sites, initial episode of care
41082	Acute myocardial infarction of other specified sites, subsequent episode of care
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41092	Acute myocardial infarction of unspecified site, subsequent episode of care
4200	Acute pericarditis in diseases classified elsewhere

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Diagnosis Code	Description
42090	Acute pericarditis, unspecified
42091	Acute idiopathic pericarditis
42099	Other acute pericarditis
4210	Acute and subacute bacterial endocarditis
4211	Acute and subacute infective endocarditis in diseases classified elsewhere
4219	Acute endocarditis, unspecified
4220	Acute myocarditis in diseases classified elsewhere
42290	Acute myocarditis, unspecified
42291	Idiopathic myocarditis
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Other acute myocarditis
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4238	Other specified diseases of pericardium
4239	Unspecified disease of pericardium
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4255	Alcoholic cardiomyopathy
4257	Nutritional and metabolic cardiomyopathy
4258	Cardiomyopathy in other diseases classified elsewhere
4259	Secondary cardiomyopathy, unspecified
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block
42652	Right bundle branch block and left anterior fascicular block
42653	Other bilateral bundle branch block
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-ganong-levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
42731	Atrial fibrillation
42732	Atrial flutter
42741	Ventricular fibrillation
42742	Ventricular flutter
4275	Cardiac arrest
42760	Premature beats, unspecified
42761	Supraventricular premature beats
42769	Other premature beats
42781	Sinoatrial node dysfunction
42789	Other specified cardiac dysrhythmias
4279	Cardiac dysrhythmia, unspecified
4280	Congestive heart failure
4281	Left heart failure
42820	Congestive heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure

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Diagnosis Code	Description
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
4290	Myocarditis, unspecified
4291	Myocardial degeneration
4292	Cardiovascular disease, unspecified
4293	Cardiomegaly
4294	Functional disturbances following cardiac surgery
4295	Rupture of chordae tendineae
4296	Rupture of papillary muscle
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other
42981	Other disorders of papillary muscle
42982	Hyperkinetic heart disease
42983	Takotsubo syndrome
42989	Other ill-defined heart diseases
4299	Heart disease, unspecified
43300	Occlusion and stenosis of basilar artery without mention of cerebral infarction
43301	Occlusion and stenosis of basilar artery with cerebral infarction
43310	Occlusion and stenosis of carotid artery without mention of cerebral infarction
43311	Occlusion and stenosis of carotid artery with cerebral infarction
43390	Occlusion and stenosis of unspecified precerebral artery without mention of cerebral infarction
43391	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction

Diagnosis Code	Description
43490	Cerebral artery occlusion, unspecified without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
4359	Unspecified transient cerebral ischemia
4372	Hypertensive encephalopathy
44100	Dissection of aorta, unspecified site
44101	Dissection of aorta, thoracic
44103	Dissection of aorta, thoracoabdominal
4411	Thoracic aneurysm, ruptured
4412	Thoracic aneurysm without mention of rupture
4416	Thoracoabdominal aneurysm, ruptured
4417	Thoracoabdominal aneurysm, without mention of rupture
4439	Peripheral vascular disease, unspecified
4440	Embolism and thrombosis of abdominal aorta
4441	Embolism and thrombosis of thoracic aorta
44421	Aneurysm of renal artery
44422	Aneurysm of iliac artery
4460	Polyarteritis nodosa
4467	Takayasu’s disease
4580	Hereditary hemorrhagic telangiectasia
45821	Hypotension of hemodialysis
4589	Other and unspecified capillary diseases
4590	Hemorrhage, unspecified
496	Chronic airway obstruction, not elsewhere classified
514	Pulmonary congestion and hypostasis
5173	Acute chest syndrome
5184	Acute edema of lung, unspecified
5185	Pulmonary insufficiency following trauma and surgery
51882	Other pulmonary insufficiency, not elsewhere classified
51884	Acute and chronic respiratory failure
51919	Other diseases of trachea and bronchus
53081	Esophageal reflux
57410	Calculus of gallbladder with other cholecystitis, without mention of obstruction

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Diagnosis Code	Description
64201	Benign essential hypertension with delivery
64202	Benign essential hypertension, with delivery, with mention of postpartum complication
64203	Antepartum benign essential hypertension
64204	Postpartum benign essential hypertension
64251	Severe pre-eclampsia, with delivery
64252	Severe pre-eclampsia, with delivery, with mention of postpartum complication
64253	Severe pre-eclampsia, antepartum
64254	Severe pre-eclampsia, postpartum
64850	Congenital cardiovascular disorders of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64851	Congenital cardiovascular disorders of mother, with delivery
64852	Congenital cardiovascular disorders of mother, with delivery, with mention of postpartum complication
64853	Congenital cardiovascular disorders of mother, antepartum
64854	Congenital cardiovascular disorders of mother, postpartum
65420	Previous cesarean delivery, unspecified as to episode of care in pregnancy
65423	Previous cesarean delivery, antepartum condition or complication
66810	Cardiac complications of anesthesia or other sedation in labor and delivery, unspecified as to episode of care
66811	Cardiac complications of anesthesia or other sedation in labor and delivery, delivered
66812	Cardiac complications of anesthesia or other sedation in labor and delivery, delivered, with mention of postpartum complication
66813	Cardiac complications of anesthesia or other sedation in labor and delivery, antepartum
66814	Cardiac complications of anesthesia or other sedation in labor and delivery, postpartum
66971	Cesarean delivery, without mention of indication, delivered, with or without mention of antepartum condition

Diagnosis Code	Description
67450	Peripartum cardiomyopathy, unspecified as to episode of care or not applicable
67451	Peripartum cardiomyopathy, delivered, with or without mention of antepartum condition
67452	Peripartum cardiomyopathy, delivered, with mention of postpartum condition
67453	Peripartum cardiomyopathy, antepartum condition or complication
67454	Peripartum cardiomyopathy, postpartum condition or complication
7100	Systemic lupus erythematosus
7142	Other rheumatoid arthritis with visceral or systemic involvement
71941	Pain in joint involving shoulder region
7200	Ankylosing spondylitis
7231	Cervicalgia
7295	Pain in limb
7336	Tietze’s disease
7450	Common truncus
74510	Complete transposition of great vessels
74511	Double outlet right ventricle
74512	Corrected transposition of great vessels
74519	Other transposition of great vessels
7452	Tetralogy of fallot
7452	Tetralogy of fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
74560	Endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other endocardial cushion defects
7457	Cor biloculare
7458	Other bulbus cordis anomalies and anomalies of cardiac septal closure
7459	Unspecified defect of septal closure
74600	Congenital pulmonary valve anomaly, unspecified
74601	Atresia of pulmonary valve, congenital
74602	Stenosis of pulmonary valve, congenital
74609	Other congenital anomalies of pulmonary valve

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Diagnosis Code	Description
7461	Tricuspid atresia and stenosis, congenital
7462	Ebstein's anomaly
7463	Congenital stenosis of aortic valve
7464	Congenital insufficiency of aortic valve
7465	Congenital mitral stenosis
7466	Congenital mitral insufficiency
7467	Hypoplastic left heart syndrome
74681	Subaortic stenosis, congenital
74682	Cor triatriatum
74683	Infundibular pulmonic stenosis, congenital
74684	Congenital obstructive anomalies of heart, not elsewhere classified
74685	Coronary artery anomaly, congenital
74686	Congenital heart block
74687	Malposition of heart and cardiac apex
74689	Other specified congenital anomalies of heart
7469	Unspecified congenital anomaly of heart
7470	Patent ductus arteriosus
74710	Coarctation of aorta (preductal) (postductal)
74711	Interruption of aortic arch
74720	Congenital anomaly of aorta, unspecified
74721	Congenital anomalies of aortic arch
74722	Congenital atresia and stenosis of aorta
74729	Other congenital anomalies of aorta
7473	Congenital anomalies of pulmonary artery
74740	Congenital anomaly of great veins, unspecified
74741	Total anomalous pulmonary venous connection
74742	Partial anomalous pulmonary venous connection
74749	Other anomalies of great veins
7580	Down's syndrome
7593	Situs inversus
75982	Marfan syndrome
78001	Coma
78002	Transient alteration of awareness
78003	Persistent vegetative state
78009	Alteration of consciousness, other
7802	Syncope and collapse
7804	Dizziness and giddiness
78079	Other malaise and fatigue
7808	Generalized hyperhidrosis
7815	Clubbing of fingers
7823	Edema
7825	Cyanosis
7850	Tachycardia, unspecified
7851	Palpitations
7852	Undiagnosed cardiac murmurs
7853	Other abnormal heart sounds
78550	Shock, unspecified
78551	Cardiogenic shock
78552	Septic shock
78559	Other shock without mention of trauma
78600	Respiratory abnormality, unspecified
78602	Orthopnea
78605	Shortness of breath
78609	Other
78650	Unspecified chest pain
78651	Precordial pain
78652	Painful respiration
78659	Other chest pain
78701	Nausea with vomiting
78702	Nausea alone
78703	Vomiting alone
7871	Heartburn
78900	Abdominal pain, unspecified site
78907	Abdominal pain, generalized
78960	Abdominal tenderness, unspecified site
79001	Precipitous drop in hematocrit
79009	Other abnormality of red blood cells
7904	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase (ldh)
7905	Other nonspecific abnormal serum enzyme levels
7906	Other abnormal blood chemistry
7932	Nonspecific abnormal findings on radiological and other examination of other intrathoracic organs
79430	Unspecified abnormal function study of cardiovascular system
79431	Nonspecific abnormal electrocardiogram (ECG) (EKG)

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Diagnosis Code	Description
79439	Other nonspecific abnormal function study of cardiovascular system
7991	Respiratory arrest
8072	Closed fracture of sternum
8073	Open fracture of sternum
8074	Flail chest
8600	Traumatic pneumothorax without mention of open wound into thorax
8601	Traumatic pneumothorax with open wound into thorax
8602	Traumatic hemothorax without mention of open wound into thorax
8603	Traumatic hemothorax with open wound into thorax
8604	Traumatic pneumohemothorax without mention of open wound into thorax
8605	Traumatic pneumohemothorax with open wound into thorax
86100	Unspecified injury of heart without mention of open wound into thorax
86101	Contusion of heart without mention of open wound into thorax
86102	Laceration of heart without penetration of heart chambers or open wound into thorax
86103	Laceration of heart with penetration of heart chambers, without mention of open wound into thorax
86110	Unspecified injury of heart with open wound into thorax
86111	Contusion of heart with open wound into thorax
86112	Laceration of heart without penetration of heart chambers, with open wound into thorax
86113	Laceration of heart with penetration of heart chambers and open wound into thorax
8628	Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity
8629	Injury to multiple and unspecified intrathoracic organs with open wound into cavity
90000	Injury to carotid artery, unspecified
90001	Injury to common carotid artery
90002	Injury to external carotid artery
90003	Injury to internal carotid artery
9001	Injury to internal jugular vein
9010	Injury to thoracic aorta

Diagnosis Code	Description
9011	Injury to innominate and subclavian arteries
9012	Injury to superior vena cava
9013	Injury to innominate and subclavian veins
90140	Injury to pulmonary vessel(s), unspecified
90141	Injury to pulmonary artery
90142	Injury to pulmonary vein
90181	Injury to intercostal artery or vein
90182	Injury to internal mammary artery or vein
90183	Injury to multiple blood vessels of thorax
9221	Contusion of chest wall
9584	Traumatic shock
9607	Poisoning by antineoplastic antibiotics
9631	Poisoning by antineoplastic and immunosuppressive drugs
96509	Poisoning by other opiates and related narcotics
9720	Poisoning by cardiac rhythm regulators
9721	Poisoning by cardiotonic glycosides and drugs of similar action
9722	Poisoning by antilipemic and antiarteriosclerotic drugs
9723	Poisoning by ganglion-blocking agents
9724	Poisoning by coronary vasodilators
9725	Poisoning by other vasodilators
9726	Poisoning by other antihypertensive agents
9727	Poisoning by antivaricose drugs, including sclerosing agents
9728	Poisoning by capillary-active drugs
9729	Poisoning by other and unspecified agents primarily affecting the cardiovascular system
9779	Poisoning by unspecified drug or medicinal substance
986	Toxic effect of carbon monoxide
9893	Toxic effect of organophosphate and carbamate
9894	Toxic effect of other pesticides, not elsewhere classified
9895	Toxic effect of venom
9920	Heat stroke and sunstroke
9921	Heat syncope
9940	Effects of lightning

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Diagnosis Code	Description
9941	Drowning and nonfatal submersion
9947	Asphyxiation and strangulation
9948	Electrocution and nonfatal effects of electric current
9950	Other anaphylactic shock, not elsewhere classified
99522	Unspecified adverse effect of anesthesia
99523	Unspecified adverse effect of insulin
99527	Other drug allergy
99600	Mechanical complications of unspecified cardiac device, implant, and graft
99601	Mechanical complication due to cardiac pacemaker (electrode)
99602	Mechanical complication due to heart valve prosthesis
99603	Mechanical complication due to coronary bypass graft
99604	Mechanical complication of automatic implantable card
99609	Other mechanical complication of cardiac device, implant, and graft
99661	Infection and inflammatory reaction due to cardiac device, implant, and graft
99671	Other complications due to heart valve prosthesis
99672	Other complications due to other cardiac device, implant, and graft
99683	Complications of transplanted heart
9971	Cardiac complications, not elsewhere classified
9980	Postoperative shock, not elsewhere classified
9993	Other infection due to medical care, not elsewhere classified
9994	Anaphylactic shock due to serum, not elsewhere classified
V151	Personal history of surgery to heart and great vessels, presenting hazards to health
V252	Sterilization
V421	Heart replaced by transplant
V422	Heart valve replaced by transplant
V426	Lung replaced by transplant
V4321	Organ or tissue replaced by other means, heart assist device
V433	Heart valve replaced by other means
V4500	Unspecified cardiac device in situ
V4501	Cardiac pacemaker in situ
V4502	Automatic implantable cardiac defibrillator in situ
V4509	Other specified cardiac device in situ
V4581	Postsurgical aortocoronary bypass status
V4582	Percutaneous transluminal coronary angioplasty status
V472	Other cardiorespiratory problems
V4983	Awaiting organ transplant status
V533	Fitting and adjustment of cardiac device
V5331	Fitting and adjustment of cardiac pacemaker
V5332	Fitting and adjustment of automatic implantable cardiac defibrillator
V5339	Fitting and adjustment of other cardiac device
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V5844	Aftercare following organ transplant
V5869	Long-term (current) use of other medications
V717	Observation for suspected cardiovascular disease
V7281	Pre-operative cardiovascular examination
V7284	Pre-operative examination, unspecified

EKG interpretations are payable. The EKG codes for which interpretation components are paid are I-93010, and I-93042.

36.4.9.10 Esophageal pH Probe Monitoring

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

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The following diagnosis codes are payable for esophageal pH probe monitoring or gastroesophageal reflux study to evaluate esophageal reflux:

Diagnosis Code	Description
5070	Pneumonitis due to inhalation of food or vomitus
53010	Esophagitis, unspecified
53011	Reflux esophagitis
53012	Acute esophagitis
53020	Ulcer of esophagus without bleeding
53021	Ulcer of esophagus with bleeding
53019	Other esophagitis
53081	Esophageal reflux
53085	Barrett's esophagus
53086	Infection of esophagostomy
53087	Mechanical complication of esophagostomy
7700	Congenital pneumonia
77010	Fetal and newborn aspiration, unspecified
77011	Meconium aspiration without respiratory symptoms
77012	Meconium aspiration with respiratory symptoms
77013	Aspiration of clear amniotic fluid without respiratory symptoms
77014	Aspiration of clear amniotic fluid with respiratory symptoms
77015	Aspiration of blood without respiratory symptoms
77016	Aspiration of blood with respiratory symptoms
77017	Other fetal and newborn aspiration without respiratory symptoms
77018	Other fetal and newborn aspiration with respiratory symptoms
7708	Other respiratory problems after birth
77087	Respiratory arrest of newborn
77088	Hypoxemia of newborn
7833	Feeding difficulties and mismanagement
78603	Apnea
78605	Shortness of Breath
78606	Tachypnea
78607	Wheezing
78609	Symptoms involving respiratory system and other chest symptoms; other

Esophageal pH probe monitoring should be coded with the following procedure codes: 2/F-91034, 2/F-91035, and 4/I/T-78262.

36.4.9.11 Electromyography (EMG)

Electromyography (EMG) is reimbursed by the Texas Medicaid Program using the following procedure codes:

Procedure Codes		
5/I/T-95860	5/I/T-95861	5/I/T-95863
5/I/T-95864	5/I/T-95867	5/I/T-95868
5/I/T-95869	5/I/T-95872	5/I/T-95875

Separate charges for more than one extremity EMG is combined and coded as the appropriate multiple extremity EMG code. A maximum of four EMGs may be paid on the same day to the same provider. More than four EMGs are denied with EOB 00103, "Services exceed allowed benefit limitations."

EMG used for the treatment of pathological muscle abnormalities or other disorders of the musculoskeletal system are considered a physical therapy procedure and are paid according to the physical therapy guidelines.

36.4.9.12 Helicobacter Pylori (H. Pylori)

The following procedure codes are covered services: 5-83013, 5-83014, 5-87338, and 5-87339.

These codes are considered to be clinical lab services and must be billed using TOS 5. The interpretation/professional component TOS I is not separately reimbursed.

When a gastrointestinal endoscopy (GED), procedure codes 2-43200, 2-43202, 2-43234, 2-43235, and 2-43239, is performed within 90 days of the H. pylori breath test or stool test, the GED is denied. The TMHP Medical Director reviews claims for payment when submitted with documentation supporting the medical necessity for the GED.

The tests available for the diagnosis of Helicobacter pylori infection differ with respect to sensitivity, specificity, invasiveness, cost, and in the additional information that they provide. The appropriate choice of test depends on the clinical situation. The following clinical scenarios are appropriate for use of the H. pylori breath test:

- Patients with classic relatively uncomplicated symptoms of peptic ulcer disease for whom antibiotic therapy is planned, if the H. pylori breath test is positive, and no GED is planned.
- Patients who have nonspecific dyspeptic symptoms with a positive H. pylori serum antibody test, and no endoscopy is planned.
- An upper gastrointestinal contrast X-ray series has been done that shows a duodenal ulcer or significant gastritis and/or duodenitis, and no endoscopy is planned.
- Persistent or recurrent symptoms occur six weeks after treatment for a documented H. pylori infection, and no endoscopy is planned.

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The H. pylori breath test is considered not medically necessary for patients who:

- Are being screened for H. pylori infection in the absence of documented upper gastrointestinal tract symptoms and/or pathology.
- Have had upper gastrointestinal endoscopies within the preceding 6 weeks or upper gastrointestinal endoscopies are planned.
- Have nonspecific dyspeptic symptoms with a negative H. pylori serum antibody test.
- Are asymptomatic after treatment of H. pylori infections (either proven or suspected) except in the situation of a history of a major complication of ulcer disease such as bleeding, perforation, penetration, or multiple recurrences, in which case an H. pylori breath test may be used to document eradication of the infection in lieu of a follow-up endoscopy.

Based on cure rates for H. pylori infection with the currently accepted regimens using antibiotics, repeat endoscopy or H. pylori breath test would be expected in less than 30 percent of patients with H. pylori infection associated with duodenal ulcer and/or gastritis/duodenitis.

Reimbursement for the H. pylori stool test is restricted to the following diagnosis codes:

Diagnosis Code	Description
53100	Acute gastric ulcer with hemorrhage, without mention of obstruction
53101	Acute gastric ulcer with hemorrhage, with obstruction
53110	Acute gastric ulcer with perforation, without mention of obstruction
53111	Acute gastric ulcer with perforation, with obstruction
53120	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction
53121	Acute gastric ulcer with hemorrhage and perforation, with obstruction
53130	Acute gastric ulcer without mention of hemorrhage or perforation, without mention of obstruction
53131	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction
53140	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction
53141	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction
53150	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction
53151	Chronic or unspecified gastric ulcer with perforation, with obstruction
53160	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction
53161	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction
53170	Chronic gastric ulcer without mention of hemorrhage or perforation, without mention of obstruction
53171	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction
53190	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, without mention of obstruction
53191	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
53200	Acute duodenal ulcer with hemorrhage, without mention of obstruction
53201	Acute duodenal ulcer with hemorrhage, with obstruction
53210	Acute duodenal ulcer with perforation, without mention of obstruction
53211	Acute duodenal ulcer with perforation, with obstruction
53220	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction
53221	Acute duodenal ulcer with hemorrhage and perforation, with obstruction
53230	Acute duodenal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53231	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction
53240	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction
53241	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction
53250	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction
53251	Chronic or unspecified duodenal ulcer with perforation, with obstruction
53260	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction

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Diagnosis Code	Description
53261	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction
53270	Chronic duodenal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53271	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction
53290	Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation, without mention of obstruction
53291	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
53400	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction
53401	Acute gastrojejunal ulcer, with hemorrhage, with obstruction
53410	Acute gastrojejunal ulcer with perforation, without mention of obstruction
53411	Acute gastrojejunal ulcer with perforation, with obstruction
53420	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction
53421	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction
53430	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, without mention of obstruction
53431	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction
53440	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction
53441	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction
53450	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction
53451	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction
53460	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction

Diagnosis Code	Description
53461	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction
53470	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, without mention of obstruct
53471	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction s
53490	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, without mention of obstruction
53491	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction
53500	Acute gastritis (without mention of hemorrhage)
53501	Acute gastritis with hemorrhage
53510	Atrophic gastritis (without mention of hemorrhage)
53511	Atrophic gastritis with hemorrhage
53550	Unspecified gastritis and gastroduodenitis (without mention of hemorrhage)
53551	Unspecified gastritis and gastroduodenitis with hemorrhage
53560	Duodenitis (without mention of hemorrhage)
53561	Duodenitis with hemorrhage
5368	Dyspepsia and other specified disorders of function of stomach
78901	Abdominal pain, right upper quadrant
78902	Abdominal pain, left upper quadrant
78906	Abdominal pain, epigastric

36.4.9.13 Mammograms

Mammography is an essential appropriate diagnostic radiology technique for breast cancer detection.

To maximize the diagnosis of breast cancer at the earliest time, the diagnostic radiology procedure of mammography must be used on a reasonable basis in a timely manner. Physical examination supplemented by patient self-examination remains the principle diagnostic modality for women with an examination every year.

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After 35 years of age, the physical examination should be augmented by the diagnostic radiology procedure of mammography on the following nationally recognized schedule, even if no symptoms are present:

Age Category	Description
Women 35 to 39	Baseline mammogram in conjunction with a professional breast examination
Women 40 and older	Mammogram every year in conjunction with a professional breast examination

The above schedule is recommended; however, claims received for this service will not be monitored for frequency of testing.

Mammography is payable with an appropriate diagnosis.

The use of mammography as an augmentation to the physical examination on the schedule above is limited to females.

The following procedure codes are payable for diagnostic radiological mammography: 4/I/T-76090, 4/I/T-76091, and 4/I/T-76092.

A mammogram may, in rare instances, be indicated in a male, based on medical necessity because of existing signs and symptoms. In such rare circumstances, the procedure codes 4/I/T-76090 and 4/I/T-76091 are payable.

A mammogram may be medically necessary based on existing signs and symptoms, and may be performed without regard to the above schedule when medically indicated.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures are payable. However, the mammography codes 4/I/T-76090, 4/I/T-76091, and 4/I/T-76092 are denied when billed on the same day as the following diagnostic radiological procedures: 4/I/T-76086, 4/I/T-76088, 4/I/T-76095, 4/I/T-76096, and 4/I/T-76098.

Digital mammography may be considered for reimbursement in addition to screening and diagnostic mammography by using the following procedure codes:

- 4/I/T-76082—Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure).
- 4/I/T-76083—Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure).

36.4.9.14 MRI of the Breast

MRI of the breast requires prior authorization and documentation by the physician explaining the need for the breast MRI. Procedure codes 4/I/T-76093 and 4/I/T-76094 may be considered for reimbursement when billing for a breast MRI.

36.4.9.15 Myocardial Perfusion Imaging

Myocardial perfusion imaging, using radionuclides, is a noninvasive stress test that measures coronary blood flow (perfusion), especially to the left ventricle.

Myocardial perfusion imaging is a covered benefit of the Medicaid program when medically indicated. Myocardial perfusion imaging studies will be limited to one study per day. This service includes, but is not limited to, the following procedures: 4/I/T-78460, 4/I/T-78461, 4/I/T-78464, and 4/I/T-78465.

When multiple procedure codes are billed, the most inclusive code will be paid, and all other codes will be denied.

Myocardial perfusion imaging may be performed at rest and/or during stress using physical exercise or pharmacologicals. The following procedure codes may be used to bill for cardiovascular stress testing: 5-93015, T-93017, and I-93018.

36.4.9.16 Nerve Conduction Studies

Nerve conduction studies are indicated whenever a need exists to locate neurologic or muscular symptomatology more precisely in post-traumatic circumstances or general widespread conditions affecting the entire neuromuscular system.

Code nerve conduction studies are as follows: 5-95900, 5-95903, 5-95904, 5-95934, and 5-95936.

Procedure codes 5-95900, 5-95903, and/or 5-95904 are reimbursed in full for the first nerve study and half for each additional study, regardless of the number of studies. Procedure code 5-95934 and/or 5-95936 are reimbursed in full when performed with procedure codes 5-95900, 5-95903, and/or 5-95904 in addition to the reimbursement for the codes 5-95900, 5-95903, and 5-95904, as outlined previously. If 5-95934 and 5-95936 are billed in multiples, the first is reimbursed in full, and all additional studies are reimbursed at half the fee.

Nerve conduction studies repeated within a three-month period on the same client by the same provider are denied except for the following diagnosis codes:

Diagnosis Code	Description
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations, type I (juvenile type), not stated as uncontrolled

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Diagnosis Code	Description
25062	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations, type I (juvenile type), uncontrolled
2650	Beriberi
2652	Pellagra
2692	Unspecified vitamin deficiency
2699	Unspecified nutritional deficiency
2771	Disorders of porphyrin metabolism
27730	Amyloidosis, unspecified
27739	Other amyloidosis
27781	Primary carnitine deficiency
27782	Carnitine deficiency due to inborn errors of metabolism
27783	Latrogenic carnitine deficiency
27784	Other secondary carnitine deficiency
27789	Other specified disorders of metabolism
3525	Disorders of hypoglossal (12th) nerve
3541	Other lesion of median nerve
3552	Other lesion of femoral nerve
3553	Lesion of lateral popliteal nerve
3558	Mononeuritis of lower limb, unspecified
3560	Hereditary peripheral neuropathy
3564	Idiopathic progressive polyneuropathy
3569	Unspecified idiopathic peripheral neuropathy
3575	Alcoholic polyneuropathy
3576	Polyneuropathy due to drugs
3577	Polyneuropathy due to other toxic agents
35781	Chronic inflammatory demyelinating polyneuritis
35782	Critical illness polyneuropathy
35789	Other inflammatory and toxic neuropathy
7220	Displacement of cervical intervertebral disc without myelopathy
72210	Displacement of lumbar intervertebral disc without myelopathy
72211	Displacement of thoracic intervertebral disc without myelopathy
7222	Displacement of intervertebral disc, site unspecified, without myelopathy
7234	Brachial neuritis or radiculitis NOS
7292	Neuralgia, neuritis, and radiculitis, unspecified
7295	Pain in limb

36.4.9.17 Pediatric Pneumogram

A pneumogram is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

Use procedure code 5/I/T-94772 when billing for the pediatric pneumogram.

The following diagnosis codes are payable for a pediatric pneumogram in infants up through 11 months of age:

Diagnosis Code	Description
5300	Achalasia and cardiospasm
53010	Esophagitis, unspecified
53011	Reflux esophagitis
53012	Acute esophagitis
53019	Other esophagitis
53081	Esophageal reflux
7685	Severe birth asphyxia
7686	Mild to moderate birth asphyxia
7689	Unspecified birth asphyxia in liveborn infant
769	Respiratory distress syndrome
7707	Chronic respiratory disease arising in the perinatal period
77081	Primary apnea of newborn
77082	Other apnea of newborn
77083	Cyanotic attacks of newborn
77084	Respiratory failure of newborn
77087	Respiratory arrest of newborn
77088	Hypoxemia of newborn
77089	Other respiratory problems after birth
78603	Apnea
78606	Tachypnea
78607	Wheezing
78609	Other dyspnea and respiratory abnormalities

Electromyograms (EMGs), polysomnography, EEGs, and ECGs will be denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms may be reimbursed on the same date of service as an apnea monitor (rented monthly) if documentation supports the medical necessity.

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Pneumogram supplies are considered part of the technical component of the reimbursement and will be denied if billed separately.

A pediatric pneumogram will be limited to two services without prior authorization based on the diagnosis codes listed in the previous table. Additional studies may be considered under THSteps-CCP with documentation of medical necessity, and will require prior authorization.

36.4.10 Doppler Studies

A Doppler examination is a noninvasive procedure that detects blood flow velocity within an artery or vein. It is commonly used to detect stenosis or occlusion of an artery or vein.

Some of the specific studies done using the Doppler ultrasound are as follows:

- Cerebrovascular evaluation—usually a peripheral flow study (arterial) is performed.
- Thrombosis evaluation—usually a peripheral vascular study (venous) is performed.
- Plethysmography technique—arterial and/or venous outflow studies, usually done as a pre-operative and post-operative evaluation.
- Evaluation of arteriovenous fistula or malformation.
- Evaluation of arteriovenous shunt.

36.4.10.1 Noninvasive Diagnostic Studies

Doppler studies of the *extracranial arteries* (4/I/T-93875, 4/I/T-93880, and 4/I/T-93882) are limited to the following diagnosis codes:

Diagnosis Code	Description
36230	Retinal vascular occlusion, unspecified
36231	Central retinal artery occlusion
36232	Retinal arterial branch occlusion
36233	Partial retinal arterial occlusion
36234	Transient retinal arterial occlusion
36284	Retinal ischemia
36811	Sudden visual loss
36812	Transient visual loss
3682	Diplopia
36840	Visual field defect, unspecified
36841	Scotoma involving central area
36842	Scotoma of blind spot area
36843	Sector or arcuate visual field defects
36844	Other localized visual field defect
36845	Generalized visual field contraction or constriction
36846	Homonymous bilateral field defects
36847	Heteronymous bilateral field defects
43310	Occlusion and stenosis of carotid artery without mention of cerebral infarction
43311	Occlusion and stenosis of carotid artery with cerebral infarction
43320	Occlusion and stenosis of vertebral artery without mention of cerebral infarction
43321	Occlusion and stenosis of vertebral artery with cerebral infarction
43330	Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction
43331	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
4352	Subclavian steal syndrome
4353	Vertebrobasilar artery syndrome
4358	Other specified transient cerebral ischemias
4359	Unspecified transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
44100	Dissection of aorta, unspecified site
44321	Aneurysm of renal artery
44281	Aneurysm of artery of neck
44323	Dissection of renal artery
44329	Dissection of other artery
44589	Other peripheral vascular disease
4531	Thrombophlebitis migrans
7802	Syncope and collapse
78094	Early satiety
7843	Aphasia
78552	Septic shock
7859	Other symptoms involving cardiovascular system
90000	Injury to carotid artery, unspecified
90001	Injury to common carotid artery
90002	Injury to external carotid artery
90003	Injury to internal carotid artery
9961	Mechanical complication of other vascular device, implant, and graft

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Doppler studies of the *intracranial arteries* (4/I/T-93886, 4/I/T-93888, 4/I/T-93890, 4/I/T-93892, and 4/I/T-93893) are limited to the following diagnosis codes:

Diagnosis Code	Description
34830	Encephalopathy, unspecified
34831	Metabolic encephalopathy
34839	Other encephalopathy
3488	Other conditions of brain
430	Ptosis of eyelid, unspecified
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction
43490	Cerebral artery occlusion, unspecified without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
4351	Vertebral artery syndrome
4352	Subclavian steal syndrome
4353	Vertebrobasilar artery syndrome
4358	Other specified transient cerebral ischemias
4359	Unspecified transient cerebral ischemia
4370	Cerebral atherosclerosis
4430	Raynaud's syndrome
44381	Peripheral angiopathy in diseases classified elsewhere
4439	Peripheral vascular disease, unspecified
4471	Stricture of artery
74781	Septic shock
74782	Spinal vessel anomaly
74783	Persistent fetal circulation
74789	Unspecified congenital anomaly of respiratory system
78552	Septic shock

Doppler studies of the *extremity arteries* (4/I/T-93922, 4/I/T-93923, 4/I/T-93924, 4/I/T-93925, 4/I/T-93926, 4/I/T-93930, and 4/I/T-93931) are limited to the following diagnosis codes:

Diagnosis Code	Description
4439	Peripheral vascular disease, unspecified
4440	Embolism and thrombosis of abdominal aorta
4441	Embolism and thrombosis of thoracic aorta
44421	Arterial embolism and thrombosis of upper extremity
44422	Arterial embolism and thrombosis of lower extremity
44481	Embolism and thrombosis of iliac artery
44489	Embolism and thrombosis of other artery
4466	Thrombotic microangiopathy
4467	Takayasu's disease
4470	Arteriovenous fistula, acquired
60782	Vascular disorders of penis
60784	Impotence of organic origin
70710	Unspecified ulcer of lower limb
70711	Ulcer of thigh
70712	Ulcer of calf
70713	Ulcer of ankle
70714	Ulcer of heel and midfoot
70715	Ulcer of other part of foot
70719	Ulcer of other part of lower limb
7854	Gangrene
78552	Septic shock
90300	Injury to axillary vessel(s), unspecified
90301	Injury to axillary artery
9031	Injury to brachial blood vessels
9032	Injury to radial blood vessels
9033	Injury to ulnar blood vessels
9034	Injury to palmar artery
9035	Injury to digital blood vessels
9038	Injury to other specified blood vessels of upper extremity
9039	Injury to unspecified blood vessel of upper extremity
9040	Injury to common femoral artery
9041	Injury to superficial femoral artery
90440	Injury to popliteal vessel(s), unspecified
90441	Injury to popliteal artery
90450	Injury to tibial vessel(s), unspecified
90451	Injury to anterior tibial artery
90453	Injury to posterior tibial artery
92300	Contusion of shoulder region
92301	Contusion of scapular region
92302	Contusion of axillary region

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Diagnosis Code	Description
92303	Contusion of upper arm
92309	Contusion of multiple sites of shoulder and upper arm
92310	Contusion of forearm
92311	Contusion of elbow
92320	Contusion of hand(s)
92321	Contusion of wrist
9233	Contusion of finger
9238	Contusion of multiple sites of upper limb
9239	Contusion of unspecified part of upper limb
92400	Contusion of thigh
92401	Contusion of hip
92410	Contusion of lower leg
92411	Contusion of knee
92420	Contusion of foot
92421	Contusion of ankle
9243	Contusion of toe
9244	Contusion of multiple sites of lower limb
9245	Contusion of unspecified part of lower limb
9248	Contusion of multiple sites, not elsewhere classified
9249	Contusion of unspecified site
92700	Crushing injury of shoulder region
92701	Crushing injury of scapular region
92702	Crushing injury of axillary region
92703	Crushing injury of upper arm
92709	Crushing injury of multiple sites of upper arm
92710	Crushing injury of forearm
92711	Crushing injury of elbow
92720	Crushing injury of hand(s)
92721	Crushing injury of wrist
9273	Crushing injury of finger(s)
9278	Crushing injury of multiple sites of upper limb
9279	Crushing injury of unspecified site of upper limb
92800	Crushing injury of thigh
92801	Crushing injury of hip
92810	Crushing injury of lower leg
92811	Crushing injury of knee
92820	Crushing injury of foot
92821	Crushing injury of ankle
9283	Crushing injury of toe(s)
9288	Crushing injury of multiple sites of lower limb
9289	Crushing injury of unspecified site of lower limb
9961	Mechanical complication of other vascular device, implant, and graft
99690	Complications of unspecified reattached extremity
99691	Complications of reattached forearm
99692	Complications of reattached hand
99693	Complications of reattached finger(s)
99694	Complications of reattached upper extremity, other and unspecified
99695	Complication of reattached foot and toe(s)
99696	Complication of reattached lower extremity, other and unspecified
99699	Complication of other specified reattached body part

Doppler studies of the *extremity veins* (4/I/T-93965, 4/I/T-93970, and 4/I/T-93971) are limited to the following diagnosis codes:

Diagnosis Code	Description
4510	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
45111	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
45119	Phlebitis and thrombophlebitis of other
4512	Phlebitis and thrombophlebitis of lower extremities, unspecified
45181	Phlebitis and thrombophlebitis of iliac vein
45182	Phlebitis and thrombophlebotis of superficial veins of upper extremities
45183	Phlebitis and thrombophlebitis of deep veins of upper extremities
45184	Phlebitis and thrombophlebitis of upper extremities, unspecified
45189	Phlebitis and thrombophlebitis of other sites
4519	Phlebitis and thrombophlebitis of unspecified site
4530	Budd-Chiari syndrome
4531	Thrombophlebitis migrans
4532	Embolism and thrombosis of vena cava

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Diagnosis Code	Description
4533	Embolism and thrombosis of renal vein
45340	Venous embolism and thrombosis of unspecified deep vessels of lower extremity
45341	Venous embolism and thrombosis of deep vessels of proximal lower extremity
45342	Venous embolism and thrombosis of deep vessels of distal lower extremity
4538	Embolism and thrombosis of other specified veins
4539	Embolism and thrombosis of unspecified site
4548	Varicose veins of the lower extremities, with other complications
45910	Postphlebetic syndrome without complications
45911	Postphlebetic syndrome with ulcer
45912	Postphlebetic syndrome with inflammation
45913	Postphlebetic syndrome with ulcer and inflammation
45919	Postphlebetic syndrome with other complication
60784	Impotence of organic origin
60785	Peyronie's disease
70710	Unspecified ulcer of lower limb
70711	Ulcer of thigh
70712	Ulcer of calf
70713	Ulcer of ankle
70714	Ulcer of heel and midfoot
70715	Ulcer of other part of foot
70719	Ulcer of other part of lower limb
7823	Edema
78552	Septic shock
90300	Injury to axillary vessel(s), unspecified
90302	Injury to axillary vein
9031	Injury to brachial blood vessels
9032	Injury to radial blood vessels
9033	Injury to ulnar blood vessels
9035	Injury to digital blood vessels
9038	Injury to other specified blood vessels of upper extremity
9039	Injury to unspecified blood vessel of upper extremity
9042	Injury to femoral veins

Diagnosis Code	Description
9043	Injury to saphenous veins
9044	Injury to popliteal blood vessels
90442	Injury to popliteal vein
90450	Injury to tibial vessel(s), unspecified
90452	Injury to anterior tibial vein
90454	Injury to posterior tibial vein
9046	Injury to deep plantar blood vessels
9047	Injury to other specified blood vessels of lower extremity
9048	Injury to unspecified blood vessel of lower extremity
9049	Injury to blood vessels of unspecified site
92700	Crushing injury of shoulder region
92701	Crushing injury of scapular region
92702	Crushing injury of axillary region
92703	Crushing injury of upper arm
92709	Crushing injury of multiple sites of upper arm
92710	Crushing injury of forearm
92711	Crushing injury of elbow
92720	Crushing injury of hand(s)
92721	Crushing injury of wrist
9273	Crushing injury of finger(s)
9278	Crushing injury of multiple sites of upper limb
9279	Crushing injury of unspecified site of upper limb
92800	Crushing injury of thigh
92801	Crushing injury of hip
92810	Crushing injury of lower leg
92811	Crushing injury of knee
92820	Crushing injury of foot
92821	Crushing injury of ankle
9283	Crushing injury of toe(s)
9288	Crushing injury of multiple sites of lower limb
9289	Crushing injury of unspecified site of lower limb
9961	Mechanical complication of other vascular device, implant, and graft
99690	Complications of unspecified reattached extremity
99691	Complications of reattached forearm
99692	Complications of reattached hand
99693	Complications of reattached finger(s)

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Diagnosis Code	Description
99694	Complications of reattached upper extremity, other and unspecified
99695	Complication of reattached foot and toe(s)
99696	Complication of reattached lower extremity, other and unspecified
99699	Complication of other specified reattached body part
9972	Peripheral vascular complications, not elsewhere classified

Procedure code 4/I/T-93325 is payable for the following diagnosis codes:

Diagnosis Code	Description
3911	Acute rheumatic endocarditis
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve unspecified
39890	Rheumatic heart disease, unspecified
41406	Coronary atherosclerosis of native coronary artery of transplanted heart
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
41411	Aneurysm of coronary vessels
4150	Acute cor pulmonale
4160	Primary pulmonary hypertension
4168	Other chronic pulmonary heart diseases
4169	Chronic pulmonary heart disease, unspecified
4170	Arteriovenous fistula of pulmonary vessels
4178	Other specified diseases of pulmonary circulation
4210	Acute and subacute bacterial endocarditis
42291	Idiopathic myocarditis
42292	Septic myocarditis
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4251	Hypertrophic obstructive cardiomyopathy
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4259	Secondary cardiomyopathy, unspecified
4280	Congestive heart failure
7450	Common truncus
74510	Complete transposition of great vessels
74511	Double outlet right ventricle
74512	Corrected transposition of great vessels
7452	Tetralogy of fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
74560	Endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other endocardial cushion defects

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Diagnosis Code	Description
74600	Congenital pulmonary valve anomaly, unspecified
74601	Atresia of pulmonary valve, congenital
74602	Stenosis of pulmonary valve, congenital
74609	Other congenital anomalies of pulmonary valve
7461	Ostium primum defect
7462	Ebstein's anomaly
7463	Congenital stenosis of aortic valve
7464	Congenital insufficiency of aortic valve
7465	Congenital mitral stenosis
7466	Congenital mitral insufficiency
7467	Hypoplastic left heart syndrome
74681	Subaortic stenosis, congenital
74682	Cor triatriatum
74683	Infundibular pulmonic stenosis, congenital
74685	Coronary artery anomaly, congenital
7470	Patent ductus arteriosus
74710	Coarctation of aorta (preductal) (postductal)
74711	Interruption of aortic arch
74722	Congenital atresia and stenosis of aorta
7473	Congenital anomalies of pulmonary artery
74741	Total anomalous pulmonary venous connection
74742	Partial anomalous pulmonary venous connection
74749	Other anomalies of great veins
7852	Undiagnosed cardiac murmurs
78552	Septic shock
9607	Poisoning by antineoplastic antibiotics
9961	Mechanical complication of other vascular device, implant, and graft
99771	Vascular complications of mesenteric artery
99772	Vascular complications of renal artery
99779	Vascular complications of other vessels
V433	Heart valve replaced by other means

Procedure codes 4/I/T-93922 and 4/I/T-93923 are limited to the following diagnosis codes:

Diagnosis Code	Description
44501	Atheroembolism, upper extremity
44502	Atheroembolism, lower extremity

Procedure codes 4/I/T-93924, 4/I/T-93925 and 4/I/T-93926, Extremity study, are limited to diagnosis code 44502, Atheroembolism, lower extremity.

Procedure codes 4/I/T-93930 and 4/I/T-93931 are limited to diagnosis code 44501, Atheroembolism, upper extremity.

Multiple Doppler procedures (for example, studies of extra-cranial arteries and intracranial arteries) billed on the same day are reimbursed at full fee for the first, and half for each additional study irrespective of the number of services billed.

Procedure codes described as bilateral, right, and left studies billed on the same day are inclusive and reimbursed at a quantity of one.

Procedure codes 4/I/T-93882, 4/I/T-93888, 4/I/T-93926, 4/I/T-934/I/T-931, 4/I/T-93971, 4/I/T-93976, and 4/I/T-93979 are considered unilateral codes. Right and left studies are reimbursed at full and one-half fee.

Procedure codes 4/I/T-93320 and 4/I/T-93321 are reimbursable in addition to procedure codes 4/I/T-93307 and 4/I/T-93308.

Procedure code 4/I/T-93325 may be considered for reimbursement separately from transthoracic and transesophageal echocardiograph procedure codes 4/I/T-93312 and 4/I/T-93350, when billed on the same date of service, by the same provider.

Procedure code 93990 is considered part of the care of the dialysis patient and is not reimbursed separately.

36.4.11 Elective Sterilization Services

The Texas Medicaid Program benefits include payment for elective sterilization (performed solely for the purpose of rendering the individual incapable of bearing or fathering children) of eligible clients when providers comply with HHS regulations (42 Code of Federal Regulations [CFR] 441.250, Subpart F).

Refer to: Section 19.3.3 "Sterilization Consent Form and Instructions" on page 20-4 for further direction.

Payment of elective sterilization is *not* made if the client meets any of the following criteria:

- Is younger than 21 years of age at the time the consent form is signed.
- Has been declared mentally incompetent for the purpose of sterilization (clients are presumed to be mentally competent unless adjudicated incompetent for the purpose of sterilization).
- Is institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.

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- Gave consent in labor or childbirth, under the influence of alcohol or other drugs, or while seeking or obtaining an abortion.

Note: *All Medicaid clients, electing sterilization services including those in a STAR or STAR+PLUS Program health plan, must sign a Sterilization Consent Form. The form must be submitted to the client's health plan.*

TMHP must have a signed, valid Sterilization Consent Form on file to reimburse an elective sterilization procedure. Typewritten, blocked, or facsimile stamped signatures are *not* acceptable for signature requirements. When a valid consent form is received by TMHP, the Medicaid client's eligibility file is updated to reflect receipt. Subsequent claims received by TMHP for the sterilization covered by the consent are referenced to the valid consent and reimbursed even if they are not accompanied by a valid consent. It is to the provider's benefit to submit a consent form with claims for sterilization rather than relying on a fellow provider. A legible, valid copy of the consent is acceptable.

Providers may copy onto their letterhead the Sterilization Consent Form. Providers may use their own consent form as long as the form has the HHS-approved language and required fields. Providers who want their own consent form must obtain approval from HHS.

A mechanism for processing Sterilization Consent Forms aimed at reducing the number of unnecessary denials for sterilization covered under family planning and billed to Medicaid is used by TMHP. Family planning providers may provide sterilization to their clients after a waiting period of 30 days, defined as 30 full 24-hour periods from the time in which formal consent was obtained from the client. The waiting period prevents the denial of sterilization claims for sterilization conducted on the 30th day, despite the fact that 30 full days (24-hour periods) passed from the time of written consent.

When a sterilization is performed at the time of a premature delivery, the time of the client's consent must be at least 72 hours before the actual delivery *and* 30 days before the expected date of delivery. (The consent form is valid for 180 days from the date of the client's signature.) If emergency abdominal surgery occurs, the time of the client's consent must be at least 72 hours before surgery.

These instructions must be followed when completing the HHS-approved consent form. All blanks should be completed unless otherwise specified.

- The client's nine-digit Medicaid number must be recorded in the blocks provided in the upper right-hand corner of the consent form.
- The first section of the consent form, *Consent to Sterilization*, must be completed in English or Spanish.
- The *Race and Ethnicity Designation* is optional.
- An interpreter must be provided if the consent form is not written in the language of the individual to be sterilized or the person obtaining consent does not speak the individual's language. If an interpreter is used, the *Interpreter's Statement* must be completed.
- The *Statement of the Person Obtaining Consent* must be completed by the person who explains the surgery and its implications, alternate methods of birth control, and the fact that the consent may be withdrawn at any time. The signature of the person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, *not* a rubber stamp.
- The physician or the person obtaining consent must allow a witness of the client's choice (if desired) when the consent form is signed, and arrangements must be made for individuals with disabilities.
- The *Physician's Statement* must be completed. The physician must indicate that 30 days or 72 hours have passed between consent and surgery by crossing out paragraph number 1 or 2 as indicated on the consent form.
- The *Physician's Statement* must be signed and dated on or after the day of surgery in all circumstances. The signature must be an original signature, *not* a rubber stamp.
- When the sterilization is performed at the time of a premature delivery, the expected date of delivery must be recorded in the space provided on the consent form and must be 30 days from date of client's signature.
- When the sterilization is performed at the time of emergency abdominal surgery, the circumstances must be described in the space provided on the consent form. If the space is not sufficient, additional documentation may be attached to the consent form.
- The physician must review the consent form with the client shortly before surgery.
- The actual sterilization procedure performed must be identical to that for which the client gave informed, written consent. Each reference to the sterilization procedure on the consent form and the claim form (for example, salpingectomy cannot be interchanged with tubal ligation) must be identical.
- Sterilization Consent forms may be faxed to 1-512-514-4229. Follow the guidelines under "Faxing Forms" on page 36-73.

Refer to: "Sterilization Consent Form Instructions (2 Pages)" on page B-92.
"Sterilization Consent Form (English, 2 Pages)" on page B-94.

36.4.12 Endoscopies

The following endoscopies are covered services in the Texas Medicaid Program:

- Bronchoscopy
- Cystourethroscopy
- Endoscopic Retrograde Cholangiopancreatography (ERCP)
- Lower GED (for example, colonoscopy)

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- Upper GED (for example, Esophagogastroduodenoscopy [EGD])
- Sinus Endoscopy

Multiple diagnostic or operative endoscopies in the same or different body areas are often billed on the same day. If done by the same provider, they may be paid the full amount allowed for the major procedure and one-half the allowed amount for each additional procedure, following multiple surgical guidelines.

If the physician bills separate charges for multiple endoscopies that are considered part of a more inclusive procedure, HHSC or its designee reviews the individual charges and pays only the procedure with the more inclusive code.

Example: *Separate charges for an esophagoscopy, a gastroscopy, and a duodenoscopy are reviewed and paid as an EGD. A surgical endoscopy always includes the diagnostic endoscopy.*

36.4.13 Epidural/Subarachnoid Infusion for Chronic Spasticity

Epidural/subarachnoid infusion of baclofen (Lioresal) for chronic spasticity is a benefit of the Texas Medicaid Program. Prior authorization is required for procedure codes 2-62350, 2-62360, 2-62361, and 2-62362.

Refer to: "Baclofen (Lioresal), Trial Injection and Pump Implantation/Catheter Insertion/Revision/Replacement" on page 36-89 for guidelines.

36.4.14 Extracorporeal Membrane Oxygenation (ECMO)

Extracorporeal membrane oxygenation (ECMO) coverage is limited to infants younger than 1 year of age. ECMO is payable only in POS 3 (hospital) and the client should be monitored in the neonatal or pediatric intensive care unit.

The following procedure codes are payable for the billing of prolonged extracorporeal circulation for cardiopulmonary insufficiency: 2-36822, 2-33960, 2-33961, and 2-33999.

Note: *For Cardiac surgery procedure, use procedure code 2-33999.*

Procedure code 2-33960 or 2-33961 is limited to one per day, any provider.

If procedure code 2-36822 or 2-33999 is billed on the same day as ECMO by the same provider, the insertion or removal is denied and the ECMO (2-33960, 2-33961) is paid.

Subsequent hospital care visits including critical care and total respiratory care billed on the same day by any provider are denied.

ECMO is payable for the following diagnosis codes:

Diagnosis Code	Description
4150	Acute cor pulmonale
4151	Pulmonary embolism and infarction
74783	Persistent fetal circulation
7479	Unspecified anomaly of circulatory system
7566	Anomalies of diaphragm
75670	Anomaly of abdominal wall, unspecified
75671	Anomaly of abdominal, prune belly syndrome
75679	Other congenital anomalies of abdominal wall
769	Respiratory distress syndrome
77010	Meconium aspiration syndrome
77012	Meconium aspiration with respiratory symptoms
77018	Other fetal and newborn aspiration with respiratory symptoms
77087	Respiratory arrest of newborn
77088	Hypoxemia of newborn
77181	Septecemia (sepsis) of newborn
77183	Bacteremia of newborn
77189	Other infections specific to the perinatal period
77581	Other acidosis of newborn
77985	Cardiac arrest of newborn

36.4.15 Family Planning Services

Physicians, PAs, NPs, and CNSs are encouraged to provide family planning services to Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required.

Family planning services are preventive health, medical, counseling, and educational services that assist an individual in controlling fertility and achieving optimal reproductive and general health. When billing for these services, use modifier FP.

The federal contribution to Texas is enhanced with the use of modifier FP, which increases the total amount of funds available for reimbursement. For the same reason, it is important for providers to give their reference laboratory a family planning diagnosis code for all eligible family planning laboratory work. Family planning drugs and supplies may be provided through providers' offices and billed to the program or they may be provided by prescription through the Vendor Drug Program (VDP). These drugs and supplies are exempt from the three prescriptions per month rule.

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For supplies unavailable through the Vendor Drug Program, clients may be able to obtain supplies through a family planning agency. Medicaid clients whose eligibility is *limited* may receive family planning services without referrals.

Reminder: *Physicians are encouraged to issue family planning prescriptions for at least six months if medically appropriate. Pharmacies under Vendor Drug must fill the prescription for six months at a time, when a physician orders a six-month supply, not one per month.*

Refer to: Section 19 “Family Planning Services” on page 20-1 for a description of reimbursable family planning services and billing procedure codes.

“Client Limited Program” on page 4-5.

36.4.16 Gamma Knife Radiosurgery (2-61793)

The following diagnosis codes are payable for 2-61793. This procedure is payable to physicians for professional services only in the inpatient and outpatient settings.

Diagnosis Code	Description
1700	Malignant neoplasm of bone and articular cartilage; bones of skull and face, except mandible
1701	Malignant neoplasm of bone and articular cartilage; mandible
1702	Malignant neoplasm of bone and articular cartilage; vertebral column, excluding sacrum and coccyx
1703	Malignant neoplasm of bone and articular cartilage; ribs, sternum, and clavicle
1704	Malignant neoplasm of bone and articular cartilage; scapula and long bones of upper limb
1705	Malignant neoplasm of bone and articular cartilage; short bones of upper limb
1706	Malignant neoplasm of bone and articular cartilage; pelvic bones, sacrum, and coccyx
1707	Malignant neoplasm of bone and articular cartilage; long bones of lower limb
1708	Malignant neoplasm of bone and articular cartilage; short bones of lower limb
1709	Malignant neoplasm of bone and articular cartilage; bone and articular cartilage, site unspecified
1710	Malignant neoplasm of connective and other soft tissue; head, face, and neck
1910	Malignant neoplasm of brain; cerebrum, except lobes and ventricles
1911	Malignant neoplasm of brain; frontal lobe
1912	Malignant neoplasm of brain; temporal lobe
1913	Malignant neoplasm of brain; parietal lobe
1914	Malignant neoplasm of brain; occipital lobe
1915	Malignant neoplasm of brain; ventricles
1916	Malignant neoplasm of brain; cerebellum NOS
1917	Malignant neoplasm of brain; brain stem
1918	Malignant neoplasm of brain; other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1944	Malignant neoplasm of pineal gland
1983	Secondary malignant neoplasm of brain and spinal cord
2251	Benign neoplasm of cranial nerves
2252	Benign neoplasm of cerebral meninges
2254	Benign neoplasm of spinal meninges
2273	Benign neoplasm of pituitary gland and craniopharyngeal duct
2370	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
2371	Neoplasm of uncertain behavior of pineal gland
2530	Acromegaly and gigantism
2531	Other and unspecified anterior pituitary hyperfunction
2550	Cushing’s syndrome
25511	Glucocorticoid-remediable aldosteronism
25512	Conn’s syndrome
25513	Bartter’s syndrome
3501	Trigeminal neuralgia
7476	Other congenital anomalies of peripheral vascular system
74781	Congenital anomalies of cerebrovascular system

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36.4.17 Genetic Services

Refer to: "Genetic Services" on page 22-1.

36.4.18 Gynecological Services

36.4.18.1 Abortion Services

According to a revision of the Hyde Amendment, under P.L. 103-112, HHSC implemented the federal directive pertaining to Medicaid reimbursement for abortions. Federal funding is available to save the life of the mother and to terminate pregnancies resulting from rape or incest. Reimbursement is based on the physician's certification that the abortion was performed to save the mother's life, terminate pregnancy resulting from rape, or terminate pregnancy resulting from incest. Prior authorization for abortions is no longer required.

At this time, the certification statement and claim must be filed on paper; electronic billing is not available. One of these statements with the exact wording must be signed by the physician for abortions performed. Substitute wording is not accepted.

Important: *To bill a client eligible for Medicaid for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client's guardian has signed an acknowledgment statement obtained by the physician who has contact with the client.*

Modifier G7, Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening, is the modifier that performing physicians, facilities, anesthesiologists, and CRNAs are required to submit with claims to be reimbursed for abortion procedures that are within the scope of rules and regulations of the Texas Medicaid Program.

Providers must enter the modifier G7 next to the procedure code that identifies abortion services.

Refer to: "Abortion Certification Statements Form" on page B-4 for a sample form.
"Family Planning Services" on page 20-1.

Drugs or devices to prevent implantation of the fertilized ovum and medical procedures necessary for the termination of an ectopic pregnancy are benefits of the Texas Medicaid Program.

36.4.18.2 Contraceptives

Implantable Contraceptive Capsules

Implantable contraceptive capsules, such as Norplant® , are no longer available. Removal of this device is payable with procedure code 2/F-11976.

Refer to: "Implantable Contraceptive Capsules" on page 25-109 for more information.

36.4.18.3 Intrauterine Devices (IUD)

Insertion of an IUD

Providers must use the following procedure codes when billing for the insertion of an IUD: 1-J7300, 1-J7302, and 2-58300.

- Procedure code 2-58300 is denied as part of another service when billed for the same date of service as 1-J7302, which includes the cost of the IUD and insertion of the IUD.
- An IUD insertion/procurement of the IUD may be reimbursed when billed on the same date of service as procedure code 2-58120. Procedure code 2-58120 is reimbursed at full allowance. Procedure code 2-58300 is denied as part of another service. Procedure codes 1-J7300 and 1-J7302 are reimbursed at full allowance.
- When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed for the same date of service as the insertion of the IUD, the surgical procedure is paid at full allowance and the IUD insertion billed using procedure code 2-58300 is paid at half the allowed amount.
- Procedure code J7302 is a payable benefit for females 10 through 55 years of age when billed with the following diagnosis codes. J7302 is limited to once every five years.

Diagnosis Code	Description
V2502	General counseling on initiation of other contraceptive measures
V2503	Encounter for emergency contraceptive counseling and prescription
V2509	Other general counseling and advice on contraceptive management
V251	Insertion of intrauterine contraceptive device
V2540	Contraceptive surveillance, unspecified
V2542	Surveillance of intrauterine contraceptive device
V2549	Surveillance of other contraceptive method
V258	Other specified contraceptive management
V259	Unspecified contraceptive management
V615	Multiparity

36.4.18.4 Removal of an IUD

Procedure code 2-58301 billed for the same date of service in addition to any of the following procedures is denied as included in the other procedure: vaginal, cervical, or uterine surgery; dilation and curettage; or IUD insertion or replacement.

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36.4.18.5 Faxing Forms

All Medicaid providers may fax Sterilization Consent Forms to 1-512-514-4229 and Hysterectomy Acknowledgment Forms to 1-512-514-4218. Include the client's Medicaid number on the form. Additionally, all consent forms should be faxed with a cover sheet identifying the provider, and including the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail or fax for correction.

Completed consent forms faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through mail to Automated Inquiry System (AIS) Appeals at the following address:

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

36.4.18.6 Hysterectomy Services

Assistant surgeons may be reimbursed when assisting a surgeon performing a surgical laparoscopy with vaginal hysterectomy, procedure code 8-58550, 8-58552, 8-58553, or 8-58554.

Note: *All Medicaid clients, receiving hysterectomy services including those in a STAR or STAR+PLUS Program health plan, must sign a Hysterectomy Acknowledgment Form. The acknowledgment must be submitted to the client's health plan.*

The Texas Medicaid Program reimburses hysterectomies when they are medically necessary. The Texas Medicaid Program does not reimburse hysterectomies performed for the sole purpose of sterilization. To obtain reimbursement, providers must submit a signed Hysterectomy Acknowledgment Form along with the claim. Each individual provider involved in the hysterectomy procedure is requested to submit a copy of a valid acknowledgment rather than relying on a fellow provider. The Medicaid client's eligibility file is updated on receipt of the signed Hysterectomy Acknowledgment Form. Subsequent claims received by TMHP, related to the hysterectomy, are referenced to the valid acknowledgment form.

Hysterectomy services are considered for reimbursement when the claim is filed with a signed Hysterectomy Acknowledgment Form or documentation supporting that the Hysterectomy Acknowledgment Form could not be obtained or was not necessary.

Refer to: "Physician Certification for Exceptions" on page 36-73.

36.4.18.7 Hysterectomy Acknowledgment Statement

Federal regulations specify that no claim for a hysterectomy may be paid without the submission of a statement to TMHP in which the client acknowledges that she was informed orally and in writing before the hysterectomy that she is permanently incapable of bearing children. She must be informed regardless of the medical necessity of the surgery, her age, or marital status. The Hysterectomy Acknowledgment Form is also required for a hysterectomy to be paid if performed during a retroactive eligibility period.

The client or her designated representative must sign and date the statement. The only time requirement for obtaining the acknowledgment is that it needs to be dated any time before surgery. A completed Sterilization Consent Form may be used in lieu of the Hysterectomy Acknowledgment form, but all items on the Form must be completed.

Refer to: "Hysterectomy Acknowledgment Form" on page B-52.

Physician Certification for Exceptions

A Hysterectomy Acknowledgment Form is not required when the performing physician certifies and places his or her signature on the claim form or attachment, that at least one of the following circumstances existed before surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (for example, congenital disorder, sterilized previously, or postmenopausal). Providers must use a post menopause diagnosis or sterilization diagnosis on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client's records, and the physician's signature will not be required on the claim form. These records are subject to retrospective review.
- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that they determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour before surgery, an emergency situation requires the patient be unconscious or under sedation and unable to sign the acknowledgment.

36.4.18.8 Hysteroscopic Sterilization

The procedure code to bill for the fallopian tube occlusion sterilization is 2/F-58565, which is considered bilateral. Procedure code 2-58565 includes the occlusive sterilization system (e.g., Essure microinsert).

A hysterosalpingogram is recommended three months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 2-58340 will be considered for reimbursement in this circumstance when billed in conjunction with the diagnosis code V252, Sterilization.

36.4.18.9 Laminaria

Insertion of a laminaria or dilateria is a covered service (usually done before a dilation and curettage). If the procedure is performed on a day preceding the uterine surgery, it should be coded as 2-59200.

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When procedure code 2-59200 is performed on the same day as another surgery (including deliveries), it is considered part of the procedure and no separate reimbursement is provided.

36.4.18.10 Pelvic Exam Under Anesthesia

Procedure 2-57410 is considered part of another gynecological surgery or other abdominal surgery performed the same day. If it is performed in conjunction with another procedure (other than gynecological or general abdominal surgery), it is rarely medically necessary.

36.4.18.11 Vabra Aspirator

2-58100 is a vacuum aspirator used to collect uterine tissue for study to detect endometrial carcinoma. This procedure is a benefit only when the patient exhibits clinical symptoms or signs of endometrial disease, such as irregular or heavy vaginal bleeding. Use of the Vabra aspirator on an asymptomatic patient is not a benefit.

36.4.18.12 Vaginoplasty/Clitoroplasty for Intersex State

The procedure codes reimbursed for vaginoplasty/clitoroplasty for intersex state are 2/8-56805 and 2/8-57335.

Reimbursement is limited to clients with genetically proven virilizing adrenogenital syndrome (diagnosis code 255.2).

36.4.19 Ilizarov Device/Procedure

Use procedure codes 2/F-20692, 2/F-20693, 2/F-20694, and 2/F-20999 when billing for the Ilizarov procedure. A global fee payment methodology of $3146.50 will be applied and includes a global period of 180 days. Procedure codes 2/F-20692, 2/F-20693, 2/F-20694, and 2/F-20999 include the preconstruction, surgical application, adjustments to the device for up to six months, and the removal of the device. Payment for broken/replacement parts to the device is currently under HHSC legal review.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 2-20690 or 2-20692, where applicable, when billing for the surgical applications.

36.4.20 Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy (HBO) is a type of therapy that is intended to increase the environmental oxygen pressure to promote the movement of oxygen from the environment into the body tissues by means of pressurization that is greater than atmospheric pressure. Such treatment is performed in specially constructed hyperbaric chambers, which may hold one or several patients.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.*

Procedure code 1-99183 is limited to one session per day, any provider.

Outpatient hospitals should use revenue code B-413, Respiratory services–HBO, for reimbursement of the technical component.

The FDA-approved indications for the hyperbaric oxygen chamber (therapy) in accordance with the guidelines established by the Undersea and Hyperbaric Medical Society are as follows:

- Air or gas embolism
- Carbon monoxide/smoke inhalation
- Compromised skin grafts and flaps
- Crush injuries/acute traumatic ischemias
- Decompression sickness
- Enhanced healing in selected problem wounds
- Exceptional blood loss (anemia)
- Gas gangrene (clostridial myonecrosis)
- Intracranial abscess
- Necrotizing soft tissue infections
- Radiation tissue damage (osteoradionecrosis)
- Refractory osteomyelitis
- Thermal burns

When requesting reimbursement of HBO for the treatment of *air or gas embolism* use the following diagnosis codes:

Diagnosis Code	Description
6396	Embolism following abortion or ectopic and molar pregnancies
67300	Obstetrical air embolism, unspecified as to episode of care
9580	Air embolism as an early complication of trauma
9991	Air embolism as a complication of medical care, not elsewhere classified

When requesting reimbursement of HBO for the treatment of *carbon monoxide/smoke inhalation,* use diagnosis code 986, Carbon monoxide poisoning and smoke inhalation.

When requesting reimbursement of HBO for the treatment of *compromised skin grafts and flaps,* use the following diagnosis codes:

Diagnosis Code	Description
99652	Mechanical complication of prosthetic graft of other tissue, not elsewhere classified
99660	Infection and inflammatory reaction due to unspecified device, implant, and graft
99661	Infection and inflammatory reaction due to cardiac device, implant, and graft

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Diagnosis Code	Description
99662	Infection and inflammatory reaction due to other vascular device, implant, and graft
99663	Infection and inflammatory reaction due to nervous system device, implant, and graft
99664	Infection and inflammatory reaction due to indwelling urinary catheter
99665	Infection and inflammatory reaction due to other genitourinary device, implant, and graft
99666	Infection and inflammatory reaction due to internal joint prosthesis
99667	Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft
99668	Infection and inflammatory reaction due to peritoneal dialysis catheter
99669	Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft
99670	Other complications due to unspecified device, implant, and graft
99671	Other complications due to heart valve prosthesis
99672	Other complications due to other cardiac device, implant, and graft
99673	Other complications due to renal dialysis device, implant, and graft
99674	Other complications due to other vascular device, implant, and graft
99675	Other complications due to nervous system device, implant, and graft
99676	Other complications due to genitourinary device, implant, and graft
99677	Other complications due to internal joint prosthesis
99678	Other complications due to other internal orthopedic device, implant, and graft
99679	Other complications due to other internal prosthetic device, implant, and graft
V423	Skin replaced by transplant

When requesting reimbursement of HBO for the treatment of *crush injuries/acute traumatic ischemias,* use the following diagnosis codes:

Diagnosis Code	Description
8690	Internal injury to unspecified or ill-defined organs without mention of open wound into cavity
8691	Internal injury to unspecified or ill-defined organs with open wound into cavity
8871	Traumatic amputation of arm and hand; (complete), (partial); unilateral, below elbow, complicated
8873	Traumatic amputation of arm and hand; (complete), (partial); unilateral, at or above elbow, complicated
8875	Traumatic amputation of arm and hand; (complete), (partial); unilateral, not specified, complicated
8877	Traumatic amputation of arm and hand; (complete), (partial); bilateral (any level), complicated
8971	Traumatic amputation of leg(s), (complete), (partial), unilateral below knee, complicated
8973	Traumatic amputation of leg(s), (complete), (partial), unilateral at or above knee, complicated
8975	Traumatic amputation of leg(s), (complete), (partial), unilateral level not specified, complicated
8977	Traumatic amputation of leg(s), (complete), (partial), bilateral any level, complicated
9251	Crushing injury of face and scalp
9252	Crushing injury of neck
9260	Crushing injury of external genitalia
92611	Crushing injury of back
92612	Crushing injury of buttock
92619	Crushing injury of other specified sites of trunk
9268	Crushing injury of multiple sites of trunk
9269	Crushing injury of unspecified site of trunk
92700	Crushing injury of shoulder region
92701	Crushing injury of scapular region
92702	Crushing injury of axillary region
92703	Crushing injury of upper arm
92709	Crushing injury of multiple sites of upper arm
92710	Crushing injury of forearm

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Diagnosis Code	Description
92711	Crushing injury of elbow
92720	Crushing injury of hand(s)
92721	Crushing injury of wrist
9273	Crushing injury of finger(s)
9278	Crushing injury of multiple sites of upper limb
9279	Crushing injury of unspecified site of upper limb
92800	Crushing injury of thigh
92801	Crushing injury of hip
92810	Crushing injury of lower leg
92811	Crushing injury of knee
92820	Crushing injury of foot
92821	Crushing injury of ankle
9283	Crushing injury of toe(s)
9288	Crushing injury of multiple sites of lower limb
9289	Crushing injury of unspecified site of lower limb
9290	Crushing injury of multiple and unspecified sites
9299	Crushing injury of unspecified site
99690	Complications of unspecified reattached extremity
99691	Complications of reattached forearm
99692	Complications of reattached hand
99693	Complications of reattached finger(s)
99694	Complications of reattached upper extremity, other and unspecified
99695	Complication of reattached foot and toe(s)
99696	Complication of reattached lower extremity, other and unspecified
99699	Complication of other specified reattached body part

When requesting reimbursement of HBO for the treatment of *decompression sickness,* use the diagnosis code 9933, Caisson disease.

When requesting reimbursement of HBO for the treatment of *enhanced healing in selected problem wounds,* use the following diagnosis codes:

Diagnosis Code	Description
25070	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
25071	Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled
25072	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled
25073	Diabetes with peripheral circulatory disorders, type I (juvenile type), uncontrolled
44023	Atherosclerosis of native arteries of the extremities with ulceration
44024	Atherosclerosis of native arteries of the extremities with gangrene
44381	Peripheral angiopathy in diseases classified elsewhere
44382	Erythromelalgia
44389	Other peripheral vascular disease
4439	Peripheral vascular disease, unspecified
4540	Varicose veins of lower extremities with ulcer
4542	Varicose veins of lower extremities with ulcer and inflammation
68600	Other local infection of skin and subcutaneous tissue, pyoderma, unspecified
68601	Other local infection of skin and subcutaneous tissue, pyoderma gangrenosum
68609	Other local infection of skin and subcutaneous tissue, other pyoderma
70700	Decubitus ulcer, unspecified site
70701	Decubitus ulcer, elbow
70702	Decubitus ulcer, upper back
70703	Decubitus ulcer, lower back
70704	Decubitus ulcer, hip
70705	Decubitus ulcer, buttock
70706	Decubitus ulcer, ankle
70707	Decubitus ulcer, heel
70709	Decubitis ulcer, other site
70710	Unspecified ulcer of lower limb
70711	Ulcer of thigh
70712	Ulcer of calf
70713	Ulcer of ankle
70714	Ulcer of heel and midfoot
70715	Ulcer other part of foot
70719	Ulcer of other part of lower limb
7078	Chronic ulcer of other specified sites
7079	Chronic ulcer of unspecified site
9895	Toxic effect of venom
99859	Other postoperative infection

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When requesting reimbursement of HBO for the treatment of *exceptional blood loss (anemia),* use the following diagnosis codes:

Diagnosis Code	Description
2851	Acute post hemorrhagic anemia
78559	Other shock without mention of trauma
9584	Traumatic shock
9980	Postoperative shock, not elsewhere classified

When requesting reimbursement of HBO for the treatment of *gas gangrene (clostridial myonecrosis),* use the following diagnosis codes:

Diagnosis Code	Description
0383	Septicemia due to anaerobes
0400	Gas gangrene

When requesting reimbursement of HBO for the treatment of *necrotizing soft tissue infections,* use the following diagnosis codes:

Diagnosis Code	Description
72886	Necrotizing fasciitis
7854	Gangrene

When requesting reimbursement of HBO for the treatment of *radiation tissue damage (osteoradionecrisis),* use the following diagnosis codes:

Diagnosis Code	Description
52689	Disease of the jaw; other osteoradionecrosis of jaw(s)
73010	Chronic osteomyelitis, site unspecified
73011	Chronic osteomyelitis involving shoulder region
73012	Chronic osteomyelitis involving upper arm
73013	Chronic osteomyelitis involving forearm
73014	Chronic osteomyelitis involving hand
73015	Chronic osteomyelitis involving pelvic region and thigh
73016	Chronic osteomyelitis involving lower leg
73017	Chronic osteomyelitis involving ankle and foot
73018	Chronic osteomyelitis involving other specified sites
73019	Chronic osteomyelitis involving multiple sites
7854	Symptoms involving cardiovascular system: gangrene
9092	Late effects of other and unspecified external causes; late effect of radiation
990	Effects of radiation, unspecified

When requesting reimbursement of HBO for the treatment of *refractory osteomyelitis,* use the following diagnosis codes:

Diagnosis Code	Description
73000	Acute osteomyelitis, site unspecified
73001	Acute osteomyelitis involving shoulder region
73002	Acute osteomyelitis involving upper arm
73003	Acute osteomyelitis involving forearm
73004	Acute osteomyelitis involving hand
73005	Acute osteomyelitis involving pelvic region and thigh
73006	Acute osteomyelitis involving lower leg
73007	Acute osteomyelitis involving ankle and foot
73008	Acute osteomyelitis involving other specified sites
73009	Acute osteomyelitis involving multiple sites
73010	Chronic osteomyelitis, site unspecified
73011	Chronic osteomyelitis involving shoulder region
73012	Chronic osteomyelitis involving upper arm
73013	Chronic osteomyelitis involving forearm
73014	Chronic osteomyelitis involving hand
73015	Chronic osteomyelitis involving pelvic region and thigh
73016	Chronic osteomyelitis involving lower leg
73017	Chronic osteomyelitis involving ankle and foot
73018	Chronic osteomyelitis involving other specified sites
73019	Chronic osteomyelitis involving multiple sites
73020	Unspecified osteomyelitis, site unspecified

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When requesting reimbursement of HBO for the treatment of *thermal burns,* use the following diagnosis codes:

Diagnosis Code	Description
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa
94100	Burn of unspecified degree of unspecified site of face and head
94101	Burn of unspecified degree of ear (any part)
94102	Burn of unspecified degree of eye (with other parts of face, head, and neck)
94103	Burn of unspecified degree of lip(s)
94104	Burn of unspecified degree of chin
94105	Burn of unspecified degree of nose (septum)
94106	Burn of unspecified degree of scalp (any part)
94107	Burn of unspecified degree of forehead and cheek
94108	Burn of unspecified degree of neck
94109	Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck
94110	Erythema due to burn (first degree) of unspecified site of face and head
94111	Erythema due to burn (first degree) of ear (any part)
94112	Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
94113	Erythema due to burn (first degree) of lip(s)
94114	Erythema due to burn (first degree) of chin
94115	Erythema due to burn (first degree) of nose (septum)
94116	Erythema due to burn (first degree) of scalp (any part)
94117	Erythema due to burn (first degree) of forehead and cheek
94118	Erythema due to burn (first degree) of neck
94119	Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck
94120	Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site
94121	Blisters, with epidermal loss due to burn (second degree) of ear (any part)
94122	Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)
94123	Blisters, with epidermal loss due to burn (second degree) of lip(s)
94124	Blisters, with epidermal loss due to burn (second degree) of chin
94125	Blisters, with epidermal loss due to burn (second degree) of nose (septum)
94126	Blisters, with epidermal loss due to burn (second degree) of scalp (any part)
94127	Blisters, with epidermal loss due to burn (second degree) of forehead and cheek
94128	Blisters, with epidermal loss due to burn (second degree) of neck
94129	Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck
94130	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
94131	Full-thickness skin loss due to burn (third degree NOS) of ear (any part)
94132	Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
94133	Full-thickness skin loss due to burn (third degree NOS) of lip(s)
94134	Full-thickness skin loss due to burn (third degree NOS) of chin
94135	Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
94136	Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
94137	Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
94138	Full-thickness skin loss due to burn (third degree NOS) of neck

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Diagnosis Code	Description
94139	Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part

Diagnosis Code	Description
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part
94200	Burn of unspecified degree of unspecified site of trunk
94201	Burn of unspecified degree of breast
94202	Burn of unspecified degree of chest wall, excluding breast and nipple
94203	Burn of unspecified degree of abdominal wall
94204	Burn of unspecified degree of back (any part)
94205	Burn of unspecified degree of genitalia
94209	Burn of unspecified degree of other and multiple sites of trunk
94210	Erythema due to burn (first degree) of unspecified site of trunk
94211	Erythema due to burn (first degree) of breast
94212	Erythema due to burn (first degree) of chest wall, excluding breast and nipple
94213	Erythema due to burn (first degree) of abdominal wall
94214	Erythema due to burn (first degree) of back (any part)
94215	Erythema due to burn (first degree) of genitalia
94219	Erythema due to burn (first degree) of other and multiple sites of trunk

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Diagnosis Code	Description
94220	Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk
94221	Blisters with epidermal loss due to burn (second degree) of breast
94222	Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
94223	Blisters with epidermal loss due to burn (second degree) of abdominal wall
94224	Blisters with epidermal loss due to burn (second degree) of back (any part)
94225	Blisters with epidermal loss due to burn (second degree) of genitalia
94229	Blisters with epidermal loss due to burn (second degree) of other and multiple sites of trunk
94230	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk
94231	Full-thickness skin loss due to burn (third degree NOS) of breast
94232	Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple
94233	Full-thickness skin loss due to burn (third degree NOS) of abdominal wall
94234	Full-thickness skin loss due to burn (third degree NOS) of back (any part)
94235	Full-thickness skin loss due to burn (third degree NOS) of genitalia
94239	Full-thickness skin loss due to burn (third degree NOS) of other and multiple sites of trunk
94240	Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part
94241	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast
94242	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall
94243	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall
94244	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back
94245	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia
94249	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part
94250	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part
94251	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast
94252	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall
94253	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall
94254	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back
94255	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia
94259	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part
94300	Burn of unspecified degree of unspecified site of upper limb
94301	Burn of unspecified degree of forearm
94302	Burn of unspecified degree of elbow
94303	Burn of unspecified degree of upper arm
94304	Burn of unspecified degree of axilla
94305	Burn of unspecified degree of shoulder
94306	Burn of unspecified degree of scapular region
94309	Burn of unspecified degree multiple sites of upper limb, except wrist and hand
94310	Erythema due to burn (first degree) of unspecified site of upper limb

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Diagnosis Code	Description
94311	Erythema due to burn (first degree) of forearm
94312	Erythema due to burn (first degree) of elbow
94313	Erythema due to burn (first degree) of upper arm
94314	Erythema due to burn (first degree) of axilla
94315	Erythema due to burn (first degree) of shoulder
94316	Erythema due to burn (first degree) of scapular region
94319	Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand
94320	Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb
94321	Blisters with epidermal loss due to burn (second degree) of forearm
94322	Blisters with epidermal loss due to burn (second degree) of elbow
94323	Blisters with epidermal loss due to burn (second degree) of upper arm
94324	Blisters with epidermal loss due to burn (second degree) of axilla
94325	Blisters with epidermal loss due to burn (second degree) of shoulder
94326	Blisters with epidermal loss due to burn (second degree) of scapular region
94329	Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand
94330	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb
94331	Full-thickness skin loss due to burn (third degree NOS) of forearm
94332	Full-thickness skin loss due to burn (third degree NOS) of elbow
94333	Full-thickness skin loss due to burn (third degree NOS) of upper arm
94334	Full-thickness skin loss due to burn (third degree NOS) of axilla
94335	Full-thickness skin loss due to burn (third degree NOS) of shoulder
94336	Full-thickness skin loss due to burn (third degree NOS) of scapular region
94339	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand
94340	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part
94341	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm
94342	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow
94343	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm
94344	Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla
94345	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder
94346	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula
94349	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb
94350	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part
94351	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm
94352	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow
94353	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm
94354	Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla
94355	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder
94356	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula

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Diagnosis Code	Description
94359	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb
94400	Burn of unspecified degree of unspecified site of hand
94401	Burn of unspecified degree of single digit (finger (nail) other than thumb
94402	Burn of unspecified degree of thumb (nail)
94403	Burn of unspecified degree of two or more digits of hand, not including thumb
94404	Burn of unspecified degree of two or more digits of hand, including thumb
94405	Burn of unspecified degree of palm of hand
94406	Burn of unspecified degree of back of hand
94407	Burn of unspecified degree of wrist
94408	Burn of unspecified degree of multiple sites of wrist(s) and hand(s)
94410	Erythema due to burn (first degree) of unspecified site of hand
94411	Erythema due to burn (first degree) of single digit (finger (nail) other than thumb
94412	Erythema due to burn (first degree) of thumb (nail)
94413	Erythema due to burn (first degree) of two or more digits of hand, not including thumb
94414	Erythema due to burn (first degree) of two or more digits of hand including thumb
94415	Erythema due to burn (first degree) of palm of hand
94416	Erythema due to burn (first degree) of back of hand
94417	Erythema due to burn (first degree) of wrist
94418	Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)
94420	Blisters with epidermal loss due to burn (second degree) of unspecified site of hand
94421	Blisters with epidermal loss due to burn (second degree) of single digit (finger (nail) other than thumb
94422	Blisters with epidermal loss due to burn of (second degree) of thumb (nail)
94423	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb
94424	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand including thumb
94425	Blisters with epidermal loss due to burn (second degree) of palm of hand
94426	Blisters with epidermal loss due to burn (second degree) of back of hand
94427	Blisters with epidermal loss due to burn (second degree) of wrist
94428	Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)
94430	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand
94431	Full-thickness skin loss due to burn (third degree NOS) of single digit (finger (nail) other than thumb
94432	Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)
94433	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb
94434	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb
94435	Full-thickness skin loss due to burn (third degree NOS) of palm of hand
94436	Full-thickness skin loss due to burn (third degree NOS) of back of hand
94437	Full-thickness skin loss due to burn (third degree NOS) of wrist
94438	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)
94440	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand
94441	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail) other than thumb, without mention of loss of finger
94442	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb

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Diagnosis Code	Description
94443	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers
94444	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers
94445	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm
94446	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand
94447	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist
94448	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), without mention of loss of a body part
94450	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand
94451	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail) other than thumb, with loss of finger
94452	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb
94453	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers
94454	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers
94455	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand
94456	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand
94457	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist
94458	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part

Diagnosis Code	Description
94500	Burn of unspecified degree of unspecified site of lower limb (leg)
94501	Burn of unspecified degree of toe(s) (nail)
94502	Burn of unspecified degree of foot
94503	Burn of unspecified degree of ankle
94504	Burn of unspecified degree of lower leg
94505	Burn of unspecified degree of knee
94506	Burn of unspecified degree of thigh (any part)
94509	Burn of unspecified degree of multiple sites of lower limb(s)
94510	Erythema due to burn (first degree) of unspecified site of lower limb (leg)
94511	Erythema due to burn (first degree) of toe(s) (nail)
94512	Erythema due to burn (first degree) of foot
94513	Erythema due to burn (first degree) of ankle
94514	Erythema due to burn (first degree) of lower leg
94515	Erythema due to burn (first degree) of knee
94516	Erythema due to burn (first degree) of thigh (any part)
94519	Erythema due to burn (first degree) of multiple sites of lower limb(s)
94520	Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)
94521	Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)
94522	Blisters with epidermal loss due to burn (second degree) of foot
94523	Blisters with epidermal loss due to burn (second degree) of ankle
94524	Blisters with epidermal loss due to burn (second degree) of lower leg
94525	Blisters with epidermal loss due to burn (second degree) of knee
94526	Blisters with epidermal loss due to burn (second degree) of thigh (any part)
94529	Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)
94530	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb

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Diagnosis Code	Description
94531	Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)
94532	Full-thickness skin loss due to burn (third degree NOS) of foot
94533	Full-thickness skin loss due to burn (third degree NOS) of ankle
94534	Full-thickness skin loss due to burn (third degree NOS) of lower leg
94535	Full-thickness skin loss due to burn (third degree NOS) of knee
94536	Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)
94539	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)
94540	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part
94541	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)
94542	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot
94543	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle
94544	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg
94545	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee
94546	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh
94549	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part
94550	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part
94551	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)
94552	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot

Diagnosis Code	Description
94553	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle
94554	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg
94555	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee
94556	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh
94559	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part
9460	Burns of multiple specified sites, unspecified degree
9461	Erythema due to burn (first degree) of multiple specified sites
9462	Blisters with epidermal loss due to burn (second degree) of multiple specified sites
9463	Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites
9464	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part
9465	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part
9470	Burn of mouth and pharynx
9471	Burn of larynx, trachea, and lung
9472	Burn of esophagus
9473	Burn of gastrointestinal tract
9474	Burn of vagina and uterus
9478	Burn of other specified sites of internal organs
9479	Burn of internal organs, unspecified site
94800	Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94810	Burn (any degree) involving 10–19 percent of body surface with third degree burn of less than 10 percent or unspecified amount

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Diagnosis Code	Description
94811	Burn (any degree) involving 10–19 percent of body surface with third degree burn of 10–19 percent
94820	Burn (any degree) involving 20–29 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94821	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 10–19 percent
94822	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 20–29 percent
94830	Burn (any degree) involving 30–39 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94831	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 10–19 percent
94832	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 20–29 percent
94833	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 30–39 percent
94840	Burn (any degree) involving 40–49 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94841	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 10–19 percent
94842	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 20–29 percent
94843	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 30–39 percent
94844	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 40–49 percent
94850	Burn (any degree) involving 50–59 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94851	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 10–19 percent
94852	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 20–29 percent

Diagnosis Code	Description
94853	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 30–39 percent
94854	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 40–49 percent
94855	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 50–59 percent
94860	Burn (any degree) involving 60–69 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94861	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 10–19 percent
94862	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 20–29 percent
94863	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 30–39 percent
94864	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 40–49 percent
94865	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 50–59 percent
94866	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 60–69 percent
94870	Burn (any degree) involving 70–79 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94871	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 10–19 percent
94872	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 20–29 percent
94873	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 30–39 percent
94874	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 40–49 percent
94875	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 50–59 percent
94876	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 60–69 percent

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Diagnosis Code	Description
94877	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 70–79 percent
94880	Burn (any degree) involving 80–89 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94881	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 10–19 percent
94882	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 20–29 percent
94883	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 30–39 percent
94884	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 40–49 percent
94885	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 50–59 percent
94886	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 60–69 percent
94887	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 70–79 percent
94888	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 80–89 percent
94890	Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount
94891	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10–19 percent
94892	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20–29 percent
94893	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30–39 percent
94894	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40–49 percent
94895	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50–59 percent
94896	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60–69 percent
94897	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70–79 percent
94898	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80–89 percent
94899	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface
9490	Burn of unspecified site, unspecified degree
9491	Erythema due to burn (first degree), unspecified site
9492	Blisters with epidermal loss due to burn (second degree), unspecified site
9493	Full-thickness skin loss due to burn (third degree NOS), unspecified site
9494	Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part
9495	Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part

An HBO that exceeds one session per day, any provider, is denied.

36.4.21 Injections

Injections are reimbursed as access-based fees under the physician fee schedule in accordance with 1 TAC §355.8085. Texas Medicaid fee decisions for blood clotting factors, pneumococcal and hepatitis B, injections, infusion drugs furnished through an item of implanted DME, and new injections are based on 89.5 percent of the average wholesale price (AWP). New injections are those that received approval for marketing by the FDA within the past 12 months.

For certain, specific injections studied by the Office of Inspector General (OIG)/General Accounting Office (GAO), Medicaid fee decisions are based on the recommended percentages of AWP resulting from those studies (Table 1 in §20 of Chapter 17 of the *Medicare Claims Processing Manual*, Pub. 100–04). For the remaining injections not listed above, Medicaid fee decisions are based on 85.0 percent of the AWP.

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

Payments for injections are excluded from the 2.5 percent Medicaid payment reduction.

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Prescriptions are covered under the Texas Medicaid VDP. The reimbursement methodology for pharmacy services is located at 1 TAC §§355.8541 through 355.8551. The dispensing fee (1 TAC §355.8551) was reduced by 2.5 percent, effective October 16, 2003.

Injection administration billed by a provider is reimbursed separately from the medication. Injection administration should be billed using procedure code 1-90772.

Injection administration is not payable to outpatient hospitals. Procedure code 1-90772 is limited to one per day, unless the claim clearly indicates the medications could not be mixed. Procedure code 1-90772 is paid in addition to an E/M or consultation visit to ensure that each injection receives one administration fee regardless of the dosage.

Providers billing injections for clients younger than 21 years of age are to bill using the appropriate national code.

Use oral medication in preference to injectable medication in the office and outpatient hospital unless one of the following applies:

- No acceptable oral equivalent is available.
- Injectable medication is the standard treatment of choice.
- The oral route is contraindicated.
- The patient has a temperature over 102 degrees Fahrenheit (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.
- The patient has demonstrated noncompliance with orally prescribed medication that is documented on the claim and in the medical record.
- Previously attempted oral medication regimens have proved ineffective as supported by the medical record.
- It is an emergency situation.

Injections into joints, bursae, tendon sheaths, or trigger points are only payable for acute conditions or acute flare-ups of chronic conditions. For reimbursement, modifier AT must be used to indicate acute conditions. If a steroid medication is injected in one of the above areas, modifier AT or KX must also be used on the charge for the drug to indicate an acute condition. When performed for a chronic condition, these procedures are denied.

The acute condition does not apply to allergy injections or medically necessary injections into joints, bursae, tendon sheaths, or trigger points when used to treat acute conditions or the acute flare-up of a chronic condition.

Oral medications are not a benefit of the Texas Medicaid Program except when given in the hospital or physician's office, or when obtained by prescription through the VDP. Take-home and self-administered drugs are not a Medicaid benefit except when provided to Medicaid clients through the VDP and should not be submitted to TMHP for payment.

Physicians billing for injectable antibiotic and steroid medications *must* indicate the appropriate modifier with the appropriate injection code. The code identifying the dose administered must be used for correct reimbursement. Multiples of codes should be billed if a code is not available to document the dose administered (for example, procedure code 1-J0290—use a quantity of *2* for 1,000 mg).

The ET and KX modifiers are acceptable. Use modifier KX to indicate:

- Oral route contraindicated or an acceptable oral equivalent is not available.
- Injectable medication is the accepted treatment of choice. Oral medication regimen has proven ineffective or is not applicable.
- The patient has a temperature over 102 degrees and a high level of antibiotic is needed immediately.
- Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.

The Texas Vaccines for Children (TVFC) Program provides vaccines for Medicaid clients who are younger than 19 years of age, according to the Recommended Childhood Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP]).

Refer to: "Vendor Drug Program" on page E-1 for more information.
"Immunizations" on page H-1.
"Immunizations" on page 43-23 for information on immunizations for infants and children.

36.4.21.1 Alatrofloxacin Mesylate (Trovan®)

Texas Medicaid follows the recommendation of the FDA about the use of intravenous alatrofloxacin mesylate, Trovan® . Trovan® is not reimbursed when provided in settings other than inpatient hospital. Trovan® should be reserved for use *only* in the treatment of patients who meet *all* the following treatment criteria:

- Have at least one of the following infections judged by the treating physician to be serious and life- or limb-threatening:
    - Nosocomial pneumonia
    - Community-acquired pneumonia
    - Complicated intra-abdominal infections (including post-surgical infections)
    - Gynecologic and pelvic infections
    - Complicated skin and skin-structure infections (including diabetic foot infections)
- Receive initial therapy in an inpatient health care facility
- The treating physician believes that, given the new safety information, the benefit of the product to the patient outweighs the risk

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36.4.21.2 Amifostine

Texas Medicaid covers Amifostine for reduction of the cumulative renal toxicity associated with administration of cisplatin in patients with advanced ovarian cancer or *nonsmall* cell lung cancer with documentation of a creatinine clearance of 50 or less and where no other chemotherapeutic agent can be used. Amifostine for injection may be considered for reimbursement through Texas Medicaid for the following indications: bone marrow toxicity, cisplatin-and cyclophosphamide-induced (prophylaxis), advanced solid tumors, head and neck carcinoma, malignant lymphoma, nonsmall cell lung cancer, myelodysplastic syndromes, nephrotoxicity, advanced ovarian carcinoma, melanoma, advanced solid tumors of nongerm cell origin, neurotoxicity, reduction in the incidence of mucositus in patients receiving radiation therapy, or radiation combined with chemotherapy, and to reduce in the incidence of xerostomia associated with post-operative radiation treatment of head and neck cancer, where the radiation port includes a substantial portion of the parotid glands. It may also be used to reduce the incidence of moderate-to-severe xerostomia in patients undergoing postoperative radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid glands. Use HCPCS procedure code 1-J0207.

36.4.21.3 Anistreplase

Reimbursement of procedure code 1-J0350 is limited to hospital facilities, freestanding radiation treatment centers (POS 5), and the office setting (POS 1). Anistreplase provided in the inpatient setting (POS 3) is part of the DRG reimbursement, and no separate payment is made.

Procedure code 1-J0350 is payable for the following diagnosis codes only:

Diagnosis Code	Description
41000	Acute myocardial infarction of antero-lateral wall, episode of care unspecified
41001	Acute myocardial infarction of antero-lateral wall, initial episode of care
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care
41020	Acute myocardial infarction of infero-lateral wall, episode of care unspecified
41021	Acute myocardial infarction of infero-lateral wall, initial episode of care
41030	Acute myocardial infarction of infero-posterior wall, episode of care unspecified
41031	Acute myocardial infarction of infero-posterior wall, initial episode of care
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41060	True posterior wall infarction, episode of care unspecified
41061	True posterior wall infarction, initial episode of care
41071	Subendocardial infarction, initial episode of care
41080	Acute myocardial infarction of other specified sites, episode of care unspecified
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41070	Subendocardial infarction, episode of care unspecified
41081	Acute myocardial infarction of other specified sites, initial episode of care
99673	Other complications due to renal dialysis device, implant, and graft

Procedure code 1-J0350 is denied when submitted with other diagnosis codes.

36.4.21.4 Antihemophilic Factor

Reimbursement for the following antihemophilic factor procedure codes is limited to the diagnosis codes of coagulation defects, noted in the second table below.

Reimbursement is available when the antihemophilic product is administered by or under the personal supervision of a physician in POS 1, 2, 5, or 8.

HCPCS Codes		
1-J7188	1-J7189	1-J7190
1-J7191	1-J7192	1-J7193
1-J7194	1-J7195	1-J7197
1-J7198	1-J7199	

Diagnosis Code	Description
2860	Congenital factor VIII disorder
2861	Congenital factor IX disorder

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Diagnosis Code	Description
2862	Congenital factor XI deficiency
2863	Congenital deficiency of other clotting factors
2864	Von Willebrand's disease
2865	Hemorrhagic disorder due to circulating anticoagulants
2866	Defibrination syndrome
2867	Acquired coagulation factor deficiency
2869	Other and unspecified coagulation defects
V8302	Symptomatic hemophilia A carrier

Reimbursement for Factor IX procedure codes 1-J7193 and 1-J7195 is limited to diagnosis code 2861, Congenital Factor IX disorder.

Reimbursement for procedure code 1-J7189 is limited to the following diagnosis codes:

Diagnosis Code	Description
2860	Congenital factor VIII disorder
2861	Congenital factor IX disorder
2863	Congenital deficiency of other clotting factors
2869	Other and unspecified coagulation defects

36.4.21.5 Bacillus Calmette-Guérin (BCG) Vaccine

Use CPT code 1-90585 when billing for BCG vaccine for tuberculosis, live, for percutaneous use (immunization).

Procedure code 1-90585 is payable for diagnosis code V032, Need for prophylactic vaccination and inoculation against bacterial diseases, tuberculosis (BCG).

Procedure code 1-J9031 and 1-90586 are payable for the following diagnosis codes:

Diagnosis Code	Description
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
2337	Carcinoma in situ of bladder

Procedure code 2-51720 may be reimbursed separately when billed for the same date of service.

36.4.21.6 Baclofen (Lioresal), Trial Injection and Pump Implantation/Catheter Insertion/Revision/Replacement

When billing for intrathecal baclofen on a trial basis, use procedure code 1-J0476.

Prior authorization is required for reimbursement of the Baclofen (Lioresal) trial injection and pump, implantation, catheter insertion/revision/replacement.

Epidural/subarachnoid infusion for chronic spasticity is allowed when prior authorized.

Reimbursement for procedure codes 2-62350, 2-62360, 2-62361, and 2-62362 require prior authorization. Providers must request prior authorization.

Initial evaluation includes age of onset of signs and symptoms, and other visits which are directly related to this request (If requesting baclofen, specify muscle groups affected, degree of spasticity). The following information is required with the request:

- Hospitalizations and other diagnoses
- Trial of intrathecal medication that is to be used. (e.g. baclofen, morphine sulfate, Dilaudid® [hydromophone HCl] or fentanyl)
- Type of surgical implantation with description of the device
- Periodic follow-up plan of care with reloading of pump and monitor changes in infusion rate
- Pertinent lab, X-ray results
- Client's weight (in kilograms)
- Family or client's role, participation, or compliance
- Follow-up evaluation of noninvasive treatments attempted, including medications, dosage route, frequency
- Expectation of benefit from procedure related to follow-up assessment to evaluate treatment goals

Separate payment for the device is *not* covered for the physician or the hospital.

Providers are to send prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: "Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section I" on page B-102.

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Use the following procedure codes when billing for epidural/subarachnoid catheter and drug administration:

Procedure Codes		
1-01996	2-62350	2-62351
2-62355	2-62360	2-62361
2-62362	2-62365	

Procedure codes 2-62350, 2-62355, 2-62360, 2-62361, 2-62362, and 2-62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 2-62350, 2-62355, 2-62360, 2-62361, 2-62362, and 2-62365 billed on the same day as an anesthesia procedure by the same physician, are denied as included in the total anesthesia time.

Procedure codes I-62367, I-62368, and 1-01996 are payable for the professional component. No payment is allowed for the technical component. Procedure codes I-62367 and I-62368 are payable in the office setting (POS 1).

36.4.21.7 Botulinum Toxin Type A

Procedure code 1-J0585 no longer requires prior authorization. It is payable for the following diagnosis codes:

Diagnosis Code	Description
3336	Genetic torsion dystonia
33381	Blepharospasm
33382	Orofacial dyskinesia
33383	Spasmodic torticollis
33384	Organic writers' cramp
33389	Other fragments of torsion dystonia
3341	Hereditary spastic paraplegia
340	Multiple sclerosis
3410	Neuromyelitis optica
3411	Schilder's disease
3418	Other demyelinating diseases of central nervous system
3419	Demyelinating disease of central nervous system, unspecified
34211	Spastic hemiplegia and hemiparesis affecting dominant side
34212	Spastic hemiplegia and hemiparesis affecting nondominant side
3430	Congenital diplegia
3431	Congenital hemiplegia
3432	Congenital quadriplegia
3433	Congenital monoplegia
3434	Infantile hemiplegia
3438	Other specified infantile cerebral palsy
3439	Infantile cerebral palsy, unspecified
34400	Quadriplegia, unspecified
34401	Quadriplegia, C1-C4, complete
34402	Quadriplegia, C1-C4, incomplete
34403	Quadriplegia, C5-C7, complete
34404	Quadriplegia, C5-C7, incomplete
34409	Other quadriplegia
3441	Paraplegia
3442	Diplegia of upper limbs
34430	Monoplegia of lower limb affecting unspecified side
34431	Monoplegia of lower limb affecting dominant side
34432	Monoplegia of lower limb affecting nondominant side
34440	Monoplegia of upper limb affecting unspecified side
34441	Monoplegia of upper limb affecting dominant side
34442	Monoplegia of upper limb affecting nondominant side
3445	Unspecified monoplegia
34460	Cauda equina syndrome without mention of neurogenic bladder
34461	Cauda equina syndrome with neurogenic bladder
34481	Locked-in state
34489	Other specified paralytic syndrome
3449	Paralysis, unspecified
3518	Other facial nerve disorders
37800	Esotropia, unspecified
37801	Monocular esotropia
37802	Monocular esotropia with A pattern
37803	Monocular esotropia with V pattern
37804	Monocular esotropia with other noncomitancies
37805	Alternating esotropia
37806	Alternating esotropia with A pattern
37807	Alternating esotropia with V pattern
37808	Alternating esotropia with other noncomitancies
37810	Exotropia, unspecified
37811	Monocular exotropia
37812	Monocular exotropia with A pattern
37813	Monocular exotropia with V pattern
37814	Monocular exotropia with other noncomitancies
37815	Alternating exotropia

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Diagnosis Code	Description
37816	Alternating exotropia with A pattern
37817	Alternating exotropia with V pattern
37818	Alternating exotropia with other noncomitancies
37820	Intermittent heterotropia, unspecified
37821	Intermittent esotropia, monocular
37822	Intermittent esotropia, alternating
37823	Intermittent exotropia, monocular
37824	Intermittent exotropia, alternating
37830	Heterotropia, unspecified
37831	Hypertropia
37832	Hypotropia
37833	Cyclotropia
37834	Monofixation syndrome
37835	Accommodative component in esotropia
37840	Heterophoria, unspecified
37841	Esophoria
37842	Exophoria
37843	Vertical heterophoria
37844	Cyclophoria
37845	Alternating hyperphoria
37850	Paralytic strabismus; paralytic strabismus, unspecified
37851	Third or oculomotor nerve palsy, partial
37852	Third or oculomotor nerve palsy, total
37853	Fourth or trochlear nerve palsy
37854	Sixth or abducens nerve palsy
37855	External ophthalmoplegia
37856	Total ophthalmoplegia
37860	Mechanical strabismus, unspecified
37861	Brown's (tendon) sheath syndrome
37862	Mechanical strabismus from other musculofascial disorders
37863	Limited duction associated with other conditions
37871	Duane's syndrome
37872	Progressive external ophthalmoplegia
37873	Strabismus in other neuromuscular disorders
37881	Palsy of conjugate gaze
37882	Spasm of conjugate gaze
37883	Convergence insufficiency or palsy
37884	Convergence excess or spasm
37885	Anomalies of divergence
37886	Internuclear ophthalmoplegia
37887	Other dissociated deviation of eye movements
3789	Unspecified disorder of eye movements
47875	Laryngeal spasm
47879	Other diseases of larynx
5300	Achalasia and cardiospasm
7235	Torticollis, unspecified
72885	Spasm of muscle
72982	Cramp of limb

If a quantity greater than 300 units of botulinim toxin is billed on the same day, supporting medical documentation must be maintained in the client's records for dosage used and is subject to retrospective review.

EMGs and/or visits, that are billed in conjunction with the administration of botulinum toxin type A, do not require prior authorization and are subject to current reimbursement guidelines. Any supplies billed by the physician for the administration of botulinum toxin type A are not paid separately.

36.4.21.8 Cidofovir

Cidofovir is a covered benefit when used for the treatment of cytomegalovirus (CMV) retinitis in clients with acquired immune deficiency syndrome (AIDS). Use diagnosis code 36320, Chorioretinitis, unspecified with procedure code 1-J0740.

36.4.21.9 Cladribine (Leustatin)

Procedure code 1-J9065 is a benefit of the Texas Medicaid Program when billed with diagnosis codes listed on the following table for hairy cell leukemia.

Diagnosis Code	Description
20240	Leukemic reticuloendotheliosis, unspecified site
20241	Leukemic reticuloendotheliosis involving lymph nodes of head, face, and neck
20242	Leukemic reticuloendotheliosis involving intrathoracic lymph nodes
20243	Leukemic reticuloendotheliosis involving intra-abdominal lymph nodes
20244	Leukemic reticuloendotheliosis involving lymph nodes of axilla and upper arm
20245	Leukemic reticuloendotheliosis involving lymph nodes of inguinal region and lower limb

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Diagnosis Code	Description
20246	Leukemic reticuloendotheliosis involving intrapelvic lymph nodes
20247	Leukemic reticuloendotheliosis involving spleen
20248	Leukemic reticuloendotheliosis involving lymph nodes of multiple sites

Cladribine is denied for all other diagnosis codes.

36.4.21.10 DaunoXome®

Liposomal encapsulated daunorubicin (DaunoXome®) for the treatment of advanced AIDS-related Kaposi's Sarcoma is reimbursable under the Texas Medicaid Program. Providers must use procedure code 1-J9999 and provide the drug name and dosage.

36.4.21.11 Deferoxamine Mesylate (Desferal®)

Deferoxamine Mesylate (Desferal®) is a drug that chelates iron by forming a stable complex that prevents the iron from entering into more chemical reactions. Deferoxamine Mesylate (Desferal®) is indicated for the treatment of acute iron intoxication and of chronic iron overload because of transfusion dependent anemias.

Use procedure code 1-J0895 when billing for Deferoxamine Mesylate (Desferal®).

Payment of Deferoxamine Mesylate (Desferal®) is limited to the following diagnosis codes:

Diagnosis Code	Description
28241	Sickle-cell thalassemia without crisis
28242	Sickle-cell thalassemia with crisis
28249	Other thalassemia
28260	Sickle-cell disease, unspecified
28261	Hb-SS disease without crisis
28262	Hb-SS disease with crisis
28263	Sickle-cell/Hb-C disease without crisis
28264	Sickle-cell/Hb-C disease with crisis
28268	Other sickle-cell disease without crisis
28269	Other sickle-cell disease with crisis
28522	Anemia in neoplastic disease
28529	Anemia of other chronic disease
2858	Other specified anemias
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
586	Renal failure, unspecified

Deferoxamine Mesylate (Desferal®) is denied for other than these listed diagnosis codes.

36.4.21.12 Denileukin Diftitox (Ontak®)

Procedure code 1-J9160 is reimbursed by the Texas Medicaid Program for clients with advanced or recurrent cutaneous T-cell lymphoma (payable, but not limited to diagnosis codes 20210 and 20220) with the CD25 component of IL-2 and failure of at least one type of traditional therapy. Documentation of diagnosis and treatment must be submitted with the claim. Denileukin diftitox is reimbursed only when given in the office or outpatient setting.

36.4.21.13 Docetaxel

Procedure code 1-J9170 is covered if billed using one of the following diagnosis codes:

Diagnosis Code	Description
1620	Malignant neoplasm of the trachea
1622	Malignant neoplasm of the main bronchus
1623	Malignant neoplasm of the upper lobe, bronchus, or lung
1624	Malignant neoplasm of the middle lobe, bronchus, or lung
1625	Malignant neoplasm of the lower lobe, bronchus, or lung
1628	Malignant neoplasm of other parts of bronchus, or lung
1629	Malignant neoplasm of bronchus and lung, unspecified
1740	Malignant neoplasm nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast

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Diagnosis Code	Description
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1830	Malignant neoplasm of ovary
1970	Secondary malignant neoplasm of lung
1971	Secondary malignant neoplasm of mediastinum
1972	Secondary malignant neoplasm of pleura
1977	Malignant neoplasm of liver, secondary
1982	Secondary malignant neoplasm of skin
1983	Secondary malignant neoplasm of brain and spinal cord
1985	Secondary malignant neoplasm of bone and bone marrow
1986	Secondary malignant neoplasm of ovary
19881	Secondary malignant neoplasm of breast
19889	Secondary malignant neoplasm of other specified sites

36.4.21.14 Dolasetron Mesylate (Anzemet®)

When billing for dolasetron mesylate (Anzemet®), use procedure code 1-J1260. Procedure code 1-J1260 is reimbursed at $15.50.

36.4.21.15 Epoetin Alfa (Erythropoietin; EPO)

Erythropoietin alfa or epoetin alfa (EPO) is a glycoprotein that stimulates red blood cell formation and production of the precursor red blood cells of bone marrow. EPO is indicated for:

- Anemia associated with chronic renal failure, including clients on dialysis (end-stage renal disease [ESRD]) and clients not on dialysis. In chronic ESRD clients, the increased blood urea nitrogen (BUN) impairs the production of EPO, leading to a chronic anemia.
- Anemia related to therapy with zidovudine (AZT) in HIV-infected patients.
- Anemia because of the effects of concomitantly administered chemotherapy in patients with nonmyeloid malignancies.
- Anemia related to rheumatoid arthritis.

Procedure code 1-J0885 is payable for the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
20300	Multiple myeloma, without mention of remission
20301	Multiple myeloma, in remission
2733	Macroglobulinemia
2800	Iron deficiency anemia secondary to blood loss (chronic)
2801	Iron deficiency anemia secondary to inadequate dietary iron intake
2808	Other specified iron deficiency anemias
2809	Iron deficiency anemia, unspecified
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis
58281	Chronic glomerulonephritis in diseases classified elsewhere
58289	Other chronic glomerulonephritis with specified pathological lesion in kidney
5829	Chronic glomerulonephritis with unspecified pathological lesion in kidney
5851	Chronic kidney disease, Stage I

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Diagnosis Code	Description
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
586	Renal failure, unspecified
7140	Rheumatoid arthritis
79001	Precipitous drop in hematocrit
99680	Complications of unspecified transplanted organ
99811	Hemorrhage complicating a procedure
V5811	Encounter for antineoplastic chemotherapy
V5812	Encounter for immunotherapy for neoplastic condition

The following diagnosis codes may be used to bill for treatment of anemia associated with ESRD patients receiving dialysis. These EPO procedure codes are for a quantity of 1 for every 1,000 units. The exact dose should be stated on the claim. For example, if a client has a hematocrit (HCT) of 34 percent with a diagnosis of ESRD and is given 5,000 units of EPO, bill a quantity of 5 with procedure code 1-J0886:

Diagnosis Code	Description
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5859	Chronic kidney disease, unspecified
586	Renal failure, unspecified
5889	Unspecified disorder resulting from impaired renal function
V420	Kidney replaced by transplant
V451	Postsurgical renal dialysis status
V4983	Awaiting Organ Transplant Status
V560	Aftercare involving extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V568	Aftercare involving other dialysis
V5844	Aftercare following organ transplant

EPO is limited to three injections per calendar week (Sunday through Saturday).

EPO is payable in the following places of service:

POS	Description
1	Office
2	Home
5	Outpatient hospital

Darbepoetin

Darbepoetin alfa is an erythropoiesis-stimulating protein closely related to EPO. Darbepoetin stimulates erythropoiesis by the same mechanism as endogenous EPO. EPO is produced in the kidney and released into the bloodstream in response to hypoxia. It interacts with progenitor stem cells to increase erythrocyte production. Darbepoetin codes 1-J0881 and/or 1-J0882 will be limited to 500 units per day (500mcg). Darbepoetin alfa should be administered once a week if the patient was receiving EPO two to three times weekly and once every two weeks if the patient was receiving EPO once per week.

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Darbeoptin will be limited to the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
20300	Multiple myeloma, without mention of remission
20301	Multiple myeloma, in remission
23872	Low grade myelodysplastic syndrome lesions
23873	High grade myelodysplastic syndrome lesions
23874	Myelodysplastic syndrome with 5q deletion
23875	Myelodysplastic syndrome, unspecified
23876	Myelofibrosis with myeloid metaplasia
23879	Other lymphatic and hematopoietic tissues
2733	Macroglobulinemia
2800	Iron deficiency anemia secondary to blood loss (chronic)
2830	Autoimmune hemolytic anemias
28409	Other neutropenia
2848	Other specified aplastic anemias
2849	Aplastic anemia, unspecified
2851	Acute posthemorrhagic anemia
2859	Anemia, unspecified
7140	Rheumatoid arthritis
79001	Precipitous drop in hematocrit
99680	Complications of unspecified transplanted organ
99811	Hemorrhage complicating a procedure
V420	Kidney replaced by transplant
V451	Postsurgical renal dialysis status
V560	Aftercare involving extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V568	Aftercare involving other dialysis
V5811	Encounter for antineoplastic chemotherapy
V5812	Encounter for immunotherapy for neoplastic condition

36.4.21.16 Gamma Globulin/Immune Globulin

Gamma globulin procedure codes 1-J1460, 1-J1470, 1-J1480, 1-J1490, 1-J1500, 1-J1510, 1-J1520, 1-J1530, 1-J1540, 1-J1550, 1-J1560, 1-J1566, 1-J1567, 1-J7504, and 1-J7511 are covered benefits for the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
20410	Lymphoid leukemia, chronic, without mention of remission
27789	Other specified disorders of metabolism
27900	Hypogammaglobulinemia, unspecified
27901	Selective IgA immunodeficiency
27902	Selective IgM immunodeficiency
27903	Other selective immunoglobulin deficiencies
27904	Congenital hypogammaglobulinemia
27905	Immunodeficiency with increased IgM
27906	Common variable immunodeficiency
27909	Other deficiency of humoral immunity
27910	Immunodeficiency with predominant T-cell defect, unspecified
27911	DiGeorge's syndrome
27912	Wiskott-Aldrich syndrome
27913	Nezelof's syndrome
27919	Other deficiency of cell-mediated immunity
2792	Combined immunity deficiency
2793	Unspecified immunity deficiency
2794	Autoimmune disease, not elsewhere classified
28409	Other constitutional aplastic anemia
28730	Primary thrombocytopenia, unspecified
28731	Immune thrombocytopenic purpura
28732	Evans' syndrome
28733	Congenital and hereditary thrombocytopenic purpura
28739	Other primary thrombocytopenia
3348	Other spinocerebellar diseases
340	Multiple sclerosis
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
3530	Brachial plexus lesions
3570	Acute infective polyneuritis

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Diagnosis Code	Description
35781	Chronic inflammatory demyelinating polyneuritis
35782	Critical illness polyneuropathy
35800	Myasthenia gravis without (acute) exacerbation
35801	Myasthenia gravis with (acute) exacerbation
3929	Rheumatic chorea without mention of heart involvement
4461	Acute febrile mucocutaneous lymph node syndrome (MCLS)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
586	Renal failure, unspecified
6463	Habitual aborter, currently pregnant
7103	Dermatomyositis
7104	Polymyositis
7140	Rheumatoid arthritis
79579	Other and unspecified nonspecific immunological findings
9895	Toxic effect of venom
V0179	Contact or exposure to other viral diseases
V0189	Contact with or exposure to communicable diseases, other communicable diseases
V0260	Carrier or suspected carrier of viral hepatitis, unspecified
V08	Asymptomatic human immunodeficiency virus (HIV) infection status
V4281	Bone marrow replaced by transplant
V4282	Peripheral stem cells replaced by transplant
V4283	Pancreas replaced by transplant
V4284	Organ or tissue replaced by transplant, intestines
V4289	Other specified organ or tissue replaced by transplant

The globulins listed in the following table are payable for clients younger than 3 years of age with a diagnosis of idiopathic thrombocytopenia (ITP) and a concurrent diagnosis of HIV/AIDS.

Procedure Codes		
1-J1460	1-J1470	1-J1480
1-J1490	1-J1500	1-J1510
1-J1520	1-J1530	1-J1540
1-J1550	1-J1560	1-J1566
1-J1567		

All claims with a primary diagnosis of HIV/AIDS suspend to Medical Policy for manual review of a concurrent diagnosis of ITP. If the client does not meet the age criteria, requests are considered by the medical director, or designee, on a case by case basis.

Immune globulin or gamimune (procedure codes 1-J1566 and 1-J1567) is an immunoglobulin preparation. It also is a covered benefit for those diagnosis codes listed previously.

36.4.21.17 Gemcitabine HCl (Gemzar®)

Gemzar® is a first-line treatment for patients with locally advanced or metastatic adenocarcinoma of the pancreas. Use and medical necessity of this chemotherapeutic agent should be determined by the provider in accordance with appropriate indications or approved criteria.

Max fee for procedure code 1-J9201 is $100.54. When billing for 1-J9201, the quantity administered, per 200 mg, must appear on the claim. For example, if a dose of 1,000 mg is administered, a quantity of 5 should appear on the claim.

36.4.21.18 Granisetron Hydrochloride

When billing for injection, granisetron hydrochloride, 100 mcg, use procedure code 1-J1626 reimbursed at $17.47. The quantity used, per 100 mcg, must appear on the claim. For example, if a dose of 800 mcg is administered, a quantity of 8 should appear on the claim.

Procedure code 1-J1626 is payable only for the following diagnosis codes:

Diagnosis Code	Description
V580	Radiotherapy
V5811	Encounter for antineoplastic chemotherapy
V5812	Encounter for immunotherapy for neoplastic condition
V661	Convalescence following radiotherapy
V662	Convalescence following chemotherapy

Effective August 1, 2005, hepatitis A vaccine is routinely recommended for all Texas children 2 through 18 years of age.

36.4.21.19 Hepatitis B Vaccine

The Texas Medicaid Program covers the hepatitis B vaccine and the hepatitis B immune globulin (HBIG) for those clients who are not otherwise covered by TVFC Program.

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Administration of the hepatitis B vaccine is indicated for immunization against infection caused by all known subtypes of the hepatitis B virus (HBV). The hepatitis B vaccine is medically necessary for patients who have been exposed to the HBV. This vaccine will not prevent hepatitis caused by other agents, such as hepatitis A, hepatitis C, or other viruses known to infect the liver.

The Texas Medicaid Program allows coverage of the hepatitis B vaccine for clients who are at high risk of contracting the disease.

Procedure codes 1-90740, 1-90746, and 1-90747 are payable for clients 19 years of age and older.

Procedure code 1-90772, Injection, sc/im is payable for the administration of the hepatitis B vaccines.

The immunization administration procedure codes 1-90471 and 1-90472 are not to be used for the administration of the hepatitis B vaccine.

Mentally retarded Medicaid-eligible individuals residing in a private (nonstate) institution for the mentally retarded (ICF-MR), are classified as at a continuing high risk for hepatitis B with an ongoing exposure potential. When provided and billed by the attending physician, Medicaid will allow coverage of hepatitis B vaccine for all inpatients of an ICF-MR (private) facility.

When the hepatitis B vaccine is provided to clients with end stage renal disease who are directly exposed, separate payment may be made as the vaccine and its administration are not included in dialysis services.

HBIG provides coverage for acute exposure to the HBV.

Procedure code 1-90371 is payable for 19 years of age and older.

Procedure code 1-90371 is covered for diagnosis code V0179, Contact or exposure to other viral diseases.

36.4.21.20 Vaccine Coverage under Texas Vaccines for Children (TVFC) Program

All children from birth through age 18 years are approved to be vaccinated against hepatitis B with vaccine supplied by the TVFC Program. It is not necessary for a client, 0 through 18 years of age, to be included in a hepatitis B high-risk group to be eligible for the state-supplied vaccine.

The ACIP recommends administration of the hepatitis B vaccine to newborns before discharge from the hospital. This is the accepted standard of care and will not be considered as a reason to upcode to a different DRG.

The administration of the hepatitis B vaccine to newborns is included in the DRG payment and will not be reimbursed separately.

TVFC provides hepatitis B vaccine free of charge to physicians, hospitals, birthing centers and THSteps providers for administration to Medicaid-eligible clients 0 through 18 years of age. For Medicaid clients who are 19 through 20 years of age, providers must purchase the vaccine. The Medicaid program will reimburse providers for the cost of the vaccine plus the administration fee.

Refer to: "Immunizations" on page H-1 for more information.
"Texas Health Steps (THSteps)" on page 43-1 for more information.

A distinction should be noted about proper billing. The billing codes in "Immunizations Billed Within THSteps Medical Checkups, Exception to Periodicity, and Follow-Up Visit" on page 43-10 and "Immunizations Billed Outside of THSteps Medical Checkups, Exception to Periodicity, or Follow-Up Visit" on page 43-10 are to be used when the client is covered by the THSteps Program or the vaccine the client receives is provided through the TVFC Program. In either case, the vaccine is provided at no cost, and providers are allowed only the $5 administration fee reimbursement.

36.4.21.21 Hormone Injections

The following hormone procedure codes are a benefit of the Texas Medicaid Program when billed with a valid and applicable diagnosis code that indicates the client's physical condition:

Procedure Codes		
1-J0725	1-J0900	1-J0970
1-J1000	1-J1051	1-J1055
1-J1056	1-J1060	1-J1070
1-J1080	1-J1380	1-J1390
1-J3120	1-J3130	1-J3140
1-J3150	1-J1435	1-J1410

Procedure code 1-J1055 is a benefit for females 10 through 55 years of age when billed for the following diagnosis codes:

Diagnosis Code	Description
V2501	General counseling on prescription of oral contraceptives
V2502	General counseling on initiation of other contraceptive measures
V2509	Other general counseling and advice on contraceptive management
V2540	Contraceptive surveillance, unspecified
V2541	Surveillance of contraceptive pill
V2549	Surveillance of other contraceptive method
V255	Insertion of implantable subdermal contraceptive
V258	Other specified contraceptive management
V259	Unspecified contraceptive management
V615	Multiparity

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Procedure code 1-J1056 is a benefit for females 10 through 55 years of age when billed for the following diagnosis codes. 1-J1056 is limited to once every 28 days.

Diagnosis Code	Description
V2501	General counseling on prescription of oral contraceptives
V2502	General counseling on initiation of other contraceptive measures
V2509	Other general counseling and advice on contraceptive management
V615	Multiparity

Growth Hormone

Vendor Drug services require prior authorization for outpatient prescriptions for biosynthetic growth hormone injections. Children with growth failure because of lack of adequate endogenous growth hormone secretion may be approved for therapy based on physician documentation of medical necessity.

Consideration for approval by Vendor Drug is based on the following criteria:

- Physical stature less than the third percentile on the growth chart
- Growth velocity 4 cm or less per year (5–10 years of age)
- Bone age a minimum of two years behind chronological age with epiphyses indicating growth potential
- Evidence of deficient growth hormone production on two pharmacological provocative tests indicating growth hormone deficiency
- Regular thyroid and other pituitary function studies (may be corrected with replacement therapy)
- Somatomedin C level or IGF/BP3

Females with Turner's Syndrome may be approved for growth hormone therapy without evidence of deficient growth hormone production on provocative testing if the other criteria are met. Documentation of chromosomal abnormality must be submitted.

Nutropin therapy may be approved for the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation with physician documentation of diagnosis and growth failure. Approval may be granted for up to a 12-month period. If an extension of benefits is requested, the provider must submit a progress report indicating growth and maturation.

Providers are to send requests for prior approval of somatrem (Protropin®) and somatropin (Nutropin® , Humatrope® , Saizen® , Genotropin®) to the following address:

Vendor Drug
Drug Use Review Unit
1100 West 49th Street
Austin, TX 78756-3174
Fax: 1-512-338-6462

36.4.21.22 Ibutilide Fumarate

Procedure code 1-J1742 is a covered benefit of Medicaid. This procedure code is covered for the following diagnosis codes:

Diagnosis Code	Description
42731	Atrial fibrillation
42732	Atrial flutter

No other diagnosis codes are covered for this procedure code.

36.4.21.23 Idarubicin/Idamycin PFS Injection

Idarubicin hydrochloride is available in ready-to-use 5-mg, 10-mg, and 20-mg powder dosages. The new powder form is payable under the existing procedure code 1-J9211. When submitting a claim for this drug, specify the used quantity and/or dose.

36.4.21.24 Imitrex

Imitrex should be billed using procedure code 1-J3030. Reimbursement is limited to:

Diagnosis Code	Description
34600	Classic migraine without mention of intractable migraine
34601	Classic migraine with mention of intractable migraine, so stated
34610	Common migraine without mention of intractable migraine
34611	Common migraine with mention of intractable migraine, so stated
34620	Variants of migraine, without mention of intractable migraine
34621	Variants of migraine with intractable migraine, so stated
34680	Other forms of migraine without mention of intractable migraine
34681	Other forms of migraine with intractable migraine, so stated
34690	Migraine unspecified without mention of intractable migraine
34691	Migraine, unspecified with intractable migraine, so stated

Procedure code 1-J3030 is denied for all other diagnosis codes.

Only use procedure code 1-J3030 when the drug is administered in the physician's office or the outpatient hospital by a physician or under the physician's direct supervision. Take-home medication for self-administration is a benefit of the Texas Medicaid Program *only* when provided to clients with Medicaid coverage through the VDP.

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36.4.21.25 Immunosuppressive Drugs

Coverage is allowed for FDA-approved intravenous immunosuppressive drugs used for immunosuppression after an approved Texas Medicaid organ transplant procedure. Benefits are limited to the one-year period following the date of the beneficiary's discharge from the hospital after an approved Texas Medicaid organ transplant, conditional on the client's Medicaid eligibility.

Intravenous immunosuppressive drugs administered by physicians or under their personal supervision are reimbursable to physicians in a physicians office, in the home setting, SNF, and a nonskilled nursing facility. These IV drugs may be reimbursed to the outpatient facility where they were administered. Immunosuppressive drugs administered in the inpatient hospital setting are included in the DRG reimbursement.

Coverage of immunosuppressive drugs includes, but is not limited to:

Procedure Codes		
1-J0480	1-J7501	1-J7504
1-J7505	1-J7511	1-J7516
1-J7525		

Procedure code 1-J7511 is restricted to the following diagnosis codes:

Diagnosis Code	Description
V420	Kidney replaced by transplant
V5844	Aftercare following organ transplant

Oral self-administered immunosuppressive drugs may be payable through the VDP.

Procedure code 1-J7525 is restricted to the following diagnosis codes:

Diagnosis Code	Description
V420	Kidney replaced by transplant
V427	Liver replaced by transplant
V5844	Aftercare following organ transplant

Procedure code 1-J0480 is restricted to the following diagnosis codes:

Diagnosis Code	Description
V420	Kidney replaced by transplant
V5844	Aftercare following organ transplant

36.4.21.26 Infliximab (Remicade)

Infliximab is a benefit for clients with an inadequate response to methotrexate therapy. Procedure code 1-J1745 is reimbursed for the following diagnosis codes:

Diagnosis Code	Description
5550	Regional enteritis of small intestine
5551	Regional enteritis of large intestine
5552	Regional enteritis of small intestine with large intestine
5559	Regional enteritis of unspecified site
5651	Anal fistula
56981	Fistula of intestine, excluding rectum and anus
7140	Rheumatoid arthritis
7141	Felty's syndrome
7142	Other rheumatoid arthritis with visceral or systemic involvement
71430	Chronic or unspecified polyarticular juvenile rheumatoid arthritis

Documentation supporting the client's inadequate response to methotrexate-only therapy must be maintained in the client's file. The documentation is subject to retrospective review.

36.4.21.27 Influenza Vaccine

TVFC will provide influenza vaccine for all eligible clients under 19 years of age as identified in the ACIP guidelines relating to the prevention and control of influenza.

Influenza vaccine is a covered benefit of the Texas Medicaid for clients who are not covered by the THSteps program, TVFC, or when the vaccine is not available through the TVFC. Providers are expected to follow the ACIP guidelines relating to Prevention and Control of Influenza. The procedure codes for billing influenza vaccine are 1-90655, 1-90656, 1-90657, and 1-90658.

In addition, the related immunization administration codes 1-90465, 1-90466, 1-90471, or 1-90472 must be billed. The procedure codes for these vaccines are processed as informational only, but must be included on the claim in order to be considered for reimbursement for the vaccine administration. Influenza vaccines that are not obtained from the TVFC Program (due to a shortage of the vaccine from the TVFC Program) will be considered for reimbursement only when using modifier U1 with the applicable influenza vaccine CPT procedure code.

36.4.21.28 Interferon Injections

The following interferon procedure codes are payable when billed with a covered diagnosis:

Procedure Codes		
1-J1825	1-J9212	1-J9213
1-J9214	1-J9215	1-J9216
1-Q3025	1-Q3026	

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The following diagnosis codes are payable for interferon injection:

Diagnosis Code	Description
07030	Viral hepatitis B without mention of hepatic coma, acute or unspecified, without mention of hepatitis delta
07031	Viral hepatitis B without mention of hepatic coma, acute or unspecified, with hepatitis delta
07051	Acute hepatitis C without mention of hepatic coma
07052	Hepatitis delta without mention of active hepatitis B disease or hepatic coma
07053	Hepatitis e without mention of hepatic coma
07054	Chronic hepatitis C without mention of hepatic coma
07059	Other specified viral hepatitis without mention of hepatic coma
07070	Unspecified viral hepatitis C without hepatic coma
07071	Unspecified viral hepatitis C with hepatic coma
07810	Viral warts, unspecified
1530	Malignant neoplasm of hepatic flexure
1531	Malignant neoplasm of transverse colon
1532	Malignant neoplasm of descending colon
1533	Malignant neoplasm of sigmoid colon
1534	Malignant neoplasm of cecum
1535	Malignant neoplasm of appendix vermiformis
1536	Malignant neoplasm of ascending colon
1537	Malignant neoplasm of splenic flexure
1538	Malignant neoplasm of other specified sites of large intestine
1539	Malignant neoplasm of colon, unspecified site
1720	Malignant melanoma of skin of lip
1721	Malignant melanoma of skin of eyelid, including canthus
1722	Malignant melanoma of skin of ear and external auditory canal
1723	Malignant melanoma of skin of other and unspecified parts of face
1724	Malignant melanoma of skin of scalp and neck
1725	Malignant melanoma of skin of trunk, except scrotum
1726	Malignant melanoma of skin of upper limb, including shoulder
1727	Malignant melanoma of skin of lower limb, including hip
1728	Malignant melanoma of other specified sites of skin
1729	Melanoma of skin, site unspecified
1730	Other malignant neoplasm of skin of lip
1731	Other malignant neoplasm of skin of eyelid, including canthus
1732	Other malignant neoplasm of skin of ear and external auditory canal
1733	Other malignant neoplasm of skin of other and unspecified parts of face
1734	Other malignant neoplasm of scalp and skin of neck
1735	Other malignant neoplasm of skin of trunk, except scrotum
1736	Other malignant neoplasm of skin of upper limb, including shoulder
1737	Other malignant neoplasm of skin of lower limb, including hip
1738	Other malignant neoplasm of other specified sites of skin
1739	Other malignant neoplasm of skin, site unspecified
1760	Kaposi's sarcoma, skin
1761	Kaposi's sarcoma, soft tissue
1762	Kaposi's sarcoma, palate
1763	Kaposi's sarcoma, gastrointestinal sites
1764	Kaposi's sarcoma, lung
1765	Kaposi's sarcoma, lymph nodes
1768	Kaposi's sarcoma, other specified sites
1769	Kaposi's sarcoma, unspecified site
1800	Malignant neoplasm of endocervix
1801	Malignant neoplasm of exocervix
1808	Malignant neoplasm of other specified sites of cervix
1809	Malignant neoplasm of cervix uteri, unspecified site
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder

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Diagnosis Code	Description
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
1890	Malignant neoplasm of kidney, except pelvis
1891	Malignant neoplasm of renal pelvis
1970	Secondary malignant neoplasm of lung
1975	Secondary malignant neoplasm of large intestine and rectum
1980	Secondary malignant neoplasm of kidney
1981	Secondary malignant neoplasm of other urinary organs
19882	Secondary malignant neoplasm of genital organs
20000	Reticulosarcoma, unspecified site
20001	Reticulosarcoma involving lymph nodes of head, face, and neck
20002	Reticulosarcoma involving intrathoracic lymph nodes
20003	Reticulosarcoma involving intra-abdominal lymph nodes
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma involving intrapelvic lymph nodes
20007	Reticulosarcoma involving spleen
20008	Reticulosarcoma involving lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspecified site
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes

Diagnosis Code	Description
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma involving spleen
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites
20080	Other named variants of lymphosarcoma and reticulosarcoma, unspecified site
20081	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of head, face, and neck
20082	Other named variants of lymphosarcoma and reticulosarcoma involving intrathoracic lymph nodes
20083	Other named variants of lymphosarcoma and reticulosarcoma involving intra-abdominal lymph nodes
20084	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of axilla and upper limb
20085	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb
20086	Other named variants of lymphosarcoma and reticulosarcoma involving intrapelvic lymph nodes
20087	Other named variants of lymphosarcoma and reticulosarcoma involving spleen
20088	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of multiple sites
20200	Nodular lymphoma, unspecified site
20201	Nodular lymphoma involving lymph nodes of head, face, and neck
20202	Nodular lymphoma involving intrathoracic lymph nodes
20203	Nodular lymphoma involving intra-abdominal lymph nodes
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb

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Diagnosis Code	Description
20206	Nodular lymphoma involving intrapelvic lymph nodes
20207	Nodular lymphoma involving spleen
20208	Nodular lymphoma involving lymph nodes of multiple sites
20210	Mycosis fungoides, unspecified site
20211	Mycosis fungoides involving lymph nodes of head, face, and neck
20212	Mycosis fungoides involving intratho-racic lymph nodes
20213	Mycosis fungoides involving intra-abdominal lymph nodes
20214	Mycosis fungoides involving lymph nodes of axilla and upper limb
20215	Mycosis fungoides involving lymph nodes of inguinal region and lower limb
20216	Mycosis fungoides involving intrapelvic lymph nodes
20217	Mycosis fungoides involving spleen
20218	Mycosis fungoides involving lymph nodes of multiple sites
20220	Sezary's disease, unspecified site
20221	Sezary's disease involving lymph nodes of head, face, and neck
20222	Sezary's disease involving intratho-racic lymph nodes
20223	Sezary's disease involving intra-abdominal lymph nodes
20224	Sezary's disease involving lymph nodes of axilla and upper limb
20225	Sezary's disease involving lymph nodes of inguinal region and lower limb
20226	Sezary's disease involving intrapelvic lymph nodes
20227	Sezary's disease involving spleen
20228	Sezary's disease involving lymph nodes of multiple sites
20240	Leukemic reticuloendotheliosis, unspecified site
20241	Leukemic reticuloendotheliosis involving lymph nodes of head, face, and neck
20242	Leukemic reticuloendotheliosis involving intrathoracic lymph nodes
20243	Leukemic reticuloendotheliosis involving intra-abdominal lymph nodes
20244	Leukemic reticuloendotheliosis involving lymph nodes of axilla and upper arm

Diagnosis Code	Description
20245	Leukemic reticuloendotheliosis involving lymph nodes of inguinal region and lower limb
20246	Leukemic reticuloendotheliosis involving intrapelvic lymph nodes
20247	Leukemic reticuloendotheliosis involving spleen
20248	Leukemic reticuloendotheliosis involving lymph nodes of multiple sites
20280	Other malignant lymphomas, unspec-ified site
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites
20300	Multiple myeloma, without mention of remission
20301	Multiple myeloma, in remission
20310	Plasma cell leukemia, without mention of remission
20311	Plasma cell leukemia, in remission
20380	Other immunoproliferative neoplasms, without mention of remission
20381	Other immunoproliferative neoplasms, in remission
20510	Myeloid leukemia, chronic, without mention of remission
20511	Myeloid leukemia, chronic, in remission
2121	Benign neoplasm of larynx
2303	Carcinoma in situ of colon
2331	Carcinoma in situ of cervix uteri
2337	Carcinoma in situ of bladder
2339	Carcinoma in situ of other and unspecified urinary organs

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Diagnosis Code	Description
2367	Neoplasm of uncertain behavior of bladder
2384	Polycythemia vera
23879	Other lymphatic and hematopoietic tissues
2394	Neoplasm of unspecified nature of bladder
2395	Neoplasm of unspecified nature of other genitourinary organs
2592	Carcinoid syndrome
28730	Primary thrombocytopenia, unspecified
2890	Polycythemia, secondary
28952	Splenic sequestration
28981	Primary hypercoagulable state
28982	Secondary hypercoagulable state
28989	Other specified diseases of blood and blood-forming organs
2899	Unspecified diseases of blood and blood-forming organs
57140	Chronic hepatitis, unspecified
57141	Chronic persistent hepatitis
57149	Other chronic hepatitis
V1052	Personal history of malignant neoplasm of kidney

Interferon injections are also covered for the following diagnoses:

- Procedure codes 1-J1825, 1-Q3025, and 1-Q3026 are payable only for diagnosis 340.
- Procedure codes 1-J9213 and 1-J9214 are payable for the following diagnosis codes:

Diagnosis Code	Description
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe
1912	Malignant neoplasm of temporal lobe
1913	Malignant neoplasm of parietal lobe
1914	Malignant neoplasm of occipital lobe
1915	Malignant neoplasm of ventricles
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site

- Procedure code 1-J9212 is payable only for diagnosis 07054.

Interferon injections for all other diagnosis codes are denied.

36.4.21.29 Intralesional Injection(s)

Payable diagnosis codes for intralesional injections include:

Diagnosis Code	Description
0780	Molluscum contagiosum
0850	Leishmaniasis visceral (kala-azar)
0851	Cutaneous leishmaniasis, urban
0852	Cutaneous leishmaniasis, Asian desert
0853	Cutaneous leishmaniasis, Ethiopian
0854	Cutaneous leishmaniasis, American
0855	Mucocutaneous leishmaniasis, (American)
0859	Leishmaniasis, unspecified
135	Sarcoidosis
69272	Acute dermatitis due to solar radiation
6953	Rosacea
6960	Psoriatic arthropathy
6961	Other psoriasis and similar disorders
6962	Parapsoriasis
6963	Pityriasis rosea
6964	Pityriasis rubra pilaris
6965	Other and unspecified pityriasis
6968	Other psoriasis and similar disorders
7014	Keloid scar
7015	Other abnormal granulation tissue
70583	Hidradenitis
7060	Acne varioliformis
7061	Other acne
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa
94100	Burn of unspecified degree of unspecified site of face and head

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Diagnosis Code	Description
94101	Burn of unspecified degree of ear (any part)
94102	Burn of unspecified degree of eye (with other parts of face, head, and neck)
94103	Burn of unspecified degree of lip(s)
94104	Burn of unspecified degree of chin
94105	Burn of unspecified degree of nose (septum)
94106	Burn of unspecified degree of scalp (any part)
94107	Burn of unspecified degree of forehead and cheek
94108	Burn of unspecified degree of neck
94109	Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck
94110	Erythema due to burn (first degree) of unspecified site of face and head
94111	Erythema due to burn (first degree) of ear (any part)
94112	Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
94113	Erythema due to burn (first degree) of lip(s)
94114	Erythema due to burn (first degree) of chin
94115	Erythema due to burn (first degree) of nose (septum)
94116	Erythema due to burn (first degree) of scalp (any part)
94117	Erythema due to burn (first degree) of forehead and cheek
94118	Erythema due to burn (first degree) of neck
94119	Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck
94120	Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site
94121	Blisters, with epidermal loss due to burn (second degree) of ear (any part)
94122	Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)
94123	Blisters, with epidermal loss due to burn (second degree) of lip(s)
94124	Blisters, with epidermal loss due to burn (second degree) of chin

Diagnosis Code	Description
94125	Blisters, with epidermal loss due to burn (second degree) of nose (septum)
94126	Blisters, with epidermal loss due to burn (second degree) of scalp (any part)
94127	Blisters, with epidermal loss due to burn (second degree) of forehead and cheek
94128	Blisters, with epidermal loss due to burn (second degree) of neck
94129	Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck
94130	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
94131	Full-thickness skin loss due to burn (third degree NOS) of ear (any part)
94132	Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
94133	Full-thickness skin loss due to burn (third degree NOS) of lip(s)
94134	Full-thickness skin loss due to burn (third degree NOS) of chin
94135	Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
94136	Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
94137	Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
94138	Full-thickness skin loss due to burn (third degree NOS) of neck
94139	Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part

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Diagnosis Code	Description
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek

Diagnosis Code	Description
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part
94200	Burn of unspecified degree of unspecified site of trunk
94201	Burn of unspecified degree of breast
94202	Burn of unspecified degree of chest wall, excluding breast and nipple
94203	Burn of unspecified degree of abdominal wall
94204	Burn of unspecified degree of back (any part)
94205	Burn of unspecified degree of genitalia
94209	Burn of unspecified degree of other and multiple sites of trunk
94210	Erythema due to burn (first degree) of unspecified site of trunk
94211	Erythema due to burn (first degree) of breast
94212	Erythema due to burn (first degree) of chest wall, excluding breast and nipple
94213	Erythema due to burn (first degree) of abdominal wall
94214	Erythema due to burn (first degree) of back (any part)
94215	Erythema due to burn (first degree) of genitalia
94219	Erythema due to burn (first degree) of other and multiple sites of trunk
94220	Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk
94221	Blisters with epidermal loss due to burn (second degree) of breast
94222	Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
94223	Blisters with epidermal loss due to burn (second degree) of abdominal wall
94224	Blisters with epidermal loss due to burn (second degree) of back (any part)
94225	Blisters with epidermal loss due to burn (second degree) of genitalia

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Diagnosis Code	Description
94229	Blisters with epidermal loss due to burn (second degree) of other and multiple sites of trunk
94230	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk
94231	Full-thickness skin loss due to burn (third degree NOS) of breast
94232	Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple
94233	Full-thickness skin loss due to burn (third degree NOS) of abdominal wall
94234	Full-thickness skin loss due to burn (third degree NOS) of back (any part)
94235	Full-thickness skin loss due to burn (third degree NOS) of genitalia
94239	Full-thickness skin loss due to burn (third degree NOS) of other and multiple sites of trunk
94240	Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part
94241	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast
94242	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall
94243	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall
94244	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back
94245	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia
94249	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part
94250	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part

Diagnosis Code	Description
94251	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast
94252	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall
94253	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall
94254	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back
94255	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia
94259	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part
94300	Burn of unspecified degree of unspecified site of upper limb
94301	Burn of unspecified degree of forearm
94302	Burn of unspecified degree of elbow
94303	Burn of unspecified degree of upper arm
94304	Burn of unspecified degree of axilla
94305	Burn of unspecified degree of shoulder
94306	Burn of unspecified degree of scapular region
94309	Burn of unspecified degree multiple sites of upper limb, except wrist and hand
94310	Erythema due to burn (first degree) of unspecified site of upper limb
94311	Erythema due to burn (first degree) of forearm
94312	Erythema due to burn (first degree) of elbow
94313	Erythema due to burn (first degree) of upper arm
94314	Erythema due to burn (first degree) of axilla
94315	Erythema due to burn (first degree) of shoulder
94316	Erythema due to burn (first degree) of scapular region

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Diagnosis Code	Description
94319	Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand
94320	Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb
94321	Blisters with epidermal loss due to burn (second degree) of forearm
94322	Blisters with epidermal loss due to burn (second degree) of elbow
94323	Blisters with epidermal loss due to burn (second degree) of upper arm
94324	Blisters with epidermal loss due to burn (second degree) of axilla
94325	Blisters with epidermal loss due to burn (second degree) of shoulder
94326	Blisters with epidermal loss due to burn (second degree) of scapular region
94329	Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand
94330	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb
94331	Full-thickness skin loss due to burn (third degree NOS) of forearm
94332	Full-thickness skin loss due to burn (third degree NOS) of elbow
94333	Full-thickness skin loss due to burn (third degree NOS) of upper arm
94334	Full-thickness skin loss due to burn (third degree NOS) of axilla
94335	Full-thickness skin loss due to burn (third degree NOS) of shoulder
94336	Full-thickness skin loss due to burn (third degree NOS) of scapular region
94339	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand
94340	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part
94341	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm
94342	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow

Diagnosis Code	Description
94343	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm
94344	Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla
94345	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder
94346	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula
94349	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb
94350	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part
94351	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm
94352	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow
94353	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm
94354	Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla
94355	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder
94356	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula
94359	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb
94400	Burn of unspecified degree of unspecified site of hand
94401	Burn of unspecified degree of single digit (finger (nail) other than thumb
94402	Burn of unspecified degree of thumb (nail)

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Diagnosis Code	Description
94403	Burn of unspecified degree of two or more digits of hand, not including thumb
94404	Burn of unspecified degree of two or more digits of hand, including thumb
94405	Burn of unspecified degree of palm of hand
94406	Burn of unspecified degree of back of hand
94407	Burn of unspecified degree of wrist
94408	Burn of unspecified degree of multiple sites of wrist(s) and hand(s)
94410	Erythema due to burn (first degree) of unspecified site of hand
94411	Erythema due to burn (first degree) of single digit (finger (nail) other than thumb
94412	Erythema due to burn (first degree) of thumb (nail)
94413	Erythema due to burn (first degree) of two or more digits of hand, not including thumb
94414	Erythema due to burn (first degree) of two or more digits of hand including thumb
94415	Erythema due to burn (first degree) of palm of hand
94416	Erythema due to burn (first degree) of back of hand
94417	Erythema due to burn (first degree) of wrist
94418	Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)
94420	Blisters with epidermal loss due to burn (second degree) of unspecified site of hand
94421	Blisters with epidermal loss due to burn (second degree) of single digit (finger (nail) other than thumb
94422	Blisters with epidermal loss due to burn of (second degree) of thumb (nail)
94423	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb
94424	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand including thumb
94425	Blisters with epidermal loss due to burn (second degree) of palm of hand
94426	Blisters with epidermal loss due to burn (second degree) of back of hand

Diagnosis Code	Description
94427	Blisters with epidermal loss due to burn (second degree) of wrist
94428	Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)
94430	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand
94431	Full-thickness skin loss due to burn (third degree NOS) of single digit (finger (nail) other than thumb
94432	Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)
94433	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb
94434	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb
94435	Full-thickness skin loss due to burn (third degree NOS) of palm of hand
94436	Full-thickness skin loss due to burn (third degree NOS) of back of hand
94437	Full-thickness skin loss due to burn (third degree NOS) of wrist
94438	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)
94440	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand
94441	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail) other than thumb, without mention of loss of finger
94442	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb
94443	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers
94444	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers
94445	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm

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Diagnosis Code	Description
94446	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand
94447	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist
94448	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), without mention of loss of a body part
94450	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand
94451	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail) other than thumb, with loss of finger
94452	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb
94453	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers
94454	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers
94455	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand
94456	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand
94457	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist
94458	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part
94500	Burn of unspecified degree of unspecified site of lower limb (leg)
94501	Burn of unspecified degree of toe(s) (nail)
94502	Burn of unspecified degree of foot
94503	Burn of unspecified degree of ankle
94504	Burn of unspecified degree of lower leg
94505	Burn of unspecified degree of knee

Diagnosis Code	Description
94506	Burn of unspecified degree of thigh (any part)
94509	Burn of unspecified degree of multiple sites of lower limb(s)
94510	Erythema due to burn (first degree) of unspecified site of lower limb (leg)
94511	Erythema due to burn (first degree) of toe(s) (nail)
94512	Erythema due to burn (first degree) of foot
94513	Erythema due to burn (first degree) of ankle
94514	Erythema due to burn (first degree) of lower leg
94515	Erythema due to burn (first degree) of knee
94516	Erythema due to burn (first degree) of thigh (any part)
94519	Erythema due to burn (first degree) of multiple sites of lower limb(s)
94520	Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)
94521	Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)
94522	Blisters with epidermal loss due to burn (second degree) of foot
94523	Blisters with epidermal loss due to burn (second degree) of ankle
94524	Blisters with epidermal loss due to burn (second degree) of lower leg
94525	Blisters with epidermal loss due to burn (second degree) of knee
94526	Blisters with epidermal loss due to burn (second degree) of thigh (any part)
94529	Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)
94530	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb
94531	Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)
94532	Full-thickness skin loss due to burn (third degree NOS) of foot
94533	Full-thickness skin loss due to burn (third degree NOS) of ankle
94534	Full-thickness skin loss due to burn (third degree NOS) of lower leg
94535	Full-thickness skin loss due to burn (third degree NOS) of knee

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Diagnosis Code	Description
94536	Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)
94539	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)
94540	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part
94541	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)
94542	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot
94543	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle
94544	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg
94545	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee
94546	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh
94549	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part
94550	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part
94551	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)
94552	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot
94553	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle
94554	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg
94555	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee

Diagnosis Code	Description
94556	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh
94559	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part
9460	Burns of multiple specified sites, unspecified degree
9461	Erythema due to burn (first degree) of multiple specified sites
9462	Blisters with epidermal loss due to burn (second degree) of multiple specified sites
9463	Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites
9464	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part
9465	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part
9470	Burn of mouth and pharynx
9471	Burn of larynx, trachea, and lung
9472	Burn of esophagus
9473	Burn of gastrointestinal tract
9474	Burn of vagina and uterus
9478	Burn of other specified sites of internal organs
9479	Burn of internal organs, unspecified site
94800	Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94810	Burn (any degree) involving 10–19 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94811	Burn (any degree) involving 10–19 percent of body surface with third degree burn of 10–19 percent
94820	Burn (any degree) involving 20–29 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94821	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 10–19 percent

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Diagnosis Code	Description
94822	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 20–29 percent
94830	Burn (any degree) involving 30–39 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94831	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 10–19 percent
94832	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 20–29 percent
94833	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 30–39 percent
94840	Burn (any degree) involving 40–49 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94841	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 10–19 percent
94842	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 20–29 percent
94843	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 30–39 percent
94844	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 40–49 percent
94850	Burn (any degree) involving 50–59 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94851	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 10–19 percent
94852	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 20–29 percent
94853	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 30–39 percent
94854	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 40–49 percent
94855	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 50–59 percent

Diagnosis Code	Description
94860	Burn (any degree) involving 60–69 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94861	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 10–19 percent
94862	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 20–29 percent
94863	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 30–39 percent
94864	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 40–49 percent
94865	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 50–59 percent
94866	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 60–69 percent
94870	Burn (any degree) involving 70–79 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94871	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 10–19 percent
94872	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 20–29 percent
94873	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 30–39 percent
94874	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 40–49 percent
94875	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 50–59 percent
94876	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 60–69 percent
94877	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 70–79 percent
94880	Burn (any degree) involving 80–89 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94881	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 10–19 percent

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Diagnosis Code	Description
94882	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 20–29 percent
94883	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 30–39 percent
94884	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 40–49 percent
94885	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 50–59 percent
94886	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 60–69 percent
94887	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 70–79 percent
94888	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 80–89 percent
94890	Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount
94891	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10–19 percent
94892	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20–29 percent
94893	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30–39 percent
94894	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40–49 percent
94895	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50–59 percent
94896	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60–69 percent
94897	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70–79 percent
94898	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80–89 percent
94899	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface
9490	Burn of unspecified site, unspecified degree
9491	Erythema due to burn (first degree), unspecified site
9492	Blisters with epidermal loss due to burn (second degree), unspecified site
9493	Full-thickness skin loss due to burn (third degree NOS), unspecified site
9494	Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part
9495	Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part

Intralesional injection(s) must be billed using procedure code 2-11900 or 2-11901.

36.4.21.30 Irinotecan

When billing for irinotecan, use procedure code 1-J9206, reimbursed at $118.21. The quantity administered, per 20 mg, must be present on the claim. For example, if a dose of 200 mg is administered, a quantity of 10 should appear on the claim.

36.4.21.31 Iron

The procedure codes for iron injection are 1-J1751, 1-J1752, 1-J1756, and 1-J2916 when billing for claims.

36.4.21.32 Iron Dextran

Procedure codes 1-J1751 and 1-J1752 are covered for the following diagnosis codes for renal diseases or conditions:

Diagnosis Code	Description
5800	Acute glomerulonephritis with lesion of proliferative glomerulonephritis
5804	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis
58081	Acute glomerulonephritis in diseases classified elsewhere

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Diagnosis Code	Description
58089	Acute glomerulonephritis with other specified pathological lesion in kidney
5809	Acute glomerulonephritis with unspecified pathological lesion in kidney
5810	Nephrotic syndrome with lesion of proliferative glomerulonephritis
5811	Nephrotic syndrome with lesion of membranous glomerulonephritis
5812	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis
5813	Nephrotic syndrome with lesion of minimal change glomerulonephritis
58181	Nephrotic syndrome in diseases classified elsewhere
58189	Other nephrotic syndrome with specified pathological lesion in kidney
5819	Nephrotic syndrome with unspecified pathological lesion in kidney
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis
58281	Chronic glomerulonephritis in diseases classified elsewhere
58289	Other chronic glomerulonephritis with specified pathological lesion in kidney
5829	Chronic glomerulonephritis with unspecified pathological lesion in kidney
5830	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis
5831	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis
5832	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis
5834	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis

Diagnosis Code	Description
5836	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis
5837	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis
58381	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere
58389	Other nephritis and nephropathy, not specified as acute or chronic, with specified pathological lesion in kidney
5839	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney
5845	Acute renal failure with lesion of tubular necrosis
5846	Acute renal failure with lesion of renal cortical necrosis
5847	Acute renal failure with lesion of renal medullary (papillary) necrosis
5848	Acute renal failure with other specified pathological lesion in kidney
5849	Acute renal failure, unspecified
5851	Chronic kidney disease, stage I
5852	Chronic kidney disease, stage II (mild)
5853	Chronic kidney disease, stage III (moderate)
5854	Chronic kidney disease, stage IV (severe)
5855	Chronic kidney disease, stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
586	Renal failure, unspecified
587	Renal sclerosis, unspecified
5880	Renal osteodystrophy
5881	Nephrogenic diabetes insipidus
58881	Secondary hyperparathyroidism (of renal origin)
58889	Other specified disorders resulting from impaired renal function
5889	Unspecified disorder resulting from impaired renal function
5890	Unilateral small kidney
5891	Bilateral small kidneys
5899	Small kidney, unspecified
59000	Chronic pyelonephritis without lesion of renal medullary necrosis

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Diagnosis Code	Description
59001	Chronic pyelonephritis with lesion of renal medullary necrosis
59010	Acute pyelonephritis without lesion of renal medullary necrosis
59011	Acute pyelonephritis with lesion of renal medullary necrosis
5902	Renal and perinephric abscess
5903	Pyeloureteritis cystica
59080	Pyelonephritis, unspecified
59081	Pyelitis or pyelonephritis in diseases classified elsewhere
5909	Infection of kidney, unspecified
591	Hydronephrosis
5920	Calculus of kidney
5921	Calculus of ureter
5929	Urinary calculus, unspecified
5930	Nephroptosis
5931	Hypertrophy of kidney
5932	Cyst of kidney, acquired
5933	Stricture or kinking of ureter
5934	Other ureteric obstruction
5935	Hydroureter
5936	Postural proteinuria
59370	Vesicoureteral reflux unspecified or without reflux nephropathy
59371	Vesicoureteral reflux with reflux nephropathy, unilateral
59372	Vesicoureteral reflux with reflux nephropathy, bilateral
59373	Other vesicoureteral reflux with reflux nephropathy NOS
59381	Vascular disorders of kidney
59382	Ureteral fistula
59389	Other specified disorders of kidney and ureter
5939	Unspecified disorder of kidney and ureter

Procedure codes 1-J1751 and 1-J1752 are covered for the following diagnosis codes for active hemorrhage:

Diagnosis Code	Description
4480	Hereditary hemorrhagic telangiectasia
4560	Esophageal varices with bleeding
4590	Hemorrhage, unspecified
5307	Gastroesophageal laceration-hemorrhage syndrome
53082	Esophageal hemorrhage
53100	Acute gastric ulcer with hemorrhage, without mention of obstruction
53101	Acute gastric ulcer with hemorrhage, with obstruction
53110	Acute gastric ulcer with perforation, without mention of obstruction
53111	Acute gastric ulcer with perforation, with obstruction
53120	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction
53121	Acute gastric ulcer with hemorrhage and perforation, with obstruction
53140	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction
53141	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction
53150	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction
53151	Chronic or unspecified gastric ulcer with perforation, with obstruction
53160	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction
53161	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction
53200	Acute duodenal ulcer with hemorrhage, without mention of obstruction
53201	Acute duodenal ulcer with hemorrhage, with obstruction
53210	Acute duodenal ulcer with perforation, without mention of obstruction
53211	Acute duodenal ulcer with perforation, with obstruction
53220	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction
53221	Acute duodenal ulcer with hemorrhage and perforation, with obstruction
53240	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction
53241	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction
53250	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction
53251	Chronic or unspecified duodenal ulcer with perforation, with obstruction

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Diagnosis Code	Description
53260	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction
53261	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction
53300	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction
53301	Acute peptic ulcer of unspecified site with hemorrhage, with obstruction
53310	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction
53311	Acute peptic ulcer of unspecified site with perforation, with obstruction
53320	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction
53321	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction
53340	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction
53341	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction
53350	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction
53351	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction
53360	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction
53361	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction
53400	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction
53401	Acute gastrojejunal ulcer, with hemorrhage, with obstruction
53410	Acute gastrojejunal ulcer with perforation, without mention of obstruction
53411	Acute gastrojejunal ulcer with perforation, with obstruction
53420	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction
53421	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction
53440	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction
53441	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction
53450	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction
53451	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction
53460	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction
53461	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction
53501	Acute gastritis with hemorrhage
53511	Atrophic gastritis with hemorrhage
53521	Gastric mucosal hypertrophy with hemorrhage
53531	Alcoholic gastritis with hemorrhage
53541	Other specified gastritis with hemorrhage
53551	Unspecified gastritis and gastroduodenitis with hemorrhage
53561	Duodenitis with hemorrhage
56202	Diverticulosis of small intestine with hemorrhage
56203	Diverticulitis of small intestine with hemorrhage
56212	Diverticulosis of colon with hemorrhage
56213	Diverticulitis of colon with hemorrhage
56985	Angiodysplasia of intestine with hemorrhage
5780	Hematemesis
5781	Blood in stool
5789	Hemorrhage of gastrointestinal tract, unspecified
7724	Gastrointestinal hemorrhage of fetus or newborn

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Procedure codes 1-J1751 and 1-J1752 are covered for the following diagnosis codes for anemia:

Diagnosis Code	Description
2800	Iron deficiency anemias; secondary to blood loss (chronic)
2801	Iron deficiency anemias; secondary to inadequate dietary iron intake
2808	Other specified iron deficiency anemias
2809	Iron deficiency anemia, unspecified
64820	Anemia of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64821	Anemia of mother, with delivery
64822	Anemia of mother, with delivery, with mention of postpartum complication
64823	Antepartum anemia
64824	Postpartum anemia

36.4.21.33 Iron Injections

Sodium Ferric Gluconate Complex in Sucrose (Ferrlecit)

Procedure code 1-J2916 is covered for the treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin (EPO) therapy. Sodium ferric gluconate complex is covered for the following diagnosis codes:

Diagnosis Code	Description
28521	Anemia in chronic kidney disease
5856	End stage renal disease

Iron Sucrose (Venofer)

Procedure code 1-J1756 is covered for the treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental EPO therapy. The following diagnosis codes are payable:

Diagnosis Code	Description
28521	Anemia in chronic kidney disease
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified

36.4.21.34 Joint Injections and Trigger Point Injections

Injections into joints should be coded using procedure codes 2-20600, 2-20605, 2-20610, and 2-20612.

Trigger point injections should be coded using procedure codes 2-20526, 2-20550, 2-20551, 2-20552, and 2-20553.

These procedures are valid only in the treatment of acute problems. Procedures for chronic diagnosis codes will be denied. The provider must use of the AT and KX modifiers to be reimbursed for the above procedures. Use modifier KX to indicate injection is medically necessary into joints, bursae, tendon sheaths, trigger points to treat an acute condition, or the acute flare up of a chronic condition.

36.4.21.35 Leuprolide Acetate (Lupron Depot®)

Leuprolide Acetate is a synthetic gonadotropin releasing hormone that has been found to be effective when administered at monthly intervals in treatment of endometriosis at a dosage of 3.75 mg and in the palliative treatment of prostatic cancer at the dosage of 7.5 mg, or 65 mg implant (annually). Procedure codes 1-J9217, 1-J1950, or 1-J9219 should be used when billing for Leuprolide Acetate.

Procedure code 1-J9217 is reimbursed when administered monthly for the following diagnosis codes:

Diagnosis Code	Description
185	Malignant neoplasm of prostate
19882	Secondary malignant neoplasm genital organs
2334	Carcinoma in situ of prostate
2591	Precocious sexual development and puberty, not elsewhere classified

Procedure code 1-J9217 is denied when billed more than once per month and for other than the diagnosis codes listed above.

Procedure code 1-J1950 is limited to once per month and the following diagnosis codes:

Diagnosis Code	Description
2180	Submucous leiomyoma of uterus
2181	Intramural leiomyoma of uterus
2182	Subserous leiomyoma of uterus
2189	Leiomyoma of uterus, unspecified
6170	Endometriosis of uterus
6171	Endometriosis of ovary
6172	Endometriosis of fallopian tube
6173	Endometriosis of pelvic peritoneum
6174	Endometriosis of rectovaginal septum and vagina
6175	Endometriosis of intestine
6176	Endometriosis in scar of skin

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Diagnosis Code	Description
6178	Endometriosis of other specified sites
6179	Endometriosis, site unspecified

Procedure code 1-J9218 is a benefit of the Texas Medicaid Program when administered by a physician in the office setting (POS 1). It is payable for the following diagnosis codes:

Diagnosis Code	Description
185	Malignant neoplasm of prostate
19882	Secondary malignant neoplasm genital organs
2334	Carcinoma in situ of prostate

Procedure code 1-J9218 is denied for other than the diagnosis codes listed above.

Procedure code 1-J9219 is payable once per year in the office and outpatient settings (POS 1 and 5), and payable for the following diagnosis codes:

Diagnosis Code	Description
185	Malignant neoplasm of prostate
2334	Carcinoma in situ of prostate

Procedure code 1-J9219 is denied when billed more than once per year and for diagnosis codes other than those listed above.

36.4.21.36 Linezolid

Effective for dates of service on or after September 1, 2000, Linezolid, a new class of antibiotic, is a benefit of the Texas Medicaid Program. The FDA-recommended uses of linezolid include:

- The treatment of vancomycin-resistant enterococcus faecium infections
- Nosocomial pneumonia
- Complicated and uncomplicated skin and skin structure infections
- Community-acquired pneumonia

Oral forms of linezolid are covered through the VDP.

Note: *Linezolid intravenous injection is covered only in the inpatient setting as a part of the DRG payment.*

36.4.21.37 Melphalan Hydrochloride

Procedure code 1-J9245 is reimbursed by Texas Medicaid when billed for the following diagnosis codes:

Diagnosis Code	Description
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1830	Malignant neoplasm of ovary
1860	Malignant neoplasm undescended testis
1869	Malignant neoplasm of other and unspecified testis
20300	Multiple myeloma without mention of remission
20301	Multiple myeloma in remission

Procedure code 1-J9245 is denied for all other diagnosis codes.

36.4.21.38 Nipent

Procedure code 1-J9268 is reimbursable by the Texas Medicaid Program for the treatment of adult patients with alpha interferon-refractory hairy cell leukemia. Alpha interferon-refractory disease is defined as a progressive disease after a minimum of three months of alpha interferon treatment or no response after six months of alpha interferon treatment. Payment of Nipent is limited to hairy cell leukemia for the following diagnosis codes:

Diagnosis Code	Description
20240	Leukemic reticuloendotheliosis, unspecified site
20241	Leukemic reticuloendotheliosis involving lymph nodes of head, face, and neck
20242	Leukemic reticuloendotheliosis involving intrathoracic lymph nodes
20243	Leukemic reticuloendotheliosis involving intra-abdominal lymph nodes
20244	Leukemic reticuloendotheliosis involving lymph nodes of axilla and upper arm
20245	Leukemic reticuloendotheliosis involving lymph nodes of inguinal region and lower limb

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Diagnosis Code	Description
20246	Leukemic reticuloendotheliosis involving intrapelvic lymph nodes
20247	Leukemic reticuloendotheliosis involving spleen
20248	Leukemic reticuloendotheliosis involving lymph nodes of multiple sites

Nipent injections for all other diagnosis codes are denied.

36.4.21.39 Omalizumab

Omalizumab is an injectable drug that is FDA approved for the treatment of clients 12 years of age and older with severe asthma. Omalizumab is a benefit to Medicaid-eligible clients when medically necessary and must be prior authorized. THSteps-eligible clients under age 12 years will be considered on an exception basis through CCP.

When requesting prior authorization, the exact dosage must be included with the request using procedure code J2357. Doses and dosing frequency are determined by body weight and by serum IgE level (IU/mL) measured before the start of the treatment. Each prior authorization of Omalizumab is based on provider documentation with the following medical necessity criteria:

- Diagnosis of asthma
- Age 12 years or older
- Documentation of positive skin test or Radioabsorbent assay test (RAST) to a perennial (not seasonal) aeroallergen within the past 36 months
- Total IgE level greater than 30 IU/ml but less than 700 IU/ml within the past 12 months
- Documentation of appropriate dose of inhaled steroid prescribed (roughly equivalent to greater than or equal to 660 microgram/day of Fluticasone [adult] or comparable dose of other inhaled steroid; based on the National Asthma Educational Prevention Program Expert Panel)
- Documentation of patient compliance with inhaled steroid regimen
- Clinical evidence of inadequate asthma control. This evidence may include:
  - dependence upon continuous systemic steroids, maximal inhaled steroid regimen with frequent systemic steroid pulses
  - or significantly declining pulmonary function test, or frequent hospitalizations for severe asthma exacerbations in the face of adequate maximal standard therapy and patient has to have been on daily therapy for persistent asthma for at least one year, with daily use of beta agonist.
- A pulmonary function test (performed within the last year) must demonstrate a Forced Expiratory Volume (FEV) 1.0 less than 80 percent of predicted in conjunction with FEV 1.0/FVC ratio<0.7 of pulmonary function test; and results demonstrating on the same test a 12 percent or greater post-Bronchodilator improvement of FEV 1.0.
- Pulmonary function tests must have been performed within the prior 12 months and be documented for all clients when requesting prior authorization for Omalizumab. Exceptions may be considered with documentation of medical reasons as to why the test cannot be performed, and with documentation of an absence of exclusion criteria (client is not currently smoking, client is not pregnant/intending pregnancy, client is not breast-feeding).

Prior authorization approvals for Omalizumab are for intervals of three months at a time. Clients must be fully compliant with their Omalizumab regiment in order to qualify for any additional authorizations. The provider must submit a statement documenting full compliance with the requests for each renewal. After nine continuous months of Omalizumab authorizations, the requesting provider must submit documentation of satisfactory clinical response to Omalizumab in order to qualify for any additional authorizations. Prior authorizations will be considered on an individual basis for lapses in treatment with provider documentation.

Providers may not bill separately for an office visit if the only reason for the visit was the Omalizumab injection.

36.4.21.40 Paclitaxel

Procedure code 1-J9265 is covered for the following diagnosis codes:

Diagnosis Code	Description
1588	Malignant neoplasm of specified parts of peritoneum
1620	Malignant neoplasm of trachea
1622	Malignant neoplasm main bronchus
1623	Malignant neoplasm upper lobe lung
1624	Malignant neoplasm middle lobe lung
1625	Malignant neoplasm lower lobe lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast

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Diagnosis Code	Description
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1760	Kaposi's sarcoma, skin
1761	Kaposi's sarcoma, soft tissue
1762	Kaposi's sarcoma, palate
1763	Kaposi's sarcoma, gastrointestinal sites
1764	Kaposi's sarcoma, lung
1765	Kaposi's sarcoma, lymph nodes
1768	Kaposi's sarcoma, other specified sites
1769	Kaposi's sarcoma, unspecified site
1830	Malignant neoplasm of ovary
1832	Malignant neoplasm of fallopian tube
1833	Malignant neoplasm of broad ligament of uterus
1834	Malignant neoplasm of parametrium
1835	Malignant neoplasm of round ligament of uterus
1838	Malignant neoplasm of other specified sites of uterine adnexa
1839	Malignant neoplasm of uterine adnexa, unspecified site
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
1950	Malignant neoplasm of head, face, and neck
1986	Secondary malignant neoplasm of ovary
19881	Secondary malignant neoplasm of breast

36.4.21.41 Pentagastrin

Pentagastrin billed in conjunction with gastric function studies is paid separately.

36.4.21.42 Pneumococcal Polysaccharide Vaccine

For individuals not covered by the THSteps or TVFC programs, the Texas Medicaid Program covers procedure code 1-90732 for high-risk clients 2 years of age and older, when medically necessary.

Pneumococcal polysaccharide vaccine is indicated for groups of individuals who have long-term health problems that lower the body's resistance to infection. The following indications for vaccination are in keeping with the recommendations of the Centers for Disease Control (CDC):

- All adults 65 years of age and older
- Persons over age 2 who have a long-term illness such as:
    - Alcoholism
    - Cirrhosis
    - Diabetes
    - Heart disease
    - Leaks of cerebrospinal fluid
    - Lung disease
    - Sickle cell disease
- Persons over two years of age who have an immunosuppressive disease or condition such as:
    - Damaged spleen, or no spleen (asplenic)
    - HIV infection or AIDS
    - Hodgkin's disease
    - Kidney failure
    - Lymphoma, leukemia
    - Multiple myeloma
    - Nephrotic syndrome
    - Organ or bone marrow transplant
- Persons two years of age who are taking medications or treatments that lower immunity such as:
    - Long-term steroids
    - Certain cancer drugs
    - Radiation therapy
- Alaskan Natives and certain Native American populations

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36.4.21.43 Pneumococcal 7 Valent Conjugate Vaccine

Effective September 1, 2005, all TVFC-eligible children who are 2 months through 59 months of age may receive pneumococcal 7-valent conjugate vaccine from any provider participating in the TVFC Program.

These children will not need a referral to an FQHC or RHC. Pneumococcal 7 valent conjugate vaccine is covered under TVFC. If a child does not meet TVFC criteria, coverage may be considered through THSteps-CCP.

36.4.21.44 Porfimer (Photofrin)

Procedure code 1-J9600 is a covered benefit and limited to the following diagnosis codes:

Diagnosis Code	Description
1500	Malignant neoplasm of cervical esophagus
1501	Malignant neoplasm of thoracic esophagus
1502	Malignant neoplasm of abdominal esophagus
1503	Malignant neoplasm of upper third of esophagus
1504	Malignant neoplasm of middle third of esophagus
1505	Malignant neoplasm of lower third of esophagus
1508	Malignant neoplasm of other specified part of esophagus
1509	Malignant neoplasm of esophagus, unspecified site
1978	Secondary malignant neoplasm of other digestive organs and spleen

36.4.21.45 Respiratory Syncytial Virus (RSV) Prophylaxis

Texas Medicaid considers the American Academy of Pediatrics (AAP) criteria as the most useful single reference describing the evidence basis for RSV prophylaxis medical necessity. RSV immune globulin, intramuscular Synagis® (palivizumab) and intravenous RespiGam® (RSV-IGIV) are benefits of the Texas Medicaid CCP when medically necessary.

Texas Medicaid considers the beginning of the RSV season as October 1st, with the season typically continuing through the end of March or early April.

Beginning at six months of age, all high-risk infants (including those who qualify for RSV prophylaxis) and their contacts should be immunized against influenza, unless influenza immunization is medically contraindicated in the case of a specific individual.

Hospitalized infants determined to be at risk of severe RSV disease should receive their first dose of RSV prophylaxis 48–72 hours before being discharged during the RSV season.

Discharge planning should arrange outpatient follow-up for continued administration of Synagis® (palivizumab) if medically indicated. *Subsequent doses of Synagis® (palivizumab) should be given every 28 to 30 days and timed to provide prophylaxis that subsides at the end of RSV season*.

Reimbursement

Texas Medicaid may consider reimbursement for the intramuscular Synagis® (palivizumab) or intravenous version RespiGam® (RSV-IGIV) of RSV prophylaxis when billed appropriately with procedure code 90378. Providers obtaining Synagis® (palivizumab) through the VDP are not allowed to bill Texas Medicaid for the medication.

Refer to: "Obtaining Synagis® (palivizumab) Through the Vendor Drug Program" on page 36-123.

Synagis® (palivizumab) is provided in single-use vials and must be billed per milligram (mg) using procedure code 90378.

Example: *If 180 mg is administered to a child and 20 mg is wasted, 200 services/units must be billed, not 4 services/units.*

Example: *If 180 mg is administered to a child and 20 mg is wasted, 4 services/units must be billed, not 200 services/units.*

Providers are required to maintain accurate records of the total number of units given and the total number of units wasted for each client. If there is billing waste, the total number of units billed must include the number of units wasted.

Texas Medicaid will only reimburse providers for waste if a partial vial is actually wasted and not if the partial vial is used for another patient.

Reimbursement is provided no more than once every 28 days. RSV prophylaxis medications are covered in the office or outpatient settings.

Prior Authorization

All Synagis® (palivizumab) requires prior authorization through CCP.

All requests for Synagis® (palivizumab) must be submitted to CCP on a completed *Synagis® (Palivizumab) Prescription Prior Authorization Request Form*.

The physician's original, handwritten signature is required on the form and must be maintained in client record.

Palivizumab may be prior authorized for Medicaid beneficiaries less than 24 months of age who have hemodynamically significant heart disease when the documentation submitted demonstrates the following:

- The presence of moderate to severe pulmonary hypertension, or

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- Active treatment for hemodynamically significant heart disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of digitalis, diuretics, or supplemental oxygen, and
- A diagnosis code consistent with hemodynamically significant congenital heart disease:
  - Congenital anatomical cardiac defects or
  - Cardiomyopathies of any etiology

The following table lists the most common cardiac diagnosis codes:

Diagnosis Code	Description
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
4170	Arteriovenous fistula of pulmonary vessels
4171	Aneurysm of pulmonary artery
4178	Other specified diseases of pulmonary circulation
4179	Unspecified disease of pulmonary circulation
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4257	Nutritional and metabolic cardiomyopathy
4259	Secondary cardiomyopathy, unspecified
4280	Congestive heart failure, unspecified
4281	Left heart failure
4289	Heart failure, unspecified
4599	Unspecified circulatory system disorder
7450	Common truncus
74510	Complete transposition of great vessels
74511	Double outlet right ventricle
74512	Corrected transposition of great vessels
74519	Other transposition of great vessels
7452	Tetralogy of fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
74560	Endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other endocardial cushion defects
7457	Cor biloculare
7458	Other bulbus cordis anomalies and anomalies of cardiac septal closure
7459	Unspecified defect of septal closure
74600	Congenital pulmonary valve anomaly, unspecified
74601	Atresia of pulmonary valve, congenital
74602	Stenosis of pulmonary valve, congenital
74609	Other congenital anomalies of pulmonary valve
7461	Tricuspid atresia and stenosis, congenital
7462	Ebstein's anomaly
7463	Congenital stenosis of aortic valve
7464	Congenital insufficiency of aortic valve
7465	Congenital mitral stenosis
7466	Congenital mitral insufficiency
7467	Hypoplastic left heart syndrome
74681	Subaortic stenosis, congenital
74682	Cor triatriatum
74683	Infundibular pulmonic stenosis, congenital
74684	Congenital obstructive anomalies of heart, not elsewhere classified
74687	Malposition of heart and cardiac apex
7470	Patent ductus arteriosus
74710	Coarctation of aorta (preductal) (postductal)
74711	Interruption of aortic arch

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Diagnosis Code	Description
74720	Congenital anomaly of aorta, unspecified
74721	Congenital anomalies of aortic arch
74722	Congenital atresia and stenosis of aorta
74729	Other congenital anomalies of aorta
7473	Congenital anomalies of pulmonary artery
74740	Congenital anomaly of great veins, unspecified
74749	Other anomalies of great veins

Palivizumab may be prior authorized for Medicaid beneficiaries less than 24 months of age who have underlying lung disease when the documentation submitted demonstrates the following:

- Active treatment for lung disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of:
    - Corticosteroids (systemic or inhaled), diuretics, or supplemental oxygen therapy or
    - Mechanical ventilation
- A diagnosis of significant lung disease:
    - Chronic respiratory failure (51883) or
    - Chronic respiratory disease arising in the perinatal period (7707) or
    - Cystic fibrosis (27700, 27701, 27702, 27703 and 27709) or
    - Congenital bronchiectasis (74861) or
    - Diaphragmatic defects (7506 and 7566) or
    - Congenital cystic lung disease (7484) or
    - Congenital agenesis, hypoplasia and dysplasia of lung (7485) or
    - Other respiratory diagnoses with supportive documentation of medical necessity

The following table identifies common chronic lung disease diagnosis codes:

Diagnosis Code	Description
27700	Cystic fibrosis without mention of meconium ileus
27701	Cystic fibrosis with meconium ileus
27702	Cystic fibrosis with pulmonary manifestations
27703	Cystic fibrosis with gastrointestinal manifestations
27709	Cystic fibrosis with other manifestations
51883	Chronic respiratory failure
7484	Congenital cystic lung
7485	Congenital agenesis, hypoplasia, and dysplasia of lung
74861	Congenital bronchiectasis
7506	Congenital hiatus hernia
7566	Congenital anomalies of diaphragm
7707	Chronic respiratory disease arising in the perinatal period

Note: *Chronic lung disease (CLD), also known as chronic respiratory disease arising in the perinatal period (diagnosis code 7707), was formerly called bronchopulmonary dysplasia. It can develop in pre-term neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RSD). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.*

Palivizumab may be prior authorized for Medicaid beneficiaries less than 12 months of age when documentation includes a diagnosis code indicating the client was born at 28 weeks estimated gestational age or earlier (76521, 76522, 76523, or 76524).

Palivizumab may be prior authorized for Medicaid beneficiaries less than six months of age when the documentation includes:

- A diagnosis code indicating the infant was born at 29–32 weeks estimated gestational age (76525, or 76526), or
- A diagnosis code indicating the infant was born between 32 and 35 weeks gestational age (76526, 76527,or 76528) and documentation of severe neuromuscular disease (including chronic respiratory failure, 51883), or
- Significant congenital anomalies of the airway expected to compromise respiratory reserve, or documentation of two of the following:
    - Direct exposure to tobacco smoke or documented environmental air pollutants, and/or

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- Regular childcare attendance, and/or
- Direct exposure to siblings who attend childcare or school outside of the home

The following table lists diagnosis codes related to congenital airway anomalies:

Diagnosis Code	Description
7480	Choanal atresia
7482	Web of larynx
7503	Congenital tracheoesophageal fistula, esophageal atresia and stenosis

Providers may request prior authorization for RSV prophylaxis through CCP for clients with medical conditions not otherwise noted. All such requests must provide documentation to support the determination of medical necessity for this service.

Reimbursement

Palivizumab will not be reimbursed for dates of service outside the RSV season.

Exception: *Palivizumab will not be reimbursed for Medicaid beneficiaries who are greater than or equal to 24 months of age at the start of the RSV season in Texas.*

CCP may consider reimbursement for the intramuscular version of the RSV prophylaxis when billed with procedure code 1-90378. Palivizumab is provided in single use vials and must be billed per mg. Providers are required to maintain accurate records of the total number of units given and the total number of units purchased, administered, and wasted for each client. If there is a billing waste, the total number of units billed must include the number of units wasted. Medicaid will only reimburse providers for waste if a partial vial is actually wasted and not if the partial vial is used for another patient.

Example: *If 180 mg is administered to a child and 20 mg is wasted, 200 services/units must be billed, not four services/units.*

Providers seeking additional information on RSV may contact DSHS or refer to the DSHS website at www.dshs.state.tx.us.

Obtaining Synagis® (palivizumab) Through the Vendor Drug Program

Providers have two options for obtaining Synagis® (palivizumab) for Medicaid clients in fee-for-service and PCCM. Providers may purchase and bill for Synagis® (palivizumab), or they may obtain the drug through the VDP. Providers may not bill Texas Medicaid if the RSV prophylaxis was obtained through the VDP.

Note: *For Medicaid Managed Care clients, contact the clients' health maintenance organization (HMO).*

Option 1–Traditional Reimbursement for Synagis® (palivizumab)

- The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with Synagis® (palivizumab).
- The provider purchases Synagis® (palivizumab) for administration to the client in office.
- The provider adheres to the Medicaid benefits policy, as outlined in "Respiratory Syncytial Virus (RSV) Prophylaxis" on page 36-120. Prior authorization is required in certain circumstances.
- The injection provider bills for the drug, an injection administration fee, and any medically necessary office-based E/M service provided at time of injection.
- The provider is reimbursed through the Medicaid claims payment system.

Option 2–Obtaining Synagis® (Palivizumab) Through the VDP

- The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with Synagis® (palivizumab).
- The provider obtains Synagis® (palivizumab) through the Vendor Drug Program.
- The provider adheres to the Medicaid Benefits policy, as outlined in "Respiratory Syncytial Virus (RSV) Prophylaxis" on page 36-120 except that prior authorization is required for all patients as noted below.
- The provider or provider's agent sends a prescription for Synagis® (palivizumab) with supporting clinical information on the request form (see "Synagis® (Palivizumab) Prescription Form" on page B-99) to a Texas Medicaid-enrolled pharmacy that is a *member of the Synagis Distribution Network.* The administering provider does not purchase the drug.

  Refer to: HHSC's Vendor Drug Program Active Pharmacy Search page (www.hhsc.state.tx.us/hcf/vdp/dw/PharmacySearch.html) to search for participating pharmacies.

- The pharmacy contacts VDP's Prior Authorization Call Center. Prior authorization is required for all patients.
- If the information submitted does not demonstrate medical necessity the request is denied. Both the pharmacy and provider are notified of the denial.
- If the information submitted demonstrates medical necessity, the request is approved and both pharmacy and provider are notified.
- The selected pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the Medicaid client, directly to the provider. An initiation packet also is mailed to the client's family, informing them of RSV, Synagis® (palivizumab) and its effects.
- The treating provider administers the Synagis® (palivizumab) injection to the Medicaid client in the office setting.
- The injection provider bills for an injection administration fee and any medically necessary office-based E/M service provided at time of injection. The provider does not bill Medicaid for the drug.

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- The pharmacy contacts the provider each month after initial injection to obtain updated client information to ensure the proper amount for the next dose.

The following client demographic information is required:

- The child's date of birth
- The child's age in months, as of November 1, 2005
- The child's estimated gestational age (in weeks) at birth
- The child's body weight (in pounds or kilograms)
- The monthly dose required

36.4.21.46 Rho(D) Immune Globulin

Use the following procedure codes as applicable when billing for Rho(D) Immune Globulin: 1-J2790 and 1-J2792. Procedure code 1-J2790 is reimbursed at a maximum fee of $126.14.

36.4.21.47 Rituximab

Rituximab is payable for diagnosis 20280, Other malignant lymphomas, unspecified site. Diagnosis code 20280 must appear on the claim, but does not require a reference to procedure code 1-J9310.

Inpatient settings may be reimbursed under a DRG methodology. Outpatient facilities may be reimbursed at their reimbursement rate.

36.4.21.48 Filgrastim, Pegfilgrastim (G-CSF), and Sargramostim (GM-CSF)

Filgrastim and pegfilgrastim are granulocyte colony stimulating factors (G-CSF). Sargramostim is a granulocyte-macrophage colony stimulating factor (GM-CSF). GM-CSF and G-CSF stimulate neutrophil production after autologous bone marrow transplant and significantly reduce the duration and impact of neutropenia. Use procedure codes 1-J1440, 1-J1441, 1-J2505, or 1-J2820 with the number of units administered.

Payment for these procedures is limited to the following diagnosis codes:

Diagnosis Code	Description
1400	Malignant neoplasm of upper lip, vermilion border
1401	Malignant neoplasm of lower lip, vermilion border
1403	Malignant neoplasm of upper lip, inner aspect
1404	Malignant neoplasm of lower lip, inner aspect
1405	Malignant neoplasm of lip, unspecified, inner aspect
1406	Malignant neoplasm of commissure of lip
1408	Malignant neoplasm of other sites of lip
1409	Malignant neoplasm of lip, unspecified, vermilion border
1410	Malignant neoplasm of base of tongue
1411	Malignant neoplasm of dorsal surface of tongue
1413	Malignant neoplasm of ventral surface of tongue
1415	Malignant neoplasm of junctional zone of tongue
1416	Malignant neoplasm of lingual tonsil
1418	Malignant neoplasm of other sites of tongue
1419	Malignant neoplasm of tongue, unspecified
1420	Malignant neoplasm of parotid gland
1421	Malignant neoplasm of submandibular gland
1422	Malignant neoplasm of sublingual gland
1428	Malignant neoplasm of other major salivary glands
1429	Malignant neoplasm of salivary gland, unspecified
1430	Malignant neoplasm of upper gum
1431	Malignant neoplasm of lower gum
1438	Malignant neoplasm of other sites of gum
1439	Malignant neoplasm of gum, unspecified
1440	Malignant neoplasm of anterior portion of floor of mouth
1441	Malignant neoplasm of lateral portion of floor of mouth
1448	Malignant neoplasm of other sites of floor of mouth
1449	Malignant neoplasm of floor of mouth, part unspecified
1450	Malignant neoplasm of cheek mucosa
1451	Malignant neoplasm of vestibule of mouth
1452	Malignant neoplasm of hard palate
1453	Malignant neoplasm of soft palate
1454	Malignant neoplasm of uvula
1455	Malignant neoplasm of palate, unspecified
1456	Malignant neoplasm of retromolar area
1458	Malignant neoplasm of other specified parts of mouth

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Diagnosis Code	Description
1459	Malignant neoplasm of mouth, unspecified
1460	Malignant neoplasm of tonsil
1461	Malignant neoplasm of tonsillar fossa
1462	Malignant neoplasm of tonsillar pillars (anterior) (posterior)
1463	Malignant neoplasm of vallecula epiglottica
1464	Malignant neoplasm of anterior aspect of epiglottis
1465	Malignant neoplasm of junctional region of oropharynx
1466	Malignant neoplasm of lateral wall of oropharynx
1467	Malignant neoplasm of posterior wall of oropharynx
1468	Malignant neoplasm of other specified sites of oropharynx
1469	Malignant neoplasm of oropharynx, unspecified site
1470	Malignant neoplasm of superior wall of nasopharynx
1471	Malignant neoplasm of posterior wall of nasopharynx
1472	Malignant neoplasm of lateral wall of nasopharynx
1473	Malignant neoplasm of anterior wall of nasopharynx
1478	Malignant neoplasm of other specified sites of nasopharynx
1479	Malignant neoplasm of nasopharynx, unspecified site
1480	Malignant neoplasm of postcricoid region of hypopharynx
1481	Malignant neoplasm of pyriform sinus
1482	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
1483	Malignant neoplasm of posterior hypopharyngeal wall
1488	Malignant neoplasm of other specified sites of hypopharynx
1489	Malignant neoplasm of hypopharynx, unspecified site
1490	Malignant neoplasm of pharynx, unspecified
1491	Malignant neoplasm of waldeyer's ring
1498	Malignant neoplasm of other sites within the lip and oral cavity
1499	Malignant neoplasm of ill-defined sites within the lip and oral cavity

Diagnosis Code	Description
1500	Malignant neoplasm of cervical esophagus
1501	Malignant neoplasm of thoracic esophagus
1502	Malignant neoplasm of abdominal esophagus
1503	Malignant neoplasm of upper third of esophagus
1504	Malignant neoplasm of middle third of esophagus
1505	Malignant neoplasm of lower third of esophagus
1508	Malignant neoplasm of other specified part of esophagus
1509	Malignant neoplasm of esophagus, unspecified site
1510	Malignant neoplasm of cardia
1511	Malignant neoplasm of pylorus
1512	Malignant neoplasm of pyloric antrum
1513	Malignant neoplasm of fundus of stomach
1514	Malignant neoplasm of body of stomach
1515	Malignant neoplasm of lesser curvature of stomach, unspecified
1516	Malignant neoplasm of greater curvature of stomach, unspecified
1518	Malignant neoplasm of other specified sites of stomach
1519	Malignant neoplasm of stomach, unspecified site
1520	Malignant neoplasm of duodenum
1521	Malignant neoplasm of jejunum
1522	Malignant neoplasm of ileum
1523	Malignant neoplasm of meckel's diverticulum
1528	Malignant neoplasm of other specified sites of small intestine
1529	Malignant neoplasm of small intestine, unspecified site
1530	Malignant neoplasm of hepatic flexure
1531	Malignant neoplasm of transverse colon
1532	Malignant neoplasm of descending colon
1533	Malignant neoplasm of sigmoid colon
1534	Malignant neoplasm of cecum
1535	Malignant neoplasm of appendix vermiformis

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Diagnosis Code	Description
1536	Malignant neoplasm of ascending colon
1537	Malignant neoplasm of splenic flexure
1538	Malignant neoplasm of other specified sites of large intestine
1539	Malignant neoplasm of colon, unspecified site
1540	Malignant neoplasm of rectosigmoid junction
1541	Malignant neoplasm of rectum
1542	Malignant neoplasm of anal canal
1543	Malignant neoplasm of anus, unspecified site
1548	Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
1550	Malignant neoplasm of liver, primary
1551	Malignant neoplasm of intrahepatic bile ducts
1552	Malignant neoplasm of liver, not specified as primary or secondary
1560	Malignant neoplasm of gallbladder
1561	Malignant neoplasm of extrahepatic bile ducts
1562	Malignant neoplasm of ampulla of vater
1568	Malignant neoplasm of other specified sites of gallbladder and extrahepatic bile ducts
1569	Malignant neoplasm of biliary tract, part unspecified site
1570	Malignant neoplasm of head of pancreas
1571	Malignant neoplasm of body of pancreas
1572	Malignant neoplasm of tail of pancreas
1573	Malignant neoplasm of pancreatic duct
1574	Malignant neoplasm of islets of langerhans
1578	Malignant neoplasm of other specified sites of pancreas
1579	Malignant neoplasm of pancreas, part unspecified
1580	Malignant neoplasm of retroperitoneum
1588	Malignant neoplasm of specified parts of peritoneum
1589	Malignant neoplasm of peritoneum, unspecified
1590	Malignant neoplasm of intestinal tract, part unspecified
1591	Malignant neoplasm of spleen, not elsewhere classified
1598	Malignant neoplasm of other sites of digestive system and intra-abdominal organs
1599	Malignant neoplasm of ill-defined sites within the digestive organs and peritoneum
1600	Malignant neoplasm of nasal cavities
1601	Malignant neoplasm of auditory tube, middle ear, and mastoid air cells
1602	Malignant neoplasm of maxillary sinus
1603	Malignant neoplasm of ethmoidal sinus
1604	Malignant neoplasm of frontal sinus
1605	Malignant neoplasm of sphenoidal sinus
1608	Malignant neoplasm of other accessory sinuses
1609	Malignant neoplasm of accessory sinus, unspecified
1610	Malignant neoplasm of glottis
1611	Malignant neoplasm of supraglottis
1612	Malignant neoplasm of subglottis
1613	Malignant neoplasm of laryngeal cartilages
1618	Malignant neoplasm of other specified sites of larynx
1619	Malignant neoplasm of larynx, unspecified
1620	Malignant neoplasm of trachea
1622	Malignant neoplasm of main bronchus
1623	Malignant neoplasm of upper lobe, bronchus or lung
1624	Malignant neoplasm of middle lobe, bronchus or lung
1625	Malignant neoplasm of lower lobe, bronchus or lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified
1630	Malignant neoplasm of parietal pleura
1631	Malignant neoplasm of visceral pleura
1638	Malignant neoplasm of other specified sites of pleura
1639	Malignant neoplasm of pleura, unspecified

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Diagnosis Code	Description
1640	Malignant neoplasm of thymus
1641	Malignant neoplasm of heart
1642	Malignant neoplasm of anterior mediastinum
1643	Malignant neoplasm of posterior mediastinum
1648	Malignant neoplasm of other parts of mediastinum
1649	Malignant neoplasm of mediastinum, part unspecified
1650	Malignant neoplasm of upper respiratory tract, part unspecified
1658	Malignant neoplasm of other sites within the respiratory system and intrathoracic organs
1659	Malignant neoplasm of ill-defined sites within the respiratory system
1700	Malignant neoplasm of bones of skull and face, except mandible
1701	Malignant neoplasm of mandible
1702	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
1703	Malignant neoplasm of ribs, sternum, and clavicle
1704	Malignant neoplasm of scapula and long bones of upper limb
1705	Malignant neoplasm of short bones of upper limb
1706	Malignant neoplasm of pelvic bones, sacrum, and coccyx
1707	Malignant neoplasm of long bones of lower limb
1708	Malignant neoplasm of short bones of lower limb
1709	Malignant neoplasm of bone and articular cartilage, site unspecified
1710	Malignant neoplasm of connective and other soft tissue of head, face, and neck
1712	Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
1713	Malignant neoplasm of connective and other soft tissue of lower limb, including hip
1714	Malignant neoplasm of connective and other soft tissue of thorax
1715	Malignant neoplasm of connective and other soft tissue of abdomen
1716	Malignant neoplasm of connective and other soft tissue of pelvis
1717	Malignant neoplasm of connective and other soft tissue of trunk, unspecified
1718	Malignant neoplasm of other specified sites of connective and other soft tissue
1719	Malignant neoplasm of connective and other soft tissue, site unspecified
1720	Malignant melanoma of skin of lip
1721	Malignant melanoma of skin of eyelid, including canthus
1722	Malignant melanoma of skin of ear and external auditory canal
1723	Malignant melanoma of skin of other and unspecified parts of face
1724	Malignant melanoma of skin of scalp and neck
1725	Malignant melanoma of skin of trunk, except scrotum
1726	Malignant melanoma of skin of upper limb, including shoulder
1727	Malignant melanoma of skin of lower limb, including hip
1728	Malignant melanoma of other specified sites of skin
1729	Melanoma of skin, site unspecified
1730	Other malignant neoplasm of skin of lip
1731	Other malignant neoplasm of skin of eyelid, including canthus
1732	Other malignant neoplasm of skin of ear and external auditory canal
1733	Other malignant neoplasm of skin of other and unspecified parts of face
1734	Other malignant neoplasm of scalp and skin of neck
1735	Other malignant neoplasm of skin of trunk, except scrotum
1736	Other malignant neoplasm of skin of upper limb, including shoulder
1737	Other malignant neoplasm of skin of lower limb, including hip
1738	Other malignant neoplasm of other specified sites of skin
1739	Other malignant neoplasm of skin, site unspecified
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast

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Diagnosis Code	Description
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1760	Kaposi's sarcoma, skin
1761	Kaposi's sarcoma, soft tissue
1762	Kaposi's sarcoma, palate
1763	Kaposi's sarcoma, gastrointestinal sites
1764	Kaposi's sarcoma, lung
1765	Kaposi's sarcoma, lymph nodes
1768	Kaposi's sarcoma, other specified sites
1769	Kaposi's sarcoma, unspecified site
179	Malignant neoplasm of uterus, part unspecified
1800	Malignant neoplasm of endocervix
1801	Malignant neoplasm of exocervix
1808	Malignant neoplasm of other specified sites of cervix
1809	Malignant neoplasm of cervix uteri, unspecified site
181	Malignant neoplasm of placenta
1820	Malignant neoplasm of corpus uteri, except isthmus
1821	Malignant neoplasm of isthmus
1828	Malignant neoplasm of other specified sites of body of uterus
1830	Malignant neoplasm of ovary
1832	Malignant neoplasm of fallopian tube
1833	Malignant neoplasm of broad ligament of uterus
1834	Malignant neoplasm of parametrium
1835	Malignant neoplasm of round ligament of uterus
1838	Malignant neoplasm of other specified sites of uterine adnexa
1839	Malignant neoplasm of uterine adnexa, unspecified site
1840	Malignant neoplasm of vagina
1841	Malignant neoplasm of labia majora
1842	Malignant neoplasm of labia minora
1843	Malignant neoplasm of clitoris
1844	Malignant neoplasm of vulva, unspecified site
1848	Malignant neoplasm of other specified sites of female genital organs
1849	Malignant neoplasm of female genital organ, site unspecified
185	Malignant neoplasm of prostate
1860	Malignant neoplasm of undescended testis
1869	Malignant neoplasm of other and unspecified testis
187	Malignant neoplasm of penis and other male genital organs
1871	Malignant neoplasm of prepuce
1872	Malignant neoplasm of glans penis
1873	Malignant neoplasm of body of penis
1874	Malignant neoplasm of penis, part unspecified
1875	Malignant neoplasm of epididymis
1876	Malignant neoplasm of spermatic cord
1877	Malignant neoplasm of scrotum
1878	Malignant neoplasm of other specified sites of male genital organs
1879	Malignant neoplasm of male genital organ, site unspecified
1880	Malignant neoplasm of trigone of urinary bladder
1881	Malignant neoplasm of dome of urinary bladder
1882	Malignant neoplasm of lateral wall of urinary bladder
1883	Malignant neoplasm of anterior wall of urinary bladder
1884	Malignant neoplasm of posterior wall of urinary bladder
1885	Malignant neoplasm of bladder neck
1886	Malignant neoplasm of ureteric orifice
1887	Malignant neoplasm of urachus

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Diagnosis Code	Description
1888	Malignant neoplasm of other specified sites of bladder
1889	Malignant neoplasm of bladder, part unspecified
1890	Malignant neoplasm of kidney, except pelvis
1891	Malignant neoplasm of renal pelvis
1892	Malignant neoplasm of ureter
1893	Malignant neoplasm of urethra
1894	Malignant neoplasm of paraurethral glands
1898	Malignant neoplasm of other specified sites of urinary organs
1899	Malignant neoplasm of urinary organ, site unspecified
1900	Malignant neoplasm of other and unspecified sites
1901	Malignant neoplasm of orbit
1902	Malignant neoplasm of lacrimal gland
1903	Malignant neoplasm of conjunctiva
1904	Malignant neoplasm of cornea
1905	Malignant neoplasm of retina
1906	Malignant neoplasm of choroid
1907	Malignant neoplasm of lacrimal duct
1908	Malignant neoplasm of other specified sites of eye
1909	Malignant neoplasm of eye, part unspecified
1910	Malignant neoplasm of cerebrum, except lobes and ventricles
1911	Malignant neoplasm of frontal lobe
1912	Malignant neoplasm of temporal lobe
1913	Malignant neoplasm of parietal lobe
1914	Malignant neoplasm of occipital lobe
1915	Malignant neoplasm of ventricles
1916	Malignant neoplasm of cerebellum NOS
1917	Malignant neoplasm of brain stem
1918	Malignant neoplasm of other parts of brain
1919	Malignant neoplasm of brain, unspecified site
1920	Malignant neoplasm of cranial nerves
1921	Malignant neoplasm of cerebral meninges
1922	Malignant neoplasm of spinal cord
1923	Malignant neoplasm of spinal meninges

Diagnosis Code	Description
1928	Malignant neoplasm of other specified sites of nervous system
1929	Malignant neoplasm of nervous system, part unspecified
193	Malignant neoplasm of thyroid gland
1940	Malignant neoplasm of adrenal gland
1941	Malignant neoplasm of parathyroid gland
1943	Malignant neoplasm of pituitary gland and craniopharyngeal duct
1944	Malignant neoplasm of pineal gland
1945	Malignant neoplasm of carotid body
1946	Malignant neoplasm of aortic body and other paraganglia
1948	Malignant neoplasm of other endocrine glands and related structures
1949	Malignant neoplasm of endocrine gland, site unspecified
1950	Malignant neoplasm of head, face, and neck
1951	Malignant neoplasm of thorax
1952	Malignant neoplasm of abdomen
1953	Malignant neoplasm of pelvis
1954	Malignant neoplasm of upper limb
1955	Malignant neoplasm of lower limb
1958	Malignant neoplasm of other specified sites
1960	Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck
1961	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
1962	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
1963	Secondary and unspecified malignant neoplasm of lymph nodes of axilla and upper limb
1965	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
1966	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
1968	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
1969	Secondary and unspecified malignant neoplasm of lymph nodes, site unspecified

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Diagnosis Code	Description
1970	Secondary malignant neoplasm of lung
1971	Secondary malignant neoplasm of mediastinum
1972	Secondary malignant neoplasm of pleura
1973	Secondary malignant neoplasm of other respiratory organs
1974	Secondary malignant neoplasm of small intestine including duodenum
1975	Secondary malignant neoplasm of large intestine and rectum
1976	Secondary malignant neoplasm of retroperitoneum and peritoneum
1977	Malignant neoplasm of liver, secondary
1978	Secondary malignant neoplasm of other digestive organs and spleen
1980	Secondary malignant neoplasm of kidney
1981	Secondary malignant neoplasm of other urinary organs
1982	Secondary malignant neoplasm of skin
1983	Secondary malignant neoplasm of brain and spinal cord
1984	Secondary malignant neoplasm of other parts of nervous system
1985	Secondary malignant neoplasm of bone and bone marrow
1986	Secondary malignant neoplasm of ovary
1987	Secondary malignant neoplasm of adrenal gland
1988	Secondary malignant neoplasm of other specified sites
19881	Secondary malignant neoplasm of breast
19882	Secondary malignant neoplasm of genital organs
19889	Secondary malignant neoplasm of other specified sites
1990	Disseminated malignant neoplasm
1991	Other malignant neoplasm of unspecified site
20000	Reticulosarcoma, unspecified site
20001	Reticulosarcoma involving lymph nodes of head, face, and neck
20002	Reticulosarcoma involving intrathoracic lymph nodes
20003	Reticulosarcoma involving intra-abdominal lymph nodes
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma involving intrapelvic lymph nodes
20007	Reticulosarcoma involving spleen
20008	Reticulosarcoma involving lymph nodes of multiple sites
20010	Lymphosarcoma, unspecified site
20011	Lymphosarcoma involving lymph nodes of head, face, and neck
20012	Lymphosarcoma involving intrathoracic lymph nodes
20013	Lymphosarcoma involving intra-abdominal lymph nodes
20014	Lymphosarcoma involving lymph nodes of axilla and upper limb
20015	Lymphosarcoma involving lymph nodes of inguinal region and lower limb
20016	Lymphosarcoma involving intrapelvic lymph nodes
20017	Lymphosarcoma involving spleen
20018	Lymphosarcoma involving lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspecified site
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma involving spleen
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites
20080	Other named variants of lymphosarcoma and reticulosarcoma, unspecified site

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Diagnosis Code	Description
20081	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of head, face, and neck
20082	Other named variants of lymphosa-rcoma and reticulosarcoma involving intrathoracic lymph nodes
20083	Other named variants of lymphosa-rcoma and reticulosarcoma involving intra-abdominal lymph nodes
20084	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of axilla and upper limb
20085	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb
20086	Other named variants of lymphosa-rcoma and reticulosarcoma involving intrapelvic lymph nodes
20087	Other named variants of lymphosa-rcoma and reticulosarcoma involving spleen
20088	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of multiple sites
20100	Hodgkin's paragranuloma, unspecified site
20101	Hodgkin's paragranuloma involving lymph nodes of head, face, and neck
20102	Hodgkin's paragranuloma involving intrathoracic lymph nodes
20103	Hodgkin's paragranuloma involving intra-abdominal lymph nodes
20104	Hodgkin's paragranuloma involving lymph nodes of axilla and upper limb
20105	Hodgkin's paragranuloma involving lymph nodes of inguinal region and lower limb
20106	Hodgkin's paragranuloma involving intrapelvic lymph nodes
20107	Hodgkin's paragranuloma involving spleen
20108	Hodgkin's paragranuloma involving lymph nodes of multiple sites
20110	Hodgkin's granuloma, unspecified site
20111	Hodgkin's granuloma involving lymph nodes of head, face, and neck
20112	Hodgkin's granuloma involving intrathoracic lymph nodes
20113	Hodgkin's granuloma involving intra-abdominal lymph nodes

Diagnosis Code	Description
20114	Hodgkin's granuloma involving lymph nodes of axilla and upper limb
20115	Hodgkin's granuloma involving lymph nodes of inguinal region and lower limb
20116	Hodgkin's granuloma involving intrapelvic lymph nodes
20117	Hodgkin's granuloma involving spleen
20118	Hodgkin's granuloma involving lymph nodes of multiple sites
20120	Hodgkin's sarcoma, unspecified site
20121	Hodgkin's sarcoma involving lymph nodes of head, face, and neck
20122	Hodgkin's sarcoma involving intrathoracic lymph nodes
20123	Hodgkin's sarcoma involving intra-abdominal lymph nodes
20124	Hodgkin's sarcoma involving lymph nodes of axilla and upper limb
20125	Hodgkin's sarcoma involving lymph nodes of inguinal region and lower limb
20126	Hodgkin's sarcoma involving intrapelvic lymph nodes
20127	Hodgkin's sarcoma involving spleen
20128	Hodgkin's sarcoma involving lymph nodes of multiple sites
20140	Hodgkin's disease, lymphocytic-histiocytic predominance, unspecified site
20141	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of head, face, and neck
20142	Hodgkin's disease, lymphocytic-histiocytic predominance involving intrathoracic lymph nodes
20143	Hodgkin's disease, lymphocytic-histiocytic predominance involving intra-abdominal lymph nodes
20144	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of axilla and upper limb
20145	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of inguinal region and lower limb
20146	Hodgkin's disease, lymphocytic-histiocytic predominance involving intrapelvic lymph nodes
20147	Hodgkin's disease, lymphocytic-histiocytic predominance involving spleen

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Diagnosis Code	Description
20148	Hodgkin's disease, lymphocytic-histiocytic predominance involving lymph nodes of multiple sites
20150	Hodgkin's disease, nodular sclerosis, unspecified site
20151	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck
20152	Hodgkin's disease, nodular sclerosis, involving intrathoracic lymph nodes
20153	Hodgkin's disease, nodular sclerosis, involving intra-abdominal lymph nodes
20154	Hodgkin's disease, nodular sclerosis, involving lymph nodes of axilla and upper limb
20155	Hodgkin's disease, nodular sclerosis, involving lymph nodes of inguinal region and lower limb
20156	Hodgkin's disease, nodular sclerosis, involving intrapelvic lymph nodes
20157	Hodgkin's disease, nodular sclerosis, involving spleen
20158	Hodgkin's disease, nodular sclerosis, involving lymph nodes of multiple sites
20160	Hodgkin's disease, mixed cellularity, unspecified site
20161	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck
20162	Hodgkin's disease, mixed cellularity, involving intrathoracic lymph nodes
20163	Hodgkin's disease, mixed cellularity, involving intra-abdominal lymph nodes
20164	Hodgkin's disease, mixed cellularity, involving lymph nodes of axilla and upper limb
20165	Hodgkin's disease, mixed cellularity, involving lymph nodes of inguinal region and lower limb
20166	Hodgkin's disease, mixed cellularity, involving intrapelvic lymph nodes
20167	Hodgkin's disease, mixed cellularity, involving spleen
20168	Hodgkin's disease, mixed cellularity, involving lymph nodes of multiple sites
20170	Hodgkin's disease, lymphocytic depletion, unspecified site
20171	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of head, face, and neck
20172	Hodgkin's disease, lymphocytic depletion, involving intrathoracic lymph nodes
20173	Hodgkin's disease, lymphocytic depletion, involving intra-abdominal lymph nodes
20174	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of axilla and upper limb
20175	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of inguinal region and lower limb
20176	Hodgkin's disease, lymphocytic depletion, involving intrapelvic lymph nodes
20177	Hodgkin's disease, lymphocytic depletion, involving spleen
20178	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of multiple sites
20190	Hodgkin's disease, unspecified type, unspecified site
20191	Hodgkin's disease, unspecified type, involving lymph nodes of head, face, and neck
20192	Hodgkin's disease, unspecified type, involving intrathoracic lymph nodes
20193	Hodgkin's disease, unspecified type, involving intra-abdominal lymph nodes
20194	Hodgkin's disease, unspecified type, involving lymph nodes of axilla and upper limb
20195	Hodgkin's disease, unspecified type, involving lymph nodes of inguinal region and lower limb
20196	Hodgkin's disease, unspecified type, involving intrapelvic lymph nodes
20197	Hodgkin's disease, unspecified type, involving spleen
20198	Hodgkin's disease, unspecified type, involving lymph nodes of multiple sites
20200	Nodular lymphoma, unspecified site
20201	Nodular lymphoma involving lymph nodes of head, face, and neck
20202	Nodular lymphoma involving intrathoracic lymph nodes
20203	Nodular lymphoma involving intra-abdominal lymph nodes
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb

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Diagnosis Code	Description
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb
20206	Nodular lymphoma involving intrapelvic lymph nodes
20207	Nodular lymphoma involving spleen
20208	Nodular lymphoma involving lymph nodes of multiple sites
20210	Mycosis fungoides, unspecified site
20211	Mycosis fungoides involving lymph nodes of head, face, and neck
20212	Mycosis fungoides involving intrathoracic lymph nodes
20213	Mycosis fungoides involving intra-abdominal lymph nodes
20214	Mycosis fungoides involving lymph nodes of axilla and upper limb
20215	Mycosis fungoides involving lymph nodes of inguinal region and lower limb
20216	Mycosis fungoides involving intrapelvic lymph nodes
20217	Mycosis fungoides involving spleen
20218	Mycosis fungoides involving lymph nodes of multiple sites
20220	Sezary's disease, unspecified site
20221	Sezary's disease involving lymph nodes of head, face, and neck
20222	Sezary's disease involving intrathoracic lymph nodes
20223	Sezary's disease involving intra-abdominal lymph nodes
20224	Sezary's disease involving lymph nodes of axilla and upper limb
20225	Sezary's disease involving lymph nodes of inguinal region and lower limb
20226	Sezary's disease involving intrapelvic lymph nodes
20227	Sezary's disease involving spleen
20228	Sezary's disease involving lymph nodes of multiple sites
20230	Malignant histiocytosis, unspecified site
20231	Malignant histiocytosis involving lymph nodes of head, face, and neck
20232	Malignant histiocytosis involving intrathoracic lymph nodes
20233	Malignant histiocytosis involving intra-abdominal lymph nodes
20234	Malignant histiocytosis involving lymph nodes of axilla and upper limb
20235	Malignant histiocytosis involving lymph nodes of inguinal region and lower limb
20236	Malignant histiocytosis involving intrapelvic lymph nodes
20237	Malignant histiocytosis involving spleen
20238	Malignant histiocytosis involving lymph nodes of multiple sites
20240	Leukemic reticuloendotheliosis, unspecified site
20241	Leukemic reticuloendotheliosis involving lymph nodes of head, face, and neck
20242	Leukemic reticuloendotheliosis involving intrathoracic lymph nodes
20243	Leukemic reticuloendotheliosis involving intra-abdominal lymph nodes
20244	Leukemic reticuloendotheliosis involving lymph nodes of axilla and upper arm
20245	Leukemic reticuloendotheliosis involving lymph nodes of inguinal region and lower limb
20246	Leukemic reticuloendotheliosis involving intrapelvic lymph nodes
20247	Leukemic reticuloendotheliosis involving spleen
20248	Leukemic reticuloendotheliosis involving lymph nodes of multiple sites
20250	Letterer-siwe disease, unspecified site
20251	Letterer-siwe disease involving lymph nodes of head, face, and neck
20252	Letterer-siwe disease involving intrathoracic lymph nodes
20253	Letterer-siwe disease involving intra-abdominal lymph nodes
20254	Letterer-siwe disease involving lymph nodes of axilla and upper limb
20255	Letterer-siwe disease involving lymph nodes of inguinal region and lower limb
20256	Letterer-siwe disease involving intrapelvic lymph nodes
20257	Letterer-siwe disease involving spleen
20258	Letterer-siwe disease involving lymph nodes of multiple sites

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Diagnosis Code	Description
20260	Malignant mast cell tumors, unspecified site
20261	Malignant mast cell tumors involving lymph nodes of head, face, and neck
20262	Malignant mast cell tumors involving intrathoracic lymph nodes
20263	Malignant mast cell tumors involving intra-abdominal lymph nodes
20264	Malignant mast cell tumors involving lymph nodes of axilla and upper limb
20265	Malignant mast cell tumors involving lymph nodes of inguinal region and lower limb
20266	Malignant mast cell tumors involving intrapelvic lymph nodes
20267	Malignant mast cell tumors involving spleen
20268	Malignant mast cell tumors involving lymph nodes of multiple sites
20280	Other malignant lymphomas, unspecified site
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of multiple sites
20300	Multiple myeloma, without mention of remission
20301	Multiple myeloma, in remission
20310	Plasma cell leukemia, without mention of remission
20311	Plasma cell leukemia, in remission
20400	Lymphoid leukemia, acute, without mention of remission
20401	Lymphoid leukemia, acute, in remission
20410	Lymphoid leukemia, chronic, without mention of remission
20411	Lymphoid leukemia, chronic, in remission
20420	Lymphoid leukemia, subacute, without mention of remission
20421	Lymphoid leukemia, subacute, in remission
20480	Other lymphoid leukemia, without mention of remission
20481	Other lymphoid leukemia, in remission
20490	Unspecified lymphoid leukemia, without mention of remission
20491	Unspecified lymphoid leukemia, in remission
20500	Myeloid leukemia, acute, without mention of remission
20501	Myeloid leukemia, acute, in remission

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Diagnosis Code	Description
20510	Myeloid leukemia, chronic, without mention of remission
20511	Myeloid leukemia, chronic, in remission
20520	Myeloid leukemia, subacute, without mention of remission
20521	Myeloid leukemia, subacute, in remission
20530	Myeloid sarcoma, without mention of remission
20531	Myeloid sarcoma, in remission
20580	Other myeloid leukemia, without mention of remission
20581	Other myeloid leukemia, in remission
20590	Unspecified myeloid leukemia, without mention of remission
20591	Unspecified myeloid leukemia, in remission
20600	Monocytic leukemia, acute, without mention of remission
20601	Monocytic leukemia, acute, in remission
20610	Monocytic leukemia, chronic without mention of remission
20611	Monocytic leukemia, chronic, in remission
20620	Monocytic leukemia, subacute, without mention of remission
20621	Monocytic leukemia, subacute, in remission
20680	Other monocytic leukemia, without mention of remission
20681	Other monocytic leukemia, in remission
20690	Unspecified monocytic leukemia, without mention of remission
20691	Unspecified monocytic leukemia, in remission
20700	Acute erythremia and erythroleukemia, without mention of remission
20701	Acute erythremia and erythroleukemia, in remission
20710	Chronic erythremia, without mention of remission
20711	Chronic erythremia, in remission
20720	Megakaryocytic leukemia, without mention of remission
20721	Megakaryocytic leukemia, in remission
20780	Other specified leukemia, without mention of remission

Diagnosis Code	Description
20781	Other specified leukemia, in remission
20800	Leukemia of unspecified cell type, acute, without mention of remission
20801	Leukemia of unspecified cell type, acute, in remission
20810	Leukemia of unspecified cell type, chronic, without mention of remission
20811	Leukemia of unspecified cell type, chronic, in remission
20820	Leukemia of unspecified cell type, subacute, without mention of remission
20821	Leukemia of unspecified cell type, subacute, in remission
20880	Other leukemia of unspecified cell type, without mention of remission
20881	Other leukemia of unspecified cell type, in remission
20890	Unspecified leukemia, without mention of remission
20891	Unspecified leukemia, in remission
2300	Carcinoma in situ of lip, oral cavity, and pharynx
2301	Carcinoma in situ of esophagus
2302	Carcinoma in situ of stomach
2303	Carcinoma in situ of colon
2304	Carcinoma in situ of rectum
2305	Carcinoma in situ of anal canal
2306	Carcinoma in situ of anus, unspecified
2307	Carcinoma in situ of other and unspecified parts of intestine
2308	Carcinoma in situ of liver and biliary system
2309	Carcinoma in situ of other and unspecified digestive organs
2310	Carcinoma in situ of larynx
2311	Carcinoma in situ of trachea
2312	Carcinoma in situ of bronchus and lung
2318	Carcinoma in situ of other specified parts of respiratory system
2319	Carcinoma in situ of respiratory system, part unspecified
2320	Carcinoma in situ of skin of lip
2321	Carcinoma in situ of eyelid, including canthus
2322	Carcinoma in situ of skin of ear and external auditory canal

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Diagnosis Code	Description
2323	Carcinoma in situ of skin of other and unspecified parts of face
2324	Carcinoma in situ of scalp and skin of neck
2325	Carcinoma in situ of skin of trunk, except scrotum
2326	Carcinoma in situ of skin of upper limb, including shoulder
2327	Carcinoma in situ of skin of lower limb, including hip
2328	Carcinoma in situ of other specified sites of skin
2329	Carcinoma in situ of skin, site unspecified
2330	Carcinoma in situ of breast
2331	Carcinoma in situ of cervix uteri
2332	Carcinoma in situ of other and unspecified parts of uterus
2333	Carcinoma in situ of other and unspecified female genital organs
2334	Carcinoma in situ of prostate
2335	Carcinoma in situ of penis
2336	Carcinoma in situ of other and unspecified male genital organs
2337	Carcinoma in situ of bladder
2339	Carcinoma in situ of other and unspecified urinary organs
2340	Carcinoma in situ of eye
2348	Carcinoma in situ of other specified sites
2349	Carcinoma in situ, site unspecified
2848	Other specified aplastic anemias
28801	Congenital neutropenia
28802	Cyclic neutropenia
28803	Drug induced neutropenia
28804	Neutropenia due to infection
7767	Transient neonatal neutropenia
9631	Poisoning by antineoplastic and immunosuppressive drugs
99685	Complications of transplanted bone marrow
V4281	Bone marrow replaced by transplant
V4282	Peripheral stem cells replaced by transplant

36.4.21.49 Strontium-89 Chloride

Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mci, is a benefit of the Texas Medicaid Program. Strontium-89 should be billed using procedure code 9-A9600 and is limited to a total of ten mci intravenously injected every 90 days, any provider.

Reimbursement of strontium-89 is restricted to the following diagnosis codes:

Diagnosis Code	Description
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
185	Malignant neoplasm of prostate
1985	Secondary malignant neoplasm of bone and bone marrow

Reimbursement of strontium-89 is limited to hospital facilities, freestanding radiation treatment centers (POS 5), and the office setting (POS 1). Metastron (strontium-89) provided in the inpatient setting (POS 3) is part of the DRG reimbursement, and no separate payment is made.

36.4.21.50 Tetanus Injections, Acute Care

Tetanus toxoid adsorbed and tetanus immune globulin, human are benefits of the Texas Medicaid Program.

Tetanus toxoid adsorbed is an immunization used to prevent tetanus. It produces immunity to tetanus by promoting antibody production. The tetanus immune globulin provides a passive immunity for injuries that are over 24 hours old, extensively contaminated, and/or for the client who has had less than two tetanus toxoid injections in a lifetime. Therefore, both of these injections can be given on the same day for the same injury event.

Tetanus toxoid absorbed and tetanus immune globulin should be billed with the following procedure codes: 1-90703 and 1-J1670.

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Tetanus toxoid and tetanus immune globulin injections are covered for injuries, such as puncture wounds, burns, or abrasions. These injections are diagnosis-restricted to the codes listed in the following table:

Diagnosis Code	Description
80000	Closed fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified
80001	Closed fracture of vault of skull without mention of intracranial injury, with no loss of consciousness
80002	Closed fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80003	Closed fracture of vault of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80004	Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80005	Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80006	Closed fracture of vault of skull without mention of intra cranial injury, with loss of consciousness of unspecified duration
80009	Closed fracture of vault of skull without mention of intracranial injury, with concussion, unspecified
80010	Closed fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified
80011	Closed fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness
80012	Closed fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80013	Closed fracture of vault of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80014	Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80015	Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80016	Closed fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80019	Closed fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified
80020	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with state of consciousness unspecified
80021	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with no loss of consciousness
80022	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with brief (less than one hour) loss of consciousness
80023	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with moderate (1-24 hours) loss of consciousness
80024	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80025	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80026	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with loss of consciousness of unspecified duration
80029	Closed fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with concussion, unspecified
80030	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80031	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness

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Diagnosis Code	Description
80032	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80033	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80034	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80035	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80036	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80039	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80040	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80041	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80042	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80043	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80044	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80045	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80046	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80049	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
80050	Open fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified
80051	Open fracture of vault of skull without mention of intracranial injury, with no loss of consciousness
80052	Open fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80053	Open fracture of vault of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80054	Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80055	Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80056	Open fracture of vault of skull without mention of intracranial injury, with loss of consciousness of unspecified duration
80059	Open fracture of vault of skull without mention of intracranial injury, with concussion, unspecified
80060	Open fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified
80061	Open fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness
80062	Open fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80063	Open fracture of vault of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
80064	Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80065	Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80066	Open fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80069	Open fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified
80070	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with state of consciousness unspecified
80071	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with no loss of consciousness
80072	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with brief (less than one hour) loss of consciousness
80073	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with moderate (1-24 hours) loss of consciousness
80074	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80075	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80076	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with loss of consciousness of unspecified duration
80079	Open fracture of vault of skull with subarachnoid, subdural, and extra-dural hemorrhage, with concussion, unspecified

Diagnosis Code	Description
80080	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80081	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness
80082	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80083	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80084	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80085	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80086	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80089	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80090	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80091	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80092	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80093	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
80094	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80095	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80096	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80099	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
80100	Closed fracture of base of skull without mention of intra cranial injury, with state of consciousness unspecified
80101	Closed fracture of base of skull without mention of intra cranial injury, with no loss of consciousness
80102	Closed fracture of base of skull without mention of intra cranial injury, with brief (less than one hour) loss of consciousness
80103	Closed fracture of base of skull without mention of intra cranial injury, with moderate (1-24 hours) loss of consciousness
80104	Closed fracture of base of skull without mention of intra cranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80105	Closed fracture of base of skull without mention of intra cranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80106	Closed fracture of base of skull without mention of intra cranial injury, with loss of consciousness of unspecified duration
80109	Closed fracture of base of skull without mention of intra cranial injury, with concussion, unspecified
80110	Closed fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified
80111	Closed fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness
80112	Closed fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80113	Closed fracture of base of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80114	Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80115	Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80116	Closed fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80119	Closed fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified
80120	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80121	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80122	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80123	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80124	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80125	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
80126	Closed fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with loss of consciousness of unspecified duration
80129	Closed fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with concussion, unspecified
80130	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80131	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness
80132	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80133	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80134	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80135	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80136	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80139	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80140	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with state of consciousness unspecified
80141	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with no loss of consciousness
80142	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with brief (less than one hour) loss of consciousness
80143	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with moderate (1-24 hours) loss of consciousness
80144	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80145	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80146	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with loss of consciousness of unspecified duration
80149	Closed fracture of base of skull with intracranial injury of other and unspec-ified nature, with concussion, unspecified
80150	Open fracture of base of skull without mention of intracranial injury, with state of consciousness unspecified
80151	Open fracture of base of skull without mention of intracranial injury, with no loss of consciousness
80152	Open fracture of base of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80153	Open fracture of base of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80154	Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80155	Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80156	Open fracture of base of skull without mention of intracranial injury, with loss of consciousness of unspecified duration
80159	Open fracture of base of skull without mention of intracranial injury, with concussion, unspecified

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Diagnosis Code	Description
80160	Open fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified
80161	Open fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness
80162	Open fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80163	Open fracture of base of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80164	Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80165	Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80166	Open fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80169	Open fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified
80170	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with state of consciousness unspecified
80171	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with no loss of consciousness
80172	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with brief (less than one hour) loss of consciousness
80173	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with moderate (1-24 hours) loss of consciousness
80174	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

Diagnosis Code	Description
80175	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80176	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with loss of consciousness of unspecified duration
80179	Open fracture of base of skull with subarachnoid, subdural, and extra-dural hemorrhage, with concussion, unspecified
80180	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80181	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness
80182	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80183	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80184	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80185	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80186	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80189	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified
80190	Open fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified

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Diagnosis Code	Description
80191	Open fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness
80192	Open fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80193	Open fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80194	Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80195	Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80196	Open fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80199	Open fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified
8020	Closed fracture of nasal bones
8021	Open fracture of nasal bones
80220	Closed fracture of unspecified site of mandible
80221	Closed fracture of condylar process of mandible
80222	Closed fracture of subcondylar process of mandible
80223	Closed fracture of coronoid process of mandible
80224	Closed fracture of unspecified part of ramus of mandible
80225	Closed fracture of angle of jaw
80226	Closed fracture of symphysis of body of mandible
80227	Closed fracture of alveolar border of body of mandible
80228	Closed fracture of other and unspecified part of body of mandible
80229	Closed fracture of multiple sites of mandible

Diagnosis Code	Description
80230	Open fracture of unspecified site of mandible
80231	Open fracture of condylar process of mandible
80232	Open fracture of subcondylar process of mandible
80233	Open fracture of coronoid process of mandible
80234	Open fracture of unspecified part of ramus of mandible
80235	Open fracture of angle of jaw
80236	Open fracture of symphysis of body of mandible
80237	Open fracture of alveolar border of body of mandible
80238	Open fracture of body of mandible, other and unspecified
80239	Open fracture of multiple sites of mandible
8024	Closed fracture of malar and maxillary bones
8025	Open fracture of malar and maxillary bones
8026	Closed fracture of orbital floor (blow-out)
8027	Open fracture of orbital floor (blow-out)
8028	Closed fracture of other facial bones
8029	Open fracture of other facial bones
80300	Other closed skull fracture without mention of intracranial injury, with state of consciousness unspecified
80301	Other closed skull fracture without mention of intracranial injury, with no loss of consciousness
80302	Other closed skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80303	Other closed skull fracture without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80304	Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80305	Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
80306	Other closed skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration
80309	Other closed skull fracture without mention of intracranial injury, with concussion, unspecified
80310	Other closed skull fracture with cerebral laceration and contusion, with state of consciousness unspecified
80311	Other closed skull fracture with cerebral laceration and contusion, with no loss of consciousness
80312	Other closed skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80313	Other closed skull fracture with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80314	Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80315	Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80316	Other closed skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80319	Other closed skull fracture with cerebral laceration and contusion, with concussion, unspecified
80320	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with state of consciousness unspecified
80321	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with no loss of consciousness
80322	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with brief (less than one hour) loss of consciousness
80323	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with moderate (1-24 hours) loss of consciousness
80324	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80325	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80326	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with loss of consciousness of unspecified duration
80329	Other closed skull fracture with subarachnoid, subdural, and extra-dural hemorrhage, with concussion, unspecified
80330	Other closed skull fracture with other and unspecified intracranial hemorrhage, with state of unconsciousness unspecified
80331	Other closed skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness
80332	Other closed skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80333	Other closed skull fracture with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80334	Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80335	Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80336	Other closed skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80339	Other closed skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified
80340	Other closed skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified

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Diagnosis Code	Description
80341	Other closed skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness
80342	Other closed skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80343	Other closed skull fracture with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80344	Other closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80345	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80346	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80349	Other site of closed skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified
80350	Other open skull fracture without mention of injury, with state of consciousness unspecified
80351	Other open skull fracture without mention of intracranial injury, with no loss of consciousness
80352	Other open skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80353	Other open skull fracture without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80354	Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80355	Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80356	Other open skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration
80359	Other open skull fracture without mention of intracranial injury, with concussion, unspecified
80360	Other open skull fracture with cerebral laceration and contusion, with state of consciousness unspecified
80361	Other open skull fracture with cerebral laceration and contusion, with no loss of consciousness
80362	Other open skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80363	Other open skull fracture with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80364	Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80365	Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80366	Other open skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80369	Other open skull fracture with cerebral laceration and contusion, with concussion, unspecified
80370	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80371	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80372	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80373	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
80374	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80375	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80376	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80379	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80380	Other open skull fracture with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80381	Other open skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness
80382	Other open skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80383	Other open skull fracture with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80384	Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80385	Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80386	Other open skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80389	Other open skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified
80390	Other open skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80391	Other open skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness
80392	Other open skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80393	Other open skull fracture with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80394	Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80395	Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80396	Other open skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80399	Other open skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified
80400	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified
80401	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness
80402	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80403	Closed fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80404	Closed fractures involving skull or face with other bones, without mention or intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80405	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
80406	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration
80409	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with concussion, unspecified
80410	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified
80411	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness
80412	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80413	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness
80414	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80415	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80416	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80419	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified
80420	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80421	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness

Diagnosis Code	Description
80422	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80423	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80424	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80425	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80426	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration
80429	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80430	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80431	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness
80432	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80433	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrrhage, with moderate (1-24 hours) loss of consciousness
80434	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level

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Diagnosis Code	Description
80435	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80436	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80439	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified
80440	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80441	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness
80442	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80443	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80444	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80445	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80446	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80449	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified

Diagnosis Code	Description
80450	Open fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified
80451	Open fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness
80452	Open fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness
80453	Open fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness
80454	Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80455	Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80456	Open fractures involving skull or face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration
80459	Open fractures involving skull or face with other bones, without mention of intracranial injury, with concussion, unspecified
80460	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified
80461	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness
80462	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness
80463	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
80464	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80465	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80466	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration
80469	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified
80470	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified
80471	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness
80472	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness
80473	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness
80474	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80475	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
80476	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration

Diagnosis Code	Description
80479	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified
80480	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified
80481	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness
80482	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness
80483	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness
80484	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80485	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss consciousness, without return to pre-existing conscious level
80486	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration
80489	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified
80490	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified
80491	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness

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Diagnosis Code	Description
80492	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness
80493	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness
80494	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
80495	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level
80496	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration
80499	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified
80500	Closed fracture of cervical vertebra, unspecified level
80501	Closed fracture of first cervical vertebra
80502	Closed fracture of second cervical vertebra
80503	Closed fracture of third cervical vertebra
80504	Closed fracture of fourth cervical vertebra
80505	Closed fracture of fifth cervical vertebra
80506	Closed fracture of sixth cervical vertebra
80507	Closed fracture of seventh cervical vertebra
80508	Closed fracture of multiple cervical vertebrae
80510	Open fracture of cervical vertebra, unspecified level
80511	Open fracture of first cervical vertebra
80512	Open fracture of second cervical vertebra
80513	Open fracture of third cervical vertebra
80514	Open fracture of fourth cervical vertebra
80515	Open fracture of fifth cervical vertebra
80516	Open fracture of sixth cervical vertebra
80517	Open fracture of seventh cervical vertebra
80518	Open fracture of multiple cervical vertebrae
8052	Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
8053	Open fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
8054	Closed fracture of lumbar vertebra without mention of spinal cord injury
8055	Open fracture of lumbar vertebra without mention of spinal cord injury
8056	Closed fracture of sacrum and coccyx without mention of spinal cord injury
8057	Open fracture of sacrum and coccyx without mention of spinal cord injury
8058	Closed fracture of unspecified part of vertebral column without mention of spinal cord injury
8059	Open fracture of unspecified part of vertebral column without mention of spinal cord injury
80600	Closed fracture of C1-C4 level with unspecified spinal cord injury
80601	Closed fracture of C1-C4 level with complete lesion of cord
80602	Closed fracture of C1-C4 level with anterior cord syndrome
80603	Closed fracture of C1-C4 level with central cord syndrome
80604	Closed fracture of C1-C4 level with other specified spinal cord injury
80605	Closed fracture of C5-C7 level with unspecified spinal cord injury
80606	Closed fracture of C5-C7 level with complete lesion of cord
80607	Closed fracture of C5-C7 level with anterior cord syndrome
80608	Closed fracture of C5-C7 level with central cord syndrome
80609	Closed fracture of C5-C7 level with other specified spinal cord injury
80610	Open fracture of C1-C4 level with unspecified spinal cord injury

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Diagnosis Code	Description
80611	Open fracture of C1-C4 level with complete lesion of cord
80612	Open fracture of C1-C4 level with anterior cord syndrome
80613	Open fracture of C1-C4 level with central cord syndrome
80614	Open fracture of C1-C4 level with other specified spinal cord injury
80615	Open fracture of C5-C7 level with unspecified spinal cord injury
80616	Open fracture of C5-C7 level with complete lesion of cord
80617	Open fracture of C5-C7 level with anterior cord syndrome
80618	Open fracture of C5-C7 level with central cord syndrome
80619	Open fracture of C5-C7 level with other specified spinal cord injury
80620	Closed fracture of T1-T6 level with unspecified spinal cord injury
80621	Closed fracture of T1-T6 level with complete lesion of cord
80622	Closed fracture of T1-T6 level with anterior cord syndrome
80623	Closed fracture of T1-T6 level with central cord syndrome
80624	Closed fracture of T1-T6 level with other specified spinal cord injury
80625	Closed fracture of T7-T12 level with unspecified spinal cord injury
80626	Closed fracture of T7-T12 level with complete lesion of cord
80627	Closed fracture of T7-T12 level with anterior cord syndrome
80628	Closed fracture of T7-T12 level with central cord syndrome
80629	Closed fracture of T7-T12 level with other specified spinal cord injury
80630	Open fracture of T1-T6 level with unspecified spinal cord injury
80631	Open fracture of T1-T6 level with complete lesion of cord
80632	Open fracture of T1-T6 level with anterior cord syndrome
80633	Open fracture of T1-T6 level with central cord syndrome
80634	Open fracture of T1-T6 level with other specified spinal cord injury
80635	Open fracture of T7-T12 level with unspecified spinal cord injury

Diagnosis Code	Description
80636	Open fracture of T7-T12 level with complete lesion of cord
80637	Open fracture of T7-T12 level with anterior cord syndrome
80638	Open fracture of T7-T12 level with central cord syndrome
80639	Open fracture of T7-T12 level with other specified spinal cord injury
8064	Closed fracture of lumbar spine with spinal cord injury
8065	Open fracture of lumbar spine with spinal cord injury
80660	Closed fracture of sacrum and coccyx with unspecified spinal cord injury
80661	Closed fracture of sacrum and coccyx with complete cauda equina lesion
80662	Closed fracture of sacrum and coccyx with other cauda equina injury
80669	Closed fracture of sacrum and coccyx with other spinal cord injury
80670	Open fracture of sacrum and coccyx with unspecified spinal cord injury
80671	Open fracture of sacrum and coccyx with complete cauda equina lesion
80672	Open fracture of sacrum and coccyx with other cauda equina injury
80679	Open fracture of sacrum and coccyx with other spinal cord injury
8068	Closed fracture of unspecified vertebra with spinal cord injury
8069	Open fracture of unspecified vertebra with spinal cord injury
80700	Closed fracture of rib(s), unspecified
80701	Closed fracture of one rib
80702	Closed fracture of two ribs
80703	Closed fracture of three ribs
80704	Closed fracture of four ribs
80705	Closed fracture of five ribs
80706	Closed fracture of six ribs
80707	Closed fracture of seven ribs
80708	Closed fracture of eight or more ribs
80709	Closed fracture of multiple ribs, unspecified
80710	Open fracture of rib(s), unspecified
80711	Open fracture of one rib
80712	Open fracture of two ribs
80713	Open fracture of three ribs
80714	Open fracture of four ribs
80715	Open fracture of five ribs

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Diagnosis Code	Description
80716	Open fracture of six ribs
80717	Open fracture of seven ribs
80718	Open fracture of eight or more ribs
80719	Open fracture of multiple ribs, unspecified
8072	Closed fracture of sternum
8073	Open fracture of sternum
8074	Flail chest
8075	Closed fracture of larynx and trachea
8076	Open fracture of larynx and trachea
8080	Closed fracture of acetabulum
8081	Open fracture of acetabulum
8082	Closed fracture of pubis
8083	Open fracture of pubis
80841	Closed fracture of ilium
80842	Closed fracture of ischium
80843	Multiple closed pelvic fractures with disruption of pelvic circle
80849	Closed fracture of other specified part of pelvis
80851	Open fracture of ilium
80852	Open fracture of ischium
80853	Multiple open pelvic fractures with disruption of pelvic circle
80859	Open fracture of other specified part of pelvis
8088	Unspecified closed fracture of pelvis
8089	Unspecified open fracture of pelvis
8090	Fracture of bones of trunk, closed
8091	Fracture of bones of trunk, open
81000	Closed fracture of clavicle, unspecified part
81001	Closed fracture of sternal end of clavicle
81002	Closed fracture of shaft of clavicle
81003	Closed fracture of acromial end of clavicle
81010	Open fracture of clavicle, unspecified part
81011	Open fracture of sternal end of clavicle
81012	Open fracture of shaft of clavicle
81013	Open fracture of acromial end of clavicle
81100	Closed fracture of scapula, unspecified part
81101	Closed fracture of acromial process of scapula

Diagnosis Code	Description
81102	Closed fracture of coracoid process of scapula
81103	Closed fracture of glenoid cavity and neck of scapula
81109	Closed fracture of other part of scapula
81110	Open fracture of scapula, unspecified part
81111	Open fracture of acromial process of scapula
81112	Open fracture of coracoid process
81113	Open fracture of glenoid cavity and neck of scapula
81119	Open fracture of other part of scapula
81200	Fracture of unspecified part of upper end of humerus, closed
81201	Fracture of surgical neck of humerus, closed
81202	Fracture of anatomical neck of humerus, closed
81203	Fracture of greater tuberosity of humerus, closed
81209	Other closed fractures of upper end of humerus
81210	Fracture of unspecified part of upper end of humerus, open
81211	Fracture of surgical neck of humerus, open
81212	Fracture of anatomical neck of humerus, open
81213	Fracture of greater tuberosity of humerus, open
81219	Other open fracture of upper end of humerus
81220	Fracture of unspecified part of humerus, closed
81221	Fracture of shaft of humerus, closed
81230	Fracture of unspecified part of humerus, open
81231	Fracture of shaft of humerus, open
81240	Fracture of unspecified part of lower end of humerus, closed
81241	Supracondylar fracture of humerus, closed
81242	Fracture of lateral condyle of humerus, closed
81243	Fracture of medial condyle of humerus, closed
81244	Fracture of unspecified condyle(s) of humerus, closed

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Diagnosis Code	Description
81249	Other closed fractures of lower end of humerus
81250	Fracture of unspecified part of lower end of humerus, open
81251	Supracondylar fracture of humerus, open
81252	Fracture of lateral condyle of humerus, open
81253	Fracture of medial condyle of humerus, open
81254	Fracture of unspecified condyle(s) of humerus, open
81259	Other fracture of lower end of humerus, open
81300	Closed fracture of upper end of forearm, unspecified
81301	Fracture of olecranon process of ulna, closed
81302	Fracture of coronoid process of ulna, closed
81303	Monteggia's fracture, closed
81304	Other and unspecified closed fractures of proximal end of ulna (alone)
81305	Fracture of head of radius, closed
81306	Fracture of neck of radius, closed
81307	Other and unspecified closed fractures of proximal end of radius (alone)
81308	Fracture of radius with ulna, upper end (any part), closed
81310	Open fracture of upper end of forearm, unspecified
81311	Fracture of olecranon process of ulna, open
81312	Fracture of coronoid process of ulna, open
81313	Monteggia's fracture, open
81314	Other and unspecified open fractures of proximal end of ulna (alone)
81315	Fracture of head of radius, open
81316	Fracture of neck of radius, open
81317	Other and unspecified open fractures of proximal end of radius (alone)
81318	Fracture of radius with ulna, upper end (any part), open
81320	Fracture of shaft of radius or ulna, unspecified, closed
81321	Fracture of shaft of radius (alone), closed
81322	Fracture of shaft of ulna (alone), closed
81323	Fracture of shaft of radius with ulna, closed
81330	Fracture of shaft of radius or ulna, unspecified, open
81331	Fracture of shaft of radius (alone), open
81332	Fracture of shaft of ulna (alone), open
81333	Fracture of shaft of radius with ulna, open
81340	Closed fracture of lower end of forearm, unspecified
81341	Colles' fracture, closed
81342	Other closed fractures of distal end of radius (alone)
81343	Fracture of distal end of ulna (alone), closed
81344	Fracture of lower end of radius with ulna, closed
81345	Torus fracture of radius
81350	Open fracture of lower end of forearm, unspecified
81351	Colles' fracture, open
81352	Other open fractures of distal end of radius (alone)
81353	Fracture of distal end of ulna (alone), open
81354	Fracture of lower end of radius with ulna, open
81380	Closed fracture of unspecified part of forearm
81381	Fracture of unspecified part of radius (alone), closed
81382	Fracture of unspecified part of ulna (alone), closed
81383	Fracture of unspecified part of radius with ulna, closed
81390	Fracture of unspecified part of forearm, open
81391	Fracture of unspecified part of radius (alone), open
81392	Fracture of unspecified part of ulna (alone), open
81393	Fracture of unspecified part of radius with ulna, open
81400	Closed fracture of carpal bone, unspecified
81401	Closed fracture of navicular (scaphoid) bone of wrist
81402	Closed fracture of lunate (semilunar) bone of wrist

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Diagnosis Code	Description
81403	Closed fracture of triquetral (cuneiform) bone of wrist
81404	Closed fracture of pisiform bone of wrist
81405	Closed fracture of trapezium bone (larger multangular) of wrist
81406	Closed fracture of trapezoid bone (smaller multangular) of wrist
81407	Closed fracture of capitate bone (os magnum) of wrist
81408	Closed fracture of hamate (unciform) bone of wrist
81409	Closed fracture of other bone of wrist
81410	Open fracture of carpal bone, unspecified
81411	Open fracture of navicular (scaphoid) bone of wrist
81412	Open fracture of lunate (semilunar) bone of wrist
81413	Open fracture of triquetral (cuneiform) bone of wrist
81414	Open fracture of pisiform bone of wrist
81415	Open fracture of trapezium bone (larger multangular) of wrist
81416	Open fracture of trapezoid bone (smaller multangular) of wrist
81417	Open fracture of capitate bone (os magnum) of wrist
81418	Open fracture of hamate (unciform) bone of wrist
81419	Open fracture of other bone of wrist
81500	Closed fracture of metacarpal bone(s), site unspecified
81501	Closed fracture of base of thumb (first) metacarpal
81502	Closed fracture of base of other metacarpal bone(s)
81503	Closed fracture of shaft of metacarpal bone(s)
81504	Closed fracture of neck of metacarpal bone(s)
81509	Closed fracture of multiple sites of metacarpus
81510	Open fracture of metacarpal bone(s), site unspecified
81511	Open fracture of base of thumb (first) metacarpal
81512	Open fracture of base of other metac-arpal bone(s)
81513	Open fracture of shaft of metacarpal bone(s)

Diagnosis Code	Description
81514	Open fracture of neck of metacarpal bone(s)
81519	Open fracture of multiple sites of metacarpus
81600	Closed fracture of phalanx or phalanges of hand, unspecified
81601	Closed fracture of middle or proximal phalanx or phalanges of hand
81602	Closed fracture of distal phalanx or phalanges of hand
81603	Closed fracture of multiple sites of phalanx or phalanges of hand
81610	Open fracture of phalanx or phalanges of hand, unspecified
81611	Open fracture of middle or proximal phalanx or phalanges of hand
81612	Open fracture of distal phalanx or phalanges of hand
81613	Open fracture of multiple sites of phalanx or phalanges of hand
8170	Multiple closed fractures of hand bones
8171	Multiple open fractures of hand bones
8180	Ill-defined closed fractures of upper limb
8181	Ill-defined open fractures of upper limb
8190	Multiple closed fractures involving both upper limbs, and upper limb with rib(s) and sternum
8191	Multiple open fractures involving both upper limbs, and upper limb with rib(s) and sternum
82000	Fracture of unspecified intracapsular section of neck of femur, closed
82001	Fracture of epiphysis (separation) (upper) of neck of femur, closed
82002	Fracture of midcervical section of femur, closed
82003	Fracture of base of neck of femur, closed
82009	Other transcervical fracture of femur, closed
82010	Fracture of unspecified intracapsular section of neck of femur, open
82011	Fracture of epiphysis (separation) (upper) of neck of femur, open
82012	Fracture of midcervical section of femur, open
82013	Fracture of base of neck of femur, open

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Diagnosis Code	Description
82019	Other transcervical fracture of femur, open
82020	Other transcervical fracture of femur, open
82021	Fracture of intertrochanteric section of femur, closed
82022	Fracture of subtrochanteric section of femur, closed
82030	Fracture of unspecified trochanteric section of femur, open
82031	Fracture of intertrochanteric section of femur, open
82032	Fracture of subtrochanteric section of femur, open
8208	Fracture of unspecified part of neck of femur, closed
8209	Fracture of unspecified part of neck of femur, open
82100	Fracture of unspecified part of femur, closed
82101	Fracture of shaft of femur, closed
82110	Fracture of unspecified part of femur, open
82111	Fracture of shaft of femur, open
82120	Fracture of lower end of femur, unspecified part, closed
82121	Fracture of femoral condyle, closed
82122	Fracture of lower epiphysis of femur, closed
82123	Supracondylar fracture of femur, closed
82129	Other fracture of lower end of femur, closed
82130	Fracture of lower end of femur, unspecified part, open
82131	Fracture of femoral condyle, open
82132	Fracture of lower epiphysis of femur, open
82133	Supracondylar fracture of femur, open
82139	Other fracture of lower end of femur, open
8220	Closed fracture of patella
8221	Open fracture of patella
8230	Fracture of upper end of tibia and fibula, closed
82300	Closed fracture of upper end of tibia
82301	Closed fracture of upper end of fibula
82302	Closed fracture of upper end of fibula with tibia
82310	Open fracture of upper end of tibia
82311	Open fracture of upper end of fibula
82312	Open fracture of upper end of fibula with tibia
82320	Closed fracture of shaft of tibia
82321	Closed fracture of shaft of fibula
82322	Closed fracture of shaft of fibula with tibia
82330	Open fracture of shaft of tibia
82331	Open fracture of shaft of fibula
82332	Open fracture of shaft of fibula with tibia
82340	Torus fracture, tibia alone
82341	Torus fracture, fibula alone
82342	Torus fracture, fibula with tibia
82380	Closed fracture of unspecified part of tibia
82381	Closed fracture of unspecified part of fibula
82382	Closed fracture of unspecified part of fibula with tibia
82390	Open fracture of unspecified part of tibia
82391	Open fracture of unspecified part of fibula
82392	Open fracture of unspecified part of fibula with tibia
8240	Fracture of medial malleolus, closed
8241	Fracture of medial malleolus, open
8242	Fracture of lateral malleolus, closed
8243	Fracture of lateral malleolus, open
8244	Bimalleolar fracture, closed
8245	Bimalleolar fracture, open
8246	Trimalleolar fracture, closed
8247	Trimalleolar fracture, open
8248	Unspecified fracture of ankle, closed
8249	Unspecified fracture of ankle, open
8250	Fracture of calcaneus, closed
8251	Fracture of calcaneus, open
82520	Fracture of unspecified bone(s) of foot (except toes), closed
82521	Fracture of astragalus, closed
82522	Fracture of navicular (scaphoid) bone of foot, closed
82523	Fracture of cuboid bone, closed
82524	Fracture of cuneiform bone of foot, closed

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Diagnosis Code	Description
82525	Fracture of metatarsal bone(s), closed
82529	Other fracture of tarsal and metatarsal bones, closed
82530	Fracture of unspecified bone(s) of foot (except toes), open
82531	Fracture of astragalus, open
82532	Fracture of navicular (scaphoid) bone of foot, open
82533	Fracture of cuboid bone, open
82534	Fracture of cuneiform bone of foot, open
82535	Fracture of metatarsal bone(s), open
82539	Other fractures of tarsal and metatarsal bones, open
8260	Closed fracture of one or more phalanges of foot
8261	Open fracture of one or more phalanges of foot
8270	Other, multiple and ill-defined fractures of lower limb, closed
8271	Other, multiple and ill-defined fractures of lower limb, open
8280	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, closed
8281	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, open
8290	Fracture of unspecified bone, closed
8291	Fracture of unspecified bone, open
8300	Closed dislocation of jaw
8301	Open dislocation of jaw
83100	Closed dislocation of shoulder, unspecified site
83101	Closed anterior dislocation of humerus
83102	Closed posterior dislocation of humerus
83103	Closed inferior dislocation of humerus
83104	Closed dislocation of acromioclavicular (joint)
83109	Closed dislocation of other site of shoulder
83110	Open dislocation of shoulder, unspecified
83111	Open anterior dislocation of humerus
83112	Open posterior dislocation of humerus
83113	Open inferior dislocation of humerus
83114	Open dislocation of acromioclavicular (joint)

Diagnosis Code	Description
83119	Open dislocation of other site of shoulder
83200	Closed dislocation of elbow, unspecified site
83201	Closed anterior dislocation of elbow
83202	Closed posterior dislocation of elbow
83203	Closed medial dislocation of elbow
83204	Closed lateral dislocation of elbow
83209	Closed dislocation of other site of elbow
83210	Open dislocation of elbow, unspecified site
83211	Open anterior dislocation of elbow
83212	Open posterior dislocation of elbow
83213	Open medial dislocation of elbow
83214	Open lateral dislocation of elbow
83219	Open dislocation of other site of elbow
83300	Closed dislocation of wrist, unspecified part
83301	Closed dislocation of radioulnar (joint), distal
83302	Closed dislocation of radiocarpal (joint)
83303	Closed dislocation of midcarpal (joint)
83304	Closed dislocation of carpometacarpal (joint)
83305	Closed dislocation of metacarpal (bone), proximal end
83309	Closed dislocation of other part of wrist
83310	Open dislocation of wrist, unspecified part
83311	Open dislocation of radioulnar (joint), distal
83312	Open dislocation of radiocarpal (joint)
83313	Open dislocation of midcarpal (joint)
83314	Open dislocation of carpometacarpal (joint)
83315	Open dislocation of metacarpal (bone), proximal end
83319	Open dislocation of other part of wrist
83400	Closed dislocation of finger, unspecified part
83401	Closed dislocation of metacarpophalangeal (joint)
83402	Closed dislocation of interphalangeal (joint), hand
83410	Open dislocation of finger, unspecified part

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Diagnosis Code	Description
83411	Open dislocation of metacarpophalangeal (joint)
83412	Open dislocation interphalangeal (joint), hand
83500	Closed dislocation of hip, unspecified site
83501	Closed posterior dislocation of hip
83502	Closed obturator dislocation of hip
83503	Other closed anterior dislocation of hip
83510	Open dislocation of hip, unspecified site
83511	Open posterior dislocation of hip
83512	Open obturator dislocation of hip
83513	Other open anterior dislocation of hip
8360	Tear of medial cartilage or meniscus of knee, current
8361	Tear of lateral cartilage or meniscus of knee, current
8362	Other tear of cartilage or meniscus of knee, current
8363	Dislocation of patella, closed
8364	Dislocation of patella, open
83650	Closed dislocation of knee, unspecified part
83651	Anterior dislocation of tibia, proximal end, closed
83652	Posterior dislocation of tibia, proximal end, closed
83653	Medial dislocation of tibia, proximal end, closed
83654	Lateral dislocation of tibia, proximal end, closed
83659	Other dislocation of knee, closed
83660	Dislocation of knee, unspecified part, open
83661	Anterior dislocation of tibia, proximal end, open
83662	Posterior dislocation of tibia, proximal end, open
83663	Medial dislocation of tibia, proximal end, open
83664	Lateral dislocation of tibia, proximal end, open
83669	Other dislocation of knee, open
8370	Closed dislocation of ankle
8371	Open dislocation of ankle
83800	Closed dislocation of foot, unspecified part
83801	Closed dislocation of tarsal (bone), joint unspecified
83802	Closed dislocation of midtarsal (joint)
83803	Closed dislocation of tarsometatarsal (joint)
83804	Closed dislocation of metatarsal (bone), joint unspecified
83805	Closed dislocation of metatarsophalangeal (joint)
83806	Closed dislocation of interphalangeal (joint), foot
83809	Closed dislocation of other part of foot
83810	Open dislocation of foot, unspecified part
83811	Open dislocation of tarsal (bone), joint unspecified
83812	Open dislocation of midtarsal (joint)
83813	Open dislocation of tarsometatarsal (joint)
83814	Open dislocation of metatarsal (bone), joint unspecified
83815	Open dislocation of metatarsophalangeal (joint)
83816	Open dislocation of interphalangeal (joint), foot
83819	Open dislocation of other part of foot
83900	Closed dislocation, cervical vertebra, unspecified
83901	Closed dislocation, first cervical vertebra
83902	Closed dislocation, second cervical vertebra
83903	Closed dislocation, third cervical vertebra
83904	Closed dislocation, fourth cervical vertebra
83905	Closed dislocation, fifth cervical vertebra
83906	Closed dislocation, sixth cervical vertebra
83907	Closed dislocation, seventh cervical vertebra
83908	Closed dislocation, multiple cervical vertebrae
83910	Open dislocation, cervical vertebra, unspecified
83911	Open dislocation, first cervical vertebra
83912	Open dislocation, second cervical vertebra

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Diagnosis Code	Description
83913	Open dislocation, third cervical vertebra
83914	Open dislocation, fourth cervical vertebra
83915	Open dislocation, fifth cervical vertebra
83916	Open dislocation, sixth cervical vertebra
83917	Open dislocation, seventh cervical vertebra
83918	Open dislocation, multiple cervical vertebrae
83920	Closed dislocation, lumbar vertebra
83921	Closed dislocation, thoracic vertebra
83930	Open dislocation, lumbar vertebra
83931	Open dislocation, thoracic vertebra
83940	Closed dislocation, vertebra, unspecified site
83941	Closed dislocation, coccyx
83942	Closed dislocation, sacrum
83949	Closed dislocation, other vertebra
83950	Open dislocation, vertebra, unspecified site
83951	Open dislocation, coccyx
83952	Open dislocation, sacrum
83959	Open dislocation, other vertebra
83961	Closed dislocation, sternum
93969	Closed dislocation, other location
83971	Open dislocation, sternum
83979	Open dislocation, other location
8398	Closed dislocation, multiple and ill-defined sites
8399	Open dislocation, multiple and ill-defined sites
8400	Acromioclavicular (joint) (ligament) sprain
8401	Coracoclavicular (ligament) sprain
8402	Coracohumeral (ligament) sprain
8403	Infraspinatus (muscle) (tendon) sprain
8404	Rotator cuff (capsule) sprain
8405	Subscapularis (muscle) sprain
8406	Supraspinatus (muscle) (tendon) sprain
8407	Superior glenoid labrum lesion
8408	Sprain of other specified sites of shoulder and upper arm
8409	Sprain of unspecified site of shoulder and upper arm

Diagnosis Code	Description
8410	Radial collateral ligament sprain
8411	Ulnar collateral ligament sprain
8412	Radiohumeral (joint) sprain
8413	Ulnohumeral (joint) sprain
8418	Sprain of other specified sites of elbow and forearm
8419	Sprain of unspecified site of elbow and forearm
84200	Sprain of unspecified site of wrist
84201	Sprain of carpal (joint) of wrist
84202	Sprain of radiocarpal (joint) (ligament) of wrist
84209	Other wrist sprain
84210	Sprain of unspecified site of hand
84211	Sprain of carpometacarpal (joint) of hand
84212	Sprain of metacarpophalangeal (joint) of hand
84213	Sprain of interphalangeal (joint) of hand
84219	Other hand sprain
8430	Iliofemoral (ligament) sprain
8431	Ischiocapsular (ligament) sprain
8438	Sprain of other specified sites of hip and thigh
8439	Sprain of unspecified site of hip and thigh
8440	Sprain of lateral collateral ligament of knee
8441	Sprain of medial collateral ligament of knee
8442	Sprain of cruciate ligament of knee
8443	Sprain of tibiofibular (joint) (ligament) superior, of knee
8448	Sprain of other specified sites of knee and leg
8449	Sprain of unspecified site of knee and leg
84500	Unspecified site of ankle sprain
84501	Deltoid (ligament), ankle sprain
84502	Calcaneofibular (ligament) ankle sprain
84503	Tibiofibular (ligament) sprain, distal
84509	Other ankle sprain
84510	Unspecified site of foot sprain
84511	Tarsometatarsal (joint) (ligament) sprain
84512	Metatarsaophalangeal (joint) sprain

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Diagnosis Code	Description
84513	Interphalangeal (joint), toe sprain
84519	Other foot sprain
8460	Lumbosacral (joint) (ligament) sprain
8461	Sacroiliac (ligament) sprain
8462	Sacrospinatus (ligament) sprain
8463	Sacrotuberous (ligament) sprain
8468	Other specified sites of sacroiliac region sprain
8469	Unspecified site of sacroiliac region sprain
8470	Neck sprain
8471	Thoracic sprain
8472	Lumbar sprain
8473	Sprain of sacrum
8474	Sprain of coccyx
8479	Sprain of unspecified site of back
8480	Sprain of septal cartilage of nose
8481	Jaw sprain
8482	Thyroid region sprain
8483	Sprain of ribs
84840	Sternum sprain, unspecified part
84841	Sternoclavicular (joint) (ligament) sprain
84842	Chondrosternal (joint) sprain
84849	Other sprain of sternum
8485	Pelvic sprain
8488	Other specified sites of sprains and strains
8489	Unspecified site of sprain and strain
8500	Concussion with no loss of consciousness
8501	Concussion with brief loss of consciousness
85011	Concussion, with loss of consciousness of 30 minutes or less
85012	Concussion, with loss of consciousness from 31 to 59 minutes
8502	Concussion with moderate loss of consciousness
8503	Concussion with prolonged loss of consciousness and return to pre-existing conscious level
8504	Concussion with prolonged loss of consciousness, without return to pre-existing conscious level
8505	Concussion with loss of consciousness of unspecified duration
8509	Concussion, unspecified

Diagnosis Code	Description
85100	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified
85101	Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified
85110	Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration
85119	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified
85120	Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified
85121	Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness
85122	Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85123	Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85124	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85129	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified
85130	Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified
85131	Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified
85140	Cerebellar or brain stem contusion without mention of open intracranial wound, with state of consciousness unspecified
85141	Cerebellar or brain stem contusion without mention of open intracranial wound, with no loss of consciousness
85142	Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85149	Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified
85150	Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified
85151	Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness
85152	Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness

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Diagnosis Code	Description
85153	Cerebellar or brain stem contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85155	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration
85159	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified

Diagnosis Code	Description
85170	Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified
85171	Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness
85172	Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85230	Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85231	Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85232	Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness

Diagnosis Code	Description
85233	Subdural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85236	Subdural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85239	Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified

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Diagnosis Code	Description
85250	Extradural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85251	Extradural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85152	Extradural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85253	Extradural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85255	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85256	Extradural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury, with open intracranial wound, with concussion, unspecified 853,Other and unspecified intracranial hemorrhage following injury
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85400	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with state of consciousness unspecified
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with concussion, unspecified
85410	Intracranial injury of other and unspecified nature, with open intracranial wound, with state of consciousness unspecified
85411	Intracranial injury of other and unspecified nature, with open intracranial wound, with no loss of consciousness
85412	Intracranial injury of other and unspecified nature, with open intracranial wound, with brief (less than one hour) loss of consciousness
85413	Intracranial injury of other and unspecified nature, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85414	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85415	Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85416	Intracranial injury of other and unspecified nature, with open intracranial wound, with loss of consciousness of unspecified duration
85419	Intracranial injury of other and unspecified nature, with open intracranial wound, with concussion, unspecified
8600	Traumatic pneumothorax without mention of open wound into thorax
8601	Traumatic pneumothorax with open wound into thorax
8602	Traumatic hemothorax without mention of open wound into thorax
8603	Traumatic hemothorax with open wound into thorax
8604	Traumatic pneumohemothorax without mention of open wound into thorax
8605	Traumatic pneumohemothorax with open wound into thorax
86100	Unspecified injury of heart without mention of open wound into thorax
86101	Contusion of heart without mention of open wound into thorax
86102	Laceration of heart without penetration of heart chambers or open wound into thorax
86103	Laceration of heart with penetration of heart chambers, without mention of open wound into thorax
86110	Unspecified injury of heart with open wound into thorax
86111	Contusion of heart with open wound into thorax
86112	Laceration of heart without penetration of heart chambers, with open wound into thorax
86113	Laceration of heart with penetration of heart chambers and open wound into thorax
86120	Unspecified injury of lung without open wound into thorax
86121	Contusion of lung without open wound into thorax

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Diagnosis Code	Description
86122	Laceration of lung without open wound into thorax
86130	Unspecified injury of lung with open wound into thorax
86131	Contusion of lung with open wound into thorax
86132	Laceration of lung with open wound into thorax
8620	Injury to diaphragm without mention of open wound into cavity
8621	Injury to diaphragm with open wound into cavity
8622	Injury to other specified intrathoracic organs without mention of open wound into cavity
86221	Injury to bronchus without open wound into cavity
86222	Injury to esophagus without mention of open wound into cavity
86229	Injury to other specified intrathoracic organs without mention of open wound into cavity
86231	Injury to bronchus with open wound into cavity
86232	Injury to esophagus with open wound into cavity
86239	Injury to other specified intrathoracic organs with open wound into cavity
8628	Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity
8629	Injury to multiple and unspecified intrathoracic organs with open wound into cavity
8630	Injury to stomach without mention of open wound into cavity
8631	Injury to stomach with open wound into cavity
86320	Injury to small intestine, unspecified site, without open wound into cavity
86321	Injury to duodenum without open wound into cavity
86329	Other injury to small intestine without open wound into cavity
86330	Injury to small intestine, unspecified site, with open wound into cavity
86331	Injury to duodenum with open wound into cavity
86339	Other injury to small intestine with open wound into cavity

Diagnosis Code	Description
86340	Injury to colon, unspecified site, without mention of open wound into cavity
86341	Injury to ascending (right) colon without open wound into cavity
86342	Injury to transverse colon without open wound into cavity
86343	Injury to descending (left) colon without open wound into cavity
86344	Injury to sigmoid colon without open wound into cavity
86345	Injury to rectum without open wound into cavity
86346	Injury to multiple sites in colon and rectum without open wound into cavity
86349	Other injury to colon and rectum, without open wound into cavity
86350	Injury to colon, unspecified site, with open wound into cavity
86351	Injury to ascending (right) colon with open wound into cavity
86352	Injury to transverse colon with open wound into cavity
86353	Injury to descending (left) colon with open wound into cavity
86354	Injury to sigmoid colon with open wound into cavity
86355	Injury to rectum with open wound into cavity
86356	Injury to multiple sites in colon and rectum with open wound into cavity
86359	Other injury to colon and rectum with open wound into cavity
86380	Injury to gastrointestinal tract, unspecified site, without open wound into cavity
86381	Injury to pancreas head without mention of open wound into cavity
86382	Injury to pancreas body without mention of open wound into cavity
86383	Injury to pancreas tail without mention of open wound into cavity
86384	Injury to pancreas, multiple and unspecified sites, without open wound into cavity
86385	Injury to appendix without open wound into cavity
86389	Injury to other and unspecified gastrointestinal sites without open wound into cavity
86390	Injury to gastrointestinal tract, unspecified site, with open wound into cavity

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Diagnosis Code	Description
86391	Injury to pancreas head with open wound into cavity
86392	Injury to pancreas body with open wound into cavity
86393	Injury to pancreas tail with open wound into cavity
86394	Injury to pancreas, multiple and unspecified sites, with open wound into cavity
86395	Injury to appendix with open wound into cavity
86399	Injury to other and unspecified gastrointestinal sites with open wound into cavity
86400	Unspecified injury to liver without mention of open wound into cavity
86401	Hematoma and contusion of liver without mention of open wound into cavity
86402	Laceration of liver, minor, without mention of open wound into cavity
86403	Laceration of liver, moderate, without mention of open wound into cavity
86404	Laceration of liver, major, without mention of open wound into cavity
86405	Laceration of liver, unspecified, without mention of open wound into cavity
86409	Other injury to liver without mention of open wound into cavity
86410	Unspecified injury to liver with open wound into cavity
86411	Hematoma and contusion of liver with open wound into cavity
86412	Laceration of liver, minor, with open wound into cavity
86413	Laceration of liver, moderate, with open wound into cavity
86414	Laceration of liver, major, with open wound into cavity
86415	Laceration of liver, unspecified, with open wound into cavity
86419	Other injury to liver with open wound into cavity
86500	Unspecified injury to spleen without mention of open wound into cavity
86501	Hematoma of spleen, without rupture of capsule, without mention of open wound into cavity

Diagnosis Code	Description
86502	Capsular tears to spleen, without major disruption of parenchyma, without mention of open wound into cavity
86503	Laceration of spleen extending into parenchyma without mention of open wound into cavity
86504	Massive parenchymal disruption of spleen without mention of open wound into cavity
86509	Other injury into spleen without mention of open wound into cavity
86510	Unspecified injury to spleen with open wound into cavity
86511	Hematoma of spleen, without rupture of capsule, with open wound into cavity
86512	Capsular tears to spleen, without major disruption of parenchyma, with open wound into cavity
86513	Laceration of spleen extending into parenchyma, with open wound into cavity
86514	Massive parenchyma disruption of spleen with open wound into cavity
86519	Other injury to spleen with open wound into cavity
86600	Unspecified injury to kidney without mention of open wound into cavity
86601	Hematoma of kidney, without rupture of capsule, without mention of open wound into cavity
86602	Laceration of kidney without mention of open wound into cavity
86603	Complete disruption of kidney parenchyma, without mention of open wound into cavity
86610	Unspecified injury to kidney with open wound into cavity
86611	Hematoma of kidney, without rupture of capsule, with open wound into cavity
86612	Laceration of kidney with open wound into cavity
86613	Complete disruption of kidney parenchyma, with open wound into cavity
8670	Injury to bladder and urethra without mention of open wound into cavity
8671	Injury to bladder and urethra with open wound into cavity
8672	Injury to ureter without mention of open wound into cavity

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Diagnosis Code	Description
8673	Injury to ureter with open wound into cavity
8674	Injury to uterus without mention of open wound into cavity
8675	Injury to uterus with open wound into cavity
8676	Injury to other specified pelvic organs without mention of open wound into cavity
8677	Injury to other specified pelvic organs with open wound into cavity
8678	Injury to unspecified pelvic organ without mention of open wound into cavity
8679	Injury to unspecified pelvic organ with open wound into cavity
86800	Injury to unspecified intra-abdominal organ without mention of open wound into cavity
86801	Injury to adrenal gland without mention of open wound into cavity
86802	Injury to bile duct and gallbladder without mention of open wound into cavity
86803	Injury to peritoneum without mention of open wound into cavity
86804	Injury to retroperitoneum without mention of open wound into cavity
86809	Injury to other and multiple intra-abdominal organs without mention of open wound into cavity
86810	Injury to unspecified intra-abdominal organ, with open wound into cavity
86811	Injury to adrenal gland, with open wound into cavity
86812	Injury to bile duct and gallbladder, with open wound into cavity
86813	Injury to peritoneum with open wound into cavity
86814	Injury to retroperitoneum with open wound into cavity
86819	Injury to other and multiple intra-abdominal organs, with open wound into cavity
8690	Internal injury to unspecified or ill-defined organs without mention of open wound into cavity
8691	Internal injury to unspecified or ill-defined organs with open wound into cavity
8700	Laceration of skin of eyelid and periocular area

Diagnosis Code	Description
8701	Laceration of eyelid, full-thickness, not involving lacrimal passages
8702	Laceration of eyelid involving lacrimal passages
8703	Penetrating wound of orbit, without mention of foreign body
8704	Penetrating wound of orbit with foreign body
8708	Other specified open wounds of ocular adnexa
8709	Unspecified open wound of ocular adnexa
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
8712	Rupture of eye with partial loss of intraocular tissue
8713	Avulsion of eye
8714	Unspecified laceration of eye
8715	Penetration of eyeball with magnetic foreign body
8716	Penetration of eyeball with (nonmagnetic) foreign body
8717	Unspecified ocular penetration
8719	Unspecified open wound of eyeball
87200	Open wound of external ear, unspecified site, uncomplicated
87201	Open wound of auricle, uncomplicated
87202	Open wound of auditory canal, uncomplicated
87210	Open wound of external ear, unspecified site, complicated
87211	Open wound of auricle, complicated
87212	Open wound of auditory canal, complicated
87261	Open wound of ear drum, uncomplicated
87262	Open wound of ossicles, uncomplicated
87263	Open wound of eustachian tube, uncomplicated
87264	Open wound of cochlea, uncomplicated
87269	Open wound of other and multiple sites, uncomplicated
87271	Open wound of ear drum, complicated
87272	Open wound of ossicles, complicated
87273	Open wound of eustachian tube, complicated

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Diagnosis Code	Description
87274	Open wound of cochlea, complicated
87279	Open wound of other and multiple sites, complicated
8728	Open wound of ear, part unspecified, without mention of complication
8729	Open wound of ear, part unspecified, complicated
8730	Open wound of scalp, without mention of complication
8731	Open wound of scalp, complicated
87320	Open wound of nose, unspecified site, uncomplicated
87321	Open wound of nasal septum, uncomplicated
87322	Open wound of nasal cavity, uncomplicated
87323	Open wound of nasal sinus, uncomplicated
87329	Open wound of multiple sites, uncomplicated
87330	Open wound of nose, unspecified site, complicated
87331	Open wound of nasal septum, complicated
87332	Open wound of nasal cavity, complicated
87333	Open wound of nasal sinus, complicated
87339	Open wound of multiple sites, complicated
87340	Open wound of face, unspecified site, uncomplicated
87341	Open wound of cheek, uncomplicated
87342	Open wound of forehead, uncomplicated
87343	Open wound of lip, uncomplicated
87344	Open wound of jaw, uncomplicated
87349	Open wound of other and multiple sites, uncomplicated
87350	Open wound of face, unspecified site, complicated
87351	Open wound of cheek, complicated
87352	Open wound of forehead, complicated
87353	Open wound of lip, complicated
87354	Open wound of jaw, complicated
87359	Open wound of other and multiple sites, complicated
87360	Open wound of mouth, unspecified site, uncomplicated

Diagnosis Code	Description
87361	Open wound of buccal mucosa, uncomplicated
87362	Open wound of gum (alveolar process), uncomplicated
87363	Tooth (broken) (fractured) (due to trauma), without mention of complication
87364	Open wound of tongue and floor of mouth, uncomplicated
87365	Open wound of palate, uncomplicated
87369	Open wound of other and multiple sites, uncomplicated
87370	Open wound of mouth, unspecified site, complicated
87371	Open wound of buccal mucosa, complicated
87372	Open wound of gum (alveolar process), complicated
87373	Tooth (broken) (fractured) (due to trauma), complicated
87374	Open wound of tongue and floor of mouth, complicated
87375	Open wound of palate, complicated
87379	Open wound of other and multiple sites, complicated
8738	Other and unspecified open wound of head without mention of complication
8739	Other and unspecified open wound of head, complicated
87400	Open wound of larynx with trachea, uncomplicated
87401	Open wound of larynx, uncomplicated
87402	Open wound of trachea, uncomplicated
87410	Open wound of larynx with trachea, complicated
87411	Open wound of larynx, complicated
87412	Open wound of trachea, complicated
8742	Open wound of thyroid gland, without mention of complication
8743	Open wound of thyroid gland, complicated
8744	Open wound of pharynx, without mention of complication
8745	Open wound of pharynx, complicated
8748	Open wound of other and unspecified parts of neck, without mention of complication
8749	Open wound of other and unspecified parts of neck, complicated

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Diagnosis Code	Description
8750	Open wound of chest (wall), without mention of complication
8751	Open wound of chest (wall), complicated
8760	Open wound of back, without mention of complication
8761	Open wound of back, complicated
8770	Open wound of buttock, without mention of complication
8771	Open wound of buttock, complicated
8780	Open wound of penis, without mention of complication
8781	Open wound of penis, complicated
8782	Open wound of scrotum and testes, without mention of complication
8783	Open wound of scrotum and testes, complicated
8784	Open wound of vulva, without mention of complication
8785	Open wound of vulva, complicated
8786	Open wound of vagina, without mention of complication
8787	Open wound of vagina, complicated
8788	Open wound of other and unspecified parts of genital organs, without mention of complication
8789	Open wound of other and unspecified parts of genital organs, complicated
8790	Open wound of breast, without mention of complication
8791	Open wound of breast, complicated
8792	Open wound of abdominal wall, anterior, without mention of complication
8793	Open wound of abdominal wall, anterior, complicated
8794	Open wound of abdominal wall, lateral, without mention of complication
8795	Open wound of abdominal wall, lateral, complicated
8796	Open wound of other and unspecified parts of trunk, without mention of complication
8797	Open wound of other and unspecified parts of trunk, complicated
8798	Open wound(s) (multiple) of unspecified site(s), without mention of complication
8799	Open wound(s) (multiple) of unspecified site(s), complicated

Diagnosis Code	Description
88000	Open wound of shoulder region, without mention of complication
88001	Open wound of scapular region, without mention of complication
88002	Open wound of axillary region, without mention of complication
88003	Open wound of upper arm, without mention of complication
88009	Open wound of multiple sites of shoulder and upper arm, without mention of complication
88010	Open wound of shoulder region, complicated
88011	Open wound of scapular region, complicated
88012	Open wound of axillary region, complicated
88013	Open wound of upper arm, complicated
88019	Open wound of multiple sites of shoulder and upper arm, complicated
88020	Open wound of shoulder region, with tendon involvement
88021	Open wound of scapular region, with tendon involvement
88022	Open wound of axillary region, with tendon involvement
88023	Open wound of upper arm, with tendon involvement
88029	Open wound of multiple sites of shoulder and upper arm, with tendon involvement
88100	Open wound of forearm, without mention of complication
88101	Open wound of elbow, without mention of complication
88102	Open wound of wrist, without mention of complication
88110	Open wound of forearm, complicated
88111	Open wound of elbow, complicated
88112	Open wound of wrist, complicated
88120	Open wound of forearm, with tendon involvement
88121	Open wound of elbow, with tendon involvement
88122	Open wound of wrist, with tendon involvement
8820	Open wound of hand except fingers alone, without mention of complication
8821	Open wound of hand except fingers alone, complicated

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Diagnosis Code	Description
8822	Open wound of hand except fingers alone, with tendon involvement
8830	Open wound of fingers, without mention of complication
8831	Open wound of fingers, complicated
8832	Open wound of fingers, with tendon involvement
8840	Multiple and unspecified open wound of upper limb, without mention of complication
8841	Multiple and unspecified open wound of upper limb, complicated
8842	Multiple and unspecified open wound of upper limb, with tendon involvement
8850	Traumatic amputation of thumb (complete) (partial), without mention of complication
8851	Traumatic amputation of thumb (complete) (partial), complicated
8860	Traumatic amputation of other finger(s) (complete) (partial), without mention of complication
8861	Traumatic amputation of other finger(s) (complete) (partial), complicated
8870	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, without mention of complication
8871	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated
8872	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication
8873	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated
8874	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, without mention of complication
8875	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated
8876	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), without mention of complication
8877	Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated

Diagnosis Code	Description
8900	Open wound of hip and thigh, without mention of complication
8901	Open wound of hip and thigh, complicated
8902	Open wound of hip and thigh, with tendon involvement
8910	Open wound of knee, leg (except thigh), and ankle, without mention of complication
8911	Open wound of knee, leg (except thigh), and ankle, complicated
8912	Open wound of knee, leg (except thigh), and ankle, with tendon involvement
8920	Open wound of foot except toe(s) alone, without mention of complication
8921	Open wound of foot except toe(s) alone, complicated
8922	Open wound of foot except toe(s) alone, with tendon involvement
8930	Open wound of toe(s), without mention of complication
8931	Open wound of toe(s), complicated
8932	Open wound of toe(s), with tendon involvement
8940	Multiple and unspecified open wound of lower limb, without mention of complication
8941	Multiple and unspecified open wound of lower limb, complicated
8942	Multiple and unspecified open wound of lower limb, with tendon involvement
8950	Traumatic amputation of toe(s) (complete) (partial), without mention of complication
8951	Traumatic amputation of toe(s) (complete) (partial), complicated
8960	Traumatic amputation of foot (complete) (partial), unilateral, without mention of complication
8961	Traumatic amputation of foot (complete) (partial), unilateral, complicated
8962	Traumatic amputation of foot (complete) (partial), bilateral, without mention of complication
8963	Traumatic amputation of foot (complete) (partial), bilateral, complicated
8970	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, without mention of complication

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Diagnosis Code	Description
8971	Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, complicated
8972	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, without mention of complication
8973	Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, complicated
8974	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, without mention of complication
8975	Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, complicated
8976	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), without mention of complication
8977	Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), complicated
90000	Injury to carotid artery, unspecified
90001	Injury to common carotid artery
90002	Injury to external carotid artery
90003	Injury to internal carotid artery
9001	Injury to internal jugular vein
9008	Injury to other specified blood vessels of head and neck
90081	Injury to external jugular vein
90082	Injury to multiple blood vessels of head and neck
90089	Injury to other specified blood vessels of head and neck
9009	Injury to unspecified blood vessel of head and neck
9010	Injury to thoracic aorta
9011	Injury to innominate and subclavian arteries
9012	Injury to superior vena cava
9013	Injury to innominate and subclavian veins
90140	Injury to pulmonary vessel(s), unspecified
90141	Injury to pulmonary artery
90142	Injury to pulmonary vein
90181	Injury to intercostal artery or vein
90182	Injury to internal mammary artery or vein

Diagnosis Code	Description
90183	Injury to multiple blood vessels of thorax
90189	Injury to other specified blood vessels of thorax
9020	Injury to abdominal aorta
90210	Injury to inferior vena cava, unspecified
90211	Injury to hepatic veins
90219	Injury to other specified branches of inferior vena cava
90220	Injury to celiac and mesenteric arteries, unspecified
90221	Injury to gastric artery
90222	Injury to hepatic artery
90223	Injury to splenic artery
90224	Injury to other specified branches of celiac axis
90225	Injury to superior mesenteric artery (trunk)
90226	Injury to primary branches of superior mesenteric artery
90227	Injury to inferior mesenteric artery
90229	Injury to other celiac and mesenteric arteries
90231	Injury to superior mesenteric vein and primary subdivisions
90232	Injury to inferior mesenteric vein
90233	Injury to portal vein
90234	Injury to splenic vein
90239	Injury to other portal and splenic veins
90240	Injury to renal vessel(s), unspecified
90241	Injury to renal artery
90242	Injury to renal vein
90249	Injury to other renal blood vessels
90250	Injury to iliac vessel(s), unspecified
90251	Injury to hypogastric artery
90252	Injury to hypogastric vein
90253	Injury to iliac artery
90254	Injury to iliac vein
90255	Injury to uterine artery
90256	Injury to uterine vein
90259	Injury to other iliac blood vessels
90281	Injury to ovarian artery
90282	Injury to ovarian vein
90287	Injury to multiple blood vessels of abdomen and pelvis

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Diagnosis Code	Description
90289	Injury to other specified blood vessels of abdomen and pelvis
9029	Injury to unspecified blood vessel of abdomen and pelvis
90300	Injury to axillary vessel(s), unspecified
90301	Injury to axillary artery
90302	Injury to axillary vein
9031	Injury to brachial blood vessels
9032	Injury to radial blood vessels
9033	Injury to ulnar blood vessels
9034	Injury to palmar artery
9035	Injury to digital blood vessels
9038	Injury to other specified blood vessels of upper extremity
9039	Injury to unspecified blood vessel of upper extremity
9040	Injury to common femoral artery
9041	Injury to superficial femoral artery
9042	Injury to femoral veins
9043	Injury to saphenous veins
90440	Injury to popliteal vessel(s), unspecified
90441	Injury to popliteal artery
90442	Injury to popliteal vein
90450	Injury to tibial vessel(s), unspecified
90451	Injury to anterior tibial artery
90452	Injury to anterior tibial vein
90453	Injury to posterior tibial artery
90454	Injury to posterior tibial vein
9046	Injury to deep plantar blood vessels
9047	Injury to other specified blood vessels of lower extremity
9048	Injury to unspecified blood vessel of lower extremity
9049	Injury to blood vessels of unspecified site
9050	Late effect of fracture of skull and face bones
9051	Late effect of fracture of spine and trunk without mention of spinal cord lesion
9052	Late effect of fracture of upper extremities
9053	Late effect of fracture of neck of femur
9054	Late effect of fracture of lower extremities
9055	Late effect of fracture of multiple and unspecified bones

Diagnosis Code	Description
9056	Late effect of dislocation
9057	Late effect of sprain and strain without mention of tendon injury
9058	Late effect of tendon injury
9059	Late effect of traumatic amputation
9060	Late effect of open wound of head, neck, and trunk
9061	Late effect of open wound of extremities without mention of tendon injury
9062	Late effect of superficial injury
9063	Late effect of contusion
9064	Late effect of crushing
9065	Late effect of burn of eye, face, head, and neck
9066	Late effect of burn of wrist and hand
9067	Late effect of burn of other extremities
9068	Late effect of burns of other specified sites
9069	Late effect of burn of unspecified site
9070	Late effect of intracranial injury without mention of skull fracture
9071	Late effect of injury to cranial nerve
9072	Late effect of spinal cord injury
9073	Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk
9074	Late effect of injury to peripheral nerve of shoulder girdle and upper limb
9075	Late effect of injury to peripheral nerve of pelvic girdle and lower limb
9079	Late effect of injury to other and unspecified nerve
9080	Late effect of internal injury to chest
9081	Late effect of internal injury to intra-abdominal organs
9082	Late effect of internal injury to other internal organs
9083	Late effect of injury to blood vessel of head, neck, and extremities
9084	Late effect of injury to blood vessel of thorax, abdomen, and pelvis
9085	Late effect of foreign body in orifice
9086	Late effect of certain complications of trauma
9089	Late effect of unspecified injury
9090	Late effect of poisoning due to drug, medicinal or biological substance
9091	Late effect of toxic effects of nonmedical substances

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Diagnosis Code	Description
9092	Late effect of radiation
9093	Late effect of complications of surgical and medical care
9094	Late effect of certain other external causes
9095	Late effect of adverse effect of drug, medicinal or biological substance
9099	Late effect of other and unspecified external causes
9100	Abrasion or friction burn of face, neck, and scalp except eye, without mention of infection
9101	Abrasion or friction burn of face, neck, and scalp except eye, infected
9102	Blister of face, neck, and scalp except eye, without mention of infection
9103	Blister of face, neck, and scalp except eye, infected
9104	Insect bite, nonvenomous of face, neck, and scalp except eye, without mention of infection
9105	Insect bite, nonvenomous of face, neck, and scalp except eye, infected
9106	Superficial foreign body (splinter) of face, neck, and scalp except eye, without major open wound and without mention of infection
9107	Superficial foreign body (splinter) of face, neck, and scalp except eye, without major open wound, infected
9108	Other and unspecified superficial injury of face, neck, and scalp, without mention of infection
9109	Other and unspecified superficial injury of face, neck, and scalp, infected
9110	Abrasion or friction burn of trunk, without mention of infection
9111	Abrasion or friction burn of trunk, infected
9112	Blister of trunk, without mention of infection
9113	Blister of trunk, infected
9114	Insect bite, nonvenomous of trunk, without mention of infection
9115	Insect bite, nonvenomous of trunk, infected
9116	Superficial foreign body (splinter) of trunk, without major open wound and without mention of infection
9117	Superficial foreign body (splinter) of trunk, without major open wound, infected
9118	Other and unspecified superficial injury of trunk, without mention of infection
9119	Other and unspecified superficial injury of trunk, infected
9120	Abrasion or friction burn of shoulder and upper arm, without mention of infection
9121	Abrasion or friction burn of shoulder and upper arm, infected
9122	Blister of shoulder and upper arm, without mention of infection
9123	Blister of shoulder and upper arm, infected
9124	Insect bite, nonvenomous of shoulder and upper arm, without mention of infection
9125	Insect bite, nonvenomous of shoulder and upper arm, infected
9126	Superficial foreign body (splinter) of shoulder and upper arm, without major open wound and without mention of infection
9127	Superficial foreign body (splinter) of shoulder and upper arm, without major open wound, infected
9128	Other and unspecified superficial injury of shoulder and upper arm, without mention of infection
9129	Other and unspecified superficial injury of shoulder and upper arm, infected
9130	Abrasion or friction burn of elbow, forearm, and wrist, without mention of infection
9131	Abrasion or friction burn of elbow, forearm, and wrist, infected
9132	Blister of elbow, forearm, and wrist, without mention of infection
9133	Blister of elbow, forearm, and wrist, infected
9134	Insect bite, nonvenomous of elbow, forearm, and wrist, without mention of infection
9135	Insect bite, nonvenomous, of elbow, forearm, and wrist, infected
9136	Superficial foreign body (splinter) of elbow, forearm, and wrist, without major open wound and without mention of infection

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Diagnosis Code	Description
9137	Superficial foreign body (splinter) of elbow, forearm, and wrist, without major open wound, infected
9138	Other and unspecified superficial injury of elbow, forearm, and wrist, without mention of infection
9139	Other and unspecified superficial injury of elbow, forearm, and wrist, infected
9140	Abrasion or friction burn of hand(s) except finger(s) alone, without mention of infection
9141	Abrasion or friction burn of hand(s) except finger(s) alone, infected
9142	Blister of hand(s) except finger(s) alone, without mention of infection
9143	Blister of hand(s) except finger(s) alone, infected
9144	Insect bite, nonvenomous, of hand(s) except finger(s) alone, without mention of infection
9145	Insect bite, nonvenomous, of hand(s) except finger(s) alone, infected
9146	Superficial foreign body (splinter) of hand(s) except finger(s) alone, without major open wound and without mention of infection
9147	Superficial foreign body (splinter) of hand(s) except finger(s) alone, without major open wound, infected
9148	Other and unspecified superficial injury of hand(s) except finger(s) alone, without mention of infection
9149	Other and unspecified superficial injury of hand(s) except finger(s) alone, infected
9150	Abrasion or friction burn of fingers, without mention of infection
9151	Abrasion or friction burn of fingers, infected
9152	Blister of fingers, without mention of infection
9153	Blister of fingers, infected
9154	Insect bite, nonvenomous, of fingers, without mention of infection
9155	Insect bite, nonvenomous of fingers, infected
9156	Superficial foreign body (splinter) of fingers, without major open wound and without mention of infection
9157	Superficial foreign body (splinter) of fingers, without major open wound, infected

Diagnosis Code	Description
9158	Other and unspecified superficial injury of fingers without mention of infection
9159	Other and unspecified superficial injury of fingers, infected
9160	Abrasion or friction burn of hip, thigh, leg, and ankle, without mention of infection
9161	Abrasion or friction burn of hip, thigh, leg, and ankle, infected
9162	Blister of hip, thigh, leg, and ankle, without mention of infection
9163	Blister of hip, thigh, leg, and ankle, infected
9164	Insect bite, nonvenomous, of hip, thigh, leg, and ankle, without mention of infection
9165	Insect bite, nonvenomous of hip, thigh, leg, and ankle, infected
9166	Superficial foreign body (splinter) of hip, thigh, leg, and ankle, without major open wound and without mention of infection
9167	Superficial foreign body (splinter) of hip, thigh, leg, and ankle, without major open wound, infected
9168	Other and unspecified superficial injury of hip, thigh, leg, and ankle, without mention of infection
9169	Other and unspecified superficial injury of hip, thigh, leg, and ankle, infected
9170	Abrasion or friction burn of foot and toe(s), without mention of infection
9171	Abrasion or friction burn of foot and toe(s), infected
9172	Blister of foot and toe(s), without mention of infection
9173	Blister of foot and toe(s), infected
9174	Insect bite, nonvenomous, of foot and toe(s), without mention of infection
9175	Insect bite, nonvenomous, of foot and toe(s), infected
9176	Superficial foreign body (splinter) of foot and toe(s), without major open wound and without mention of infection
9177	Superficial foreign body (splinter) of foot and toe(s), without major open wound, infected
9178	Other and unspecified superficial injury of foot and toes, without mention of infection

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Diagnosis Code	Description
9179	Other and unspecified superficial injury of foot and toes, infected
9180	Superficial injury of eyelids and periocular area
9181	Superficial injury of cornea
9182	Superficial injury of conjunctiva
9189	Other and unspecified superficial injuries of eye
9190	Abrasion or friction burn of other, multiple, and unspecified sites, without mention of infection
9191	Abrasion or friction burn of other, multiple, and unspecified sites, infected
9192	Blister of other, multiple, and unspecified sites, without mention of infection
9193	Blister of other, multiple, and unspecified sites, infected
9194	Insect bite, nonvenomous, of other, multiple, and unspecified sites, without mention of infection
9195	Insect bite, nonvenomous, of other, multiple, and unspecified sites, infected
9196	Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound and without mention of infection
9197	Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound, infected
9198	Other and unspecified superficial injury of other, multiple, and unspecified sites, without mention of infection
9199	Other and unspecified superficial injury of other, multiple, and unspecified sites, infected
920	Contusion of face, scalp, and neck except eye(s)
9210	Black eye, not otherwise specified
9211	Contusion of eyelids and periocular area
9212	Contusion of orbital tissues
9213	Contusion of eyeball
9219	Unspecified contusion of eye
9220	Contusion of breast
9221	Contusion of chest wall
9222	Contusion of abdominal wall
92231	Contusion of back
92232	Contusion of buttock
92233	Contusion of interscapular region
9224	Contusion of genital organs
9228	Contusion of multiple sites of trunk
9229	Contusion of unspecified part of trunk
92300	Contusion of shoulder region
92301	Contusion of scapular region
92302	Contusion of axillary region
92303	Contusion of upper arm
92309	Contusion of multiple sites of shoulder and upper arm
92310	Contusion of forearm
92311	Contusion of elbow
92320	Contusion of hand(s)
92321	Contusion of wrist
9233	Contusion of finger
9238	Contusion of multiple sites of upper limb
9239	Contusion of unspecified part of upper limb
92400	Contusion of thigh
92401	Contusion of hip
92410	Contusion of lower leg
92411	Contusion of knee
92420	Contusion of foot
92421	Contusion of ankle
9243	Contusion of toe
9244	Contusion of multiple sites of lower limb
9245	Contusion of unspecified part of lower limb
9248	Contusion of multiple sites, not elsewhere classified
9249	Contusion of unspecified site
9251	Crushing injury of face and scalp
9252	Crushing injury of neck
9260	Crushing injury of external genitalia
92611	Crushing injury of back
92612	Crushing injury of buttock
92619	Crushing injury of other specified sites of trunk
9268	Crushing injury of multiple sites of trunk
9269	Crushing injury of unspecified site of trunk
92700	Crushing injury of shoulder region
92701	Crushing injury of scapular region

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Diagnosis Code	Description
92702	Crushing injury of axillary region
92703	Crushing injury of upper arm
92709	Crushing injury of multiple sites of upper arm
92710	Crushing injury of forearm
92711	Crushing injury of elbow
92720	Crushing injury of hand(s)
92721	Crushing injury of wrist
9273	Crushing injury of finger(s)
9278	Crushing injury of multiple sites of upper limb
9279	Crushing injury of unspecified site of upper limb
92800	Crushing injury of thigh
92801	Crushing injury of hip
92810	Crushing injury of lower leg
92811	Crushing injury of knee
92820	Crushing injury of foot
92821	Crushing injury of ankle
9283	Crushing injury of toe(s)
9288	Crushing injury of multiple sites of lower limb
9289	Crushing injury of unspecified site of lower limb
9290	Crushing injury of multiple sites, not elsewhere classified
9299	Crushing injury of unspecified site
9300	Corneal foreign body
9301	Foreign body in conjunctival sac
9302	Foreign body in lacrimal punctum
9308	Foreign body in other and combined sites on external eye
9309	Foreign body in unspecified site on external eye
931	Foreign body in ear
932	Foreign body in nose
9330	Foreign body in pharynx
9331	Foreign body in larynx
9340	Foreign body in trachea
9341	Foreign body in main bronchus
9348	Foreign body in other specified parts bronchus and lung
9349	Foreign body in respiratory tree, unspecified
9350	Foreign body in mouth
9351	Foreign body in esophagus
9352	Foreign body in stomach

Diagnosis Code	Description
936	Foreign body in intestine and colon
937	Foreign body in anus and rectum
938	Foreign body in digestive system, unspecified
9390	Foreign body in bladder and urethra
9391	Foreign body in uterus, any part
9382	Foreign body in vulva and vagina
9393	Foreign body in penis
9399	Foreign body in unspecified site in genitourinary tract
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa
94100	Burn of unspecified degree of unspecified site of face and head
94101	Burn of unspecified degree of ear (any part)
94102	Burn of unspecified degree of eye (with other parts of face, head, and neck)
94103	Burn of unspecified degree of lip(s)
94104	Burn of unspecified degree of chin
94105	Burn of unspecified degree of nose (septum)
94106	Burn of unspecified degree of scalp (any part)
94107	Burn of unspecified degree of forehead and cheek
94108	Burn of unspecified degree of neck
94109	Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck
94110	Erythema due to burn (first degree) of unspecified site of face and head
94111	Erythema due to burn (first degree) of ear (any part)
94112	Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
94113	Erythema due to burn (first degree) of lip(s)

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Diagnosis Code	Description
94114	Erythema due to burn (first degree) of chin
94115	Erythema due to burn (first degree) of nose (septum)
94116	Erythema due to burn (first degree) of scalp (any part)
94117	Erythema due to burn (first degree) of forehead and cheek
94118	Erythema due to burn (first degree) of neck
94119	Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck
94120	Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site
94121	Blisters, with epidermal loss due to burn (second degree) of ear (any part)
94122	Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)
94123	Blisters, with epidermal loss due to burn (second degree) of lip(s)
94124	Blisters, with epidermal loss due to burn (second degree) of chin
94125	Blisters, with epidermal loss due to burn (second degree) of nose (septum)
94126	Blisters, with epidermal loss due to burn (second degree) of scalp (any part)
94127	Blisters, with epidermal loss due to burn (second degree) of forehead and cheek
94128	Blisters, with epidermal loss due to burn (second degree) of neck
94129	Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck
94130	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
94131	Full-thickness skin loss due to burn (third degree NOS) of ear (any part)
94132	Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
94133	Full-thickness skin loss due to burn (third degree NOS) of lip(s)
94134	Full-thickness skin loss due to burn (third degree NOS) of chin

Diagnosis Code	Description
94135	Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
94136	Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
94137	Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
94138	Full-thickness skin loss due to burn (third degree NOS) of neck
94139	Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part

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Diagnosis Code	Description
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part
94200	Burn of unspecified degree of unspecified site of trunk
94201	Burn of unspecified degree of breast
94202	Burn of unspecified degree of chest wall, excluding breast and nipple
94203	Burn of unspecified degree of abdominal wall
94204	Burn of unspecified degree of back (any part)
94205	Burn of unspecified degree of genitalia
94209	Burn of unspecified degree of other and multiple sites of trunk
94210	Erythema due to burn (first degree) of unspecified site of trunk
94211	Erythema due to burn (first degree) of breast
94212	Erythema due to burn (first degree) of chest wall, excluding breast and nipple

Diagnosis Code	Description
94213	Erythema due to burn (first degree) of abdominal wall
94214	Erythema due to burn (first degree) of back (any part)
94215	Erythema due to burn (first degree) of genitalia
94219	Erythema due to burn (first degree) of other and multiple sites of trunk
94220	Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk
94221	Blisters with epidermal loss due to burn (second degree) of breast
94222	Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
94223	Blisters with epidermal loss due to burn (second degree) of abdominal wall
94224	Blisters with epidermal loss due to burn (second degree) of back (any part)
94225	Blisters with epidermal loss due to burn (second degree) of genitalia
94229	Blisters with epidermal loss due to burn (second degree) of other and multiple sites of trunk
94230	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk
94231	Full-thickness skin loss due to burn (third degree NOS) of breast
94232	Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple
94233	Full-thickness skin loss due to burn (third degree NOS) of abdominal wall
94234	Full-thickness skin loss due to burn (third degree NOS) of back (any part)
94235	Full-thickness skin loss due to burn (third degree NOS) of genitalia
94239	Full-thickness skin loss due to burn (third degree NOS) of other and multiple sites of trunk
94240	Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part
94241	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast

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Diagnosis Code	Description
94242	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall
94243	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall
94244	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back
94245	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia
94249	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part
94250	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part
94251	Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast
94252	Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall
94253	Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall
94254	Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back
94255	Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia
94259	Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part
94300	Burn of unspecified degree of unspecified site of upper limb
94301	Burn of unspecified degree of forearm
94302	Burn of unspecified degree of elbow
94303	Burn of unspecified degree of upper arm
94304	Burn of unspecified degree of axilla
94305	Burn of unspecified degree of shoulder
94306	Burn of unspecified degree of scapular region
94309	Burn of unspecified degree multiple sites of upper limb, except wrist and hand
94310	Erythema due to burn (first degree) of unspecified site of upper limb
94311	Erythema due to burn (first degree) of forearm
94312	Erythema due to burn (first degree) of elbow
94313	Erythema due to burn (first degree) of upper arm
94314	Erythema due to burn (first degree) of axilla
94315	Erythema due to burn (first degree) of shoulder
94316	Erythema due to burn (first degree) of scapular region
94319	Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand
94320	Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb
94321	Blisters with epidermal loss due to burn (second degree) of forearm
94322	Blisters with epidermal loss due to burn (second degree) of elbow
94323	Blisters with epidermal loss due to burn (second degree) of upper arm
94324	Blisters with epidermal loss due to burn (second degree) of axilla
94325	Blisters with epidermal loss due to burn (second degree) of shoulder
94326	Blisters with epidermal loss due to burn (second degree) of scapular region
94329	Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand
94330	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb
94331	Full-thickness skin loss due to burn (third degree NOS) of forearm
94332	Full-thickness skin loss due to burn (third degree NOS) of elbow
94333	Full-thickness skin loss due to burn (third degree NOS) of upper arm
94334	Full-thickness skin loss due to burn (third degree NOS) of axilla

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Diagnosis Code	Description
94335	Full-thickness skin loss due to burn (third degree NOS) of shoulder
94336	Full-thickness skin loss due to burn (third degree NOS) of scapular region
94339	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand
94340	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part
94341	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm
94342	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow
94343	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm
94344	Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla
94345	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder
94346	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula
94349	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb
94350	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part
94351	Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm
94352	Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow
94353	Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm
94354	Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla

Diagnosis Code	Description
94355	Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder
94356	Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula
94359	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb
94400	Burn of unspecified degree of unspecified site of hand
94401	Burn of unspecified degree of single digit (finger (nail) other than thumb
94402	Burn of unspecified degree of thumb (nail)
94403	Burn of unspecified degree of two or more digits of hand, not including thumb
94404	Burn of unspecified degree of two or more digits of hand, including thumb
94405	Burn of unspecified degree of palm of hand
94406	Burn of unspecified degree of back of hand
94407	Burn of unspecified degree of wrist
94408	Burn of unspecified degree of multiple sites of wrist(s) and hand(s)
94410	Erythema due to burn (first degree) of unspecified site of hand
94411	Erythema due to burn (first degree) of single digit (finger (nail) other than thumb
94412	Erythema due to burn (first degree) of thumb (nail)
94413	Erythema due to burn (first degree) of two or more digits of hand, not including thumb
94414	Erythema due to burn (first degree) of two or more digits of hand including thumb
94115	Erythema due to burn (first degree) of palm of hand
94416	Erythema due to burn (first degree) of back of hand
94417	Erythema due to burn (first degree) of wrist
94418	Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)
94420	Blisters with epidermal loss due to burn (second degree) of unspecified site of hand

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Diagnosis Code	Description
94421	Blisters with epidermal loss due to burn (second degree) of single digit (finger (nail) other than thumb
94422	Blisters with epidermal loss due to burn of (second degree) of thumb (nail)
94423	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb
94424	Blisters with epidermal loss due to burn (second degree) of two or more digits of hand including thumb
94425	Blisters with epidermal loss due to burn (second degree) of palm of hand
94426	Blisters with epidermal loss due to burn (second degree) of back of hand
94427	Blisters with epidermal loss due to burn (second degree) of wrist
94428	Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)
94430	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand
94431	Full-thickness skin loss due to burn (third degree NOS) of single digit (finger (nail) other than thumb
94432	Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)
94433	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb
94434	Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb
94435	Full-thickness skin loss due to burn (third degree NOS) of palm of hand
94436	Full-thickness skin loss due to burn (third degree NOS) of back of hand
94437	Full-thickness skin loss due to burn (third degree NOS) of wrist
94438	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)
94440	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand
94441	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail) other than thumb, without mention of loss of finger
94442	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb
94443	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers
94444	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers
94445	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm
94446	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand
94447	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist
94448	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), without mention of loss of a body part
94450	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand
94451	Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger (nail) other than thumb, with loss of finger
94452	Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb
94453	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers
94454	Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers
94455	Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand
94456	Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand

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Diagnosis Code	Description
94457	Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist
94458	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part
94500	Burn of unspecified degree of unspecified site of lower limb (leg)
94501	Burn of unspecified degree of toe(s) (nail)
94502	Burn of unspecified degree of foot
94503	Burn of unspecified degree of ankle
94504	Burn of unspecified degree of lower leg
94505	Burn of unspecified degree of knee
94506	Burn of unspecified degree of thigh (any part)
94509	Burn of unspecified degree of multiple sites of lower limb(s)
94510	Erythema due to burn (first degree) of unspecified site of lower limb (leg)
94511	Erythema due to burn (first degree) of toe(s) (nail)
94512	Erythema due to burn (first degree) of foot
94513	Erythema due to burn (first degree) of ankle
94514	Erythema due to burn (first degree) of lower leg
94515	Erythema due to burn (first degree) of knee
94516	Erythema due to burn (first degree) of thigh (any part)
94519	Erythema due to burn (first degree) of multiple sites of lower limb(s)
94520	Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)
94521	Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)
94522	Blisters with epidermal loss due to burn (second degree) of foot
94523	Blisters with epidermal loss due to burn (second degree) of ankle
94524	Blisters with epidermal loss due to burn (second degree) of lower leg
94525	Blisters with epidermal loss due to burn (second degree) of knee
94526	Blisters with epidermal loss due to burn (second degree) of thigh (any part)

Diagnosis Code	Description
94529	Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)
94530	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb
94531	Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)
94532	Full-thickness skin loss due to burn (third degree NOS) of foot
94533	Full-thickness skin loss due to burn (third degree NOS) of ankle
94534	Full-thickness skin loss due to burn (third degree NOS) of lower leg
94535	Full-thickness skin loss due to burn (third degree NOS) of knee
94536	Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)
94539	Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)
94540	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part
94541	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)
94542	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot
94543	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle
94544	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg
94545	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee
94546	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh
94549	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part
94550	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part

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Diagnosis Code	Description
94551	Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)
94552	Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot
94553	Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle
94554	Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg
94555	Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee
94556	Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh
94559	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part
9460	Burns of multiple specified sites, unspecified degree
9461	Erythema due to burn (first degree) of multiple specified sites
9462	Blisters with epidermal loss due to burn (second degree) of multiple specified sites
9463	Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites
9464	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part
9465	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part
9470	Burn of mouth and pharynx
9471	Burn of larynx, trachea, and lung
9472	Burn of esophagus
9473	Burn of gastrointestinal tract
9474	Burn of vagina and uterus
9478	Burn of other specified sites of internal organs
9479	Burn of internal organs, unspecified site
94800	Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount

Diagnosis Code	Description
94810	Burn (any degree) involving 10–19 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94811	Burn (any degree) involving 10–19 percent of body surface with third degree burn of 10–19 percent
94820	Burn (any degree) involving 20–29 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94821	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 10–19 percent
94822	Burn (any degree) involving 20–29 percent of body surface with third degree burn of 20–29 percent
94830	Burn (any degree) involving 30–39 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94831	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 10–19 percent
94832	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 20–29 percent
94833	Burn (any degree) involving 30–39 percent of body surface with third degree burn of 30–39 percent
94840	Burn (any degree) involving 40–49 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94841	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 10–19 percent
94842	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 20–29 percent
94843	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 30–39 percent
94844	Burn (any degree) involving 40–49 percent of body surface with third degree burn of 40–49 percent
94850	Burn (any degree) involving 50–59 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94851	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 10–19 percent

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Diagnosis Code	Description
94852	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 20–29 percent
94853	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 30–39 percent
94854	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 40–49 percent
94855	Burn (any degree) involving 50–59 percent of body surface with third degree burn of 50–59 percent
94860	Burn (any degree) involving 60–69 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94861	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 10–19 percent
94862	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 20–29 percent
94863	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 30–39 percent
94864	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 40–49 percent
94865	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 50–59 percent
94866	Burn (any degree) involving 60–69 percent of body surface with third degree burn of 60–69 percent
94870	Burn (any degree) involving 70–79 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94871	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 10–19 percent
94872	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 20–29 percent
94873	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 30–39 percent
94874	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 40–49 percent
94875	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 50–59 percent

Diagnosis Code	Description
94876	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 60–69 percent
94877	Burn (any degree) involving 70–79 percent of body surface with third degree burn of 70–79 percent
94880	Burn (any degree) involving 80–89 percent of body surface with third degree burn of less than 10 percent or unspecified amount
94881	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 10–19 percent
94882	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 20–29 percent
94883	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 30–39 percent
94884	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 40–49 percent
94885	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 50–59 percent
94886	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 60–69 percent
94887	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 70–79 percent
94888	Burn (any degree) involving 80–89 percent of body surface with third degree burn of 80–89 percent
94890	Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount
94891	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10–19 percent
94892	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20–29 percent
94893	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30–39 percent
94894	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40–49 percent
94895	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50–59 percent

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Diagnosis Code	Description
94896	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60–69 percent
94897	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70–79 percent
94898	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80–89 percent
94899	Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface
9490	Burn of unspecified site, unspecified degree
9491	Erythema due to burn (first degree), unspecified site
9492	Blisters with epidermal loss due to burn (second degree), unspecified site
9493	Full-thickness skin loss due to burn (third degree NOS), unspecified site
9494	Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part
9495	Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part
9500	Optic nerve injury
9501	Injury to optic chiasm
9502	Injury to optic pathways
9503	Injury to visual cortex
9509	Injury to unspecified optic nerve and pathways
9510	Injury to oculomotor nerve
9511	Injury to trochlear nerve
9512	Injury to trigeminal nerve
9513	Injury to abducens nerve
9514	Injury to facial nerve
9515	Injury to acoustic nerve
9516	Injury to accessory nerve
9517	Injury to hypoglossal nerve
9518	Injury to other specified cranial nerves
9519	Injury to unspecified cranial nerve
95200	C1-C4 level spinal cord injury, unspecified
95201	C1-C4 level with complete lesion of spinal cord
95202	C1-C4 level with anterior cord syndrome
95203	C1-C4 level with central cord syndrome
95204	C1-C4 level with other specified spinal cord injury
95205	C5-C7 level spinal cord injury, unspecified
95206	C5-C7 level with complete lesion of spinal cord
95207	C5-C7 level with anterior cord syndrome
95208	C5-C7 level with central cord syndrome
95209	C5-C7 level with other specified spinal cord injury
95210	T1-T6 level spinal cord injury, unspecified
95211	T1-T6 level with complete lesion of spinal cord
95212	T1-T6 level with anterior cord syndrome
95213	T1-T6 level with central cord syndrome
95214	T1-T6 level with other specified spinal cord injury
95215	T7-T12 level spinal cord injury, unspecified
95216	T7-T12 level with complete lesion of spinal cord
95217	T7-T12 level with anterior cord syndrome
95218	T7-T12 level with central cord syndrome
95219	T7-t12 level with other specified spinal cord injury
9522	Lumbar spinal cord injury without spinal bone injury
9523	Sacral spinal cord injury without spinal bone injury
9524	Cauda equina spinal cord injury without spinal bone injury
9528	Multiple sites of spinal cord injury without spinal bone injury
9529	Unspecified site of spinal cord injury without spinal bone injury
9530	Injury to cervical nerve root
9531	Injury to dorsal nerve root
9532	Injury to lumbar nerve root
9533	Injury to sacral nerve root
9534	Injury to brachial plexus
9535	Injury to lumbosacral plexus

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Diagnosis Code	Description
9538	Injury to multiple sites of nerve roots and spinal plexus
9539	Injury to unspecified site of nerve roots and spinal plexus
9540	Injury to cervical sympathetic nerve, excluding shoulder and pelvic girdles
9541	Injury to other sympathetic nerve, excluding shoulder and pelvic girdles
9548	Injury to other specified nerve(s) of trunk, excluding shoulder and pelvic girdles
9549	Injury to unspecified nerve of trunk, excluding shoulder and pelvic girdles
9550	Injury to axillary nerve
9551	Injury to median nerve
9552	Injury to ulnar nerve
9553	Injury to radial nerve
9554	Injury to musculocutaneous nerve
9555	Injury to cutaneous sensory nerve, upper limb
9556	Injury to digital nerve, upper limb
9557	Injury to other specified nerve(s) of shoulder girdle and upper limb
9558	Injury to multiple nerves of shoulder girdle and upper limb
9559	Injury to unspecified nerve of shoulder girdle and upper limb
9560	Injury to sciatic nerve
9561	Injury to femoral nerve
9562	Injury to posterior tibial nerve
9563	Injury to peroneal nerve
9564	Injury to cutaneous sensory nerve, lower limb
9565	Injury to other specified nerve(s) of pelvic girdle and lower limb
9568	Injury to multiple nerves of pelvic girdle and lower limb
9569	Injury to unspecified nerve of pelvic girdle and lower limb
9570	Injury to superficial nerves of head and neck
9571	Injury to other specified nerve(s)
9578	Injury to multiple nerves in several parts
9579	Injury to nerves, unspecified site
9580	Air embolism as an early complication of trauma
9581	Fat embolism as an early complication of trauma

Diagnosis Code	Description
9582	Secondary and recurrent hemorrhage as an early complication of trauma
9583	Post-traumatic wound infection not elsewhere classified
9584	Traumatic shock
9585	Traumatic anuria
9586	Volkmann's ischemic contracture
9587	Traumatic subcutaneous emphysema
9588	Other early complications of trauma
95901	Other and unspecified injury to head
95909	Other and unspecified injury to face and neck
95911	Other injury of chest wall
95912	Other injury of abdomen
95913	Fracture of corpus cavernosum penis
95914	Other injury of external genitals
95919	Other injury of other sites of trunk
9592	Other and unspecified injury to shoulder and upper arm
9593	Other and unspecified injury to elbow, forearm, and wrist
9594	Other and unspecified injury to hand, except finger
9595	Other and unspecified injury to finger
9596	Other and unspecified injury to hip and thigh
9597	Other and unspecified injury to knee, leg, ankle, and foot
9598	Other and unspecified injury to other specified sites, including multiple
9599	Other and unspecified injury to unspecified site

36.4.21.51 Thymoglobulin®

Thymoglobulin® anti-thymocyte globulin (procedure code 1-J7511) is a benefit of the Texas Medicaid Program. Thymoglobulin is approved by the FDA for treatment of inpatients with a diagnosis of renal transplant acute rejection.

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36.4.21.52 Thyrogen® (Thyrotropin Alpha for Injection)

Procedure code 1-J3240 reimburses at $465.40, and is a benefit of the Texas Medicaid Program. The injection is reimbursed when billed with one of the following diagnosis codes:

Diagnosis Code	Description
1613	Malignant neoplasm of laryngeal cartilages
193	Malignant neoplasm of thyroid gland
2310	Carcinoma in situ of larynx
2348	Carcinoma in situ of other specified sites
2356	Neoplasm of uncertain behavior of larynx
2374	Neoplasm of uncertain behavior, thyroid gland
2397	Neoplasm of unspecified nature of endocrine glands and other parts of nervous system
2409	Goiter, unspecified
24200	Toxic diffuse goiter without mention of thyrotoxic crisis or storm
24220	Toxic multinodular goiter without mention of thyrotoxic crisis or storm
V1087	Personal history of malignant neoplasm of thyroid

36.4.21.53 Topotecan

Use procedure code 1-J9350 to bill Topetecan. It is payable if used for the treatment of females with metastatic ovarian carcinoma after failure of first-line or subsequent chemotherapy for the following diagnosis codes only:

Diagnosis Code	Description
1623	Malignant neoplasm of upper lobe, bronchus or lung
1624	Malignant neoplasm of middle lobe, bronchus or lung
1625	Malignant neoplasm of lower lobe, bronchus or lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified
1830	Malignant neoplasm of ovary
1986	Secondary malignant neoplasm of ovary

36.4.21.54 Trastuzumab

Procedure code 1-J9355 is a benefit. Reimbursement for this drug is considered when it is used as a single agent for the treatment of clients with metastatic breast cancer whose tumors overexpress the HER2 protein and who have received one or more chemotherapy regimens for their metastatic disease.

Trastuzumab is also payable when used in combination with paclitaxel for the treatment of clients with metastatic breast cancer whose tumors overexpress the HER2 protein and who have not received chemotherapy for their metastatic disease. Use Herceptin only on patients whose tumors have HER2 protein overexpression.

When billing for procedure code 1-J9355, one of the following appropriate diagnosis codes must appear on the claim:

Diagnosis Code	Description
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast

Procedure code 1-J9355 is payable in the office, home, outpatient hospital, and nursing home. If a provider requests that a CCP client receive this drug in the home, prior authorization must be obtained through the TMHP CCP Department. Trastuzumab, intravenous, per 10 mg, is paid at a maximum of $52.38 per 10 mg to physicians, PAs, NPs, CNSs, and medical suppliers. Inpatient facilities are reimbursed under their DRG, and outpatient facilities are reimbursed at their reimbursement rate.

When billing for the test used to determine whether a client overexpresses the HER2 protein, use procedure code 5-83950. This test is payable in the office, inpatient/outpatient hospital, and independent laboratory. Procedure code 5-83950 is reimbursed at a maximum of $89.01. Diagnosis of overexpression of the HER2 protein must be made before the Texas Medicaid

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Program will consider reimbursement for trastuzumab. This test is payable only once in a client's lifetime for the same provider. An additional test by the same provider requires more information to support the medical necessity.

36.4.21.55 Valrubicin Sterile Solution for Intravesical Instillation (Valstar)

Procedure code 1-J9357 is reimbursed for clients with the diagnosis of bladder cancer in situ who have been treated unsuccessfully with BCG therapy and have an unacceptable morbidity or mortality risk if immediate cystectomy should be performed. Documentation of diagnosis and treatment must be submitted with the claim. Valrubicin is reimbursed only when given in the office or outpatient setting.

36.4.21.56 Vitamin B_{12} (Cyanocobalamin)

Vitamin B_{12} or cyanocobalamin is a water-soluble B-Complex vitamin that helps maintain the myelin sheath that surrounds the nerves. It is needed for the production of red blood cells and the metabolism of fatty acids, carbohydrates, and proteins. Vitamin B_{12} or cyanocobalamin is essential for DNA synthesis, cell division, and growth in children.

Use procedure code 1-J3420 when requesting reimbursement of vitamin B_{12} (cyanocobalamin) injections.

Reimbursement of Vitamin B_{12} (cyanocobalamin) injections is limited to the following diagnosis codes:

Diagnosis Code	Description
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
25061	Diabetes with neurological manifestations, type I (juvenile type), not stated as uncontrolled
25062	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled
25063	Diabetes with neurological manifestations, type I (juvenile type), uncontrolled
2810	Pernicious anemia
3572	Polyneuropathy in diabetes
5793	Other and unspecified postsurgical nonabsorption
5798	Other specified intestinal malabsorption
5799	Unspecified intestinal malabsorption
64820	Anemia of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
V152	Personal history of surgery to other major organs, presenting hazards to health

36.4.22 Laboratory Services

Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the patient's medical record as medically necessary and referenced to an appropriate diagnosis. Medicaid does not reimburse baseline or screening laboratory studies.

If a physician performs more than 100 laboratory tests per year for other providers in their laboratory, the laboratory must be certified by Medicare, and the provider must enroll as an independent laboratory with TMHP. A physician laboratory is defined as one owned by the physician, located in the office area, and the laboratory where the physician performs or personally supervises laboratory tests daily. Personal supervision means the physician must be in the building of the office or facility when and where the service is provided.

Exception: *All laboratory work related to a THSteps medical checkup must be submitted to the DSHS Laboratory.*

Refer to: *Section 26.3.1, "Texas Health Steps (THSteps) Outpatient Laboratory Services" on page 26-3 and Section 43.3.1, "Laboratory Services" on page 43-27, for specific information on the required use of the DSHS Laboratory for THSteps laboratory tests.*

Only physicians may bill for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory should not be billed on the physician's claim. The laboratory bills Medicaid directly for the tests it performs. A physician may bill a laboratory handling fee (1-99000) if the specimen is obtained by venipuncture or catheterization *and* sent to an outside lab. The identity of the laboratory must be listed on the claim form.

The laboratory handling fee covers the expense of obtaining and packaging the specimen to a reference laboratory. Providers may be reimbursed one laboratory handling fee a day per client, unless *multiple* specimens are obtained and sent to *different* laboratories. When billing for a laboratory handling fee, the physician must document that a specimen was sent to a reference laboratory in Block 20 of the CMS-1500 claim form and indicate the reference laboratory name and address or nine-digit provider identifier in the appropriate field of the electronic claim form or Block 32 of the CMS-1500 paper claim form. The physician is required to forward the client's name, address, Medicaid number, and diagnosis,

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if appropriate, with the specimen to the reference laboratory so the laboratory may bill the Texas Medicaid Program for its services.

A physician may bill only one laboratory handling fee per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This policy does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

Interpretation of laboratory tests for patients is considered part of the physician's professional services (hospital, office, or emergency room visits) and should not be billed separately.

Laboratory tests generally considered part of a laboratory panel (chemistries, CBCs, urinalyses [UAs] and performed on the same day must be billed as a panel regardless of the method used to perform the tests [automated or manual]).

Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and referral laboratory providers must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. These services are not billable to Medicaid-covered clients. Physician interpretations, that are requested of a consulting pathologist and require professional reading and reporting of results, may be billed to Medicaid separately as a professional charge.

All providers of laboratory services must comply with CLIA rules and regulations. Providers not complying with CLIA cannot be reimbursed for laboratory services.

The *Deficit Reduction Act* (DEFRA) limited reimbursement of clinical laboratory services provided by a physician laboratory or an independent laboratory to a national fee schedule.

Refer to: "Laboratory Paneling" on page 26-5 for claims processing instructions.
"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.
"Reimbursement" on page 2-2.

36.4.22.1 Blood Counts

A CBC is a comprehensive service that includes components. A CBC is billed with one of the following procedure codes: 5-85025, 5-85027, and 5-85032.

The components of a CBC are listed in the following table. Any of these procedure codes billed for the same date of service as a CBC procedure code will deny as part of another service:

Procedure Codes		
5-85004	5-85007	5-85008
5-85009	5-85013	5-85014
5-85018	5-85041	5-85048
5-85049	5-85055	

Procedure code 5-85049 may be reimbursed separately in addition to procedure codes 5-85031, 5-85014, 5-85018, and 5-85032. If this procedure code is billed for the same date of service as procedure codes 5-85004, 5-85007, 5-85008, 5-85009, or 5-85025 and 5-85027, it will deny as part of another service.

The following reticulocyte procedure codes may be reimbursed in addition to a CBC: 5-85044, 5-85045, and 5-85046.

36.4.22.2 Clinical Lab Panel Implementation

The AMA has discontinued the following general multi-channel automated panel codes because the panel did not define exactly what tests were performed:

Procedure Codes		
5-80002	5-80003	5-80004
5-80005	5-80006	5-80007
5-80008	5-80009	5-80010
5-80011	5-80012	5-80016
5-80018	5-80019	5-G0058
5-G0059	5-G0060	

A new Medicare policy pertaining to laboratory paneling procedures was implemented by the Texas Medicaid Program. The new organ and disease panel codes 5-80048, 5-80051, and 5-80053 must be used instead of the general multichannel automated panel codes above.

The new organ or disease panels include the following codes:

5-80048 – Basic metabolic panel includes:		
5-82310	5-82374	5-82435
5-82565	5-82947	5-84132
5-84295	5-84520	

5-80051 – Electrolyte panel includes:		
5-82374	5-82435	5-84132
5-84295		

5-80053 – Comprehensive metabolic panel includes:		
5-82040	5-82247	5-82310
5-82374	5-82435	5-82565
5-82947	5-84075	5-84132
5-84155	5-84295	5-84450
5-84460	5-84520	

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36.4.22.3 Clinical Pathology Consultations

Procedure codes 3-80500 and 3-80502 should be used for clinical pathology consultations.

Providers may be reimbursed for clinical pathology consultation when the claim indicates the following information:

- The request is initiated by the client's attending physician and includes the name and address or Medicaid provider identifier of the physician requesting the consultation.
- The request relates to a test result that lies outside the normal or expected range in view of the condition of the patient.
- The patient's diagnosis.
- The clinical test(s) requiring the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client's medical record.

If the claim does not include *all* of this information, the clinical pathology consultation will be denied.

Clinical pathology consultations cannot be paid for surgical and anatomical pathology services or any other pathology services payable in an inpatient hospital (POS 3) and an outpatient hospital (POS 5) (e.g., bone marrows, gross and microscopic exam, etc.).

A pathology consultation must always involve *medical interpretive judgment* that ordinarily requires a physician. Routine conversations held between a pathologist and attending physicians about test orders or results are not consultations.

Generally, only one clinical pathology consultation should be allowed per day by the same provider. Additional consultations per day, with supporting documentation of medical necessity, will be considered for payment on an individual basis.

Certain procedures are not usually performed by a pathologist, such as the following procedure codes used for office, outpatient, or inpatient consultations:

Procedure Codes		
3-99241	3-99242	3-99243
3-99244	3-99245	3-99251
3-99252	3-99253	3-99254
3-99255		

Therefore, if these procedures should be billed by this specialty type, the procedure code will autodeny with the message, "This procedure not covered for this provider specialty." Payment will be considered on an individual appeal basis if a pathologist can document the medical necessity of performing these procedures.

The specialties designated for pathologists are listed in the following table:

Specialty	Description
21	Pathology (DO)
22	Pathology (MD)

36.4.22.4 Cytogenetics Testing for Leukemia and Lymphoma

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes. This does not refer to genetic services.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

Diagnosis Code	Description
20280	Other malignant lymphomas, unspecified site
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites
2029	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb

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Diagnosis Code	Description
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of multiple sites
20400	Lymphoid leukemia, acute, without mention of remission
20401	Lymphoid leukemia, acute, in remission
20410	Lymphoid leukemia, chronic, without mention of remission
20411	Lymphoid leukemia, chronic, in remission
20420	Lymphoid leukemia, subacute, without mention of remission
20421	Lymphoid leukemia, subacute, in remission
20480	Other lymphoid leukemia, without mention of remission
20481	Other lymphoid leukemia, in remission
20490	Unspecified lymphoid leukemia, without mention of remission
20491	Unspecified lymphoid leukemia, in remission
20500	Myeloid leukemia, acute, without mention of remission
20501	Myeloid leukemia, acute, in remission
20510	Myeloid leukemia, chronic, without mention of remission
20511	Myeloid leukemia, chronic, in remission
20520	Myeloid leukemia, subacute, without mention of remission
20521	Myeloid leukemia, subacute, in remission
20530	Myeloid sarcoma, without mention of remission
20531	Myeloid sarcoma, in remission
20580	Other myeloid leukemia, without mention of remission
20581	Other myeloid leukemia, in remission

Diagnosis Code	Description
20590	Unspecified myeloid leukemia, without mention of remission
20591	Unspecified myeloid leukemia, in remission
20600	Monocytic leukemia, acute, without mention of remission
20601	Monocytic leukemia, acute, in remission
20610	Monocytic leukemia, chronic without mention of remission
20611	Monocytic leukemia, chronic, in remission
20620	Monocytic leukemia, subacute, without mention of remission
20621	Monocytic leukemia, subacute, in remission
20680	Other monocytic leukemia, without mention of remission
20681	Other monocytic leukemia, in remission
20690	Unspecified monocytic leukemia, without mention of remission
20691	Unspecified monocytic leukemia, in remission
20700	Acute erythremia and erythroleu-kemia, without mention of remission
20701	Acute erythremia and erythroleu-kemia, in remission
20710	Chronic erythremia, without mention of remission
20711	Chronic erythremia, in remission
20720	Megakaryocytic leukemia, without mention of remission
20721	Megakaryocytic leukemia, in remission
20780	Other specified leukemia, without mention of remission
20781	Other specified leukemia, in remission
20800	Leukemia of unspecified cell type, acute, without mention of remission
20801	Leukemia of unspecified cell type, acute, in remission
20810	Leukemia of unspecified cell type, chronic, without mention of remission
20811	Leukemia of unspecified cell type, chronic, in remission
20820	Leukemia of unspecified cell type, subacute, without mention of remission

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Diagnosis Code	Description
20821	Leukemia of unspecified cell type, subacute, in remission
20880	Other leukemia of unspecified cell type, without mention of remission
20881	Other leukemia of unspecified cell type, in remission
20890	Unspecified leukemia, without mention of remission
20891	Unspecified leukemia, in remission

Cytogenetics testing is payable with the following procedure codes:

Procedure Codes		
Tissue Cultures		
5-88230	5-88233	5-88235
5-88237	5-88239	
Cryopreservation and Thawing		
5-88240	5-88241	
Chromosome Analysis		
5-88245	5-88248	5-88249
5-88261	5-88262	5-88263
5-88264	5-88267	5-88269
5-88280	5-88283	5-88285
5-88289		
Molecular Cytogenetics		
5-88271	5-88272	5-88273
5-88274	5-88275	
Interpretation and Report		
5-88291		

The following information pertains to the procedure codes in the Cytogenetics Testing Procedure Code table above:

- Each provider may be paid one culture procedure (tissue culture section) and one chromosome analysis procedure (chromosome analysis section) for the same client on the same day. Each client will be limited to six culture procedures (tissue culture section) and six chromosome analysis procedures (chromosome analysis section) per 365 days. Each client will be limited to one cryopreservation and thawing procedure (cryopreservation and thawing section) and one molecular cytogenetics procedure (molecular cytogenetics section) per 365 days.
- The procedures listed in the tissue cultures, cryopreservation and thawing, and molecular cytogenetics sections may be reimbursed when billed together for the same date of service. Only one procedure per section will be reimbursed and the others will be denied as *part of*.
- Within the chromosome analysis section, only one procedure code can be reimbursed for each of the following subcategories. The other procedure codes will be denied as *part of.*
  - Breakage syndromes: 5-88245, 5-88248, 5-88249 (when billed together, only one of these procedure codes will be reimbursed).
  - Cell counts: 5-88261, 5-88262, 5-88263, and 5-88264 (when billed together, only one of these procedure codes will be reimbursed).
  - Additional studies: 5-88280, 5-88283, 5-88285, 5-88289 (when billed together, only one of these procedure codes will be reimbursed).

36.4.22.5 Maternal Serum Alpha-Fetoprotein

Maternal serum alpha-fetoprotein (MSAFP) may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim.

Refer to: "Genetic Services" on page 22-1 for genetic follow-up to a positive MSAFP.

36.4.23 Mastectomy and Breast Reconstruction

Mastectomy is a covered benefit of the Texas Medicaid Program. Reimbursement is provided for the following mastectomy procedure codes:

Procedure Codes		
2/8/F-19160	2/8/F-19162	2/8/F-19180
2/8/F-19182	2/8-19200	2/8-19220
2/8 -19240		

Mastectomy is a medically necessary procedure for a diagnosis of malignant breast cancer. Mastectomy is a benefit of the Texas Medicaid Program and is diagnosis-restricted. Reimbursement for a mastectomy is provided when billed with a diagnosis listed in the following table:

Diagnosis Code	Description
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast

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Diagnosis Code	Description
1748	Malignant neoplasm of other specified sites of female breast
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
19881	Secondary malignant neoplasm of breast
2330	Carcinoma in situ of breast
V103	Personal history of malignant neoplasm of breast

Breast reconstruction following a medically necessary mastectomy is a covered benefit of the Texas Medicaid Program when the following criteria are met:

- The client is Medicaid-eligible at the time of the breast reconstruction.
- The physician has documented a plan addressing the recommended breast reconstruction in the client's chart.

Breast reconstruction following a medically necessary mastectomy is diagnosis-restricted to the codes listed in the previous table.

Procedure Codes		
2/8/F-19340	2/8/F-19342	2/F-19350
2/8/F-19357	2/8/F-19361	2/8/F-19364
2/8/F-19366	2/8/F-19367	2/8/F-19368
2/8/F-19369		

Reimbursement is provided for complications of breast reconstruction, if any, when the complications occur during the time the client is eligible for the breast reconstruction benefit.

Procedure codes 2/F-19370, 2/F-19371, and 2/F-19380 may be used when billing for surgical intervention of complications following reconstructive breast surgery.

Breast reconstruction may be completed as multiple, staged procedures, such as tissue expansion followed by implants, and nipple/areola reconstruction.

Breast reconstruction may be completed using either saline or silicone implants or tissue transfers such as TRAM, latissimus dorsi, or gluteal flaps.

Surgery on the unaffected breast to achieve symmetry is not a covered benefit.

An external breast prosthesis is not a covered benefit.

The professional billing for Medicaid clients who are members of PCCM will be processed using the same diagnosis restrictions that apply to mastectomy and breast reconstruction for Medicaid fee-for-service clients. However, the associated hospitalizations are subject to concurrent review, and therefore hospitals must notify PCCM of admissions within the time frames for all of their hospital notification requirements.

36.4.24 Obstetrics/Prenatal Care

Medicaid reimburses antepartum care, deliveries (to include Cesarean sections performed by physicians), and postpartum care as individual procedures. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on *one* claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide antepartum care and choose to submit antepartum visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Important: *Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and be received by TMHP within 95 days of the date of service.*

Use modifier TH with all antepartum procedure codes.

Initial prenatal visits are payable with the following procedure codes with modifier TH: 1-99201, 1-99202, 1-99203, 1-99204, and 1-99205. These procedure codes for initial prenatal visits are limited to one per pregnancy, same provider. If billed more frequently than every seven months, documentation must support that the visits are for two different pregnancies. High risk pregnancy visits should be billed based on level of care and complexity of the visit using the appropriate procedure code with the TH modifier.

Antepartum care visits are payable for the following procedure codes with modifier TH: 2-99211, 2-99212, 2-99213, 2-99214, 2-99215, 2-99341, 2-99342, 2-99343, 2-99344, and 2-99345.

The initial antepartum visit is limited to one per client, per pregnancy, per provider.

The following is a recommended guide for the frequency of antepartum visits for a low-risk pregnancy:

- One visit every four weeks for the first 28 weeks
- One visit every two to three weeks from 28 to 36 weeks
- One visit every week at greater than 36 weeks to delivery

In POS 1 (office), 5 (outpatient), and 7 (birthing center), physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 antepartum care visits per pregnancy and two postpartum care visits after discharge from the hospital. Routine pregnancies are

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anticipated to require around 11 visits per pregnancy, and high-risk pregnancies are anticipated to require around 20 visits per pregnancy.

More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.

Providers are reimbursed more for high-risk antepartum care visits than for regular pregnancy antepartum care visits.

The high-risk diagnosis must be documented on the claim form. The nature of the high-risk care visit must be identified in the Diagnosis field (Block 21) of the CMS-1500 claim form or the appropriate electronic field.

Antepartum and postpartum care visits billed in and inpatient hospital (POS 3) are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

Postpartum care provided after discharge must be billed using procedure code 2-59430 with modifier TH. A maximum of two postpartum visits are allowed.

If a client is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis listed on the claim. Use of the appropriate E/M, antepartum, or postpartum procedure codes is necessary for appropriate reimbursement.

If the physician in the office sees a client for a diagnosis unrelated to the pregnancy, the nonpregnancy diagnosis must be listed as the primary diagnosis on the claim and the services referenced appropriately. Use of the appropriate E/M, antepartum, or postpartum procedure code is necessary for appropriate reimbursement.

The following are the delivery and Cesarean section procedure codes physicians must use to bill the Texas Medicaid Program: 2-59409, 2-59410, 2-59515, 2-59614, and 8-59515.

Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined under "Anesthesia for Labor and Delivery" on page 36-24. The Texas Medicaid Program reimburses the anesthesia services and the delivery at full allowance when provided by the delivering obstetrician. Procedure codes 2-62311 and 2-62319 are reimbursed according to the TMRM fee. For continuous epidural analgesia, the Texas Medicaid Program reimburses for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences. Claims for procedure codes 7-01967 and 7-01968 must indicate the time spent administering the epidural and actual time spent with the client. Insertion and injection of the epidural are not reimbursed separately when billed with the CPT anesthesia delivery codes (2-59410, 2-59515, 2-59614, 2/8-59622). Medicaid reimburses only one delivery or Cesarean section procedure code per client in a seven month period; reimbursement includes multiple births.

Procedure code 1-99140 is not reimbursed when diagnosis codes 650 (Normal delivery), or 66970 (Cesarean delivery, without mention of indication, unspecified as to episode of care) are documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client's life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate CPT E/M care codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.

Refer to: "Anesthesia" on page 36-24 for complete information about anesthesia for obstetrical procedures.

36.4.24.1 Ultrasound of the Pregnant Uterus

Ultrasound of the pregnant uterus is a covered benefit of the Texas Medicaid Program when medically indicated. Ultrasound of the pregnant uterus may be paid separately when billed by physicians.

Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Medical documentation supporting the medical necessity and appropriateness of additional ultrasounds *must* be present in the client's chart and is subject to retrospective review.

The total component of the codes listed in the following table may be considered for reimbursement in the office and outpatient settings. The professional component may be considered for reimbursement in the office or outpatient setting, when billed by a different provider or by the same provider in a different POS with documentation that supports the need for both visits. The professional component is considered part of a hospital or consultation visit, when provided in the inpatient setting. The technical component may be considered for reimbursement in the office and outpatient settings.

The following procedures may be billed for ultrasound of the pregnant uterus:

Procedure Codes		
4/I/T-76801	4/I/T-76802	4/I/T/G-76805
4/I/T/G-76810	4/I/T/G-76811	4/I/T/G-76812
4/I/T/G-76815	4/I/T/G-76816	4/I/T-76817
4/I/T/G-76818	4/I/T/G-76819	4/I/T-76820
4/I/T-76821		

The modifier TS may be billed with procedure codes 76811 and 76812 to indicate follow-up ultrasounds.

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When multiple ultrasound procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied. Fetal biophysical profile (4/I/T/G-76818 and 4/I/T/G-76819) may be reimbursed separately when billed with 4/I/T-76801, 4/I/T-76802, 4/I/T/G-76805, 4/I/T/G-76810, 4/I/T/G-76811, 4/I/T/G-76812, 4/I/T/G-76815, or 4/I/T/G-76816 on the same day. Procedure code 4/I/T/G-76819 will deny as part of procedure code 4/I/T/G-76818 when billed for the same date of service.

Procedure codes G-76805, G-76810, G-76811, G-76812, G-76815, G-76816, G-76818, or G-76819 may be reimbursed to providers of genetic services. A repeat ultrasound study performed as a result of abnormal genetic findings must be billed using procedure code G-76816 when medically appropriate.

Procedure codes 4/T-76805, 4/T-76810, 4/T-76811, 4/T-76812, 4/T-76815, 4/T-76816, and 4/T-76818 may be reimbursed to the following provider types: County Indigent Health Care Program (CIHCP) providers, NPs, CNSs, PAs, physicians, CNMs, outpatient hospitals, and hospital-based RHCs.

Procedure codes I-76805, I-76810, I-76811, I-76812, I-76815, I-76816, and I-76818 may be reimbursed to the following provider types: CIHCP providers, NPs, CNSs, PAs, physicians, and CNMs.

Physicians, such as fetal-maternal specialists, caring for high-risk clients are anticipated to perform an increased number of follow-up ultrasounds. Medical documentation supporting the medical necessity and appropriateness of additional ultrasounds must be present in the client's chart and is subject to retrospective review.

36.4.24.2 External Cephalic Version

External cephalic version is the external manipulation of a fetus to alter its position in the uterus to make it more favorable for delivery.

Procedure code 2-59412 is payable in the inpatient hospital (POS 3) or outpatient hospital (POS 5) setting when billed as an independent procedure performed by a physician at least one day before delivery. Procedure code 2-59412 billed on the same day as a delivery by the same provider is denied.

Emergency room and subsequent hospital care visit procedure codes billed the same day as external cephalic version by the same provider are denied.

36.4.24.3 Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT

Procedure code 2-59000 is the procedure of inserting a needle into the uterus through the abdominal wall for the purpose of withdrawing amniotic fluid, which is used to assess fetal health and maturity.

Procedure code 2-59012 is the procedure of entering the pregnant uterus and amniotic sac, identifying the umbilical cord, and obtaining a blood sample from a vein in the umbilical cord.

Procedure code 2-36460 is the procedure of accessing a fetal blood vessel to transfuse the fetus in utero.

In addition to the physician performing the amniocentesis, cordocentesis, or FIUT, another physician may assist with echography control.

Procedure Codes		
2-36460	2/G-59000	2-59001
2-59012	4/I/T-76941	4/I/T-76946

Procedure code 2-59001 is diagnosis-restricted to the following codes:

Diagnosis Code	Description
65700	Polyhydramnios, unspecified as to episode of care
65701	Polyhydramnios, with delivery
65703	Polyhydramnios, antepartum complication

FIUT, cordocentesis, and ultrasonic guidance are payable benefits of the Texas Medicaid Program when billed with an appropriate diagnosis:

Diagnosis Code	Description
65610	Rhesus isoimmunization, unspecified as to episode of care in pregnancy
65611	Rhesus isoimmunization, affecting management of mother, delivered
65613	Rhesus isoimmunization, affecting management of mother, antepartum condition
65620	Isoimmunization from other and unspecified blood-group incompatibility, unspecified as to episode of care in pregnancy
65621	Isoimmunization from other and unspecified blood-group incompatibility, affecting management of mother, delivered
65623	Isoimmunization from other and unspecified blood-group incompatibility, affecting management of mother, antepartum

The Medical Director reviews cordocentesis requests for diagnosis codes other than those listed above, on a case by case basis.

Procedure code 4/I/T-76946, 4/I/T-76941, or 4/I/T-76941 is reimbursed separately when billed by a different physician. Ultrasonic guidance is denied as part of the amniocentesis, cordocentesis, or intrauterine fetal transfusion procedure when it is billed on the same day by the same provider as one of the other procedures.

Cordocentesis or umbilical blood sampling is included in the global fee for procedure code 2-36460.

FIUT is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis.

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No other fetal surgery is a benefit of the Texas Medicaid Program.

36.4.24.4 Fetal Fibronectin

Procedure code 5-82731 is a benefit of the Texas Medicaid Program.

36.4.24.5 Certified Nurse-Midwife (CNM)

Deliveries performed in a home (POS 2) by a CNM without prior authorization are denied. A written prior authorization request must be submitted during the client's third trimester of pregnancy. Documentation must include a statement signed by a licensed physician who has examined the client during the third trimester and determined that at the time of examination the client is not at high risk and is suitable for a home delivery.

36.4.24.6 Nonstress Testing, Contraction Stress Testing

The following diagnosis codes are payable for *both* nonstress and contraction stress testing:

Diagnosis Code	Description
30393	Chronic alcoholism
30403	Opioid type dependence, in remission
30410	Sedative, hypnotic or anxiolytic dependence, unspecified
30411	Sedative, hypnotic or anxiolytic dependence, continuous
30412	Sedative, hypnotic or anxiolytic dependence, episodic
30413	Sedative, hypnotic or anxiolytic dependence, in remission
30420	Cocaine dependence, unspecified use
30421	Cocaine dependence, continuous use
30422	Cocaine dependence, episodic use
30423	Cocaine dependence, in remission
30430	Cannabis dependence, unspecified use
30431	Cannabis dependence, continuous use
30432	Cannabis dependence, episodic use
30433	Cannabis dependence, in remission
30440	Amphetamine and other psychostimulant dependence, unspecified use
30441	Amphetamine and other psychostimulant dependence, continuous use
30442	Amphetamine and other psychostimulant dependence, episodic use
30443	Amphetamine and other psychostimulant dependence, in remission
30450	Hallucinogen dependence, unspecified use
30451	Hallucinogen dependence, continuous use
30452	Hallucinogen dependence, episodic use
30453	Hallucinogen dependence, in remission
30460	Other specified drug dependence, unspecified use
30461	Other specified drug dependence, continuous use
30462	Other specified drug dependence, episodic use
30463	Other specified drug dependence, in remission
30470	Combinations of opioid type drug with any other drug dependence, unspecified use
30471	Combinations of opioid type drug with any other drug dependence, continuous use
30472	Combinations of opioid type drug with any other drug dependence, episodic use
30473	Combinations of opioid type drug with any other drug dependence, in remission
30480	Combinations of drug dependence excluding opioid type drug, unspecified use
30481	Combinations of drug dependence excluding opioid type drug, continuous use
30482	Combinations of drug dependence excluding opioid type drug, episodic use
30483	Combinations of drug dependence excluding opioid type drug, in remission
30490	Unspecified drug dependence, unspecified use
30491	Unspecified drug dependence, continuous use
30492	Unspecified drug dependence, episodic use
30493	Unspecified drug dependence, in remission
5851	Chronic kidney disease, Stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)

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Diagnosis Code	Description
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
64210	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64211	Hypertension secondary to renal disease, with delivery
64212	Hypertension secondary to renal disease, with delivery, with mention of postpartum complication
64213	Hypertension secondary to renal disease, antepartum
64214	Hypertension secondary to renal disease, postpartum
64220	Other pre-existing hypertension complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care
64221	Other pre-existing hypertension, with delivery
64222	Other pre-existing hypertension, with delivery, with mention of postpartum complication
64223	Other pre-existing hypertension, antepartum
64224	Other pre-existing hypertension, postpartum
64230	Transient hypertension of pregnancy, unspecified as to episode of care
64231	Transient hypertension of pregnancy, with delivery
64232	Transient hypertension of pregnancy, with delivery, with mention of postpartum complication
64233	Antepartum transient hypertension
64240	Mild or unspecified pre-eclampsia, unspecified as to episode of care
64241	Mild or unspecified pre-eclampsia, with delivery
64242	Mild or unspecified pre-eclampsia, with delivery, with mention of postpartum complication
64243	Mild or unspecified pre-eclampsia, antepartum
64244	Mild or unspecified pre-eclampsia, postpartum
64250	Severe pre-eclampsia, unspecified as to episode of care
64251	Severe pre-eclampsia, with delivery

Diagnosis Code	Description
64252	Severe pre-eclampsia, with delivery, with mention of postpartum complication
64253	Severe pre-eclampsia, antepartum
64254	Severe pre-eclampsia, postpartum
64260	Eclampsia complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care
64261	Eclampsia, with delivery
64262	Eclampsia, with delivery, with mention of postpartum complication
64263	Eclampsia, antepartum
64264	Eclampsia, postpartum
64270	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64271	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery
64272	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery, with mention of postpartum complication
64400	Threatened premature labor, unspecified as to episode of care
64403	Threatened premature labor, antepartum
64410	Other threatened labor, unspecified as to episode of care
64413	Other threatened labor, antepartum
64510	Post term pregnancy, unspecified episode of care
64513	Post term pregnancy, antepartum condition or complication
64520	Prolonged pregnancy, unspecified episode of care
64523	Prolonged pregnancy, antepartum condition or complication
64700	Syphilis of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64701	Syphilis of mother, complicating pregnancy, with delivery
64702	Syphilis of mother, complicating pregnancy, with delivery, with mention of postpartum complication
64703	Antepartum syphilis
64704	Postpartum syphilis

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Diagnosis Code	Description
64710	Gonorrhea of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64711	Gonorrhea of mother, with delivery
64712	Gonorrhea of mother, with delivery, with mention of postpartum complication
64713	Antepartum gonorrhea
64714	Postpartum gonorrhea
64720	Other venereal diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64721	Other venereal diseases of mother, with delivery
64722	Other venereal diseases of mother, with delivery, with mention of postpartum complication
64723	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, antepartum
64723	Other antepartum venereal diseases
64724	Other postpartum venereal diseases
64730	Tuberculosis of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64731	Tuberculosis of mother, with delivery
64732	Tuberculosis of mother, with delivery, with mention of postpartum complication
64733	Antepartum tuberculosis
64734	Postpartum tuberculosis
64740	Malaria of mother, complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care
64741	Malaria of mother, with delivery
64742	Malaria of mother, with delivery, with mention of postpartum complication
64743	Antepartum malaria
64744	Postpartum malaria
64750	Rubella of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64751	Rubella of mother, with delivery
64752	Rubella of mother, with delivery, with mention of postpartum complication
64753	Antepartum rubella

Diagnosis Code	Description
64754	Postpartum rubella
64760	Other viral diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64761	Other viral diseases of mother, with delivery
64762	Other viral diseases of mother, with delivery, with mention of postpartum complication
64763	Other antepartum viral diseases
64764	Other postpartum viral diseases
64780	Other specified infectious and parasitic diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64781	Other specified infectious and parasitic diseases of mother, with delivery
64782	Other specified infectious and parasitic diseases of mother, with delivery, with mention of postpartum complication
64783	Other specified infectious and parasitic diseases of mother, antepartum
64800	Diabetes mellitus of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care
64801	Diabetes mellitus of mother, with delivery
64802	Diabetes mellitus of mother, with delivery, with mention of postpartum complication
64803	Antepartum diabetes mellitus
65130	Twin pregnancy with fetal loss and retention of one fetus, unspecified as to episode of care or not applicable
65131	Twin pregnancy with fetal loss and retention of one fetus, delivered, with or without mention of antepartum condition
65133	Twin pregnancy with fetal loss and retention of one fetus, antepartum condition or complication
65140	Triplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable

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Diagnosis Code	Description
65141	Triplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65143	Triplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65150	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable
65151	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65153	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65160	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care
65161	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition
65163	Other multiple pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication
65633	Fetal distress, affecting management of mother, antepartum
65650	Poor fetal growth, affecting management of mother, unspecified as to episode of care
65651	Poor fetal growth, affecting management of mother, delivered
65653	Poor fetal growth, affecting management of mother, antepartum condition or complication
65660	Excessive fetal growth, affecting management of mother, unspecified as to episode of care
65661	Excessive fetal growth, affecting management of mother, delivered
65663	Excessive fetal growth, affecting management of mother, antepartum
65840	Infection of amniotic cavity, unspecified as to episode of care
65841	Infection of amniotic cavity, delivered
65843	Infection of amniotic cavity, antepartum

Diagnosis Code	Description
V231	Supervision of high-risk pregnancy with history of tropho blastic disease
V232	Supervision of high-risk pregnancy with history of abortion
V233	Supervision of high-risk pregnancy with grand multiparity
V2341	Pregnancy with history of pre-term labor
V2349	Pregnancy with other poor obstetric history
V235	Supervision of high-risk pregnancy with other poor reproductive history
V237	Supervision of high-risk pregnancy with insufficient prenatal care
V2381	Supervision of high-risk pregnancy with elderly primigravida
V2382	Supervision of high-risk pregnancy with elderly multigravida
V2383	Supervision of high-risk pregnancy with young primigravida
V2384	Supervision of high-risk pregnancy with young multigravida
V2389	Supervision of other high-risk pregnancy
V239	Supervision of unspecified high-risk pregnancy

When billing for 2-59025 performed because of decreased fetal movement, use the following diagnosis codes:

Diagnosis Code	Description
64110	Hemorrhage from placenta previa, unspecified as to episode of care
64111	Hemorrhage from placenta previa, with delivery
64113	Hemorrhage from placenta previa, antepartum
64120	Premature separation of placenta, unspecified as to episode of care
64121	Premature separation of placenta, with delivery
64123	Premature separation of placenta, antepartum
64130	Antepartum hemorrhage associated with coagulation defects, unspecified as to episode of care
64131	Antepartum hemorrhage associated with coagulation defects, with delivery
64133	Antepartum hemorrhage associated with coagulation defects
64180	Other antepartum hemorrhage, unspecified as to episode of care

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Diagnosis Code	Description
64181	Other antepartum hemorrhage, with delivery
64183	Other antepartum hemorrhage
64190	Unspecified antepartum hemorrhage, unspecified as to episode of care
64191	Unspecified antepartum hemorrhage, with delivery
64193	Unspecified antepartum hemorrhage
64520	Prolonged pregnancy, unspecified episode of care
64521	Prolonged pregnancy, delivered with or without mention of antepartum condition
64523	Prolonged pregnancy, antepartum condition or complication
65570	Decreased fetal movements, affecting management of mother, unspecified as to episode of care
65571	Decreased fetal movements, affecting management of mother, delivered
65573	Decreased fetal movements, affecting management of mother, antepartum condition or complication

Procedure code 2-59020 is also payable for the following diagnosis codes:

Diagnosis Code	Description
2824	Thalassemias
2825	Sickle-cell trait
28263	sickle-cell/hb-c disease without crisis
65613	Rhesus isoimmunization, affecting management of mother, antepartum condition
65623	Isoimmunization from other and unspecified blood-group incompatibility, affecting management of mother, antepartum
65803	Oligohydramnios, antepartum

Nonstress testing is only payable to a physician when this service is performed in the office (POS 1) and should be billed with procedure code 2-59025.

The contraction stress test is payable to a physician when performed in an inpatient hospital (POS 3) or outpatient hospital (POS 5) setting and should be billed with procedure code 2-59020 and the appropriate POS code.

Procedure code 2-59025 can be reimbursed on the same day/different provider, without appeal. Procedure code 2-59025, billed more than once per day, same provider, is denied. The provider must appeal with documentation that supports the performing of the test more than once on the same day/same provider.

Procedure code 2-59020 can be reimbursed on the same day/different provider, without appeal. Procedure code 2-59020, billed more than once per day, by the same provider, is denied. The provider must appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

Procedure code 2-59025 is payable to physicians, NPs, CNSs, PAs, CNMs, and CIHCP providers in the office setting only. Procedure code 2-59020 is payable to physicians, NPs, CNSs, PAs, CNMs, and CIHCP providers in the inpatient and outpatient settings only.

Fetal monitoring and fetal stress testing are payable for outpatient hospital stays and to hospital-based RHCs only with revenue code B-729, Labor room delivery-other. The inpatient hospital stay is reimbursed under the hospital's DRG.

To prevent repeat unintended or unwanted pregnancies, physicians are urged to include family planning services or referrals in the maternity care of the client. Genetic diagnosis and counseling is also available through Medicaid for clients suspected of having a genetic disorder for informed reproductive decision making.

Refer to: "Family Planning Services" on page 20-1 for more information.

36.4.24.7 Screening of Pregnant Women for Syphilis, HIV, and Hepatitis B Required

Health and Safety Code Chapter 81, Section 81.090 requires pregnant women in Texas to be screened for HBV infection, HIV, and syphilis at their first prenatal examination and delivery. The requirement applies only to the physician or other person who attends a pregnant woman during gestation and at delivery of her infant. Hepatitis B screening of pregnant women has been recommended since 1991 by the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), and Advisory Committee on Immunization Practices (ACIP).

Hepatitis B prenatal testing identifies pregnant women who are hepatitis B surface antigen positive and alerts physicians and clinic staff to vaccinate infants with HBIG and the first dose of the hepatitis B vaccine. Immunotherapy for infants will prevent 97 percent of subsequent HBV infection in those infants born to mothers who are infected with hepatitis B virus. Ninety percent of infants who become infected through perinatal transmission will become chronic virus carriers. Infants infected perinatally are at increased risk for developing chronic liver disease (cirrhosis or chronic active or persistent hepatitis) or primary hepatocellular carcinoma later in life. Children of unidentified HBV-infected mothers are at high risk of becoming infected with HBV through person-to-person transmission during the first five years of their lives. It is estimated that as many as 25 percent of infants infected through perinatal transmission will die of chronic liver disease as adults. Hepatitis B virus disease can be prevented.

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Immunotherapy for infants born to HBsAg-positive women includes administration of 0.5 mL HBIG and 0.5 mL hepatitis B vaccine, within 12 hours of delivery. Subsequent doses of hepatitis B vaccine should be administered to the infant at 1 and 6 months of age. When the infant is 12 months old, a post-vaccine serology test should be performed to determine the success or failure of the vaccine intervention. Physicians should request that the laboratory test the infant's blood for anti-HBs and HBsAg. A positive anti-HBs test result and a negative HBsAg test result show the infant is protected against HBV. A negative anti-HBs and a positive HBsAg show the infant is infected with HBV and should be referred for clinical follow-up. For infants whose blood test is negative for anti-HBs and HBsAg, administration of a second series of vaccine is indicated. A second post-vaccine serology test should be performed two months after completion of the second series.

The DSHS Perinatal Hepatitis B Prevention Program provides hepatitis B vaccine and post-vaccine serology tests for infants born to HBsAg-positive women. HBIG is provided to hospitals for infants, on a case-by-case basis. Prevaccination susceptibility testing and hepatitis B vaccine for susceptible sexual and nonsexual household contacts of HBsAg-positive pregnant women is provided through DSHS regional and local health department clinics.

For more information on the Perinatal Hepatitis B Prevention Program, including a program protocol, reporting forms, fax sheets for physicians, and hospital reporting forms for HBsAg-positive pregnant women, providers should call the Perinatal Hepatitis B Coordinator at 1-800-252-9152.

Pregnant women must be tested for HIV unless they object. If the patient objects to the HIV antibody test, the attending health care provider must make a note in the patient's record that:

- The HIV test was offered.
- The patient declined testing.
- A referral to an anonymous testing site was made.
- The patient was provided with appropriate literature.

36.4.25 Newborn Services

36.4.25.1 Apnea Monitors

Apnea monitors, to measure chest movement and heart rate, are a benefit of THSteps–CCP for infants. Apnea monitors used in the home will be paid for two months without prior authorization for infants with one of the following diagnosis codes:

Diagnosis Code	Description
53010	Esophagitis, unspecified
53011	Reflux esophagitis
53012	Acute esophagitis
53019	Other esophagitis
53081	Esophageal reflux
7707	Chronic respiratory disease arising in the perinatal period
77081	Primary apnea of newborn
77082	Other apnea of newborn
77083	Cyanotic attacks of newborn
77084	Respiratory failure of newborn
77089	Other respiratory problems after birth
78603	Apnea
V198	Family history of other condition

When billing for apnea monitors, use procedure code L-E0619.

All apnea monitors provided to THSteps–CCP clients must be capable of recording apneic episodes.

The POS for apnea monitors is in the client's home.

Prior authorization is required for rental of an apnea monitor, if one of the following conditions exist:

- The child is more than 4 months of age
- The initial two-month rental period has expired

Prior authorization must be obtained in writing and must include *all* of the following items:

- A completed THSteps-CCP Prior Authorization Request Form, signed and dated by the physician
- Documentation to support the medical necessity and appropriateness of the apnea monitor
- A physician interpretation, signed and dated by the physician, of the most recent two-month's apnea monitor downloads

Apnea monitors will not be authorized, if the documentation does not support medical necessity.

Procedure code I-93272 may be used by the physician to bill for the interpretation of the apnea monitor recordings.

Electrodes and lead wires for the apnea monitor are a benefit only if the apnea monitor is owned by the client. If the apnea monitor is rented, the electrodes and lead wires are considered part of the rental fee. The electrodes and lead wires may be considered for purchase with the procedure codes 9-A4556 and 9-A4557 only with documentation of medical necessity and a statement from the physician that the client owns the monitor.

Refer to: "Apnea Monitor" on page 43-44 for authorization of apnea monitors through THSteps-CCP.

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36.4.25.2 Circumcisions

The Texas Medicaid Program provides reimbursement for circumcisions billed with the following procedure codes:

Procedure Code	Maximum Fee
2-54150	$50.75
2-54152	$86.28
2-54160	$101.50
2-54161	$152.25

Circumcisions performed on clients older than 1 year of age must be documented with medical necessity.

36.4.25.3 Claims Filing Instructions, Eligibility Requirements

Claims submitted for services provided to a newborn child that is eligible for Medicaid should be filed using the newborn child's Medicaid client number. *Filing a claim for a newborn client under the mother's client number may cause a delay in claim payment.* For information on the newborn's eligibility status, call TMHP at 1-800-925-9126. Claims with charges for newborn care must be submitted separately from claims with charges for the mother eligible for Medicaid.

Exception: *Services for a newborn's unsuccessful resuscitation may be billed under the mother's Medicaid number using procedure code 1-99499.*

Note: *Newborns are enrolled in the same STAR Program health plan that the mother is enrolled in, if the mother is eligible for Medicaid and enrolled in the plan on the date of birth. Check with individual health plans on the billing of newborn claims.*

Also, the Medicaid claim filing deadline is based on claim receipt within 95 days of the date of service *or* 95 days of the date the client's eligibility information is added to TMHP's eligibility file (in the case of retroactive eligibility). Retroactive eligibility occurs when an individual has applied for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of services. The *add date* is the date the client's eligibility was added to the eligibility file. Client eligibility information is available through AIS.

A newborn child is eligible for Medicaid for up to one year if all the following conditions are met:

- The mother is receiving Medicaid at the time of the child's birth.
- The child continues to live with the mother.
- The mother continues to be eligible for Medicaid or would be eligible for Medicaid, if she were pregnant. It is not acceptable for a provider to require a deposit for newborn care from a client. The child's eligibility ceases, if the mother relinquishes her parental rights or it is determined that the child is not a member of her household.

To provide information about each child born to a mother eligible for Medicaid, FQHCs, hospitals, birthing centers, and FQHCs with birthing centers should complete "Hospital Report (Newborn Child or Children) HHSC Form 7484" on page B-51 and submit it to DADS Data Control within five days of the child's birth. The use of *Baby Boy* or *Baby Girl* delays the assignment of a number. *Filing this form expedites the assignment of a Medicaid number for the newborn child.* Do not complete this form for stillbirths.

The facility should complete this form within five days of the child's birth and send it to DADS at the address referenced on the form. This five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child's eligibility. Facilities should duplicate the form as needed; duplicates are *not* supplied by HHSC, DADS, or TMHP.

On receipt of a completed Form 7484, DADS Data Control verifies the newborn's eligibility and within ten workdays, sends notices to the mother, caseworker, hospital, birthing center, and attending physician, if identified. The notice includes the child's Medicaid client number and the effective date of coverage. After the child has been added to the HHSC eligibility file, HHSC issues a Medicaid Identification Form (Form H3087).

The attending physician's notification letter is sent to the address on file by license number at the Texas Medical Board. It is imperative that this address be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Refer to: "Automated Inquiry System (AIS)" on page xiii.

36.4.25.4 Inpatient Newborn Exams

An inpatient newborn examination performed by a physician, FNP/PNP, or a CNM in an inpatient hospital, birthing center, or freestanding birthing center is considered a THSteps medical checkup and must include all of the inpatient newborn checkup procedures shown on the "THSteps Medical Checkups Periodicity Schedule" on page 43-15. A THSteps newborn checkup exam includes:

- History
- Physical exam including length, weight, and head circumference
- Vision and hearing screening
- Health education with the parents
- The state-required newborn hereditary/metabolic laboratory testing
- Administration of the hepatitis B immunization.

Inpatient newborn exams/screens are to be billed on the CMS-1500 claim form using HCPCS code 1-99431 or 1-99432, when used for billing the initial newborn exam. If the provider chooses to do a brief examination (not including all of the above components), the provider may bill the CPT code 1-99431 or 1-99432 with modifier 52, which will not count as a THSteps checkup.

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Physicians and FNP/PNPs are encouraged to enroll in the THSteps medical checkup Program to provide *outpatient* preventive THSteps medical checkups for Medicaid children younger than 21 years of age. As shown on the "THSteps Medical Checkups Periodicity Schedule" on page 43-15, children are eligible for a total of 21 medical checkups reimbursed at a maximum fee of $70 each. A $5 fee is paid for each immunization given.

Refer to: "Texas Health Steps (THSteps)" on page 43-1 for more information.

36.4.25.5 Newborn Hearing Screening

Health and Safety Code, Chapter 47, *Vernon's Texas Codes Annotated* requires facilities where births occur to offer all newborns a hearing screening as a part of their newborn hospital stay. Procedures for newborn hearing screening provided for infants born outside of a birthing facility, not admitted to a birthing facility for newborn assessment and monitoring after birth, and performed during the initial THSteps visit are considered part of the initial newborn medical checkup and are not reimbursed as separate procedures. Providers who are not enrolled in THSteps must refer the infant to an enrolled THSteps provider for an initial THSteps medical checkup, which includes newborn hearing testing. For more information on newborn hearing screening, providers may contact:

Bureau of Children's Health
1100 West 49th Street
Austin, TX 78756
1-512-458-7724
www.tdh.state.tx.us/audio/audiology.htm

***Note:** This procedure is a screening, not diagnostic, and will not be reimbursed separately from the usual newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants.*

All newborns who have abnormal screening results should be referred to a local Program for Amplification for Children of Texas (PACT) provider for follow-up care. PACT provides services and hearing aids for children ages birth through 20 years who have permanent hearing loss and are Medicaid-eligible.

Traditional Medicaid providers are reimbursed for the diagnosis and treatment of abnormal hearing screen follow-up when a local PACT provider is not available. Providers should use the following procedure codes when billing for follow-up of diagnosis of abnormal hearing screens: 5/I-92585, 5/I/T-92587, and 5/I/T-92588.

Procedure code 5-92586 is considered a diagnostic, not a screening, test.

For a complete list of PACT providers, contact:

HHSC
Bureau of Children's Health
Program for Amplification for Children of Texas (PACT)
1100 West 49th Street
Austin, TX 78756
1-512-458-7724

36.4.25.6 Neonatal Intensive Care

Neonatal intensive care is the comprehensive care of the critically ill neonate or infant in an NICU.

Neonatal intensive care procedure codes are comprehensive per diem (daily) care codes for physicians who personally deliver and supervise the delivery of health care by the neonatal intensive care team to the neonate or infant and may be billed only once per day per neonate or infant. These procedure codes may be used only during the period of time that the neonate or infant is considered to be critically ill. After the neonate or infant is no longer considered to be critically ill, use the E/M codes for subsequent hospital care (1-99231, 1-99232, 1-99233, and 1-99300).

Refer to: "Neonatal Intensive Care" on page 36-204 and "Hospital Visits" on page 36-13 for more details.

36.4.25.7 Newborn Resuscitation

Procedure code 1-99440 is not limited to once per lifetime. Procedure code 1-99440 billed in addition to critical care (1-99291 and 1-99292) is denied.

Use procedure code 1-99436 to attend a Cesarean section or high-risk newborn. When using this procedure code for stand-by for a high-risk newborn, documentation of the maternal high-risk condition in Block 21 of the CMS-1500 claim form is recommended.

Refer to: "Risk Assessment" on page 31-4 for information about maternal high-risk conditions.

36.4.25.8 Nonroutine Care

Care for sick newborns (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is considered nonroutine newborn care. For admission, visits, intensive care, and therapeutic procedures, the appropriate CPT codes must be used.

36.4.25.9 Pediatric Stand-by

Pediatric standby for a Cesarean section is coded as 1-99436 and must be billed on the infant's claim form.

When billing for attendance at Cesarean section or high-risk delivery, use CPT procedure code 1-99436. The attendance fee is considered a newborn charge and is not paid to the same provider billing for delivery or anesthesia services. Procedure code 1-99440 is appropriate when only resuscitation is performed. If 1-99440 and 1-99436 are billed on the same day by the same provider, procedure code 1-99436 is denied as part of another procedure on the same day.

36.4.25.10 Potential SSI/Medicaid Eligibility for Premature Infants

The Supplemental Security Income (SSI) program includes financial and Medicaid benefits for people who are disabled. When determining eligibility for SSI, the Social Security Administration (SSA) must establish that the

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person meets financial and disability criteria. When determining financial eligibility for a newborn child, SSA does not consider the income and resources of the child's parents until the month following the month the child leaves the hospital and begins living with the parents. Determinations of disability are made by the state's Disability Determination Services (DDS) and may take several months.

Federal regulations state that infants with birth weights less than 1,200 grams are considered to meet the SSI disability criteria.

In May 1993, the SSA issued a new policy to local SSA offices to make presumptive SSI disability decisions and payments for these children, making it possible for a child to receive SSI and Medicaid benefits while waiting for a final disability determination to be made by DDS.

The child's parent or legal guardian must file an SSI application with the SSA. It is in the child's best interest that the application with the SSA be filed as soon as possible after birth. The SSA accepts a birth certificate with the child's birth weight or a hospital medical summary as evidence for the presumptive disability decision.

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

36.4.25.11 Routine Care

Routine newborn care is defined as care given to a well baby immediately after birth and during the initial hospital stay. Use procedure codes 1-99431, 1-99432, 1-99433, and 1-99435 for billing routine newborn care.

Physicians must submit separate charges for each day of care. Procedure codes 1-99431, 1-99432, 1-99433, and 1-99435 are limited to one code per day, per provider. The claim must not reflect any diagnosis other than *well newborn* diagnosis listed in the table below:

Diagnosis Code	Description
V3000	Single liveborn, born in hospital, delivered without mention of cesarean section
V3001	Single liveborn, born in hospital, delivered by cesarean section
V301	Single liveborn, born before admission to hospital
V302	Single liveborn, born outside hospital and not hospitalized
V3100	Twin birth, mate liveborn, born in hospital, delivered without mention of cesarean section
V3101	Twin birth, mate liveborn, born in hospital, delivered by cesarean section
V311	Twin birth, mate liveborn, born before admission to hospital
V312	Twin birth, mate liveborn, born outside hospital and not hospitalized
V3200	Twin birth, mate stillborn, born in hospital, delivered without mention of cesarean section
V3201	Twin birth, mate stillborn, born in hospital, delivered by cesarean section
V321	Twin birth, mate stillborn, born before admission to hospital
V322	Twin birth, mate stillborn, born outside hospital and not hospitalized
V3300	Twin birth, unspecified whether mate liveborn or stillborn, born in hospital, delivered without mention of cesarean section
V3301	Twin birth, unspecified whether mate liveborn or stillborn, born in hospital, delivered by cesarean section
V331	Twin birth, unspecified whether mate liveborn or stillborn, born before admission to hospital
V332	Twin birth, unspecified whether mate liveborn or stillborn, born outside hospital and not hospitalized
V3400	Other multiple birth (three or more), mates all liveborn, born in hospital, delivered without mention of cesarean section
V3401	Other multiple birth (three or more), mates all liveborn, born in hospital, delivered by cesarean section
V341	Other multiple birth (three or more), mates all liveborn, born before admission to hospital
V342	Other multiple birth (three or more), mates all liveborn, born outside hospital and not hospitalized
V3500	Other multiple birth (three or more), mates all still born, born in hospital, delivered without mention of cesarean section
V3501	Other multiple birth (three or more), mates all still born, born in hospital, delivered by cesarean section
V351	Other multiple birth (three or more), mates all stillborn, born before admission to hospital
V352	Other multiple birth (three or more), mates all stillborn, born outside of hospital and not hospitalized

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Diagnosis Code	Description
V3600	Other multiple birth (three or more), mates liveborn and stillborn, born in hospital, delivered without mention of cesarean section
V3601	Other multiple birth (three or more), mates liveborn and stillborn, born in hospital, delivered without mention of cesarean section
V361	Other multiple birth (three or more), mates liveborn and stillborn, born before admission to hospital
V362	Other multiple birth (three or more), mates liveborn and stillborn, born outside hospital and not hospitalized
V3700	Other multiple birth (three or more), unspecified whether mates liveborn or stillborn, born in hospital, delivered without mention of cesarean section
V3701	Other multiple birth (three or more), unspecified whether mates liveborn or stillborn, born in hospital, delivered by cesarean section
V371	Other multiple birth (three or more), unspecified whether mates liveborn or stillborn, born before admission to hospital
V372	Other multiple birth (three or more), unspecified whether mates liveborn or stillborn, born outside of hospital
V3900	Liveborn, unspecified whether single, twin or multiple, born in hospital, delivered without mention of cesarean section Unspecified anomaly of eye, congenital
V3901	Liveborn, unspecified whether single, twin or multiple, born in hospital, delivered by cesarean section
V391	Liveborn, unspecified whether single, twin or multiple, born before admission to hospital

Providers may elect to bill subsequent care or regular newborn care in a POS other than the inpatient setting for newborns discharged within 24 hours of birth. Procedure code 1-99432 may be billed in lieu of history and examination in hospital setting (1-99431). If procedure code 1-99433 has been paid by Medicaid to any provider, procedure code 1-99432 is denied. Procedure codes 1-99431 or 1-99432 are limited to once per lifetime. Use modifier 52 to indicate a brief newborn exam that does not include the components of a THSteps screen.

The continued hospitalization of a newborn to support the bonding process is covered when the mother is required to remain hospitalized for medical reasons.

36.4.26 Noncoronary Percutaneous Transluminal Angioplasty

Percutaneous transluminal angioplasty (PTA) is a procedure involving insertion of a balloon catheter into a narrowed or occluded vessel; by inflating the balloon, the artery is recanalized and dilated. Several recognized subdivisions of PTA have become standard as recognized surgical procedures in lieu of other more invasive surgical procedures.

A repeat PTA within 90 days may be reviewed retrospectively for documentation of medical necessity for the repeat.

Noncoronary PTA is a covered benefit of the Texas Medicaid Program. PTA services should be billed using the following procedure codes:

Procedure Codes		
2/F-35470	2/F-35471	2/F-35472
2/F-35473	2/F-35474	2/F-35475
2/F-35476	2/F-92997	2/F-92998

36.4.27 Nuclear Medicine

Medicaid covers the following procedure codes: 4/I/T-78890 and 4/I/T-78891.

Important: *When procedure code* 4/I/T-*78890 is billed with* 4/I/T-*78891, procedure code* 4/I/T-*78890 is denied as part of* 4/I/T-*78891. Only one procedure code is paid per day when multiples of the same code are billed on the same day.*

Refer to: "Inpatient Hospital Visits" on page 36-15 for specific details.

36.4.28 Ophthalmology

When an ophthalmologist sees a patient for a minor condition, such as conjunctivitis, that does not require a complete eye exam, providers are to use the appropriate office E/M code.

Providers are to use the following eye exam procedure codes with a diagnosis of ophthalmological disease or injury. If the client is seen by an ophthalmologist for a diagnosis of refractive error or to rule out a refractive error, the code 1-S0620 or 1-S0621 must be billed. Refractions are limited for clients younger than 21 years of age to once every state fiscal year (SFY) (September 1 through August 31).

For clients younger than 21 years of age, this limitation may be exceeded, if any of the following situations apply and the claim documentation supports the situation:

- A diopter change of 0.5 or more
- A school nurse, teacher, or parent requests the eye exam
- Medical necessity

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Clients 21 years of age and older are allowed one eye exam for refractive error once every 24 months. For example, if the exam for refractive error occurs in May 2001, the client older than 21 years of age is eligible for another exam in June 2003.

If a client is eligible for Medicare and Medicaid, the eye exam for a diagnosis of eye disease, injury, or aphakia (1-92002, 1-92004, 1-92012, or 1-92014) must be billed to Medicare in accordance with Medicare filing procedures. The refractive portion of the exam must be billed to Medicaid within 95 days of the eye refraction with a medical diagnosis. Medicare does *not* cross over the refractive portion of the eye exam to the Texas Medicaid Program.

When billed correctly, providers receive three payments:

- Medicare's allowance for the eye exam
- A Medicare/Medicaid payment crossover for the allowed deductible and coinsurance on the eye exam
- A Medicaid-only payment for the refractive portion of the exam

Procedure code 1-92015 is used when billing for just the refraction on a client who is eligible for Medicaid and has Medicare. Use procedure code 1-92015 when the refraction is the only service performed when evaluating a patient with ocular disease.

A new patient eye examination in any POS is changed to an established patient eye exam if history shows that the same physician has furnished a medical service (TOS 1), surgical service (TOS 2), or consultation (TOS 3) within two years. Services coded as new patient eye exams in excess of this limitation are changed as follows:

If billed as:	Change to:
1-92002	1-92012
1-92004	1-92014

Unless specifically designated by CPT as a unilateral code, all ophthalmological services listed are considered bilateral and should not be billed as a quantity of two. However, procedure codes 1-92225, 1-92226, 1-92230, and 1-92235 are considered unilateral codes and are paid as a quantity of two, if both eyes are evaluated.

36.4.28.1 Complete Eye Exams

New Patient

Procedure Codes		
1-92002	1-92004	1-99201
1-99202	1-99203	1-99204
1-99205	1-S0620	

Established Patient

Procedure Codes		
1-92012	1-92014	1-92015
1-99211	1-99212	1-99213
1-99214	1-99215	1-S0621

Evaluation and Management Office Visit or Consultation Billed in Addition to the Eye Examination

When an E/M office visit or consultation is billed in addition to the eye examination, the most inclusive code is paid and the other denied.

Services Billed in Addition to an Evaluation and Management Service or Eye Examination

The following services are not reimbursed when billed with an office visit/eye examination on the same date of service. They are considered part of the office visit/eye examination. If no code exists for a procedure, code as the appropriate 1-99201 or 1-99211 service.:

Procedure Codes		
1-92020	1-92060	1-92100

Procedure code 1-99173 will deny as part of another procedure/service billed on the same day (e.g., THSteps-EPSDT visit or E/M service).

Special Ophthalmological Services Reimbursed When Billed the Same Day as General Ophthalmological Services

The following special ophthalmological services are reimbursed when billed in addition to a general ophthalmological service, for the same date of service:

Procedure Codes		
1-92018	1-92019	1-92081*
1-92082*	1-92083*	1-92120
1-92135	1-92140	1-S0820

* Procedure codes that are considered bilateral.

A new or established patient office visit or ophthalmological medical examination is denied, if any of the following ophthalmological/ophthalmoscopy services are performed on the same day:

Procedure Codes		
1-92136	1-92225	1-92226
1-92230	1-92235	1-92240
1-92250*	1-92260*	1-92265*
1-92270*	1-92275*	5/T/I-95930*
1-92285*	1-92286*	1-92287*

* Procedure codes that are considered bilateral.

Procedure code 1-92230 is not paid in addition to 1-92235.

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Valid Diagnosis Codes for Evaluation and Management Services, Consultation Codes, or Medical Eye Examinations

Client E/M services, medical eye examinations, and consultations are payable when indicated and billed for the following diagnosis codes:

Diagnosis Code	Description
05320	Herpes zoster dermatitis of eyelid
05321	Herpes zoster keratoconjunctivitis
05322	Herpes zoster iridocyclitis
05329	Herpes zoster with other ophthalmic complications
05440	Herpes simplex with unspecified ophthalmic complication
05441	Herpes simplex dermatitis of eyelid
05442	Dendritic keratitis
05443	Herpes simplex disciform keratitis
05444	Herpes simplex iridocyclitis
05449	Herpes simplex with other ophthalmic complications
0760	Trachoma, initial stage
0761	Trachoma, active stage
0769	Trachoma, unspecified
0770	Inclusion conjunctivitis
0771	Epidemic keratoconjunctivitis
0772	Pharyngoconjunctival fever
0773	Other adenoviral conjunctivitis
0774	Epidemic hemorrhagic conjunctivitis
0778	Other viral conjunctivitis
07798	Unspecified diseases of conjunctiva due to chlamydiae
07799	Unspecified diseases of conjunctiva due to viruses
0903	Syphilitic interstitial keratitis
09150	Syphilitic uveitis, unspecified
09151	Syphilitic chorioretinitis (secondary)
09152	Syphilitic iridocyclitis (secondary)
09840	Gonococcal conjunctivitis (neonatorum)
09841	Gonococcal iridocyclitis
09842	Gonococcal endophthalmia
09843	Gonococcal keratitis
09849	Other gonococcal infection of eye
11502	Histoplasma capsulatum retinitis
11512	Histoplasma duboisii retinitis
11592	Histoplasmosis retinitis, unspecified
1301	Conjunctivitis due to toxoplasmosis
1302	Chorioretinitis due to toxoplasmosis

Diagnosis Code	Description
1900	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
1901	Malignant neoplasm of orbit
1902	Malignant neoplasm of lacrimal gland
1903	Malignant neoplasm of conjunctiva
1904	Malignant neoplasm of cornea
1905	Malignant neoplasm of retina
1906	Malignant neoplasm of choroid
1907	Malignant neoplasm of lacrimal duct
1908	Malignant neoplasm of other specified sites of eye
1909	Malignant neoplasm of eye, part unspecified
2240	Benign neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
2241	Benign neoplasm of orbit
2242	Benign neoplasm of lacrimal gland
2243	Benign neoplasm of conjunctiva
2244	Benign neoplasm of cornea
2245	Benign neoplasm of retina
2246	Benign neoplasm of choroid
2247	Benign neoplasm of lacrimal duct
2248	Benign neoplasm of other specified parts of eye
2249	Benign neoplasm of eye, part unspecified
2340	Carcinoma in situ of eye
36000	Purulent endophthalmitis, unspecified
36001	Acute endophthalmitis
36002	Panophthalmitis
36003	Chronic endophthalmitis
36004	Vitreous abscess
36011	Sympathetic uveitis
36012	Panuveitis
36013	Parasitic endophthalmitis NOS
36014	Ophthalmia nodosa
36019	Other endophthalmitis
36020	Degenerative disorder of globe, unspecified
36021	Progressive high (degenerative) myopia
36023	Siderosis of globe
36024	Other metallosis of globe

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Diagnosis Code	Description
36029	Other degenerative disorders of globe
36030	Hypotony of eye, unspecified
36031	Primary hypotony of eye
36032	Ocular fistula causing hypotony
36033	Hypotony associated with other ocular disorders
36034	Flat anterior chamber of eye
36040	Degenerated globe or eye, unspecified
36041	Blind hypotensive eye
36042	Blind hypertensive eye
36043	Hemophthalmos, except current injury
36044	Leucocoria
36050	Foreign body, magnetic, intraocular, unspecified
36051	Foreign body, magnetic, in anterior chamber of eye
36052	Foreign body, magnetic, in iris or ciliary body
36053	Foreign body, magnetic, in lens
36054	Foreign body, magnetic, in vitreous
36055	Foreign body, magnetic, in posterior wall
36059	Intraocular foreign body, magnetic, in other or multiple site
36060	Foreign body, intraocular, unspecified
36061	Foreign body in anterior chamber
36062	Foreign body in iris or ciliary body
36063	Foreign body in lens
36064	Foreign body in vitreous
36065	Foreign body in posterior wall of eye
36069	Intraocular foreign body in other or multiple sites
36081	Luxation of globe
36089	Other disorders of globe
3609	Unspecified disorder of globe
36100	Retinal detachment with retinal defect, unspecified
36101	Recent retinal detachment, partial, with single defect
36102	Recent retinal detachment, partial, with multiple defects
36103	Recent retinal detachment, partial, with giant tear

Diagnosis Code	Description
36104	Recent retinal detachment, partial, with retinal dialysis
36105	Recent retinal detachment, total or subtotal
36106	Old retinal detachment, partial
36107	Old retinal detachment, total or subtotal
36110	Retinoschisis, unspecified
36111	Flat retinoschisis
36112	Bullous retinoschisis
36113	Primary retinal cysts
36114	Secondary retinal cysts
36119	Other retinoschisis and retinal cysts
3612	Serous retinal detachment
36130	Retinal defect, unspecified
36131	Round hole of retina without detachment
36132	Horseshoe tear of retina without detachment
36133	Multiple defects of retina without detachment
36181	Traction detachment of retina
36189	Other forms of retinal detachment
3619	Unspecified retinal detachment
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
36203	Nonproliferative diabetic retinopathy NOS
36204	Mild nonproliferative diabetic retinopathy
36205	Moderate nonproliferative diabetic retinopathy
36206	Severe nonproliferative diabetic retinopathy
36207	Diabetic macular edema
36210	Background retinopathy, unspecified
36211	Hypertensive retinopathy
36212	Exudative retinopathy
36213	Changes in vascular appearance of retina
36214	Retinal microaneurysms NOS
36215	Retinal telangiectasia
36216	Retinal neovascularization NOS
36217	Other intraretinal microvascular abnormalities
36218	Retinal vasculitis
36221	Retrolental fibroplasia

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Diagnosis Code	Description
36229	Other nondiabetic proliferative retinopathy
36230	Retinal vascular occlusion, unspecified
36231	Central retinal artery occlusion
36232	Retinal arterial branch occlusion
36233	Partial retinal arterial occlusion
36234	Transient retinal arterial occlusion
36235	Central retinal vein occlusion
36236	Venous tributary (branch) occlusion of retina
36237	Venous engorgement of retina
36240	Retinal layer separation, unspecified
36241	Central serous retinopathy
36242	Serous detachment of retinal pigment epithelium
36243	Hemorrhagic detachment of retinal pigment epithelium
36250	Macular degeneration (senile) of retina, unspecified
36251	Nonexudative senile macular degeneration of retina
36252	Exudative senile macular degeneration of retina
36253	Cystoid macular degeneration of retina
36254	Macular cyst, hole, or pseudohole of retina
36255	Toxic maculopathy of retina
36256	Macular puckering of retina
36257	Drusen (degenerative) of retina
36260	Peripheral retinal degeneration, unspecified
36261	Paving stone degeneration of retina
36262	Microcystoid degeneration of retina
36263	Lattice degeneration of retina
36264	Senile reticular degeneration of retina
36265	Secondary pigmentary degeneration of retina
36266	Secondary vitreoretinal degenerations
36270	Hereditary retinal dystrophy, unspecified
36271	Retinal dystrophy in systemic or cerebroretinal lipidoses
36272	Retinal dystrophy in other systemic disorders and syndromes
36273	Vitreoretinal dystrophies
36274	Pigmentary retinal dystrophy
36275	Other dystrophies primarily involving the sensory retina
36276	Dystrophies primarily involving the retinal pigment epithelium
36277	Retinal dystrophies primarily involving Bruch's membrane
36281	Retinal hemorrhage
36282	Retinal exudates and deposits
36283	Retinal edema
36284	Retinal ischemia
36285	Retinal nerve fiber bundle defects
36289	Other retinal disorders
3629	Unspecified retinal disorder
36300	Focal chorioretinitis, unspecified
36301	Focal choroiditis and chorioretinitis, juxtapapillary
36303	Focal choroiditis and chorioretinitis of other posterior pole
36304	Focal choroiditis and chorioretinitis, peripheral
36305	Focal retinitis and retinochoroiditis, juxtapapillary
36306	Focal retinitis and retinochoroiditis, macular or paramacular
36307	Focal retinitis and retinochoroiditis of other posterior pole
36308	Focal retinitis and retinochoroiditis, peripheral
36310	Disseminated chorioretinitis, unspecified
36311	Disseminated choroiditis and chorioretinitis, posterior pole
36312	Disseminated choroiditis and chorioretinitis, peripheral
36313	Disseminated choroiditis and chorioretinitis, generalized
36314	Disseminated retinitis and retinochoroiditis, metastatic
36315	Disseminated retinitis and retinochoroiditis, pigment epitheliopathy
36320	Chorioretinitis, unspecified
36321	Pars planitis
36322	Harada's disease
36330	Chorioretinal scar, unspecified
36331	Solar retinopathy
36332	Other macular scars of retina
36333	Other scars of posterior pole of retina

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Diagnosis Code	Description
36334	Peripheral scars of retina
36335	Disseminated scars of retina
36340	Choroidal degeneration, unspecified
36341	Senile atrophy of choroid
36342	Diffuse secondary atrophy of choroid
36343	Angioid streaks of choroid
36350	Hereditary choroidal dystrophy or atrophy, unspecified
36351	Circumpapillary dystrophy of choroid, partial
36352	Circumpapillary dystrophy of choroid, total
36353	Central dystrophy of choroid, partial
36354	Central choroidal atrophy, total
36355	Choroideremia
36356	Other diffuse or generalized dystrophy of choroid, partial
36357	Other diffuse or generalized dystrophy of choroid, total
36361	Choroidal hemorrhage, unspecified
36362	Expulsive choroidal hemorrhage
36363	Choroidal rupture
36370	Choroidal detachment, unspecified
36371	Serous choroidal detachment
36372	Hemorrhagic choroidal detachment
3638	Other disorders of choroid
3639	Unspecified disorder of choroid
36400	Acute and subacute iridocyclitis, unspecified
36401	Primary iridocyclitis
36402	Recurrent iridocyclitis
36403	Secondary iridocyclitis, infectious
36404	Secondary iridocyclitis, noninfectious
36405	Hypopyon
36410	Chronic iridocyclitis, unspecified
36411	Chronic iridocyclitis in diseases classified elsewhere
36421	Fuchs' heterochromic cyclitis
36422	Glaucomatocyclitic crises
36423	Lens-induced iridocyclitis
36424	Vogt-koyanagi syndrome
3643	Unspecified iridocycliti
36441	Hyphema of iris and ciliary body
36442	Rubeosis iridis
36451	Essential or progressive iris atrophy
36452	Iridoschisis

Diagnosis Code	Description
36453	Pigmentary iris degeneration
36454	Degeneration of pupillary margin
36455	Miotic cysts of pupillary margin
36456	Degenerative changes of chamber angle
36457	Degenerative changes of ciliary body
36459	Other iris atrophy
36460	Idiopathic cysts of iris and ciliary body
36461	Implantation cysts of iris and ciliary body
36462	Exudative cysts of iris or anterior chamber
36463	Primary cyst of pars plana
36464	Exudative cyst of pars plana
36470	Adhesions of iris, unspecified
36471	Posterior synechiae of iris
36472	Anterior synechiae of iris
36473	Goniosynechiae
36474	Adhesions and disruptions of pupillary membranes
36475	Pupillary abnormalities
36476	Iridodialysis
36477	Recession of chamber angle of eye
3648	Other disorders of iris and ciliary body
3649	Unspecified disorder of iris and ciliary body
36500	Preglaucoma, unspecified
36501	Open angle with borderline glaucoma findings
36502	Anatomical narrow angle borderline glaucoma
36503	Steroid responders borderline glaucoma
36504	Ocular hypertension
36510	Open-angle glaucoma, unspecified
36511	Primary open angle glaucoma
36512	Low tension open-angle glaucoma
36513	Pigmentary open-angle glaucoma
36514	Glaucoma of childhood
36515	Residual stage of open angle glaucoma
36520	Primary angle-closure glaucoma, unspecified
36521	Intermittent angle-closure glaucoma
36522	Acute angle-closure glaucoma

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Diagnosis Code	Description
36523	Chronic angle-closure glaucoma
36524	Residual stage of angle-closure glaucoma
36531	Corticosteroid-induced glaucoma, glaucomatous stage
36532	Corticosteroid-induced glaucoma, residual stage
36541	Glaucoma associated with chamber angle anomalies
36542	Glaucoma associated with anomalies of iris
36543	Glaucoma associated with other anterior segment anomalies
36544	Glaucoma associated with systemic syndromes
36551	Phacolytic glaucoma
36552	Pseudoexfoliation glaucoma
36559	Glaucoma associated with other lens disorders
36560	Glaucoma associated with unspecified ocular disorder
36561	Glaucoma associated with pupillary block
36562	Glaucoma associated with ocular inflammations
36563	Glaucoma associated with vascular disorders of eye
36564	Glaucoma associated with tumors or cysts
36565	Glaucoma associated with ocular trauma
36581	Hypersecretion glaucoma
36582	Glaucoma with increased episcleral venous pressure
36583	Aqueous misdirection
36589	Other specified glaucoma
3659	Unspecified glaucoma
36600	Nonsenile cataract, unspecified
36601	Anterior subcapsular polar nonsenile cataract
36602	Posterior subcapsular polar nonsenile cataract
36603	Cortical, lamellar, or zonular nonsenile cataract
36604	Nuclear nonsenile cataract
36609	Other and combined forms of nonsenile cataract
36610	Senile cataract, unspecified
36611	Pseudoexfoliation of lens capsule

Diagnosis Code	Description
36612	Incipient senile cataract
36613	Anterior subcapsular polar senile cataract
36614	Posterior subcapsular polar senile cataract
36615	Cortical senile cataract
36616	Senile nuclear sclerosis
36617	Total or mature cataract
36618	Hypermature cataract
36619	Other and combined forms of senile cataract
36620	Traumatic cataract, unspecified
36621	Localized traumatic opacities
36622	Total traumatic cataract
36623	Partially resolved traumatic cataract
36630	Cataracta complicata, unspecified
36631	Cataract secondary to glaucomatous flecks (subcapsular)
36632	Cataract in inflammatory ocular disorders
36633	Cataract with ocular neovascularization
36634	Cataract in degenerative ocular disorders
36641	Diabetic cataract
36642	Tetanic cataract
36643	Myotonic cataract
36644	Cataract associated with other syndromes
36645	Toxic cataract
36646	Cataract associated with radiation and other physical influences
36650	After-cataract, unspecified
36651	Soemmering's ring
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision
3668	Other cataract
3669	Unspecified cataract
36752	Total or complete internal ophthalmoplegia
36753	Spasm of accommodation
36800	Amblyopia, unspecified
36801	Strabismic amblyopia
36802	Deprivation amblyopia
36803	Refractive amblyopia

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Diagnosis Code	Description
36810	Subjective visual disturbance, unspecified
36811	Sudden visual loss
36812	Transient visual loss
36813	Visual discomfort
36814	Visual distortions of shape and size
36815	Other visual distortions and entoptic phenomena
36816	Psychophysical visual disturbances
3682	Diplopia
36830	Binocular vision disorder, unspecified
36831	Suppression of binocular vision
36832	Simultaneous visual perception without fusion
36833	Fusion with defective stereopsis
36834	Abnormal retinal correspondence
36840	Visual field defect, unspecified
36841	Scotoma involving central area
36842	Scotoma of blind spot area
36843	Sector or arcuate visual field defects
36844	Other localized visual field defect
36845	Generalized visual field contraction or constriction
36846	Homonymous bilateral field defects
36847	Heteronymous bilateral field defects
36851	Protan defect
36852	Deutan defect
36853	Tritan defect
36854	Achromatopsia
36855	Acquired color vision deficiencies
36859	Other color vision deficiencies
36860	Night blindness, unspecified
36861	Congenital night blindness
36862	Acquired night blindness
36863	Abnormal dark adaptation curve
36869	Other night blindness
3688	Other specified visual disturbances
3689	Unspecified visual disturbance
36900	Blindness of both eyes, impairment level not further specified
36901	Better eye: total vision impairment; lesser eye: total vision impairment
36902	Better eye: near-total vision impairment; lesser eye: not further specified

Diagnosis Code	Description
36903	Better eye: near-total vision impairment; lesser eye: total vision impairment
36904	Better eye: near-total vision impairment; lesser eye: near-total vision impairment
36905	Better eye: profound vision impairment; lesser eye: not further specified
36906	Better eye: profound vision impairment; lesser eye: total vision impairment
36907	Better eye: profound vision impairment; lesser eye: near-total vision impairment
36908	Better eye: profound vision impairment; lesser eye: profound vision impairment
36910	Blindness, one eye; low vision other eye
36911	Better eye: severe vision impairment; lesser eye: blind, not further specified
36912	Better eye: severe vision impairment; lesser eye: total vision impairment
36913	Better eye: severe vision impairment; lesser eye: near-total vision impairment
36914	Better eye: severe vision impairment; lesser eye: profound vision impairment
36915	Better eye: moderate vision impairment; lesser eye: blind, not further specified
36916	Better eye: moderate vision impairment; lesser eye: total vision impairment
36917	Better eye: moderate vision impairment; lesser eye: near-total vision impairment
36918	Better eye: moderate vision impairment; lesser eye: profound vision impairment
36920	Low vision, both eyes, not otherwise specified
36921	Better eye: severe vision impairment; lesser eye; impairment not further specified
36922	Better eye: severe vision impairment; lesser eye: severe vision impairment
36923	Better eye: moderate vision impairment; lesser eye: impairment not further specified

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Diagnosis Code	Description
36924	Better eye: moderate vision impairment; lesser eye: severe vision impairment
36925	Better eye: moderate vision impairment; lesser eye: moderate vision impairment
3693	Unqualified visual loss, both eyes
3694	Legal blindness, as defined in U.S.A.
36960	Blindness, one eye, not otherwise specified
36961	One eye: total vision impairment; other eye: not specified
36962	One eye: total vision impairment; other eye: near-normal vision
36963	One eye: total vision impairment; other eye: normal vision
36964	One eye: near-total vision impairment; other eye: vision not specified
36965	One eye: near-total vision impairment; other eye: near-normal vision
36966	One eye: near-total vision impairment; other eye: normal vision
36967	One eye: profound vision impairment; other eye: vision not specified
36968	One eye: profound vision impairment; other eye: near-normal vision
36969	One eye: profound vision impairment; other eye: normal vision
36970	Low vision, one eye, not otherwise specified
36971	One eye: severe vision impairment; other eye: vision not specified
36972	One eye: severe vision impairment; other eye: near-normal vision
36973	One eye: severe vision impairment; other eye: normal vision
36974	One eye: moderate vision impairment; other eye: vision not specified
36975	One eye: moderate vision impairment; other eye: near-normal vision
36976	One eye: moderate vision impairment; other eye: normal vision
3698	Unqualified visual loss, one eye
3699	Unspecified visual loss
37000	Corneal ulcer, unspecified

Diagnosis Code	Description
37001	Marginal corneal ulcer
37002	Ring corneal ulcer
37003	Central corneal ulcer
37004	Hypopyon ulcer
37005	Mycotic corneal ulcer
37006	Perforated corneal ulcer
37007	Mooren’s ulcer
37020	Superficial keratitis, unspecified
37021	Punctate keratitis
37022	Macular keratitis
37023	Filamentary keratitis
37024	Photokeratitis
37031	Phlyctenular keratoconjunctivitis
37032	Limbar and corneal involvement in vernal conjunctivitis
37033	Keratoconjunctivitis sicca, not specified as Sjogren’s
37034	Exposure keratoconjunctivitis
37035	Neurotrophic keratoconjunctivitis
37040	Keratoconjunctivitis, unspecified
37044	Keratitis or keratoconjunctivitis in exanthema
37049	Other keratoconjunctivitis, unspecified
37050	Interstitial keratitis, unspecified
37052	Diffuse interstitial keratitis
37054	Sclerosing keratitis
37055	Corneal abscess
37059	Other interstitial and deep keratitis
37060	Corneal neovascularization, unspecified
37061	Localized vascularization of cornea
37062	Pannus (corneal)
37063	Deep vascularization of cornea
37064	Ghost vessels (corneal)
3708	Other forms of keratitis
3709	Unspecified keratitis
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37105	Phthisical cornea
37110	Corneal deposit, unspecified
37111	Anterior corneal pigmentations

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Diagnosis Code	Description
37112	Stromal corneal pigmentations
37113	Posterior corneal pigmentations
37114	Kayser-Fleischer ring
37115	Other corneal deposits associated with metabolic disorders
37116	Argentous corneal deposits
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37124	Corneal edema due to wearing of contact lenses
37130	Corneal membrane change, unspecified
37131	Folds and rupture of bowman's membrane
37132	Folds in Descemet's membrane
37133	Rupture in Descemet's membrane
37140	Corneal degeneration, unspecified
37141	Senile corneal changes
37142	Recurrent erosion of cornea
37143	Band-shaped keratopathy
37144	Other calcerous degenerations of cornea
37145	Keratomalacia NOS
37146	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Other corneal degenerations
37150	Hereditary corneal dystrophy, unspecified
37151	Juvenile epithelial corneal dystrophy
37152	Other anterior corneal dystrophies
37153	Granular corneal dystrophy
37154	Lattice corneal dystrophy
37155	Macular corneal dystrophy
37156	Other stromal corneal dystrophies
37157	Endothelial corneal dystrophy
37158	Other posterior corneal dystrophies
37160	Keratoconus, unspecified
37161	Keratoconus, stable condition
37162	Keratoconus, acute hydrops
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal staphyloma

Diagnosis Code	Description
37181	Corneal anesthesia and hypoesthesia
37182	Corneal disorder due to contact lens
37189	Other corneal disorders
3719	Unspecified corneal disorder
37200	Acute conjunctivitis, unspecified
37201	Serous conjunctivitis, except viral
37202	Acute follicular conjunctivitis
37203	Other mucopurulent conjunctivitis
37204	Pseudomembranous conjunctivitis
37205	Acute atopic conjunctivitis
37210	Chronic conjunctivitis, unspecified
37211	Simple chronic conjunctivitis
37212	Chronic follicular conjunctivitis
37213	Vernal conjunctivitis
37214	Other chronic allergic conjunctivitis
37215	Parasitic conjunctivitis
37220	Blepharoconjunctivitis, unspecified
37221	Angular blepharoconjunctivitis
37222	Contact blepharoconjunctivitis
37230	Conjunctivitis, unspecified
37231	Rosacea conjunctivitis
37233	Conjunctivitis in mucocutaneous disease
37239	Other conjunctivitis
37240	Pterygium, unspecified
37241	Peripheral pterygium, stationary
37242	Peripheral pterygium, progressive
37243	Central pterygium
37244	Double pterygium
37245	Recurrent pterygium
37250	Conjunctival degeneration, unspecified
37251	Pinguecula
37252	Pseudopterygium
37253	Conjunctival xerosis
37254	Conjunctival concretions
37255	Conjunctival pigmentations
37256	Conjunctival deposits
37261	Granuloma of conjunctiva
37262	Localized adhesions and strands of conjunctiva
37263	Symblepharon
37264	Scarring of conjunctiva
37271	Hyperemia of conjunctiva

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Diagnosis Code	Description
37272	Conjunctival hemorrhage
37273	Conjunctival edema
37274	Vascular abnormalities of conjunctiva
37275	Conjunctival cysts
37281	Conjunctivochalasis
37289	Other disorders of conjunctiva
3729	Unspecified disorder of conjunctiva
37300	Blepharitis, unspecified
37301	Ulcerative blepharitis
37302	Squamous blepharitis
37311	Hordeolum externum
37312	Hordeolum internum
37313	Abscess of eyelid
3732	Chalazion
37331	Eczematous dermatitis of eyelid
37332	Contact and allergic dermatitis of eyelid
37333	Xeroderma of eyelid
37334	Discoid lupus erythematosus of eyelid
3734	Infective dermatitis of eyelid of types resulting in deformity
3735	Other infective dermatitis of eyelid
3736	Parasitic infestation of eyelid
3738	Other inflammations of eyelids
3739	Unspecified inflammation of eyelid
37400	Entropion, unspecified
37401	Senile entropion
37402	Mechanical entropion
37403	Spastic entropion
37404	Cicatricial entropion
37405	Trichiasis of eyelid without entropion
37410	Ectropion, unspecified
37411	Senile ectropion
37412	Mechanical ectropion
37413	Spastic ectropion
37414	Cicatricial ectropion
37420	Lagophthalmos, unspecified
37421	Paralytic lagophthalmos
37422	Mechanical lagophthalmos
37423	Cicatricial lagophthalmos
37430	Ptosis of eyelid, unspecified
37431	Paralytic ptosis
37432	Myogenic ptosis

Diagnosis Code	Description
37433	Mechanical ptosis
37434	Blepharochalasis
37441	Lid retraction or lag
37443	Abnormal innervation syndrome of eyelid
37444	Sensory disorders of eyelid
37445	Other sensorimotor disorders of eyelid
37446	Blepharophimosis
37450	Degenerative disorder of eyelid, unspecified
37451	Xanthelasma of eyelid
37452	Hyperpigmentation of eyelid
37453	Hypopigmentation of eyelid
37454	Hypertrichosis of eyelid
37455	Hypotrichosis of eyelid
37456	Other degenerative disorders of skin affecting eyelid
37481	Hemorrhage of eyelid
37482	Edema of eyelid
37483	Elephantiasis of eyelid
37484	Cysts of eyelids
37485	Vascular anomalies of eyelid
37486	Retained foreign body of eyelid
37487	Dermatochalasis
37489	Other disorders of eyelid
3749	Unspecified disorder of eyelid
37500	Dacryoadenitis, unspecified
37501	Acute dacryoadenitis
37502	Chronic dacryoadenitis
37503	Chronic enlargement of lacrimal gland
37511	Dacryops
37512	Other lacrimal cysts and cystic degeneration
37513	Primary lacrimal atrophy
37514	Secondary lacrimal atrophy
37515	Tear film insufficiency, unspecified
37516	Dislocation of lacrimal gland
37520	Epiphora, unspecified as to cause
37521	Epiphora due to excess lacrimation
37522	Epiphora due to insufficient drainage
37530	Dacryocystitis, unspecified
37531	Acute canaliculitis, lacrimal
37532	Acute dacryocystitis
37533	Phlegmonous dacryocystitis

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Diagnosis Code	Description
37541	Chronic canaliculitis
37542	Chronic dacryocystitis
37543	Lacrimal mucocele
37551	Eversion of lacrimal punctum
37552	Stenosis of lacrimal punctum
37553	Stenosis of lacrimal canaliculi
37554	Stenosis of lacrimal sac
37555	Obstruction of nasolacrimal duct, neonatal
37556	Stenosis of nasolacrimal duct, acquired
37557	Dacryolith
37561	Lacrimal fistula
37569	Other changes of lacrimal passages
37581	Granuloma of lacrimal passages
37589	Other disorders of lacrimal system
3759	Unspecified disorder of lacrimal system
37600	Acute inflammation of orbit, unspecified
37601	Orbital cellulitis
37602	Orbital periostitis
37603	Orbital osteomyelitis
37604	Orbital tenonitis
37610	Chronic inflammation of orbit, unspecified
37611	Orbital granuloma
37612	Orbital myositis
37613	Parasitic infestation of orbit
37621	Thyrotoxic exophthalmos
37622	Exophthalmic ophthalmoplegia
37630	Exophthalmos, unspecified
37631	Constant exophthalmos
37632	Orbital hemorrhage
37633	Orbital edema or congestion
37634	Intermittent exophthalmos
37635	Pulsating exophthalmos
37636	Lateral displacement of globe
37640	Deformity of orbit, unspecified
37641	Hypertelorism of orbit
37642	Exostosis of orbit
37643	Local deformities of orbit due to bone disease
37644	Orbital deformities associated with craniofacial deformities
37645	Atrophy of orbit

Diagnosis Code	Description
37646	Enlargement of orbit
37647	Deformity of orbit due to trauma or surgery
37650	Enophthalmos, unspecified as to cause
37651	Enophthalmos due to atrophy of orbital tissue
37652	Enophthalmos due to trauma or surgery
3766	Retained (old) foreign body following penetrating wound of orbit
37681	Orbital cysts
37682	Myopathy of extraocular muscles
37689	Other orbital disorders
3769	Unspecified disorder of orbit
37700	Papilledema, unspecified
37701	Papilledema associated with increased intracranial pressure
37702	Papilledema associated with decreased ocular pressure
37703	Papilledema associated with retinal disorder
37704	Foster-kennedy syndrome
37710	Optic atrophy, unspecified
37711	Primary optic atrophy
37712	Postinflammatory optic atrophy
37713	Optic atrophy associated with retinal dystrophies
37714	Glaucomatous atrophy (cupping) of optic disc
37715	Partial optic atrophy
37716	Hereditary optic atrophy
37721	Drusen of optic disc
37722	Crater-like holes of optic disc
37723	Coloboma of optic disc
37724	Pseudopapilledema
37730	Optic neuritis, unspecified
37731	Optic papillitis
37732	Retrobulbar neuritis (acute)
37733	Nutritional optic neuropathy
37734	Toxic optic neuropathy
37739	Other optic neuritis
37741	Ischemic optic neuropathy
37742	Hemorrhage in optic nerve sheaths
37743	Optic nerve hypoplasia
37749	Other disorders of optic nerve

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Diagnosis Code	Description
37751	Disorders of optic chiasm associated with pituitary neoplasms and disorders
37752	Disorders of optic chiasm associated with other neoplasms
37753	Disorders of optic chiasm associated with vascular disorders
37754	Disorders of optic chiasm associated with inflammatory disorders
37761	Disorders of other visual pathways associated with neoplasms
37762	Disorders of other visual pathways associated with vascular disorders
37763	Disorders of other visual pathways associated with inflammatory disorders
37771	Disorders of visual cortex associated with neoplasms
37772	Disorders of visual cortex associated with vascular disorders
37773	Disorders of visual cortex associated with inflammatory disorders
37775	Cortical blindness
3779	Unspecified disorder of optic nerve and visual pathways
37800	Esotropia, unspecified
37801	Monocular esotropia
37802	Monocular esotropia with A pattern
37803	Monocular esotropia with V pattern
37804	Monocular esotropia with other noncomitancies
37805	Alternating esotropia
37806	Alternating esotropia with A pattern
37807	Alternating esotropia with V pattern
37808	Alternating esotropia with other noncomitancies
37810	Exotropia, unspecified
37811	Monocular exotropia
37812	Monocular exotropia with A pattern
37813	Monocular exotropia with V pattern
37814	Monocular exotropia with other noncomitancies
37815	Alternating exotropia
37816	Alternating exotropia with A pattern
37817	Alternating exotropia with V pattern
37818	Alternating exotropia with other noncomitancies
37820	Intermittent heterotropia, unspecified
37821	Intermittent esotropia, monocular
37822	Intermittent esotropia, alternating
37823	Intermittent exotropia, monocular
37824	Intermittent exotropia, alternating
37830	Heterotropia, unspecified
37831	Hypertropia
37832	Hypotropia
37833	Cyclotropia
37834	Monofixation syndrome
37835	Accommodative component in esotropia
37840	Heterophoria, unspecified
37841	Esophoria
37842	Exophoria
37843	Vertical heterophoria
37844	Cyclophoria
37845	Alternating hyperphoria
37850	Paralytic strabismus, unspecified
37851	Third or oculomotor nerve palsy, partial
37852	Third or oculomotor nerve palsy, total
37853	Fourth or trochlear nerve palsy
37854	Sixth or abducens nerve palsy
37855	External ophthalmoplegia
37856	Total ophthalmoplegia
37860	Mechanical strabismus, unspecified
37861	Brown’s (tendon) sheath syndrome
37862	Mechanical strabismus from other musculofascial disorders
37863	Limited duction associated with other conditions
37871	Duane’s syndrome
37872	Progressive external ophthalmoplegia
37873	Strabismus in other neuromuscular disorders
37881	Palsy of conjugate gaze
37882	Spasm of conjugate gaze
37883	Convergence insufficiency or palsy
37884	Convergence excess or spasm
37885	Anomalies of divergence
37886	Internuclear ophthalmoplegia
37887	Other dissociated deviation of eye movements
3789	Unspecified disorder of eye movements

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Diagnosis Code	Description
37900	Scleritis, unspecified
37901	Episcleritis periodica fugax
37902	Nodular episcleritis
37903	Anterior scleritis
37904	Scleromalacia perforans
37905	Scleritis with corneal involvement
37906	Brawny scleritis
37907	Posterior scleritis
37909	Other scleritis
37911	Scleral ectasia
37912	Staphyloma posticum
37913	Equatorial staphyloma
37914	Anterior staphyloma, localized
37915	Ring staphyloma
37916	Other degenerative disorders of sclera
37919	Other scleral disorders
37921	Vitreous degeneration
37922	Crystalline deposits in vitreous
37923	Vitreous hemorrhage
37924	Other vitreous opacities
37925	Vitreous membranes and strands
37926	Vitreous prolapse
37929	Other disorders of vitreous
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
37939	Other disorders of lens
37940	Abnormal pupillary function, unspecified
37941	Anisocoria
37942	Miosis (persistent), not due to miotics
37943	Mydriasis (persistent), not due to mydriatics
37945	Argyll robertson pupil, atypical
37946	Tonic pupillary reaction
37949	Other anomalies of pupillary function
37950	Nystagmus, unspecified
37951	Congenital nystagmus
37952	Latent nystagmus
37953	Visual deprivation nystagmus
37954	Nystagmus associated with disorders of the vestibular system

Diagnosis Code	Description
37955	Dissociated nystagmus
37956	Other forms of nystagmus
37957	Deficiencies of saccadic eye movements
37958	Deficiencies of smooth pursuit movements
37959	Other irregularities of eye movements
3798	Other specified disorders of eye and adnexa
37990	Disorder of eye, unspecified
37991	Pain in or around eye
37992	Swelling or mass of eye
37993	Redness or discharge of eye
37999	Other ill-defined disorders of eye
74300	Clinical anophthalmos, unspecified
74303	Cystic eyeball, congenital
74306	Cryptophthalmos
74310	Microphthalmos, unspecified
74311	Simple microphthalmos
74312	Microphthalmos associated with other anomalies of eye and adnexa
74320	Buphthalmos, unspecified
74321	Simple buphthalmos
74322	Buphthalmos associated with other ocular anomalies
74330	Congenital cataract, unspecified
74331	Congenital capsular and subcapsular cataract
74332	Congenital cortical and zonular cataract
74333	Congenital nuclear cataract
74334	Congenital total and subtotal cataract
74335	Congenital aphakia
74336	Congenital anomalies of lens shape
74337	Congenital ectopic lens
74339	Other congenital cataract and lens anomalies
74341	Congenital anomalies of corneal size and shape
74342	Congenital corneal opacities, interfering with vision
74343	Other congenital corneal opacities
74344	Specified congenital anomalies of anterior chamber, chamber angle
74345	Aniridia

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Diagnosis Code	Description
74346	Other specified congenital anomalies of iris and ciliary body
74347	Specified congenital anomalies of sclera
74348	Multiple and combined congenital anomalies of anterior segment
74349	Other congenital anomalies of anterior segment
74351	Vitreous anomalies, congenital
74352	Fundus coloboma
74353	Chorioretinal degeneration, congenital
74354	Congenital folds and cysts of posterior segment
74355	Congenital macular changes
74356	Other retinal changes, congenital
74357	Specified congenital anomalies of optic disc
74358	Vascular anomalies, congenital
74359	Other congenital anomalies of posterior segment
74361	Congenital ptosis of eyelid
74362	Congenital deformities of eyelids
74363	Other specified congenital anomalies of eyelid
74364	Specified congenital anomalies of lacrimal gland
74365	Specified congenital anomalies of lacrimal passages
74366	Specified congenital anomalies of orbit
74369	Other congenital anomalies of eyelids, lacrimal system, and orbit
7438	Other specified anomalies of eye, congenital
7439	Unspecified anomaly of eye, congenital
8700	Laceration of skin of eyelid and periocular area
8701	Laceration of eyelid, full-thickness, not involving lacrimal passages
8702	Laceration of eyelid involving lacrimal passages
8703	Penetrating wound of orbit, without mention of foreign body
8704	Penetrating wound of orbit with foreign body
8708	Other specified open wounds of ocular adnexa
8709	Unspecified open wound of ocular adnexa
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
8712	Rupture of eye with partial loss of intraocular tissue
8713	Avulsion of eye
8714	Unspecified laceration of eye
8715	Penetration of eyeball with magnetic foreign body
8716	Penetration of eyeball with (nonmagnetic) foreign body
8717	Unspecified ocular penetration
8719	Unspecified open wound of eyeball
9180	Superficial injury of eyelids and periocular area
9181	Superficial injury of cornea
9182	Superficial injury of conjunctiva
9189	Other and unspecified superficial injuries of eye
9210	Black eye, not otherwise specified
9211	Contusion of eyelids and periocular area
9212	Contusion of orbital tissues
9213	Contusion of eyeball
9219	Unspecified contusion of eye
9300	Corneal foreign body
9301	Foreign body in conjunctival sac
9302	Foreign body in lacrimal punctum
9308	Foreign body in other and combined sites on external eye
9309	Foreign body in unspecified site on external eye
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa

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Important: *Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above and are payable even if the Medicaid ID form does not have a checkmark under the Eye Exam column.*

36.4.28.2 Blepharoplasty Procedures

Procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, 2-67908, and 2-67909 are payable for children up to 21 years of age without prior authorization when performed for one of the following diagnosis codes:

Diagnosis Code	Description
74361	Congenital ptosis
74362	Congenital deformities of eyelids
74390	Unspecified anomaly of eye

Procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, and 2-67908 do not require prior authorization for clients 21 years of age or older when billed for the following diagnosis codes:

Diagnosis Code	Description
37431	Paralytic ptosis
37432	Myogenic ptosis
37433	Mechanical ptosis
37434	Blepharochalasis

Blepharoplasty and eyelid repair for adults 21 years of age and older requires mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty or eyelid repair for procedure codes 2-15820, 2-15821, 2-15822, 2-15823, 2-67900, 2-67909, 2-67911, 2-67961, 2-67966, 2-67971, 2-67973, 2-67974, and 2-67975:

- A brief history and physical evaluation
- Photographs of the eyelid problem
- Visual field measurements
- ICD-9-CM diagnosis(es)

The following blepharoplasty procedures do *not* require prior authorization: 2-67916, 2-67917, 2-67923, and 2-67924.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

36.4.28.3 Corneal Topography

Procedure code 1-S0820 is a covered benefit. An initial or established visit/consultation is payable on the same day as corneal topography. These visits remain subject to the global surgery fee guidelines. If the topography is performed within the global surgical pre- and post-care days of the following ophthalmic procedures, the topography is denied as part of the procedure.

Procedure Codes		
2-65275	2-65280	2-65285
2-65286	2-65400	2-65420
2-65426	2-65450	2-65600
2-65710	2-65730	2-65750
2-65755	2-65880	2-66600
2-66605	2-66625	2-66630
2-66635	2-66820	2-66821
2-66983	2-66984	2-66985
2-66986	2-66830	2-66840
2-66850	2-66852	2-66920
2-66930	2-66940	

Interpretations are payable in the office and outpatient and inpatient settings. The technical component is only reimbursed in the office setting. Depending on the POS billed, a maximum of two interpretations (one for each eye) and one technical component *or* one total component and one additional interpretation (if topography was performed on both eyes) may be reimbursed.

Procedure Code	Maximum Fee
1-S0820	$85.22
I-S0820	$40.35
T-S0820	$44.88

Prior authorization is required for procedure code 1-S0820 when used for the fitting of contact lenses for diagnosis codes 36720, 36722, and 74341. Prior authorization criteria must be met for both corneal topography and contact lenses. Procedure code 1-S0820 also must be prior authorized when using diagnosis code 74341 for any reason.

Providers are to send prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Topography is payable *without prior authorization* for conditions identified by the following diagnosis codes:

Diagnosis Code	Description
37000	Corneal ulcer, unspecified
37001	Marginal corneal ulcer
37002	Ring corneal ulcer
37003	Central corneal ulcer
37004	Hypopyon ulcer
37005	Mycotic corneal ulcer
37006	Perforated corneal ulcer

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Diagnosis Code	Description
37007	Mooren's ulcer
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37140	Corneal degeneration, unspecified
37142	Recurrent erosion of cornea
37146	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Corneal degenerations; other
37160	Keratoconus, unspecified
37161	Keratoconus, stable condition
37162	Keratoconus, acute hydrops
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal Staphyloma
37240	Pterygium, unspecified
37241	Peripheral pterygium, stationary
37242	Peripheral pterygium, progressive
37243	Central pterygium
37244	Double pterygium
37245	Recurrent pterygium
37289	Other disorders of conjunctiva
37821	Intermittent esotropia, monocular
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
99651	Mechanical complication due to corneal graft
V425	Organ or tissue replaced by trans-plant; cornea
V4560	States following surgery of eye and adnexa
V4561	Cataract extraction status
V4569	Other states following surgery of eye and adnexa

36.4.28.4 Echography Ophthalmic, A & B Scan

Procedure codes 4/I/T-76511, 4/I/T-76512, 4/I/T-76516, and 4/I/T-76519 are reimbursed for the following diagnosis codes. Ophthalmic A-scan (4/I/T-76511, 4/I/T-76516, or 4/I/T-76519) is reimbursed on the same day as ophthalmic B-scan (4/I/T-76512) when each meets the following diagnosis criteria:

Diagnosis Code	Description
36100	Retinal detachment with retinal defect, unspecified
36600	Nonsenile cataract, unspecified
36601	Anterior subcapsular polar nonsenile cataract
36602	Posterior subcapsular polar nonsenile cataract
36603	Cortical, lamellar, or zonular nonsenile cataract
36604	Nuclear nonsenile cataract
36609	Other and combined forms of nonsenile cataract
36610	Senile cataract, unspecified
36611	Pseudoexfoliation of lens capsule
36612	Incipient senile cataract
36613	Anterior subcapsular polar senile cataract
36614	Posterior subcapsular polar senile cataract
36615	Cortical senile cataract
36616	Senile nuclear sclerosis
36617	Total or mature cataract
36618	Hypermature cataract
36619	Other and combined forms of senile cataract
36620	Traumatic cataract, unspecified
36621	Localized traumatic opacities
36622	Total traumatic cataract
36623	Partially resolved traumatic cataract
36630	Cataracta complicata, unspecified
36631	Cataract secondary to glaucomatous flecks (subcapsular)
36632	Cataract in inflammatory ocular disorders
36633	Cataract with ocular neovascularization

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Diagnosis Code	Description
36634	Cataract in degenerative ocular disorders
36641	Diabetic cataract
36642	Tetanic cataract
36643	Myotonic cataract
36644	Cataract associated with other syndromes
36645	Toxic cataract
36646	Cataract associated with radiation and other physical influences
36650	After-cataract, unspecified
36651	Soemmering's ring
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision
3668	Other cataract
3669	Unspecified cataract
37015	Phthisical cornea
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37110	Corneal deposit, unspecified
37111	Anterior corneal pigmentations
37112	Stromal corneal pigmentations
37113	Posterior corneal pigmentations
37114	Kayser-Fleischer ring
37115	Other corneal deposits associated with metabolic disorders
37116	Argentous corneal deposits
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37124	Corneal edema due to wearing of contact lenses
37130	Corneal membrane change, unspecified
37131	Folds and rupture of bowman's membrane
37132	Folds in Descemet's membrane
37133	Rupture in Descemet's membrane
37140	Corneal degeneration, unspecified
37141	Senile corneal changes
37142	Recurrent erosion of cornea

Diagnosis Code	Description
37143	Band-shaped keratopathy
37144	Other calcerous degenerations of cornea
37145	Keratomalacia NOS
37146	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Other corneal degenerations
37150	Hereditary corneal dystrophy, unspecified
37151	Juvenile epithelial corneal dystrophy
37152	Other anterior corneal dystrophies
37153	Granular corneal dystrophy
37154	Lattice corneal dystrophy
37155	Macular corneal dystrophy
37156	Other stromal corneal dystrophies
37158	Other posterior corneal dystrophies
37160	Keratoconus, unspecified
37162	Keratoconus, acute hydrops
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal staphyloma
37181	Corneal anesthesia and hypoesthesia
37182	Corneal disorder due to contact lens
37189	Other corneal disorders
3719	Unspecified corneal disorder
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
37939	Other disorders of lens
74330	Congenital cataract, unspecified
74331	Congenital capsular and subcapsular cataract
74332	Congenital cortical and zonular cataract
74333	Congenital nuclear cataract
74334	Congenital total and subtotal cataract
74335	Congenital aphakia
74336	Congenital anomalies of lens shape
74337	Congenital ectopic lens
74339	Other congenital cataract and lens anomalies

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36.4.28.5 Echography Ophthalmic Biometry, A-Mode

Procedure codes 4-76511, 4-76512, 4-76516, and 4-76519 are payable for the following diagnosis codes:

Diagnosis Code	Description
36600	Nonsenile cataract, unspecified
36601	Anterior subcapsular polar nonsenile cataract
36602	Posterior subcapsular polar nonsenile cataract
36603	Cortical, lamellar, or zonular nonsenile cataract
36604	Nuclear nonsenile cataract
36609	Other and combined forms of nonsenile cataract
36610	Senile cataract, unspecified
36611	Pseudoexfoliation of lens capsule
36612	Incipient senile cataract
36613	Anterior subcapsular polar senile cataract
36614	Posterior subcapsular polar senile cataract
36615	Cortical senile cataract
36616	Senile nuclear sclerosis
36617	Total or mature cataract
36618	Hypermature cataract
36619	Other and combined forms of senile cataract
36620	Traumatic cataract, unspecified
36621	Localized traumatic opacities
36622	Total traumatic cataract
36623	Partially resolved traumatic cataract
36630	Cataracta complicata, unspecified
36631	Cataract secondary to glaucomatous flecks (subcapsular)
36632	Cataract in inflammatory ocular disorders
36633	Cataract with ocular neovascularization
36634	Cataract in degenerative ocular disorders
36641	Diabetic cataract
36642	Tetanic cataract
36643	Myotonic cataract
36644	Cataract associated with other syndromes
36645	Toxic cataract
36646	Cataract associated with radiation and other physical influences
36650	After-cataract, unspecified
36651	Soemmering's ring
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision
3668	Other cataract
3669	Unspecified cataract
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37105	Phthisical cornea
37110	Corneal deposit, unspecified
37111	Anterior corneal pigmentations
37112	Stromal corneal pigmentations
37113	Posterior corneal pigmentations
37114	Kayser-Fleischer ring
37115	Other corneal deposits associated with metabolic disorders
37116	Argentous corneal deposits
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37124	Corneal edema due to wearing of contact lenses
37130	Corneal membrane change, unspecified
37131	Folds and rupture of bowman's membrane
37132	Folds in Descemet's membrane
37133	Rupture in Descemet's membrane
37140	Corneal degeneration, unspecified
37141	Senile corneal changes
37142	Recurrent erosion of cornea
37143	Band-shaped keratopathy
37144	Other calcerous degenerations of cornea
37145	Keratomalacia NOS
37446	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Other corneal degenerations
37150	Hereditary corneal dystrophy, unspecified
37151	Juvenile epithelial corneal dystrophy
37152	Other anterior corneal dystrophies

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Diagnosis Code	Description
37153	Granular corneal dystrophy
37154	Lattice corneal dystrophy
37155	Macular corneal dystrophy
37156	Other stromal corneal dystrophies
37158	Other posterior corneal dystrophies
37160	Keratoconus, unspecified
37162	Keratoconus, acute hydrops
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal staphyloma
37181	Corneal anesthesia and hypoesthesia
37182	Corneal disorder due to contact lens
37189	Other corneal disorders
3719	Unspecified corneal disorder
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
37939	Other disorders of lens
74330	Congenital cataract, unspecified
74331	Congenital capsular and subcapsular cataract
74332	Congenital cortical and zonular cataract
74333	Congenital nuclear cataract
74334	Congenital total and subtotal cataract
74335	Congenital aphakia
74336	Congenital anomalies of lens shape
74337	Congenital ectopic lens
74339	Other congenital cataract and lens anomalies

36.4.28.6 Echography Scan, Ophthalmic

Procedure codes 4/I/T-76510, 4/I/T-76511, 4/I/T-76512, 4/I/T-76513, and 4/I/T-76999 are payable for the following diagnosis codes or conditions:

Diagnosis Code	Description
1900	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
1901	Malignant neoplasm of orbit
1984	Secondary malignant neoplasm of other parts of nervous system
2240	Benign neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
2241	Benign neoplasm of orbit
2340	Carcinoma in situ of eye
2388	Neoplasm of uncertain behavior of other specified sites
2389	Neoplasm of uncertain behavior, site unspecified
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled
35257	Drusen (degenerative) of retina
36100	Retinal detachment with retinal defect, unspecified
36101	Recent retinal detachment, partial, with single defect
36102	Recent retinal detachment, partial, with multiple defects
36103	Recent retinal detachment, partial, with giant tear
36104	Recent retinal detachment, partial, with retinal dialysis
36105	Recent retinal detachment, total or subtotal
36106	Old retinal detachment, partial
36107	Old retinal detachment, total or subtotal
36110	Retinoschisis, unspecified
36111	Flat retinoschisis
36112	Bullous retinoschisis
36113	Primary retinal cysts
36114	Secondary retinal cysts
36119	Other retinoschisis and retinal cysts
3612	Serous retinal detachment
36130	Retinal defect, unspecified
36131	Round hole of retina without detachment
36132	Horseshoe tear of retina without detachment
36133	Multiple defects of retina without detachment
36135	Central retinal vein occlusion

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Diagnosis Code	Description
36136	Venous tributary (branch) occlusion of retina
36181	Traction detachment of retina
36189	Other forms of retinal detachment
3619	Unspecified retinal detachment
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
36203	Nonproliferative diabetic retinopathy NOS
36204	Mild nonproliferative diabetic retinopathy
36205	Moderate nonproliferative diabetic retinopathy
36206	Severe nonproliferative diabetic retinopathy
36207	Diabetic macular edema
36210	Background retinopathy, unspecified
36211	Hypertensive retinopathy
36212	Exudative retinopathy
36213	Changes in vascular appearance of retina
36214	Retinal microaneurysms NOS
36215	Retinal telangiectasia
36216	Retinal neovascularization NOS
36217	Other intraretinal microvascular abnormalities
36218	Retinal vasculitis
36221	Retrolental fibroplasia
36229	Other nondiabetic proliferative retinopathy
36230	Retinal vascular occlusion, unspecified
36231	Central retinal artery occlusion
36232	Retinal arterial branch occlusion
36233	Partial retinal arterial occlusion
36234	Transient retinal arterial occlusion
36237	Venous engorgement of retina
36240	Retinal layer separation, unspecified
36241	Central serous retinopathy
36242	Serous detachment of retinal pigment epithelium
36243	Hemorrhagic detachment of retinal pigment epithelium
36250	Macular degeneration (senile) of retina, unspecified
36251	Nonexudative senile macular degeneration of retina

Diagnosis Code	Description
36252	Exudative senile macular degeneration of retina
36253	Cystoid macular degeneration of retina
36254	Macular cyst, hole, or pseudohole of retina
36255	Toxic maculopathy of retina
36256	Macular puckering of retina
36260	Peripheral retinal degeneration, unspecified
36261	Paving stone degeneration of retina
36262	Microcystoid degeneration of retina
36263	Lattice degeneration of retina
36264	Senile reticular degeneration of retina
36265	Secondary pigmentary degeneration of retina
36266	Secondary vitreoretinal degenerations
36270	Hereditary retinal dystrophy, unspecified
36271	Retinal dystrophy in systemic or cerebroretinal lipidoses
36272	Retinal dystrophy in other systemic disorders and syndromes
36273	Vitreoretinal dystrophies
36274	Pigmentary retinal dystrophy
36275	Other dystrophies primarily involving the sensory retina
36276	Dystrophies primarily involving the retinal pigment epithelium
36277	Retinal dystrophies primarily involving Bruch's membrane
36281	Retinal hemorrhage
36282	Retinal exudates and deposits
36283	Retinal edema
36284	Retinal ischemia
36285	Retinal nerve fiber bundle defects
36289	Other retinal disorders
36340	Choroidal degeneration, unspecified
36341	Senile atrophy of choroid
36342	Diffuse secondary atrophy of choroid
36343	Angioid streaks of choroid
36361	Choroidal hemorrhage, unspecified
36362	Expulsive choroidal hemorrhage
36363	Choroidal rupture
36370	Choroidal detachment, unspecified
36371	Serous choroidal detachment

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Diagnosis Code	Description
36372	Hemorrhagic choroidal detachment
36441	Hyphema of iris and ciliary body
36641	Diabetic cataract
37921	Vitreous degeneration
37922	Crystalline deposits in vitreous
37923	Vitreous hemorrhage
37925	Vitreous membranes and strands
37926	Vitreous prolapse
37934	Other vitreous opacities
37992	Swelling or mass of eye

36.4.28.7 Eye Surgery by Laser

All procedures are limited to reimbursement once every 90 days for the same eye with the exception of infants 0 through 23 months of age. Procedures performed on infants age 0 through 23 months are not subject to any frequency restrictions.

36.4.28.8 The Anterior Segment of the Eye–The Lens

Reimbursement for YAG laser surgery (2-66821) is limited to the following diagnosis codes:

Diagnosis Code	Description
36650	After-cataract, unspecified
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision

The Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by Laser-In-Situ Keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of the Texas Medicaid Program

Reimbursement for laser surgery to the cornea, procedure codes 2-65450, 2-65855, and 2-65860 is restricted to the following diagnosis codes:

Diagnosis Code	Description
36500	Preglaucoma, unspecified
36501	Open angle with borderline glaucoma findings
36502	Anatomical narrow angle borderline glaucoma
36503	Steroid responders borderline glaucoma
36504	Ocular hypertension
36510	Open-angle glaucoma, unspecified
36511	Primary open angle glaucoma
36512	Low tension open-angle glaucoma
36513	Pigmentary open-angle glaucoma
36514	Glaucoma of childhood
36515	Residual stage of open angle glaucoma
36520	Primary angle-closure glaucoma, unspecified
36521	Intermittent angle-closure glaucoma
36522	Acute angle-closure glaucoma
36523	Chronic angle-closure glaucoma
36524	Residual stage of angle-closure glaucoma
36531	Corticosteroid-induced glaucoma, glaucomatous stage
36532	Corticosteroid-induced glaucoma, residual stage
36541	Glaucoma associated with chamber angle anomalies
36542	Glaucoma associated with anomalies of iris
36543	Glaucoma associated with other anterior segment anomalies
36544	Glaucoma associated with systemic syndromes
36551	Phacolytic glaucoma
36552	Pseudoexfoliation glaucoma
36559	Glaucoma associated with other lens disorders
36560	Glaucoma associated with unspecified ocular disorder
36561	Glaucoma associated with pupillary block
36562	Glaucoma associated with ocular inflammations
36563	Glaucoma associated with vascular disorders of eye
36564	Glaucoma associated with tumors or cysts
36565	Glaucoma associated with ocular trauma
36581	Hypersecretion glaucoma
36582	Glaucoma with increased episcleral venous pressure
36583	Aqueous misdirection
36589	Other specified glaucoma
3659	Unspecified glaucoma

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The Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body will be reimbursed only when billed with one of the following procedure codes:

Procedure Codes		
2-66600	2-66605	2-66710
2-66761	2-66762	2-66770

Reimbursement for procedure codes 2-66600, 2-66605, 2-66710, 2-66711, 2-66761, 2-66762, and 2-66770 is restricted to the following diagnosis codes:

Diagnosis Code	Description
36400	Acute and subacute iridocyclitis, unspecified
36401	Primary iridocyclitis
36402	Recurrent iridocyclitis
36403	Secondary iridocyclitis, infectious
36404	Secondary iridocyclitis, noninfectious
36405	Hypopyon
36410	Chronic iridocyclitis, unspecified
36411	Chronic iridocyclitis in diseases classified elsewhere
3642	Certain types of iridocyclitis
36421	Fuchs' heterochromic cyclitis
36422	Glaucomatocyclitic crises
36423	Lens-induced iridocyclitis
36424	Vogt-koyanagi syndrome
3643	Unspecified iridocyclitis
36500	Preglaucoma, unspecified
36501	Open angle with borderline glaucoma findings
36502	Anatomical narrow angle borderline glaucoma
36503	Steroid responders borderline glaucoma
36504	Ocular hypertension
36510	Open-angle glaucoma, unspecified
36511	Primary open angle glaucoma
36512	Low tension open-angle glaucoma
36513	Pigmentary open-angle glaucoma
36514	Glaucoma of childhood
36515	Residual stage of open angle glaucoma
36520	Primary angle-closure glaucoma, unspecified
36521	Intermittent angle-closure glaucoma
36522	Acute angle-closure glaucoma
36523	Chronic angle-closure glaucoma
36524	Residual stage of angle-closure glaucoma
36531	Corticosteroid-induced glaucoma, glaucomatous stage
36532	Corticosteroid-induced glaucoma, residual stage
36541	Glaucoma associated with chamber angle anomalies
36542	Glaucoma associated with anomalies of iris
36543	Glaucoma associated with other anterior segment anomalies
36544	Glaucoma associated with systemic syndromes
36551	Phacolytic glaucoma
36552	Pseudoexfoliation glaucoma
36559	Glaucoma associated with other lens disorders
36560	Glaucoma associated with unspecified ocular disorder
36561	Glaucoma associated with pupillary block
36562	Glaucoma associated with ocular inflammations
36563	Glaucoma associated with vascular disorders of eye
36564	Glaucoma associated with tumors or cysts
36565	Glaucoma associated with ocular trauma
36581	Hypersecretion glaucoma
36582	Glaucoma with increased episcleral venous pressure
36583	Aqueous misdirection
36589	Other specified glaucoma
3659	Unspecified glaucoma

Claims for iridectomy (2-66600 or 2-66605) are not reimbursed when billed for the same date of service as a trabeculectomy (2-66170 or 2-66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends to Medical Policy for review.

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An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (2-66600 or 2-66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

Procedure Codes		
2-65920	2-66840	2-66850
2-66852	2-66920	2-66930
2-66940	2-66983	2-66984
2-66985	2-66986	

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid will be reimbursed only when billed with one of the following procedure codes:

Procedure Codes		
2-67105	2-67107	2-67108
2-67110	2-67112	2-67145
2-67210	2-67220	2-67221
2-67225	2-67228	2/F-G0183
2/F-G0186		

Reimbursement for procedure codes, listed in the previous table, is restricted to the following diagnosis codes:

Diagnosis Code	Description
1905	Malignant neoplasm of retina
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled
36100	Retinal detachment with retinal defect, unspecified
36101	Recent retinal detachment, partial, with single defect
36102	Recent retinal detachment, partial, with multiple defects
36103	Recent retinal detachment, partial, with giant tear
36104	Recent retinal detachment, partial, with retinal dialysis
36105	Recent retinal detachment, total or subtotal
3612	Serous retinal detachment
36131	Round hole of retina without detachment
36132	Horseshoe tear of retina without detachment
36133	Multiple defects of retina without detachment
36181	Traction detachment of retina
36189	Other forms of retinal detachment
3619	Unspecified retinal detachment
36201	Background diabetic retinopathy
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
36203	Nonproliferative diabetic retinopathy NOS
36204	Mild nonproliferative diabetic retinopathy
36205	Moderate nonproliferative diabetic retinopathy
36206	Severe nonproliferative diabetic retinopathy
36207	Diabetic macular edema
36210	Background retinopathy, unspecified
36211	Hypertensive retinopathy
36212	Exudative retinopathy
36213	Changes in vascular appearance of retina
36214	Retinal microaneurysms NOS
36215	Retinal telangiectasia
36216	Retinal neovascularization NOS
36217	Other intraretinal microvascular abnormalities
36218	Retinal vasculitis
36221	Retrolental fibroplasia
36229	Other nondiabetic proliferative retinopathy
36230	Retinal vascular occlusion, unspecified
36231	Central retinal artery occlusion
36232	Retinal arterial branch occlusion
36233	Partial retinal arterial occlusion
36234	Transient retinal arterial occlusion
36234	Senile reticular degeneration of retina
36235	Central retinal vein occlusion
36236	Venous tributary (branch) occlusion of retina
36237	Venous engorgement of retina

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Diagnosis Code	Description
36240	Retinal layer separation, unspecified
36241	Central serous retinopathy
36242	Serous detachment of retinal pigment epithelium
36243	Hemorrhagic detachment of retinal pigment epithelium
36250	Macular degeneration (senile) of retina, unspecified
36251	Nonexudative senile macular degeneration of retina
36252	Exudative senile macular degeneration of retina
36253	Cystoid macular degeneration of retina
36254	Macular cyst, hole, or pseudohole of retina
36255	Toxic maculopathy of retina
36256	Macular puckering of retina
36257	Drusen (degenerative) of retina
36260	Peripheral retinal degeneration, unspecified
36261	Paving stone degeneration of retina
36262	Microcystoid degeneration of retina
36263	Lattice degeneration of retina
36265	Secondary pigmentary degeneration of retina
36266	Secondary vitreoretinal degenerations
36281	Retinal hemorrhage

When billed for the same date of service, same eye, same provider, only one of the following procedure codes is reimbursed: 2/F-67220, 2-67221, 2/F-G0183, 2/F-G0184, or 2/F-G0186.

The Posterior Segment of the Eye, Vitreous–Vitrectomy

Laser surgery to the vitreous will be reimbursed only when billed with one of the following procedure codes: 2-67031, 2-67039, and 2-67040.

Reimbursement for procedure codes 2-67031, 2-67039, and 2-67040 is restricted to the following diagnosis codes:

Diagnosis Code	Description
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled
36000	Purulent endophthalmitis, unspecified
36001	Acute endophthalmitis
36002	Panophthalmitis
36003	Chronic endophthalmitis
36004	Vitreous abscess
36012	Panuveitis
36050	Foreign body, magnetic, intraocular, unspecified
36051	Foreign body, magnetic, in anterior chamber of eye
36052	Foreign body, magnetic, in iris or ciliary body
36053	Foreign body, magnetic, in lens
36054	Foreign body, magnetic, in vitreous
36055	Foreign body, magnetic, in posterior wall
36059	Intraocular foreign body, magnetic, in other or multiple sites
36060	Foreign body, intraocular, unspecified
36061	Foreign body in anterior chamber
36062	Foreign body in iris or ciliary body
36063	Foreign body in lens
36064	Foreign body in vitreous
36065	Foreign body in posterior wall of eye
36069	Foreign body, in other or multiple sites, nonmagnetic
36100	Retinal detachment with retinal defect, unspecified
36102	Recent retinal detachment, partial, with multiple defects
36103	Recent retinal detachment, partial, with giant tear
36104	Recent retinal detachment, partial, with retinal dialysis
36105	Recent retinal detachment, total or subtotal
36106	Old retinal detachment, partial
36107	Old retinal detachment, total or subtotal
36130	Retinal defect, unspecified
36132	Horseshoe tear of retina without detachment
36202	Proliferative diabetic retinopathy

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Diagnosis Code	Description
36203	Nonproliferative diabetic retinopathy NOS
36204	Mild nonproliferative diabetic retinopathy
36205	Moderate nonproliferative diabetic retinopathy
36206	Severe nonproliferative diabetic retinopathy
36207	Diabetic macular edema
36212	Exudative retinopathy
36252	Exudative senile macular degeneration of retina
36254	Macular cyst, hole, or pseudohole of retina
36256	Macular puckering of retina
36281	Retinal hemorrhage
36362	Expulsive choroidal hemorrhage
36370	Choroidal detachment, unspecified
36371	Serous choroidal detachment
36372	Hemorrhagic choroidal detachment
36520	Primary angle-closure glaucoma, unspecified
3711	Corneal pigmentations and deposits
3712	Corneal edema
3713	Changes of corneal membranes
3714	Corneal degenerations
3715	Hereditary corneal dystrophies
3716	Keratoconus
3717	Other corneal deformities
3718	Other corneal disorders
3719	Unspecified corneal disorder
37923	Vitreous hemorrhage
37924	Other vitreous opacities
37925	Vitreous membranes and strands
37926	Vitreous prolapse
37929	Other disorders of vitreous
37932	Subluxation of lens
37934	Posterior dislocation of lens
8710	Open wound of eyeball
99653	Mechanical complication of prosthetic ocular lens prosthesis
99882	Cataract fragments in eye following cataract surgery

- When billed for the same date of service, same eye, any provider procedure codes 2-67500 and 2-69990 are denied as part of 2-66821.
- Procedure code 2-66821 is denied as part of 2-66830, 2-67031, and 2-67228.
- Procedure codes 2-66820, 2-66984, 2-66985, and 2-67036 will pay according to multiple surgery guidelines when billed with procedure code 2-66821.
- When billed for the same date of service, same eye, different provider procedure codes 266821, 2-67005, 2-67010, and 2-69990 will deny as part of 2-67031.
- When billed for the same date of service, same eye, any provider procedure code 2-67031 will deny as part of any of the following procedure codes: 2-67036, 2-67120, 2-67121, 2-67208, 2-67218, 2-67108, 2-67110, 2-67227, and 2-67228.

All laser eye surgeries are payable only to the following provider types:

Provider Type	Description
03	CIHCP
19	Physician (DO)
20	Physician (MD)
21	Physician group (DO)
22	Physician group (MD)

36.4.28.9 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 2-66500, 2-66505, 2-66600, 2-66605, 2-66625, 2-66630, and 66635 are denied as part of another procedure when billed with procedure codes 2-66170 or 2-66172 on the same eye for the same date of surgery.
- Effective January 1, 2005, when cataract extraction and vitrectomy are billed on the same date of service for clients 8 years of age and under, the vitrectomy will pay at full TMRM allowance and the cataract extraction will pay at 50 percent per multiple surgical procedure payment guidelines.
- Procedure code 2-66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 2-67036 is reimbursed when billed alone.
- Procedure code 2-67036 is denied as part of another procedure when billed with procedure codes 2-67038, 2-67039, 2-67040, and/or 2-67108.
- Procedure codes 2-67039 and 2-67040 are combined and reimbursed as procedure code 2-67108 when billed by the same provider for the same date of service.

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- For clients 8 years of age or younger, the following procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

Procedure Codes		
2-66840	2-66850	2-66852
2-66920	2-66930	2-66940
2-66983	2-66984	2-67005
2-67010	2-67015	2-67025
2-67027	2-67028	2-67030
2-67031	2-67036	2-67038
2-67039	2-67040	

- For clients older than 8 years of age, the following procedure codes will be paid when performed on the same eye:

Procedure Codes		
2-67005	2-67010	2-67015
2-67025	2-67027	2-67028
2-67030	2-67031	2-67036
2-67038	2-67039	2-67040

- For clients older than 8 years of age, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye.

Procedure Codes		
2-66840	2-66850	2-66852
2-66920	2-66930	2-66940
2-66983	2-66984	

Vitrectomy procedure codes 2/F-67036, 2/F-67038, 2/F-67039, and 2/F-67040 are diagnosis-restricted to the following codes:

Diagnosis Code	Description
25050	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled
25051	Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled
25052	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled
25053	Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled
36000	Purulent endophthalmitis, unspecified
36001	Acute endophthalmitis
36002	Panophthalmitis
36003	Chronic endophthalmitis
36004	Vitreous abscess
36012	Panuveitis
36050	Foreign body, magnetic, intraocular, unspecified
36051	Foreign body, magnetic, in anterior chamber of eye
36052	Foreign body, magnetic, in iris or ciliary body
36053	Foreign body, magnetic, in lens
36054	Foreign body, magnetic, in vitreous
36055	Foreign body, magnetic, in posterior wall
36059	Intraocular foreign body, magnetic, in other or multiple sites
36060	Foreign body, intraocular, unspecified
36061	Foreign body in anterior chamber
36062	Foreign body in iris or ciliary body
36063	Foreign body in lens
36064	Foreign body in vitreous
36065	Foreign body in posterior wall of eye
36069	Intraocular foreign body in other or multiple sites
36100	Retinal detachment with retinal defect, unspecified
36102	Recent retinal detachment, partial, with multiple defects
36103	Recent retinal detachment, partial, with giant tear
36104	Recent retinal detachment, partial, with retinal dialysis
36105	Recent retinal detachment, total or subtotal
36106	Old retinal detachment, partial
36107	Old retinal detachment, total or subtotal
36130	Retinal defect, unspecified
36132	Horseshoe tear of retina without detachment
36202	Proliferative diabetic retinopathy
36212	Exudative retinopathy
36252	Exudative senile macular degeneration
36254	Macular cyst, hole or pseudohole
36256	Macular puckering
36281	Retinal hemorrhage
36362	Expulsive choroidal hemorrhage
36370	Proliferative diabetic retinopathy
36371	Serous choroidal detachment
36372	Hemorrhagic choroidal detachment

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Diagnosis Code	Description
36520	Primary angle-closure glaucoma, unspecified
37923	Disorders of vitreous
37924	Other vitreous opacities
37925	Vitreous membranes and strands
37926	Vitreous prolapse
37929	Other disorders of the vitreous
37932	Subluxation of lens
37934	Posterior dislocation of lens
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
8712	Rupture of eye with partial loss of intraocular tissue
8713	Avulsion of eye
8714	Unspecified laceration of eye
8715	Penetration of eyeball with magnetic foreign body
8716	Penetration of eyeball with (nonmagnetic) foreign body
8717	Unspecified ocular penetration
8719	Unspecified open wound of eyeball
99653	Mechanical complications of prosthetic device due to ocular lens prosthesis
99882	Cataract fragments in eye following cataract surgery

Cataract procedure codes 2/F-66983, 2/F-66984, 2/F-66985, and 2/F-66986 are diagnosis-restricted to the following codes:

Diagnosis Code	Description
36551	Phacolytic glaucoma
36600	Nonsenile cataract, unspecified
36601	Anterior subcapsular polar nonsenile cataract
36602	Posterior subcapsular polar nonsenile cataract
36603	Cortical, lamellar, or zonular nonsenile cataract
36604	Nuclear nonsenile cataract
36609	Other and combined forms of nonsenile cataract
36610	Senile cataract, unspecified
36611	Pseudoexfoliation of lens capsule
36612	Incipient senile cataract
36613	Anterior subcapsular polar senile cataract
36614	Posterior subcapsular polar senile cataract
36615	Cortical senile cataract
36616	Senile nuclear sclerosis
36617	Total or mature cataract
36618	Hypermature cataract
36619	Other and combined forms of senile cataract
36620	Traumatic cataract
36621	Localized traumatic opacities
36622	Total traumatic cataract
36623	Partially resolved traumatic cataract
36630	Cataracta complicata, unspecified
36631	Cataract secondary to glaucomatous flecks (subcapsular)
36632	Cataract in inflammatory ocular disorders
36633	Cataract with ocular neovascularization
36634	Cataract in degenerative ocular disorders
36641	Diabetic cataract
36642	Tetanic cataract
36643	Myotonic cataract
36644	Cataract associated with other syndromes
36645	Toxic cataract
36646	Cataract associated with radiation and other physical influences
36650	After-cataract, unspecified
36651	Soemmering's ring
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision
3668	Other cataract
3669	Unspecified cataract

36.4.28.10 Fomivirsen Sodium Intravitreal Injectable, Vitravene®

Procedure code 1-J1452 is reimbursed when billed for the following diagnosis codes:

Diagnosis Code	Description
0785	Cytomegaloviral disease
36320	Chorioretinitis, unspecified

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36.4.28.11 Intraocular Lenses

An intraocular lens (IOL) (9-V2630, 9-V2631, and 9-V2632) is reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer's invoice for the IOL to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed 5 percent of the acquisition cost.

Important: *Medicaid does not reimburse physicians who supply IOLs to* ASCs/HASCs*; payment for the IOL is included in the facility fee.*

Physicians are reimbursed for the IOL in the office setting (POS 1). Physicians are not reimbursed in the inpatient setting (POS 3) or ASCs/HASCs, and outpatient facilities (POS 5). ASCs/HASCs are paid by surgical code: 9-V2630, 9-V2631, and 9-V2632.

Reimbursement for an IOL is limited to the following provider types:

Provider Type	Description
03	CIHCP
19	Physician (DO)
20	Physician (MD)
21	Physician group (DO)
22	Physician group (MD)

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

36.4.28.12 Intravitreal Drug Delivery System

Procedure codes 2/F-67027 and 2/F-67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to autodeny when billed concurrently.

The following diagnosis codes are valid for procedure code 2/F-67027:

Diagnosis Code	Description
0785	Cytomegaloviral disease
36320	Chorioretinitis, unspecified

36.4.28.13 Iridectomy/Iridotomy/Trabeculectomy

If separate charges are billed for an iridectomy (2-66600, 2-66605, 2-66625, 2-66630, and 2-66635), or iridotomy (2-66500 and 2-66505), and a trabeculectomy (2-66170) on the same day, only the trabeculectomy is paid.

36.4.28.14 Ophthalmic Ultrasound Foreign Body Localization

Procedure code 4-76529 is payable for the following diagnosis codes:

Diagnosis Code	Description
36050	Foreign body, magnetic, intraocular, unspecified
36051	Foreign body, magnetic, in anterior chamber of eye
36052	Foreign body, magnetic, in iris or ciliary body
36063	Foreign body, magnetic, in lens
36054	Foreign body, magnetic, in vitreous
36055	Foreign body, magnetic, in posterior wall
36059	Intraocular foreign body, magnetic, in other or multiple sites
36060	Foreign body, intraocular, unspecified
36061	Foreign body in anterior chamber
36063	Foreign body in lens
36064	Foreign body in vitreous
36065	Foreign body in posterior wall of eye
36069	Intraocular foreign body in other or multiple sites
3766	Retained (old) foreign body following penetrating wound of orbit
8704	Penetrating wound of orbit with foreign body
8715	Penetration of eyeball with magnetic foreign body
8716	Penetration of eyeball with (nonmagnetic) foreign body
9300	Corneal foreign body
9301	Foreign body in conjunctival sac
9302	Foreign body in lacrimal punctum
9308	Foreign body in other and combined sites on external eye
9309	Foreign body in unspecified site on external eye

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36.4.28.15 Ophthalmological Services Billed with a Diagnosis of Cataract

Claims submitted with the following procedure codes and the diagnosis of cataract(s) are denied because they are not routinely medically indicated:

Procedure Codes		
1-92020	1-92060	1-92081
1-92082	1-92083	1-92100
1-92120	1-92225	1-92226
1-92230	1-92235	1-92250
1-92260	1-92265	1-92270
1-92275	1-92285	1-92286
1-92287	5-95930	

36.4.29 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, lung, liver, kidney, and combined heart/lung, are a benefit of the Texas Medicaid Program. Organ/tissue transplants are reimbursed only when performed in an institution that is fully qualified by the Texas Medicaid Program to perform transplant services.

If a Medicaid client receives a transplant in a facility not approved by the Texas Medicaid Program, the patient must be discharged from the facility to be considered to receive other medical and hospital benefits under the Texas Medicaid Program. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable.

Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities not approved by the Texas Medicaid Program.

Transplants are covered by the Medicare program; therefore, for clients eligible for both Medicare and Medicaid, Medicaid will pay the deductible or coinsurance portion only as applicable. Medicaid will not pay a transplant service denied by Medicare for a Medicare-eligible client.

If a transplant has been prior authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay. Physician services that HHSC or its designee determines to be reasonable and medically necessary also are covered during the 30-day period. Day limitations do not apply for clients younger than 21 years of age.

Expenses for a single inpatient hospital admission for a prior authorized transplant are not included in the annual $200,000 inpatient expenditure cap. Dollar limitations do not apply for clients younger than 21 years of age.

Refer to: "Organ/Tissue Transplant Services" on page 25-10 for more information about the transplant facility approval criteria.

36.4.29.1 Stem Cell Transplants

1) Allogeneic and autologous stem cell transplantation is a covered benefit of the Texas Medicaid Program when prior authorized and performed in an approved stem cell transplantation facility. Stem cell transplantation is a process in which stem cells are obtained from either a client's or donor's bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.
2) Benefits are not available for any experimental or investigational services, supplies, or procedures.
3) Coverage of stem cell transplantation is limited to the following procedure codes: 2-38240, 2-38241, 2-38242, and 2-38999. The unlisted procedure code 2-38999 should be used to indicate an umbilical cord blood transplant.
4) *Allogenic* stem cell transplantation is a covered benefit for the following diagnosis codes with associated restrictions referenced in paragraph six.

Diagnosis Code	Description
1916	Malignant neoplasm of cerebellum NOS
20000	Reticulosarcoma, unspecified site
20001	Reticulosarcoma involving lymph nodes of head, face, and neck
20002	Reticulosarcoma involving intrathoracic lymph nodes
20003	Reticulosarcoma involving intra-abdominal lymph nodes
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma involving intrapelvic lymph node
20007	Reticulosarcoma involving spleen
20008	Reticulosarcoma involving lymph nodes of multiple sites
20010	Lymphosarcoma, unspecified site
20011	Lymphosarcoma involving lymph nodes of head, face, and neck

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Diagnosis Code	Description
20012	Lymphosarcoma involving intrathoracic lymph nodes
20013	Lymphosarcoma involving intra-abdominal lymph nodes
20014	Lymphosarcoma involving lymph nodes of axilla and upper limb
20015	Lymphosarcoma involving lymph nodes of inguinal region and lower limb
20016	Lymphosarcoma involving intrapelvic lymph nodes
20017	Lymphosarcoma involving spleen
20018	Lymphosarcoma involving lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspecified site
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma involving spleen
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites
20080	Other named variants of lymphosarcoma and reticulosarcoma, unspecified site
20081	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of head, face, and neck
20082	Other named variants of lymphosarcoma and reticulosarcoma involving intrathoracic lymph nodes
20083	Other named variants of lymphosarcoma and reticulosarcoma involving intra-abdominal lymph nodes
20084	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of axilla and upper limb
20085	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb

Diagnosis Code	Description
20086	Other named variants of lymphosarcoma and reticulosarcoma involving intrapelvic lymph nodes
20087	Other named variants of lymphosarcoma and reticulosarcoma involving spleen
20088	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of multiple sites
20100	Hodgkin's disease
20102	Hodgkin's paragranuloma involving intrathoracic lymph nodes
20103	Hodgkin's paragranuloma involving intra-abdominal lymph nodes
20104	Hodgkin's paragranuloma involving lymph nodes of axilla and upper limb
20105	Hodgkin's paragranuloma involving lymph nodes of inguinal region and lower limb
20106	Hodgkin's paragranuloma involving intrapelvic lymph nodes
20107	Hodgkin's paragranuloma involving spleen
20108	Hodgkin's paragranuloma involving lymph nodes of multiple sites
20110	Hodgkin's granuloma, unspecified site
20111	Hodgkin's granuloma involving lymph nodes of head, face, and neck
20112	Hodgkin's granuloma involving intrathoracic lymph nodes
20113	Hodgkin's granuloma involving intra-abdominal lymph nodes
20114	Hodgkin's granuloma involving lymph nodes of axilla and upper limb
20115	Hodgkin's granuloma involving lymph nodes of inguinal region and lower limb
20116	Hodgkin's granuloma involving intrapelvic lymph nodes
20117	Hodgkin's granuloma involving spleen
20118	Hodgkin's granuloma involving lymph nodes of multiple sites
20120	Hodgkin's sarcoma, unspecified site
20121	Hodgkin's sarcoma involving lymph nodes of head, face, and neck
20122	Hodgkin's sarcoma involving intrathoracic lymph nodes
20123	Hodgkin's sarcoma involving intra-abdominal lymph nodes

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Diagnosis Code	Description
20124	Hodgkin's sarcoma involving lymph nodes of axilla and upper limb
20125	Hodgkin's sarcoma involving lymph nodes of inguinal region and lower limb
20126	Hodgkin's sarcoma involving intrapelvic lymph nodes
20127	Hodgkin's sarcoma involving spleen
20128	Hodgkin's sarcoma involving lymph nodes of multiple sites
20140	Hodgkin's disease, lymphocytic-histi-ocytic predominance, unspecified site
20141	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of head, face, and neck
20142	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving intrathoracic lymph nodes
20143	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving intra-abdominal lymph nodes
20144	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of axilla and upper limb
20145	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of inguinal region and lower limb
20146	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving intrapelvic lymph nodes
20147	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving spleen
20148	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of multiple s
20150	Hodgkin's disease, nodular sclerosis, unspecified site
20151	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck
20152	Hodgkin's disease, nodular sclerosis, involving intrathoracic lymph nodes
20153	Hodgkin's disease, nodular sclerosis, involving intra-abdominal lymph nodes
20154	Hodgkin's disease, nodular sclerosis, involving lymph nodes of axilla and upper limb
20155	Hodgkin's disease, nodular sclerosis, involving lymph nodes of inguinal region and lower limb

Diagnosis Code	Description
20156	Hodgkin's disease, nodular sclerosis, involving intrapelvic lymph nodes
20157	Hodgkin's disease, nodular sclerosis, involving spleen
20158	Hodgkin's disease, nodular sclerosis, involving lymph nodes of multiple sites
20160	Hodgkin's disease, mixed cellularity, unspecified site
20161	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck
20162	Hodgkin's disease, mixed cellularity, involving intrathoracic lymph nodes
20163	Hodgkin's disease, mixed cellularity, involving intra-abdominal lymph nodes
20164	Hodgkin's disease, mixed cellularity, involving lymph nodes of axilla and upper limb
20165	Hodgkin's disease, mixed cellularity, involving lymph nodes of inguinal region and lower limb
20166	Hodgkin's disease, mixed cellularity, involving intrapelvic lymph nodes
20167	Hodgkin's disease, mixed cellularity, involving spleen
20168	Hodgkin's disease, mixed cellularity, involving lymph nodes of multiple sites
20170	Hodgkin's disease, lymphocytic depletion, unspecified site
20171	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of head, face, and neck
20172	Hodgkin's disease, lymphocytic depletion, involving intrathoracic lymph nodes
20173	Hodgkin's disease, lymphocytic depletion, involving intra-abdominal lymph nodes
20174	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of axilla and upper limb
20175	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of inguinal region and lower limb
20176	Hodgkin's disease, lymphocytic depletion, involving intrapelvic lymph nodes
20177	Hodgkin's disease, lymphocytic depletion, involving spleen

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Diagnosis Code	Description
20178	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of multiple sites
20190	Hodgkin's disease, unspecified type, unspecified site
20191	Hodgkin's disease, unspecified type, involving lymph nodes of head, face, and neck
20192	Hodgkin's disease, unspecified type, involving intrathoracic lymph nodes
20193	Hodgkin's disease, unspecified type, involving intra-abdominal lymph nodes
20194	Hodgkin's disease, unspecified type, involving lymph nodes of axilla and upper limb
20195	Hodgkin's disease, unspecified type, involving lymph nodes of inguinal region and lower limb
20196	Hodgkin's disease, unspecified type, involving intrapelvic lymph nodes
20197	Hodgkin's disease, unspecified type, involving spleen
20198	Hodgkin's disease, unspecified type, involving lymph nodes of multiple sites
20200	Nodular lymphoma, unspecified site
20201	Nodular lymphoma involving lymph nodes of head, face, and neck
20202	Nodular lymphoma involving intratho-racic lymph nodes
20203	Nodular lymphoma involving intra-abdominal lymph nodes
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb
20206	Nodular lymphoma involving intrapelvic lymph nodes
20207	Nodular lymphoma involving spleen
20208	Nodular lymphoma involving lymph nodes of multiple sites
20280	Other malignant lymphomas, unspec-ified site
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes

Diagnosis Code	Description
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites
20290	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue, unspecified site
20291	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving lymph nodes of axilla and upper limb
20295	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving intrapelvic lymph node
20297	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histio-cytic tissue involving spleen
20401	Lymphoid leukemia, acute, in remission
20501	Myeloid leukemia, acute, in remission
20510	Myeloid leukemia, chronic, without mention of remission
20601	Monocytic leukemia, acute, in remission
20701	Acute erythremia and erythroleu-kemia, in remission

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Diagnosis Code	Description
20801	Leukemia of unspecified cell type, acute, in remission
27912	Wiskott-Aldrich syndrome
2792	Combined immunity deficiency
28241	Sickle-cell thalassemia without crisis
28249	Other thalassemia
28260	Sickle-cell disease, unspecified
28261	HH-SS disease without crisis
28262	HH-SS disease with crisis
23263	Sickle-cell/HH-C disease without crisis
28264	Sickle-cell/HH-C disease with crisis
28268	Other sickle-cell disease without crisis
28269	Other sickle-cell disease with crisis
28401	Constitutional red blood cell aplasia
28409	Other constitutional aplastic anemia
2848	Other specified aplastic anemias
2849	Aplastic anemia, unspecified
74259	Other specified congenital anomalies of spinal cord
75652	Osteopetrosis
See ICD-9-CM Neoplasm by site, malignant	Refractory and/or recurrent neuro-blastoma, solid tumors of neuroblastoma in remission

5) *Autologous* stem cell transplantation is a covered benefit for the following diagnosis codes with associated restrictions referenced in paragraph 6.

Diagnosis Code	Description
1860	Malignant neoplasm of undescended testis
1869	Malignant neoplasm of other and unspecified testis
1916	Malignant neoplasm of cerebellum NOS
19882	Secondary malignant neoplasm of genital organs
20000	Reticulosarcoma (see paragraph 6)
20001	Reticulosarcoma involving lymph nodes of head, face, and neck
20002	Reticulosarcoma involving intratho-racic lymph nodes
20003	Reticulosarcoma involving intra-abdominal lymph nodes
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma involving intrapelvic lymph nodes
20007	Reticulosarcoma involving spleen
20008	Reticulosarcoma involving lymph nodes of multiple sites
20010	Lymphosarcoma, unspecified site
20011	Lymphosarcoma involving lymph nodes of head, face, and neck
20012	Lymphosarcoma involving intratho-racic lymph nodes
20013	Lymphosarcoma involving intra-abdominal lymph nodes
20014	Lymphosarcoma involving lymph nodes of axilla and upper limb
20015	Lymphosarcoma involving lymph nodes of inguinal region and lower limb
20016	Lymphosarcoma involving intrapelvic lymph nodes
20017	Lymphosarcoma involving spleen
20018	Lymphosarcoma involving lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspec-ified site
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma involving spleen
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites
20080	Other named variants of lymphosa-rcoma and reticulosarcoma, unspecified site
20081	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of head, face, and neck
20082	Other named variants of lymphosa-rcoma and reticulosarcoma involving intrathoracic lymph nodes

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Diagnosis Code	Description
20083	Other named variants of lymphosa-rcoma and reticulosarcoma involving intra-abdominal lymph nodes
20084	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of axilla and upper limb
20085	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb
20086	Other named variants of lymphosa-rcoma and reticulosarcoma involving intrapelvic lymph nodes
20087	Other named variants of lymphosa-rcoma and reticulosarcoma involving spleen
20088	Other named variants of lymphosa-rcoma and reticulosarcoma involving lymph nodes of multiple sites
20100	Hodgkin's disease
20102	Hodgkin's paragranuloma involving intrathoracic lymph nodes
20103	Hodgkin's paragranuloma involving intra-abdominal lymph nodes
20104	Hodgkin's paragranuloma involving lymph nodes of axilla and upper limb
20105	Hodgkin's paragranuloma involving lymph nodes of inguinal region and lower limb
20106	Hodgkin's paragranuloma involving intrapelvic lymph nodes
20107	Hodgkin's paragranuloma involving spleen
20108	Hodgkin's paragranuloma involving lymph nodes of multiple sites
20110	Hodgkin's granuloma, unspecified site
20111	Hodgkin's granuloma involving lymph nodes of head, face, and neck
20112	Hodgkin's granuloma involving intrathoracic lymph nodes
20113	Hodgkin's granuloma involving intra-abdominal lymph nodes
20114	Hodgkin's granuloma involving lymph nodes of axilla and upper limb
20115	Hodgkin's granuloma involving lymph nodes of inguinal region and lower limb
20116	Hodgkin's granuloma involving intrapelvic lymph nodes
20117	Hodgkin's granuloma involving spleen

Diagnosis Code	Description
20118	Hodgkin's granuloma involving lymph nodes of multiple sites
20120	Hodgkin's sarcoma, unspecified site
20121	Hodgkin's sarcoma involving lymph nodes of head, face, and neck
20122	Hodgkin's sarcoma involving intratho-racic lymph nodes
20123	Hodgkin's sarcoma involving intra-abdominal lymph nodes
20124	Hodgkin's sarcoma involving lymph nodes of axilla and upper limb
20125	Hodgkin's sarcoma involving lymph nodes of inguinal region and lower limb
20126	Hodgkin's sarcoma involving intrapelvic lymph nodes
20127	Hodgkin's sarcoma involving spleen
20128	Hodgkin's sarcoma involving lymph nodes of multiple sites
20140	Hodgkin's disease, lymphocytic-histi-ocytic predominance, unspecified site
20141	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of head, face, and neck
20142	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving intrathoracic lymph nodes
20143	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving intra-abdominal lymph nodes
20144	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of axilla and upper limb
20145	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of inguinal region and lower limb
20146	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving intrapelvic lymph nodes
20147	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving spleen
20148	Hodgkin's disease, lymphocytic-histi-ocytic predominance involving lymph nodes of multiple
20150	Hodgkin's disease, nodular sclerosis, unspecified site
20151	Hodgkin's disease, nodular sclerosis, involving lymph nodes of head, face, and neck
20152	Hodgkin's disease, nodular sclerosis, involving intrathoracic lymph nodes

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Diagnosis Code	Description
20153	Hodgkin's disease, nodular sclerosis, involving intra-abdominal lymph nodes
20154	Hodgkin's disease, nodular sclerosis, involving lymph nodes of axilla and upper limb
20155	Hodgkin's disease, nodular sclerosis, involving lymph nodes of inguinal region and lower limb
20156	Hodgkin's disease, nodular sclerosis, involving intrapelvic lymph nodes
20157	Hodgkin's disease, nodular sclerosis, involving spleen
20158	Hodgkin's disease, nodular sclerosis, involving lymph nodes of multiple site
20160	Hodgkin's disease, mixed cellularity, unspecified site
20161	Hodgkin's disease, mixed cellularity, involving lymph nodes of head, face, and neck
20162	Hodgkin's disease, mixed cellularity, involving intrathoracic lymph nodes
20163	Hodgkin's disease, mixed cellularity, involving intra-abdominal lymph nodes
20164	Hodgkin's disease, mixed cellularity, involving lymph nodes of axilla and upper limb
20165	Hodgkin's disease, mixed cellularity, involving lymph nodes of inguinal region and lower limb
20166	Hodgkin's disease, mixed cellularity, involving intrapelvic lymph nodes
20167	Hodgkin's disease, mixed cellularity, involving spleen
20168	Hodgkin's disease, mixed cellularity, involving lymph nodes of multiple sites
20170	Hodgkin's disease, lymphocytic depletion, unspecified site
20171	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of head, face, and neck
20172	Hodgkin's disease, lymphocytic depletion, involving intrathoracic lymph nodes
20173	Hodgkin's disease, lymphocytic depletion, involving intra-abdominal lymph nodes
20174	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of axilla and upper limb
20175	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of inguinal region and lower limb
20176	Hodgkin's disease, lymphocytic depletion, involving intrapelvic lymph nodes
20177	Hodgkin's disease, lymphocytic depletion, involving spleen
20178	Hodgkin's disease, lymphocytic depletion, involving lymph nodes of multiple sites
20190	Hodgkin's disease, unspecified type, unspecified site
20191	Hodgkin's disease, unspecified type, involving lymph nodes of head, face, and neck
20192	Hodgkin's disease, unspecified type, involving intrathoracic lymph nodes
20193	Hodgkin's disease, unspecified type, involving intra-abdominal lymph nodes
20194	Hodgkin's disease, unspecified type, involving lymph nodes of axilla and upper limb
20195	Hodgkin's disease, unspecified type, involving lymph nodes of inguinal region and lower limb
20196	Hodgkin's disease, unspecified type, involving intrapelvic lymph nodes
20197	Hodgkin's disease, unspecified type, involving spleen
20198	Hodgkin's disease, unspecified type, involving lymph nodes of multiple sites
20200	Nodular lymphoma, unspecified site
20201	Nodular lymphoma involving lymph nodes of head, face, and neck
20202	Nodular lymphoma involving intratho-racic lymph nodes
20203	Nodular lymphoma involving intra-abdominal lymph nodes
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb
20206	Nodular lymphoma involving intrapelvic lymph nodes
20207	Nodular lymphoma involving spleen
20208	Nodular lymphoma involving lymph nodes of multiple sites

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Diagnosis Code	Description
20280	Other malignant lymphomas, unspecified site
20281	Other malignant lymphomas involving lymph nodes of head, face, and neck
20282	Other malignant lymphomas involving intrathoracic lymph nodes
20283	Other malignant lymphomas involving intra-abdominal lymph nodes
20284	Other malignant lymphomas involving lymph nodes of axilla and upper limb
20285	Other malignant lymphomas involving lymph nodes of inguinal region and lower limb
20286	Other malignant lymphomas involving intrapelvic lymph nodes
20287	Other malignant lymphomas involving spleen
20288	Other malignant lymphomas involving lymph nodes of multiple sites
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph nodes
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen

Diagnosis Code	Description
20300	Multiple myeloma, without mention of remission
20401	Lymphoid leukemia, acute, in remission
20501	Myeloid leukemia, acute, in remission
20601	Acute monocytic leukemia, in remission
20701	Acute erythremia and erythroleukemia, in remission
20801	Acute leukemia of unspecified cell type, in remission
See ICD-9-CM, Neoplasm by site, malignant	Refractory and/or recurrent neuroblastoma, solid tumors of neuroblastoma in remission

6) Associated restrictions for diagnosis codes referenced in the two above tables are:
   - Medulloblastoma is only allowed for recurrent disease or relapse after a first remission following initial therapy.
   - The following diagnosis codes are a type of Non-Hodgkin's lymphoma:

Diagnosis Code	Description
20000	Reticulosarcoma, unspecified site
20001	Reticulosarcoma involving lymph nodes of head, face, and neck
20002	Reticulosarcoma involving intrathoracic lymph nodes
20003	Reticulosarcoma involving intra-abdominal lymph nodes
20004	Reticulosarcoma involving lymph nodes of axilla and upper limb
20005	Reticulosarcoma involving lymph nodes of inguinal region and lower limb
20006	Reticulosarcoma involving intrapelvic lymph nodes
20007	Reticulosarcoma involving spleen
20008	Reticulosarcoma involving lymph nodes of multiple sites
20010	Lymphosarcoma, unspecified site
20011	Lymphosarcoma involving lymph nodes of head, face, and neck
20012	Lymphosarcoma involving intrathoracic lymph nodes
20013	Lymphosarcoma involving intra-abdominal lymph nodes
20014	Lymphosarcoma involving lymph nodes of axilla and upper limb
20015	Lymphosarcoma involving lymph nodes of inguinal region and lower limb

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Diagnosis Code	Description
20016	Lymphosarcoma involving intrapelvic lymph nodes
20017	Lymphosarcoma involving spleen
20018	Lymphosarcoma involving lymph nodes of multiple sites
20020	Burkitt's tumor or lymphoma, unspecified site
20021	Burkitt's tumor or lymphoma involving lymph nodes of head, face, and neck
20022	Burkitt's tumor or lymphoma involving intrathoracic lymph nodes
20023	Burkitt's tumor or lymphoma involving intra-abdominal lymph nodes
20024	Burkitt's tumor or lymphoma involving lymph nodes of axilla and upper limb
20025	Burkitt's tumor or lymphoma involving lymph nodes of inguinal region and lower limb
20026	Burkitt's tumor or lymphoma involving intrapelvic lymph nodes
20027	Burkitt's tumor or lymphoma involving spleen
20028	Burkitt's tumor or lymphoma involving lymph nodes of multiple sites
20080	Other named variants of lymphosarcoma and reticulosarcoma, unspecified site
20081	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of head, face, and neck
20082	Other named variants of lymphosarcoma and reticulosarcoma involving intrathoracic lymph nodes
20083	Other named variants of lymphosarcoma and reticulosarcoma involving intra-abdominal lymph nodes
20084	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of axilla and upper limb
20085	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of inguinal region and lower limb
20086	Other named variants of lymphosarcoma and reticulosarcoma involving intrapelvic lymph nodes
20087	Other named variants of lymphosarcoma and reticulosarcoma involving spleen
20088	Other named variants of lymphosarcoma and reticulosarcoma involving lymph nodes of multiple sites

Diagnosis Code	Description
20200	Nodular lymphoma, unspecified site
20201	Nodular lymphoma involving lymph nodes of head, face, and neck
20202	Nodular lymphoma involving intrathoracic lymph nodes
20203	Nodular lymphoma involving intra-abdominal lymph nodes
20204	Nodular lymphoma involving lymph nodes of axilla and upper limb
20205	Nodular lymphoma involving lymph nodes of inguinal region and lower limb
20206	Nodular lymphoma involving intrapelvic lymph nodes
20207	Nodular lymphoma involving spleen
20208	Nodular lymphoma involving lymph nodes of multiple sites
20290	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site
20291	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of head, face, and neck
20292	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrathoracic lymph nodes
20293	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intra-abdominal lymph node
20294	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of axilla and upper limb
20295	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving lymph nodes of inguinal region and lower limb
20296	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving intrapelvic lymph nodes
20297	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen
20298	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue involving spleen

- Stem cell transplant is allowed for Hodgkin's diagnosis in advanced disease state with failure of conventional therapy.

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- Other lymphomas refers to T-cell lymphomas, which are a type of non-Hodgkin's lymphoma. Coverage is allowed after recurrence of disease.
- Coverage of lymphoid leukemia is allowed for acute lymphoblastic or acute lymphocytic leukemias in remission.
- Wiskott-Aldrich syndrome is an x-linked disorder affecting lymphocyte and platelet function.
- Coverage of combined immunity deficiency is allowed only for severe combined immunodeficiency (SCID), which is a condition of absent or defective lymphoid stem cells.
- Thalassemias and sickle-cell anemia are transfusion-dependent red blood cell disorders that require greater than one transfusion per year.
- Coverage of aplastic anemia is allowed for severe aplastic anemia, and includes Fanconi's anemia, an autosomal recessive hereditary aplastic anemia.
- Coverage of other congenital anomalies of the spinal cord is allowed only for myelodysplasia.
- Coverage of secondary malignant neoplasm of other specified sites–genital organs, is allowed only for testicular cancer.
- Coverage of multiple myeloma is allowed only for chemotherapy-responsive cases.

7) Stem cell transplantation for breast cancer is not a benefit of the Texas Medicaid Program.
8) All stem cell transplants require mandatory prior authorization by HHSC or its designee and must be performed in an approved Texas Medicaid stem cell transplant facility. Prior authorization is effective from the date of the prior authorization approval letter until the end of the transplant facility's approval period. If the transplant has not been performed by the end of the authorization period, the facility and physician need to apply for an extension.
9) Documentation supplied with the prior authorization request should include:
   - 9.1) A complete history and physical
   - 9.2) A current statement of the medical problems present
   - 9.3) The status of the client, including the expected long-term prognosis for the client from the proposed procedure
10) Coverage is limited to an initial transplant and one subsequent retransplant due to rejection, for a total of two transplants per lifetime regardless of payor. The subsequent stem cell transplant must be prior authorized separately. A subsequent transplant is not included in the prior authorization for the initial transplant.
11) Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but should not be approved when performed simultaneously.
12) If a stem cell transplant has been prior authorized, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.
13) Physician services for bone marrow harvesting (2-38230) or peripheral stem cell harvesting (2-38231) in conjunction with Allogeneic bone marrow transplants are not a separate payable benefit of the Texas Medicaid Program, and are considered part of the allogeneic stem cell transplant service (procedure code 2-38240).
14) Physician services for bone marrow harvesting (2/F-38230) or peripheral stem cell harvesting (2/F-38206) for Autologous stem cell transplants are a benefit of Medicaid and require mandatory prior authorization by HHSC or its designee.
15) Autologous harvesting of stem cells (single or multiple sessions) is reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.
16) Physician services for the harvesting and/or storage of umbilical cord stem cells are not a benefit of the Texas Medicaid Program.
17) Donor expenses are included in the global fee for the transplant recipient and are not a separately payable benefit of the Texas Medicaid Program.
18) The reimbursement to DRG hospitals for a stem cell transplant includes the cost of the procurement of the stem cells and the associated services. Documentation must be maintained to identify where the stem cells were obtained.
19) Stem cell transplants for very rare conditions and diseases may be considered on a case by case basis. Documentation for prior authorization must be submitted to HHSC or its designee to determine whether the transplant is medically necessary and appropriate.

36.4.29.2 Heart Transplants

Under current Texas Medicaid Program policy, procedures are considered to be medically necessary and reasonable, based on safety and efficacy, demonstrated by scientific evidence and by controlled clinical studies.

Based on published research and clinical studies, heart transplants have been determined to be a benefit of the Texas Medicaid Program. A heart transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a heart transplant facility by the Texas Medicaid Program.

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A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage under this policy.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered individually.

Guidelines for Coverage of a Heart Transplant

Heart transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. To be reimbursed by the Texas Medicaid Program, the facility must document the following considerations:

- A critical medical need that fits in one of the categories below:
  - NYHA Class Stage III or IV cardiac disease
  - Congenital heart disease
  - Valvular heart disease
  - Viral cardiomyopathies
  - Familial and restrictive cardiomyopathies
- A heart transplant will result in a return to improved functional independence.
- An absence of comorbidities such as:
  - Severe pulmonary hypertension.
  - End-stage renal, hepatic or other organ dysfunction unrelated to primary disorder.
  - Active, uncontrolled HIV infection or AIDS-defining illness.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
- Documented compliance with other medical treatments, regimen, and plan of care.
- Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.
- Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

36.4.29.3 Intestinal Transplants

Intestinal transplantation currently is not a benefit of the Texas Medicaid Program.

36.4.29.4 Liver Transplants

Under current Texas Medicaid policy, procedures are considered to be medically necessary and reasonable, based on safety and efficacy, demonstrated by scientific evidence and by controlled clinical studies.

Based on published research and clinical studies, liver transplants have been determined to be a benefit of the Texas Medicaid Program for Medicaid-eligible clients. A liver transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a liver transplant facility by the Texas Medicaid Program.

Guidelines for Coverage

Authorization of liver transplantation requires documentation of life threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. To be reimbursed by the Texas Medicaid Program, the facility must document the following considerations:

- A critical medical need with a likelihood of a successful clinical outcome
- Liver disease in one of the following categories:
  - Primary cholestatic liver disease
  - Other cirrhosis:
    - Alcoholic
    - Hepatitis C, non-A, non-B, and Hepatitis B
  - Fulminant hepatic failure
  - Metabolic diseases
  - Malignant neoplasms
  - Benign neoplasms
  - Biliary atresia
- An absence of comorbidities such as:
  - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
- Documented compliance with other medical treatments, regimen, and plan of care
- Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen
- Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen

Payment for liver transplant professional services is made under procedure code 2/8-47135 or 2/8-47136. These procedures include six months of professional postoperative care. Separate charges for procedure code 2/8-47780 are denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the client's Medicaid eligibility.

Services unrelated to the liver transplant surgery are paid separately.

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Two assistant surgeons are allowed for liver transplant surgery using procedure codes 8-47135 or 8-47136.

36.4.29.5 Lung Transplants

Under current Texas Medicaid Program policy, procedures are considered to be medically necessary and reasonable, based on safety and efficacy, demonstrated by scientific evidence and by controlled clinical studies.

Based on published research and clinical studies, lung transplants (single lung with bronchial anastomosis or double sequential lung with bilateral bronchial anastomosis) have been determined to be a benefit of the Texas Medicaid Program. A lung transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a lung transplant facility by the Texas Medicaid Program.

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage under this policy.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered on an individual basis.

Guidelines for Coverage of a Lung Transplant

Lung transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double) transplant procedure on a long-term basis. To be reimbursed by the Texas Medicaid Program, the facility must document the following considerations:

- A critical medical need with a likelihood of a successful clinical outcome
- Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
- Lung transplantation may be authorized with documentation of end-stage pulmonary diseases in these categories:
    - Obstructive lung disease
    - Restrictive lung disease
    - Cystic Fibrosis
    - Pulmonary hypertension
- An absence of comorbidities such as:
    - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder
    - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
- Documented compliance with other medical treatments, regimen, and plan of care
- Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen
- Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen

Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records. *Organ procurement costs are not payable to a physician.*

Important: *Physician services for the procurement of peripheral stem cells are not reimbursable.*

36.4.29.6 Prior Authorization

It is the requesting physician and facility's responsibility to receive prior authorization through TMHP Special Medical Prior Authorization.

HHSC or its designee must prior authorize all transplant services provided by facilities and professionals. Documentation supplied with the prior authorization request must address the criteria listed for each type of transplant above, and must be medically necessary, reasonable, and federally allowable.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g, laboratory services, status post visits, radiology services.) Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent retransplant because of organ rejection. A subsequent transplant is not included in the prior authorization for the initial transplant; therefore, it must be prior authorized separately.

A transplant request signed by a physician associated with one of the Texas Medicaid Program-approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol. Additional documentation may be required, which is addressed in the previous specific organ/tissue information.

The Texas Medicaid Program does not pay for transplants or post-transplant services in a nonqualifying facility, nor are physician charges reimbursed for transplants in a nonqualifying facility.

Benefits are not available for any experimental or investigational services, supplies, or procedures.

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All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

36.4.30 Occupational Therapy

Occupational therapy is a payable benefit to physicians and outpatient and inpatient hospitals. Occupational therapy *must be billed with the modifier AT and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary.* Occupational therapy is billed with CPT procedure codes. These procedure codes are subject to the guidelines outlined in the above paragraphs for physical therapy:

CPT Code	Frequency
1-97012	Once per day
1-97014	Once per day
1-97016	Once per day
1-97018	Once per day
1-97022	Once per day
1-97024	Once per day
1-97026	Once per day
1-97028	Once per day
1-97032	Two hours maximum
1-97033	Two hours maximum
1-97034	Two hours maximum
1-97035	Two hours maximum
1-97036	Two hours maximum
1-97039	Two hours maximum
1-97110	Two hours maximum
1-97112	Two hours maximum
1-97113	Two hours maximum
1-97116	Two hours maximum
1-97124	Two hours maximum
1-97139	Two hours maximum

Occupational Therapy Only Codes

CPT Code	Frequency
1-97003	Once every six months
1-97004	Once per month

Occupational therapy prescribed primarily as an adjunct to psychotherapy is not a benefit.

Refer to: "Physical Therapists/Independent Practitioners" on page 35-1 and "Home Health Services" on page 24-6 and "Claims Information" on page 43-10 for authorization and requirements, and coverage or noncoverage of the above 2000 CPT Physical Medicine and Rehabilitation codes.

36.4.30.1 Limitations

Occupational therapy must be billed with the modifier AT and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. Occupational therapy is to be billed with CPT procedure codes.

The AT modifier is described as representing treatment provided for an acute musculoskeletal or neuromuscular condition, or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition, that persists fewer than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is defined as the point at which maximal improvement has been documented and more improvement ceases.

Procedure codes 1-97012, 1-97014, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one per day. The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes		
1-97032	1-97033	1-97034
1-97035	1-97036	1-97039
1-97110	1-97112	1-97113
1-97116	1-97124	1-97139
1-97140	1-97530	1-97535
1-97537	1-97760	1-97761

Procedure code 1-97760 is only payable for clients younger than 21 years of age. Procedure code 1-97010 is not a benefit.

Procedure codes that may be billed in multiple quantities (e.g., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure code 1-97762 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit is denied as part of another procedure billed the same day. Procedure codes 1-97535, 1-97537, 1-97542, and 1-97762 are only payable for clients younger than 21 years of age.

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Procedure code 1-97004 is payable once per month, any provider, same facility. These codes are not payable on the same day as the following codes:

Procedure Codes		
1-97012	1-97014	1-97018
1-97022	1-97024	1-97026
1-97028	1-97032	1-97033
1-97034	1-97035	1-97036
1-97039	1-97110	1-97112
1-97113	1-97116	1-97124
1-97139	1-97140	1-97150
1-97530	1-97750	1-97760
1-97761	1-97762	

36.4.31 Osteopathic Manipulative Treatment Services

Osteopathic manipulative treatment (OMT) performed by a provider licensed to perform OMT is a covered benefit of the Texas Medicaid Program for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component. Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929.

When multiples of procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 are billed on the same day by the same provider, the most inclusive code is paid and the others are denied. An initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day.

Procedure code 1-97140 will deny as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

36.4.32 Pentamadine, Aerosol

Aerosol pentamidine treatments will be reimbursed using procedure code 1-94642.

Additionally, the provider may also be reimbursed for the medication using procedure code 1-J2545.

Payment for aerosol pentamidine treatments is limited to the following diagnosis codes:

Diagnosis Code	Description
042	Human immunodeficiency virus [HIV] disease
07951	Human T-cell lymphotrophic virus, type I [HTLV-I]
07952	Human T-cell lymphotrophic cirus, type II [HTLV-II]
07953	Human immunodeficiency virus, type 2 [HIV-2]
1363	Pneumocystosis
48284	Pneumonia due to Legionnaires' disease
5186	Allergic bronchopulmonary aspergillosis

Aerosol pentamidine treatments are limited to one treatment every 28 days.

36.4.33 Percutaneous Transluminal Coronary Interventions

Percutaneous transluminal coronary interventions are a therapeutic option for clients with arteriosclerotic heart disease. The procedure codes listed below are reimbursed by the Texas Medicaid Program:

Procedure Codes		
2/F-92973	2/F-92974	2/F-92980
2/F-92981	2/F-92982	2/F-92984
2/F-92995	2/F-92996	2/F-G0290
2/F-G0291		

When any of the following procedure codes are performed on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure will be reimbursed: 2/F-92973, 2/F-92982, 2/F-92984, 2/F-92995, and 2/F-92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels will be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

Procedure code 2/F-92974 may be reimbursed as a separately payable service in addition to the primary stenting procedure, even when performed on the same vessel.

36.4.34 Physical Therapy Services

Physical medicine is the use of physical agents such as heat, massage, electricity, traction, or exercises in the treatment of disease. Payments for physical medicine are limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical medicine to restore function. The acute modifier AT must be billed for payment to be made.

Physical therapy must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. Physical therapy is to be billed with CPT procedure codes.

Examples of what may be considered *acute* are as follows:

- A new injury

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- Therapy before or after surgery, acute exacerbations of conditions, such as rheumatoid arthritis
- Interventions such as a newly implanted intrathecal pump to decrease spasticity or botulinum toxin type A injections

Physical medicine, including functional evaluations, must be provided according to the current (within 60 days) written orders of a physician and based on medical necessity. It may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

36.4.34.1 Limitations

Procedure codes 1-97012, 1-97014, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one per day. The following procedure codes may be paid in multiple 15-minute quantities:

Procedure Codes		
1-97032	1-97033	1-97034
1-97035	1-97036	1-97039
1-97110	1-97112	1-97113
1-97116	1-97124	1-97139
1-97140	1-97530	1-97535
1-97537	1-97760	1-97761

Procedure code 1-97760 is only payable for clients younger than 21 years of age. Procedure code 1-97010 is not a benefit.

Procedure codes that may be billed in multiple quantities (e.g., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure codes 1-97762 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit is denied as part of another procedure billed the same day. Procedure codes 1-97535, 1-97537, 1-97542, and 1-97762 are only payable for clients younger than 21 years of age.

Procedure code 1-97001 is payable once per six months, any provider, same facility. Procedure code 1-97002 is payable once per month, any provider, same facility. These codes are not payable on the same day as the following procedure codes:

Procedure Codes		
1-97012	1-97014	1-97018
1-97022	1-97024	1-97026
1-97028	1-97032	1-97033
1-97034	1-97035	1-97036
1-97039	1-97110	1-97112
1-97113	1-97116	1-97124
1-97139	1-97140	1-97150
1-97530	1-97750	1-97760
1-97761	1-97762	

Refer to: "Occupational Therapy" on page 36-247 for additional CPT codes.

36.4.34.2 Nursing Facility

Separate payment cannot be made to a physician or an independently practicing physical therapist who provides physical medicine to a resident of a nursing facility. These services must be made available to nursing facility residents as needed and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources as part of the daily care. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

36.4.35 Podiatrist Services

Podiatry services that are provided in a skilled, intermediate, or extended care nursing facility are a benefit of the Texas Medicaid Program.

36.4.35.1 Clubfoot Casting

CPT code 2-29450 is payable to a physician in the management of clubfoot when no surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. CPT code 2-29750 is payable to a physician in addition to the initial casting or strapping procedure.

Unilateral casting should be billed as cast code 2-29450. Procedure code 2-29750 is payable in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting for a diagnosis of clubfoot is covered if the client is 0–3 years of age and has one of the following conditions:

Diagnosis Code	Description
73671	Acquired equinovarus deformity
75450	Congenital talipes varus
75451	Congenital talipes equinovarus
75452	Congenital metatarsus primus varus
75453	Congenital metatarsus varus
75459	Other congenital varus deformities of feet
75460	Congenital talipes valgus
75461	Congenital pes planus
75462	Talipes calcaneovalgus
75469	Other congenital valgus deformities of feet
75470	Talipes, unspecified

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Diagnosis Code	Description
75471	Talipes cavus
75479	Other congenital deformities of feet

36.4.35.2 Echography/Ultrasound of Extremity

The following procedure codes are payable to podiatrists. Claim processing is subject to modifier 76 auditing: 4/I/T-76880 and 4/I/T-76999.

Reimbursement is based on TMRM. If the technical (TOS T) and/or interpretation (TOS I) components are billed by any provider for the same date of service as the total component (TOS 4), the total component of the corresponding procedure is denied.

For example, if T-76880 and 4-76880 are billed by any provider, on the same day, the total component code, 4-76880 is denied.

36.4.35.3 Flat Foot Treatment

Treatment of flat foot conditions and the procurement of supportive devices (including special shoes) is not covered.

Diagnosis code 72670, Enthesopathy of ankle and tarsus, is not considered a flat foot condition.

36.4.35.4 Nerve Conduction Studies Performed by Podiatrist

Doctors of podiatry may be reimbursed for nerve conduction studies for foot and ankle diagnosis codes. Bill nerve conduction studies using the following codes: 5-95900, 5-95903, 5-95904, 5-95934, and 5-95936.

Procedure codes 5(I)-95900, 5(I)-95903, and/or 5(I)-95904 are reimbursed at full for the first nerve study and half for each additional study irrespective of the number of studies.

Procedure code 5/I/T-95934 or 5/I/T-95936 are reimbursed at full fee when performed on the same date of service as procedure codes 5/I/T-95900, 5/I/T-95903 or 5/I/T-95904.

If 5/I/T-95934 and 5/I/T-95936 are billed in multiples, the first study is reimbursed at full fee and all additional studies at half fee.

Nerve conduction studies repeated within a three-month period on the same client by the same provider are denied except for the following diagnosis codes:

Diagnosis Code	Descriptions
25060	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled
2650	Beriberi
2652	Pellagra
2692	Unspecified vitamin deficiency
2699	Unspecified nutritional deficiency
2771	Disorders of porphyrin metabolism
27730	Amyloidosis, unspecified
27739	Other amyloidosis
27781	Primary carnitine deficiency
27782	Carnitine deficiency due to inborn errors of metabolism
27783	Iatrogenic carnitine deficiency
27784	Other secondary carnitine deficiency
27789	Other specified disorders of metabolism
3525	Disorders of hypoglossal (12th) nerve
3541	Other lesion of median nerve
3552	Other lesion of femoral nerve
3553	Lesion of lateral popliteal nerve
3558	Mononeuritis of lower limb, unspecified
3560	Hereditary peripheral neuropathy
3564	Idiopathic progressive polyneuropathy
3569	Unspecified idiopathic peripheral neuropathy
3572	Polyneuropathy in diabetes
3575	Alcoholic polyneuropathy
3576	Polyneuropathy due to drugs
3577	Polyneuropathy due to other toxic agents
7220	Displacement of cervical intervertebral disc without myelopathy
7221	Displacement of thoracic or lumbar intervertebral disc without myelopathy
7222	Displacement of intervertebral disc, site unspecified, without myelopathy
7234	Brachial neuritis or radiculitis NOS
7292	Neuralgia, neuritis, and radiculitis, unspecified
7295	Pain in limb

Podiatrists must use modifiers LT (left), RT (right), or AT when appropriate. Specific toe modifiers should also be used when appropriate.

36.4.35.5 Nursing Facility

Podiatry services provided in a skilled, intermediate, or extended care nursing facility are a benefit of the Texas Medicaid Program.

36.4.35.6 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to

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one service every six months per client, regardless of provider specialty: 2-11055, 2-11056, 2-11057, 2-11719, and 2-G0127.

Use modifiers TT, UN, UP, UQ, UR, and US for services rendered in a nursing facility when multiple patients are seen.

36.4.35.7 Vascular Studies Performed by Podiatrist

The following procedure codes are payable when billed by podiatrists:

Procedure Codes		
4/I/T-93922	4/I/T-93925	4/I/T-93926
4/I/T-93965	4/I/T-93970	4/I/T-93971

36.4.35.8 X-Ray Procedures by Podiatrist

A podiatrist may be reimbursed for the following X-ray and noninvasive diagnostic procedures:

Procedure Codes		
4I/T-73600	4/I/T-73610	4/I/T-73620
4/I/T-73630	4/I/T-73650	4/I/T-73660

36.4.36 Polysomnography

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a one to four lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental EMG.

Additional parameters of sleep include, but are not limited to:

- ECG
- Airflow
- Ventilation and respiratory effort
- Gas exchange by oximetry
- Extremity/motor activity movement
- Extended EEG monitoring
- Penile tumescence
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 5/I/T-95805, 5/I/T-95808, 5/I/T-95810, and 5/I/T-95811

Sleep studies (5/I/T-95806 and 5/I/T-95807) are not a benefit of the Texas Medicaid Program.

When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes denied.

Polysomnography (5/I/T-95808, 5/I/T-95810, 5/I/T-95811) is allowed for the following diagnosis codes:

Diagnosis Code	Description
32700	Organic insomnia, unspecified
32710	Organic hypersomnia, unspecified
32711	Idiopathic hypersomnia with long sleep time
32712	Idiopathic hypersomnia without long sleep time
32713	Recurrent hypersomnia
32714	Hypersomnia due to medical condition
32715	Hypersomnia due to mental disorder
32719	Other organic hypersomnia
32720	Organic sleep apnea, unspecified
32721	Primary central sleep apnea
32722	High altitude periodic breathing
32723	Obstructive sleep apnea (adult) (pediatric)
32724	Idiopathic sleep related non-obstructive alveolar hypoventilation
32725	Congenital central alveolar hypoventilation syndrome
32726	Sleep related hypoventilation/hypoxemia in conditions classifiable elsewhere
32727	Central sleep apnea in conditions classified elsewhere
32729	Other organic sleep apnea
32730	Circadian rhythm sleep disorder, unspecified
32731	Circadian rhythm sleep disorder, delayed sleep phase type
32732	Circadian rhythm sleep disorder, advanced sleep phase type
32733	Circadian rhythm sleep disorder, irregular sleep-wake type
32734	Circadian rhythm sleep disorder, free-running type
32735	Circadian rhythm sleep disorder, jet lag type
32736	Circadian rhythm sleep disorder, shift work type
32737	Circadian rhythm sleep disorder in conditions classified elsewhere
32739	Other circadian rhythm sleep disorder
32740	Organic parasomnia, unspecified
32741	Confusional arousals
32742	REM sleep behavior disorder
32743	Recurrent isolated sleep paralysis

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Diagnosis Code	Description
32744	Parasomnia in conditions classified elsewhere
32749	Other organic parasomnia
32751	Periodic limb movement disorder
32759	Other organic sleep related movement disorders
3278	Other organic sleep disorders
34700	Narcolepsy, without cataplexy
34701	Narcolepsy, with cataplexy
34710	Narcolepsy in conditions classified elsewhere, without cataplexy
34711	Narcolepsy in conditions classified elsewhere, with cataplexy
78050	Unspecified sleep disturbance
78051	Insomnia with sleep apnea, unspecified
78052	Insomnia, unspecified
78053	Hypersomnia with sleep apnea, unspecified
78054	Hypersomnia, unspecified
78055	Disruption of 24 hour sleep wake cycle, unspecified
78056	Dysfunctions associated with sleep stages or arousal from sleep
78057	Unspecified sleep apnea
78059	Other sleep disturbances

Multiple sleep latency test (5/I/T-95805) is restricted to the following diagnosis codes:

Diagnosis Code	Description
34700	Narcolepsy, without cataplexy
34701	Narcolepsy, with cataplexy
34710	Narcolepsy in conditions classified elsewhere, without cataplexy
34711	Narcolepsy in conditions classified elsewhere, with cataplexy
78050	Sleep disturbance unspecified
78051	Insomnia with sleep apnea
78052	Other insomnia
75053	Hypersomnia with sleep apnea
78054	Other hypersomnia
78055	Disruptions of 24 hour sleep-wake cycle
78056	Dysfunctions associated with sleep stages or arousal from sleep
78057	Other and unspecified sleep apnea
78058	Sleep related movement disorder
78059	Sleep disturbances, NEC

36.4.37 Prostate Surgeries

A transurethral resection of the prostate (TURP) is the most common procedure performed to treat benign prostatic hyperplasia (BPH). A TURP may be billed with the following procedure codes:

Procedure Codes		
2/F-52601	2/F-52606	2/F-52612
2/F-52614	2/F-52620	2/F-52630
2/F-52640		

If a physician bills separate charges for any of the TURP procedure codes listed above, and any of the following procedure codes on the same date of service, the charges for the services listed below will be denied as part of the TURP procedure.

Procedure Codes		
2/F-52000	2/F-52204	2/F-52214
2/F-52275	2/F-52276	2/F-52281
2/F-52310	2/F-52315	2/F-52351
2/F-52354	2/F-53020	

36.4.38 Psychiatric Pharmacological Management Services

Procedure codes 1-M0064 and 1-90862 may be billed for pharmacological management services.

Procedure code 1-M0064 indicates the client is stable but pharmacologic regimen oversight is necessary.

A brief visit for the sole purpose of monitoring or changing drug prescriptions (1-M0064) refers to a lesser level of drug monitoring such as monitoring, simple dosage adjustment, or changing drug prescriptions where the client is evaluated during a face-to-face visit and treated in the office setting.

Procedure code 1-90862 is defined as the assessment and management of psychopharmacological agents with no more than minimal medical psychotherapy.

Pharmacological management (1-90862) is not intended to refer to a brief evaluation of the client's state, simple dosage adjustment, or long term medication. Pharmacological management refers to the in-depth management of psychopharmacological agents which are medications with serious side effects and represents a very skilled aspect of care for a client who is determined to be mentally or physically unstable. It is intended for use for clients who are being managed primarily by psychotropics, antidepressants, ECT, and/or other types of psychopharmacologic medications.

Pharmacological management must be provided during a face-to-face visit with the client and any psychotherapy must be less than 20 minutes.

The focus of a pharmacological management visit is the use of medication for relief of client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness neces-

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sitating discussion beyond minimal psychotherapy in a given day, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Procedure codes 1-90862 and 1-M0064 describe a physician service and cannot be delegated to a nonphysician or *incident to* a physician's service. APNs whose scope of license permit them to prescribe may use these codes if they perform the service. The service must only be billed if the physician or APN actually performs the service.

Texas Medicaid does not reimburse for 1-90862 or 1-M0064 for actual administration of medication or for observation of the patient taking an oral medication. Administration and supply of oral medication are noncovered services.

All documentation must support that the service was reasonable and medically necessary for the billed diagnosis.

Documentation of medical necessity for pharmacological management (1-90862) must address all of the following information in the client's medical record in legible format:

- Date
- Diagnosis
- Medication history
- Current symptoms and problems to include presenting mental status and/or physical symptoms that indicate the client requires a medication adjustment (current presenting mental status or physical symptoms that indicate the client is in an unstable state of mind or body)
- Problems, reactions, and side effects, if any, to medications and/or ECT
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome(s)

Documentation of medical necessity for a brief office visit for the sole purpose of monitoring or changing drug prescriptions (1-M0064) must address all of the following information in the client's medical record:

- The client is evaluated and determined to be stable, but continues to have a psychiatric diagnosis that needs close monitoring of therapeutic drug levels or
- The client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment and
- Provider has documented the medication history in the client's records with current signs and symptoms, new medication modifications with anticipated outcome.

Pharmacological management procedure codes 1-90862 and 1-M0064 will not be reimbursed for the same date of service. If the two procedure codes are billed for the same date of service by any provider, 1-M0064 will deny as part of 1-90862.

E/M services include pharmacological management. Procedure codes 1- 90862 and 1-M0064 should not be billed in addition to the E/M service. Pharmacological management (1-M0064 or 1-90862), will be denied as part of any E/M service billed for the same date of service by the same provider.

If the primary reason for the office visit is for psychotherapy, then the specific psychotherapy procedure code should be billed. Pharmacological management codes 1-M0064 or 1-90862, will be denied as part of any psychotherapy service that is billed for the same date of service, by the same provider.

Pharmacological management procedure codes (1-90862 and 1-M0064) will not count against the 30 encounter annual limitation for outpatient behavioral health services.

The treating provider must document the medical necessity of the chosen treatment and list the diagnosis code that most accurately describes the condition of the client that necessitated the need for the pharmacological management on the claim and in the client's medical record. The medical record (hospital or outpatient records, reports, or progress notes) should be clear and concise, documenting the reason(s) for the pharmacological management treatment and the outcome.

Pharmacological management procedure codes 1-90862 and 1-M0064 are not payable more than one service per day, per client, by any provider in any setting. Procedure code 1-M0064 is limited to the office setting.

If behavioral health pharmacological services are needed beyond the current diagnosis and frequency limitations, the claim may be appealed with additional documentation to demonstrate the medical necessity.

Limitations for procedure code 1-M0064 or 1-90862 may be appealed with documentation supporting medical necessity.

The following diagnosis codes are the *only* payable diagnosis codes for billing pharmacological management procedure codes 1-M0064 or 1-90862.

Diagnosis Code	Description
2900	Senile dementia, uncomplicated
29010	Presenile dementia, uncomplicated
29011	Presenile dementia with delirium
29012	Presenile dementia with delusional features
29013	Presenile dementia with depressive features
29020	Senile dementia with delusional features
29021	Senile dementia with depressive features

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Diagnosis Code	Description
2903	Senile dementia with delirium
29040	Vascular dementia, uncomplicated
29041	Vascular dementia with delirium
29042	Vascular dementia with delusions
29043	Vascular dementia with depressed mood
2908	Other specified senile psychotic conditions
2909	Unspecified senile psychotic condition
2910	Alcohol withdrawal delirium
2911	Alcohol induced persisting amnesic disorder
2912	Alcohol induced persisting dementia
2913	Alcohol induced psychotic disorder with hallucinations
2914	Idiosyncratic alcohol intoxication
2915	Alcohol induced psychotic disorder with delusions
29181	Alcohol withdrawal
29182	Alcohol induced sleep disorders
29189	Other
2919	Unspecified alcohol induced mental disorders
2920	Drug withdrawal
29211	Drug induced psychotic disorder with delusions
29212	Drug induced psychotic disorder with hallucinations
2922	Pathological drug intoxication
29281	Drug induced delirium
29282	Drug induced persisting dementia
29283	Drug induced persisting amnesic disorder
29284	Drug induced mood disorder
29285	Drug induced sleep disorders
29289	Other
2929	Unspecified drug induced mental disorder
2930	Delirium due to conditions classified elsewhere
2931	Subacute delirium
29381	Psychotic disorder with delusions in conditions classified elsewhere
29382	Psychotic disorder with hallucinations in conditions classified elsewhere
29384	Anxiety disorder in conditions classified elsewhere

Diagnosis Code	Description
29389	Other specified transient mental disorders due to conditions classified elsewhere, other
2939	Unspecified transient mental disorder in conditions classified elsewhere
2940	Amnesic disorder in conditions classified elsewhere
29410	Dementia in conditions classified elsewhere without behavioral disturbances
29411	Dementia in conditions classified elsewhere with behavioral disturbance
2948	Other persistent mental disorders due to conditions classified elsewhere
2949	Unspecified persistent mental disorders due to conditions classified elsewhere
29500	Schizophrenic disorders, simple type unspecified
29501	Schizophrenic disorders, simple type subchronic
29502	Schizophrenic disorders, simple type chronic
29503	Schizophrenic disorders, simple type subchronic with acute exacerbation
29504	Schizophrenic disorders, simple type chronic with acute exacerbation
29505	Schizophrenic disorders, simple type in remission
29510	Schizophrenic disorders, disorganized type unspecified
29511	Schizophrenic disorders, disorganized type subchronic
29512	Schizophrenic disorders, disorganized type chronic
29513	Schizophrenic disorders, disorganized type subchronic with acute exacerbation
29514	Schizophrenic disorders, disorganized type chronic with acute exacerbation
29515	Schizophrenic disorders, disorganized type in remission
29520	Schizophrenic disorders, catatonic type unspecified
29521	Schizophrenic disorders, catatonic type subchronic
29522	Schizophrenic disorders, catatonic type chronic

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Diagnosis Code	Description
29523	Schizophrenic disorders catatonic type subchronic with acute exacerbation
29524	Schizophrenic disorders catatonic type chronic with acute exacerbation
29525	Schizophrenic disorders catatonic type in remission
29530	Schizophrenic disorders paranoid type unspecified
29531	Schizophrenic disorders paranoid type subchronic
29532	Schizophrenic disorders paranoid type chronic
29533	Schizophrenic disorders paranoid type subchronic with acute exacerbation
29534	Schizophrenic disorders paranoid type chronic with acute exacerbation
29535	Schizophrenic disorders paranoid type in remission
29540	Schizophrenic disorders schizo-phreniform unspecified
29541	Schizophrenic disorders schizo-phreniform subchronic
29542	Schizophrenic disorders schizo-phreniform chronic
29543	Schizophrenic disorders schizo-phreniform subchronic with acute exacerbation
29544	Schizophrenic disorders schizo-phreniform chronic with acute exacerbation
29545	Schizophrenic disorders schizo-phreniform in remission
29550	Schizophrenic disorders latent schizo-phrenia unspecified
29551	Schizophrenic disorders latent schizo-phrenia subchronic
29552	Schizophrenic disorders latent schizo-phrenia chronic
29553	Schizophrenic disorders latent schizo-phrenia subchronic with acute exacerbation
29554	Schizophrenic disorders latent schizo-phrenia chronic with acute exacerbation
29555	Schizophrenic disorders latent schizo-phrenia in remission
29560	Schizophrenic disorders residual unspecified
29561	Schizophrenic disorders residual subchronic

Diagnosis Code	Description
29562	Schizophrenic disorders residual chronic
29563	Schizophrenic disorders residual subchronic with acute exacerbation
29564	Schizophrenic disorders residual chronic with acute exacerbation
29565	Schizophrenic disorders residual in remission
29570	Schizophrenic disorders schizoaf-fective disorder unspecified
29571	Schizophrenic disorders schizoaf-fective disorder subchronic
29572	Schizophrenic disorders schizoaf-fective disorder chronic
29573	Schizophrenic disorders schizoaf-fective disorder subchronic with acute exacerbation
29574	Schizophrenic disorders schizoaf-fective disorder chronic with acute exacerbation
29575	Schizophrenic disorders schizoaf-fective disorder in remission
29580	Schizophrenic disorders, other specified types of schizophrenia unspecified
29581	Schizophrenic disorders, other specified types of schizophrenia subchronic
29582	Schizophrenic disorders, other specified types of schizophrenia chronic
29583	Schizophrenic disorders, other specified types of schizophrenia subchronic with acute exacerbation
29584	Schizophrenic disorders, other specified types of schizophrenia chronic with acute exacerbation
29585	Schizophrenic disorders, other specified types of schizophrenia in remission
29590	Schizophrenic disorders, unspecified schizophrenia unspecified
29591	Schizophrenic disorders, unspecified schizophrenia subchronic
29592	Schizophrenic disorders, unspecified schizophrenia chronic
29593	Schizophrenic disorders, unspecified schizophrenia subchronic with acute exacerbation
29594	Schizophrenic disorders, unspecified schizophrenia chronic with acute exacerbation

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Diagnosis Code	Description
29595	Schizophrenic disorders, unspecified schizophrenia other specified types of schizophrenia in remission
29600	Bipolar I disorder single manic episode unspecified
29601	Bipolar I disorder single manic episode mild
29602	Bipolar I disorder single manic episode moderate
29603	Bipolar I disorder single manic episode severe without mention of psychotic behavior
29604	Bipolar I disorder single manic episode severe specified as with psychotic behavior
29605	Bipolar I disorder single manic episode in partial or unspecified remission
29606	Bipolar I disorder single manic episode in full remission
29610	Manic disorder recurrent episode unspecified
29611	Manic disorder recurrent episode mild
29612	Manic disorder recurrent episode moderate
29613	Manic disorder recurrent episode severe without mention of psychotic behavior
29614	Manic disorder recurrent episode severe specified as with psychotic behavior
29615	Manic disorder recurrent episode severe in partial or unspecified remission
29616	Manic disorder recurrent episode in full remission
29620	Major depressive disorder single episode unspecified
29621	Major depressive disorder single episode mild
29622	Major depressive disorder single episode moderate
29623	Major depressive disorder single episode severe without mention of psychotic behavior
29624	Major depressive disorder, single episode, specified as with psychotic behavior
29625	Major depressive disorder, single episode, in partial or unspecified remission

Diagnosis Code	Description
29626	Major depressive disorder, single episode, in full remission
29630	Major depressive disorder, recurrent episode, unspecified
29631	Major depressive disorder, recurrent episode, mild
29632	Major depressive disorder, recurrent episode, moderate
29633	Major depressive disorder, recurrent episode, severe without mention of psychotic behavior
29634	Major depressive disorder, recurrent episode, specified as with psychotic behavior
29635	Major depressive disorder, recurrent episode, in partial or unspecified remission
29636	Major depressive disorder, recurrent episode, in full remission
29640	Bipolar I disorder, most recent episode (or current) manic, unspecified
29641	Bipolar I disorder, most recent episode (or current) manic, mild
29642	Bipolar I disorder, most recent episode (or current) manic, moderate
29643	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior
29644	Bipolar I disorder, most recent episode (or current) manic, specified as with psychotic behavior
29645	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission
29646	Bipolar I disorder, most recent episode (or current) manic, in full remission
29650	Bipolar I disorder, most recent episode (or current) depressed, unspecified
29651	Bipolar I disorder, most recent episode (or current) depressed, mild
29652	Bipolar I disorder, most recent episode (or current) depressed, moderate
29653	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior
29654	Bipolar I disorder, most recent episode (or current) depressed, specified as with psychotic behavior

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Diagnosis Code	Description
29655	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission
29656	Bipolar I disorder, most recent episode (or current) depressed, in full remission
29660	Bipolar I disorder, most recent episode (or current) mixed, unspecified
29661	Bipolar I disorder, most recent episode (or current) mixed, mild
29662	Bipolar I disorder, most recent episode (or current) mixed, moderate
29663	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior
29664	Bipolar I disorder, most recent episode (or current) mixed, specified as with psychotic behavior
29665	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified
29666	Bipolar I disorder, most recent episode (or current) mixed, in full remission
2967	Bipolar I disorder, most recent episode (or current) unspecified
29680	Bipolar disorder, unspecified
29681	Atypical manic disorder
29682	Atypical depressive disorder
29689	Other
29690	Unspecified episodic mood disorder
29699	Other specified episodic mood disorder
2970	Paranoid state, simple
2971	Delusional disorder
2972	Paraphrenia
2973	Shared psychotic disorder
2978	Other specified paranoid states
2979	Unspecified paranoid state
2980	Depressive type psychosis
2981	Excitative type psychosis
2982	Reactive confusion
2983	Acute paranoid reaction
2984	Psychogenic paranoid psychosis
2988	Other and unspecified reactive psychosis
2989	Unspecified psychosis

Diagnosis Code	Description
2990	Pervasive developmental disorders current or active state
2991	Pervasive developmental disorders residual state
30000	Anxiety state, unspecified
30001	Panic disorder without agoraphobia
30002	Generalized anxiety disorder
30009	Other
30010	Hysteria, unspecified
30011	Conversion disorder
30012	Dissociative amnesia
30013	Dissociative fugue
30014	Dissociative identity disorder
30015	Dissociative disorder or reaction, unspecified
30016	Factitious disorder with predominantly psychological signs and symptoms
30019	Other and unspecified factitious illness
30020	Phobic, unspecified
30021	Agoraphobia with panic disorder
30022	Agoraphobia without mention of panic attacks
30023	Social phobia
30029	Other isolated or specific phobias
3003	Obsessive-compulsive disorders
3004	Dysrhythmic disorder
3005	Neurasthenia
3006	Depersonalization disorder
3007	Hypochondriasis
30081	Somatization disorder
30082	Undifferentiated somatoform disorder
30089	Other somatoform disorders
3010	Paranoid personality disorder
30110	Affective personality disorder
30111	Chronic hypomanic personality disorder
30112	Chronic depressive personality disorder
30113	Cyclothymic disorder
30120	Schizoid personality disorder, unspecified
30121	Introverted personality
30122	Schizotypal personality disorder
3013	Explosive personality

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Diagnosis Code	Description
3014	Obsessive-compulsive personality disorder
30150	Histrionic personality disorder, unspecified
30151	Chronic factitious illness with physical symptoms
30159	Other histrionic personality disorder
3016	Dependant personality disorder
3017	Antisocial personality disorder
30181	Narcissistic personality disorder
30182	Avoidant personality disorder
30183	Borderline personality disorder
30184	Passive-aggressive personality
30189	Other personality disorders
3019	Unspecified personality disorder
3020	Ego-dystonic sexual orientation
3021	Zoophilia
3022	Pedophilia
3023	Transvestic fetishism
3024	Exhibitionism
30250	Trans-sexualism, with unspecified sexual history
30251	Trans-sexualism, with asexual history
30252	Trans-sexualism, with homosexual history
30253	Trans-sexualism, with heterosexual history
3026	Gender identity disorder in children
30270	Psychosexual dysfunction, unspecified
30271	Hypoactive sexual desire disorder
30272	Psychosexual dysfunction with inhibited sexual excitement
30273	Female orgasmic disorder
30274	Male orgasmic disorder
30275	Premature ejaculation
30276	Dyspareunia, psychogenic
30279	With other specified psychosexual dysfunctions
30281	Fetishism
30282	Voyeurism
30283	Sexual masochism
30284	Sexual sadism
30285	Gender identity disorder in adolescents or adults
30289	Other specified psychosexual disorders

Diagnosis Code	Description
3029	Unspecified psychosexual disorder
30300	Acute alcoholic intoxication in alcoholism, unspecified drinking behavior
30301	Acute alcoholic intoxication in alcoholism, continuous drinking behavior
30302	Acute alcoholic intoxication in alcoholism, episodic drinking behavior
30303	Acute alcoholic intoxication in alcoholism, in remission
30390	Other and unspecified alcohol dependence, unspecified
30391	Other and unspecified alcohol dependence, continuous
30392	Other and unspecified alcohol dependence, episodic
30393	Other and unspecified alcohol dependence, in remission
30400	Opioid type dependence unspecified
30401	Opioid type dependence continuous
30402	Opioid type dependence episodic
30403	Opioid type dependence in remission
30410	Sedative hypnotic or anxiolytic dependence unspecified
30411	Sedative hypnotic or anxiolytic dependence continuous
30412	Sedative hypnotic or anxiolytic dependence episodic
30413	Sedative hypnotic or anxiolytic dependence in remission
30420	Cocaine dependence unspecified
30421	Cocaine dependence continuous
30422	Cocaine dependence episodic
30423	Cocaine dependence in remission
30430	Cannabis dependence unspecified
30431	Cannabis dependence continuous
30432	Cannabis dependence episodic
30433	Cannabis dependence in remission
30440	Amphetamine and other psychostimulant dependence unspecified
30441	Amphetamine and other psychostimulant dependence continuous
30442	Amphetamine and other psychostimulant dependence episodic
30443	Amphetamine and other psychostimulant dependence in remission

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Diagnosis Code	Description
30450	Hallucinogen dependence unspecified
30451	Hallucinogen dependence continuous
30452	Hallucinogen dependence episodic
30453	Hallucinogen dependence in remission
30460	Other specified drug dependence unspecified
30461	Other specified drug dependence continuous
30462	Other specified drug dependence episodic
30463	Other specified drug dependence in remission
30470	Combination of opioid type drug with any other unspecified
30471	Combination of opioid type drug with any other continuous
30472	Combination of opioid type drug with any other episodic
30473	Combination of opioid type drug with any other in remission
30480	Combination of drug dependence excluding opioid type drug with any other unspecified
30481	Combination of drug dependence excluding opioid type drug with any other continuous
30482	Combination of drug dependence excluding opioid type drug with any other episodic
30483	Combination of drug dependence excluding opioid type drug with any other in remission
30490	Unspecified drug dependence unspecified
30491	Unspecified drug dependence continuous
30492	Unspecified drug dependence episodic
30493	Unspecified drug dependence in remission
30500	Alcohol abuse unspecified
30501	Alcohol abuse continuous
30502	Alcohol abuse episodic
30503	Alcohol abuse in remission
30520	Cannabis abuse unspecified
30521	Cannabis abuse continuous
30522	Cannabis abuse episodic
30523	Cannabis abuse in remission

Diagnosis Code	Description
30530	Hallucinogen abuse unspecified
30531	Hallucinogen abuse, continuous
30532	Hallucinogen abuse, episodic
30533	Hallucinogen abuse, in remission
30540	Sedative, hypnotic or anxiolytic abuse, unspecified
30541	Sedative, hypnotic or anxiolytic abuse, continuous
30542	Sedative, hypnotic or anxiolytic abuse, episodic
30543	Sedative, hypnotic or anxiolytic abuse, in remission
30550	Opioid abuse, unspecified
30551	Opioid abuse, continuous
30552	Opioid abuse, episodic
30553	Opioid abuse, in remission
30560	Cocaine abuse, unspecified
30561	Cocaine abuse, continuous
30562	Cocaine abuse, episodic
30563	Cocaine abuse, in remission
30570	Amphetamine abuse or related acting sympathomimetic abuse, unspecified
30571	Amphetamine abuse or related acting sympathomimetic abuse, continuous
30572	Amphetamine abuse or related acting sympathomimetic abuse, episodic
30573	Amphetamine abuse or related acting sympathomimetic abuse, in remission
30580	Antidepressant type abuse, unspecified
30581	Antidepressant type abuse, continuous
30582	Antidepressant type abuse, episodic
30583	Antidepressant type abuse, in remission
30590	Other, mixed, or unspecified drug abuse, unspecified
30591	Other, mixed, or unspecified drug abuse, continuous
30592	Other, mixed, or unspecified drug abuse, episodic
30593	Other, mixed, or unspecified drug abuse, in remission
3060	Musculoskeletal malfunction arising from mental factors
3061	Respiratory malfunction arising from mental factors

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Diagnosis Code	Description
3062	Cardiovascular malfunction arising from mental factors
3063	Skin disorder arising from mental factors
3064	Gastrointestinal malfunction arising from mental factors
3065	Genitourinary malfunction arising from mental factors
30650	Psychogenic genitourinary malfunction, unspecified
30651	Psychogenic vaginismus
30652	Psychogenic dysmenorrhea
30653	Psychogenic dysuria
30659	Other genitourinary malfunction arising from mental factors
3066	Endocrine disorder arising from mental factors
3067	Disorder of organs of special sense arising from mental factors
3068	Other specified psychophysiological malfunction
3069	Unspecified psychophysiological malfunction
3070	Stuttering
3071	Anorexia nervosa
30720	Tic disorder, unspecified
30721	Transient tic disorder
30722	Chronic motor or vocal tic disorder
30723	Tourette's disorder
3073	Stereotypic movement disorder
3074	Specific disorders of sleep of nonorganic origin
30740	Nonorganic sleep disorder, unspecified
30741	Transient disorder of initiating or maintaining sleep
30742	Persistent disorder of initiating or maintaining sleep
30743	Transient disorder of initiating or maintaining wakefulness
30744	Persistent disorder of initiating or maintaining wakefulness
30745	Circadian rhythm sleep disorder of nonorganic origin
30746	Sleep arousal disorder
30747	Other dysfunctions of sleep stages or arousal from sleep
30748	Repetitive intrusions of sleep

Diagnosis Code	Description
30749	Other specific disorders of sleep of nonorganic origin
30750	Eating disorder, unspecified
30751	Bulimia nervosa
30752	Pica
30753	Rumination disorder
30754	Psychogenic vomiting
30759	Other disorders of eating
3076	Enuresis
3077	Encopresis
3078	Psychalgia
30780	Psychogenic pain, site unspecified
30781	Tension headache
30789	Other, pain disorder related to psychological factors
3079	Other and unspecified special symptoms or syndromes, not elsewhere classified
3080	Predominant disturbance of emotions
3081	Predominant disturbance of consciousness
3082	Predominant psychomotor disturbance
3083	Other acute reactions to stress
3084	Mixed disorders as reaction to stress
3089	Unspecified acute reaction to stress
3090	Adjustment disorder with depressed mood
3091	Prolonged depressive reaction
30921	Separation anxiety disorder
30922	Emancipation disorder of adolescence and early adult life
30923	Specific academic or work inhibition
30928	Adjustment disorder with mixed anxiety and depressed mood
30929	Other
3093	Adjustment disorder with disturbance of conduct
3094	Adjustment disorder with mixed disturbance of emotions and conduct
30981	Posttraumatic stress disorder
30982	Adjustment reaction with physical symptoms
30983	Adjustment reaction with withdrawal
30989	Other specified adjustment reactions
3100	Frontal lobe syndrome
3101	Personality change due to conditions classified elsewhere

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Diagnosis Code	Description
311	Depressive disorder not elsewhere classified
31200	Undersocialized conduct disorder, aggressive type, unspecified
31201	Undersocialized conduct disorder, aggressive type, mild
31202	Undersocialized conduct disorder, aggressive type, moderate
31203	Undersocialized conduct disorder, aggressive type, severe
31210	Undersocialized conduct disorder, unaggressive type, unspecified
31211	Undersocialized conduct disorder, aggressive type, mild
31212	Undersocialized conduct disorder, aggressive type, moderate
31213	Undersocialized conduct disorder, aggressive type, severe
31220	Socialized conduct disorder, unspecified
31221	Socialized conduct disorder, mild
31222	Socialized conduct disorder, moderate
31223	Socialized conduct disorder, severe
31230	Impulse control disorder, unspecified
31231	Pathological gambling
31232	Kleptomania
31234	Intermittent explosive disorder
31235	Isolated explosive disorder
31239	Other disorders of impulse control
3124	Mixed disturbance of conduct and emotions
31281	Conduct disorder, childhood onset type
31282	Conduct disorder, adolescent onset type
31289	Other conduct disorder
3129	Unspecified disturbance of conduct
3130	Overanxious disorder
3131	Misery and unhappiness disorder
31321	Shyness disorder of childhood
31322	Introverted disorder of childhood
31323	Selective mutism
3133	Relationship problems
31381	Oppositional defiant disorder
31382	Identity disorder
31383	Academic underachievement disorder
31389	Other emotional disturbances of childhood or adolescence
3139	Unspecified emotional disturbance of childhood or adolescence
31400	Attention deficit disorder, without mention of hyperactivity
31401	Attention deficit disorder, with hyperactivity
3141	Hyperkinesis with developmental delay
3142	Hyperkinetic conduct disorder
3148	Other specified manifestations of hyperkinetic syndrome
3149	Unspecified hyperkinetic syndrome
31500	Developmental reading disorder, unspecified
31501	Alexia
31502	Developmental dyslexia
31509	Other specific developmental reading disorder
3151	Mathematics disorder
3152	Other specific developmental learning difficulties
3153	Developmental speech or language disorder
31531	Expressive language disorder
31532	Mixed receptive-expressive language disorder
31539	Other developmental speech disorder
3154	Developmental coordination disorder
3155	Mixed development disorder
3158	Other specified delays in development
3159	Unspecified delay in development
316	Psychic factors associated with diseases classified elsewhere

36.4.39 Psychiatric Services

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day (group therapy services will be handled on a retrospective basis). Each individual who is delegated to perform these services by an MD or DO is limited to performing a combined total of 12 hours of behavioral health services per day.

Retrospective review may be done of not only billed hours but total hours worked per day, since providers performing group therapy may possibly bill in excess of 12 hours in a given day. Documentation requirements for all services billed are listed for each individual specialty in this manual.

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Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. *This limitation includes encounters/visits by all practitioners.* School Health and Related Services (SHARS) behavioral rehabilitation services, MHMR services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Each Medicaid client is limited to 30 encounters/visits per calendar year.

If a provider determines that additional services are medically necessary within the calendar year, prior authorization must be obtained before providing the 25th service.

Note: *Psychiatrists and psychologists in the Dallas service area must be enrolled as a network provider in the NorthSTAR Behavioral Health Organizations (BHO) network to provide services to NorthSTAR clients.*

Important: *NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Physicians that provide behavioral health services to clients in NorthSTAR must be a network provider of the NorthSTAR BHO to provide services to NorthSTAR clients.*

It is anticipated that this limitation, which allows for 6 months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required.

A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit. This request for prior authorization helps ensure the client does not miss any necessary encounters/visits with the mental health provider by having prior authorization in place before providing the 25th service. It will also assist the provider with timely and accurate claims payment.

It is recognized that sometimes a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit. This information must be submitted in addition to the usual medical necessity information required with every request.

Prior authorization will not be granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. *It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days prior to the date of service being requested, so that the most current information is provided.*

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30 encounter limitation are limited to 10 encounters/visits per request and must be submitted on the Request for Extended Outpatient Psychotherapy/Counseling Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated and planned frequency of encounters/visits)
- Number, type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided
- All areas of request must be completed with the information required by the form if additional room is needed providers may state "see attached" but the attachment must contain the specific information required in that section of the form

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts for court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

For more information, call the TMHP Contact Center at 1-800-925-9126.

Treatment for chronic diagnosis codes such as mental retardation are not covered by Medicaid.

Psychological testing (5-96101) and neuropsychological testing (5-96118) are covered services for the following diagnosis codes only:

Diagnosis Code	Description
0360	Meningococcal meningitis
0361	Meningococcal Encephalitis
03681	Meningococcal optic neutris
04503	Acute paralytic poliomyelitis specified as bulbar (unspecified - type 3)

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Diagnosis Code	Description
04510	Acute poliomyelitis with other paralysis (unspecified - type 3)
04523	Acute nonparalytic poliomyelitis (unspecified - type 3)
04593	Acute poliomyelitis, unspecified (unspecified - type 3)
0460	Kuru
0461	Jacob-Creutzfeldt disease
0462	Subacute sclerosing pan encephalitis
0463	Progressive multifocal leukoencephalopathy
0468	Other specified slow virus infection of central nervous system Progressive multifocal leukoecephalopathy
0469	Unspecified slow virus infection of central nervous system
0470	Coxsackie virus meningitis
0471	ECHO virus miniguides
0478	Other specified viral meningitis
0479	Unspecified viral meningitis
048	Other enterovirus disease of central nervous system
0490	Lymphocytic choriomeningitis
0491	Meningitis due to adenovirus
0498	Other specified non-arthropod-borne viral diseases of central nervous system
0499	Unspecified non-arthropod-borne viral diseases of central nervous system
2900	Senile dementia, uncomplicated
29010	Presenile dementia, uncomplicated
29011	Presenile dementia with delirium
29012	Presenile dementia with delusional features
29013	Presenile dementia with depressive features
29020	Senile dementia with delusional features
29021	Senile dementia with depressive features
2903	Senile dementia with delirium
29040	Vascular dementia, uncomplicated
29041	Vascular dementia with delirium
29042	Vascular dementia with delusions
29043	Vascular dementia with depressed mood
2908	Other specified senile psychotic conditions

Diagnosis Code	Description
2909	Unspecified senile psychotic condition
2911	Alcohol amnestic syndrome
2912	Other alcoholic dementia
2915	Alcoholic jealousy
29189	Other alcohol withdrawal
2919	Unspecified alcoholic psychosis
2920	Drug withdrawal syndrome
2922	Pathological drug intoxication
29281	Other specified drug-induced mental disorders
2929	Unspecified drug-induced mental disorder
2930	Delirium due to conditions classified elsewhere
2931	Subacute delirium
29381	Psychotic disorder with delusions in conditions classified elsewhere
29382	Psychotic disorder with hallucinations in conditions classified elsewhere
29384	Anxiety disorder in conditions classified elsewhere
29389	Other specified transient mental disorders due to conditions classified elsewhere, other
2939	Unspecified transient mental disorder in conditions classified elsewhere
2940	Amnesic disorder in conditions classified elsewhere
29410	Dementia in conditions classified elsewhere without behavioral disturbances
29411	Dementia in conditions classified elsewhere with behavioral disturbance
2948	Other persistent mental disorders due to conditions classified elsewhere
2949	Unspecified persistent mental disorders due to conditions classified elsewhere
29500	Schizophrenic disorders, simple type unspecified
29501	Schizophrenic disorders, simple type subchronic
29502	Schizophrenic disorders, simple type chronic
29503	Schizophrenic disorders, simple type subchronic with acute exacerbation
29504	Schizophrenic disorders, simple type chronic with acute exacerbation

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Diagnosis Code	Description
29505	Schizophrenic disorders, simple type in remission
29510	Schizophrenic disorders, disorganized type unspecified
29511	Schizophrenic disorders, disorganized type subchronic
29512	Schizophrenic disorders, disorganized type chronic
29513	Schizophrenic disorders, disorganized type subchronic with acute exacerbation
29514	Schizophrenic disorders, disorganized type chronic with acute exacerbation
29515	Schizophrenic disorders, disorganized type in remission
29520	Schizophrenic disorders, catatonic type unspecified
29521	Schizophrenic disorders, catatonic type subchronic
29522	Schizophrenic disorders, catatonic type chronic
29523	Schizophrenic disorders, catatonic type subchronic with acute exacerbation
29524	Schizophrenic disorders, catatonic type chronic with acute exacerbation
29525	Schizophrenic disorders, catatonic type in remission
29530	Schizophrenic disorders, paranoid type unspecified
29531	Schizophrenic disorders, paranoid type subchronic
29532	Schizophrenic disorders, paranoid type chronic
29533	Schizophrenic disorders, paranoid type subchronic with acute exacerbation
29534	Schizophrenic disorders, paranoid type chronic with acute exacerbation
29535	Schizophrenic disorders, paranoid type in remission
29540	Schizophrenic disorders, schizophreniform unspecified
29541	Schizophrenic disorders, schizophreniform subchronic
29542	Schizophrenic disorders, schizophreniform chronic
29543	Schizophrenic disorders, schizophreniform subchronic with acute exacerbation
29544	Schizophrenic disorders, schizophreniform chronic with acute exacerbation
29545	Schizophrenic disorders, schizophreniform in remission
29550	Schizophrenic disorders, latent schizophrenia unspecified
29551	Schizophrenic disorders, latent schizophrenia subchronic
29552	Schizophrenic disorders, latent schizophrenia chronic
29553	Schizophrenic disorders, latent schizophrenia subchronic with acute exacerbation
29554	Schizophrenic disorders, latent schizophrenia chronic with acute exacerbation
29555	Schizophrenic disorders, latent schizophrenia in remission
29560	Schizophrenic disorders, residual unspecified
29561	Schizophrenic disorders, residual subchronic
29562	Schizophrenic disorders, residual chronic
29563	Schizophrenic disorders, residual subchronic with acute exacerbation
29564	Schizophrenic disorders, residual chronic with acute exacerbation
29565	Schizophrenic disorders, residual in remission
29570	Schizophrenic disorders, schizoaffective disorder unspecified
29571	Schizophrenic disorders, schizoaffective disorder subchronic
29572	Schizophrenic disorders, schizoaffective disorder chronic
29573	Schizophrenic disorders, schizoaffective disorder subchronic with acute exacerbation
29574	Schizophrenic disorders, schizoaffective disorder chronic with acute exacerbation
29575	Schizophrenic disorders, schizoaffective disorder in remission
29580	Schizophrenic disorders, other specified types of schizophrenia unspecified
29581	Schizophrenic disorders, other specified types of schizophrenia subchronic

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Diagnosis Code	Description
29582	Schizophrenic disorders, other specified types of schizophrenia chronic
29583	Schizophrenic disorders, other specified types of schizophrenia subchronic with acute exacerbation
29584	Schizophrenic disorders, other specified types of schizophrenia chronic with acute exacerbation
29585	Schizophrenic disorders, other specified types of schizophrenia in remission
29590	Schizophrenic disorders, unspecified schizophrenia unspecified
29591	Schizophrenic disorders, unspecified schizophrenia subchronic
29592	Schizophrenic disorders, unspecified schizophrenia chronic
29593	Schizophrenic disorders, unspecified schizophrenia subchronic with acute exacerbation
29594	Schizophrenic disorders, unspecified schizophrenia chronic with acute exacerbation
29595	Schizophrenic disorders, unspecified schizophrenia other specified types of schizophrenia in remission
29600	Bipolar I disorder, single manic episode unspecified
29601	Bipolar I disorder, single manic episode mild
29602	Bipolar I disorder, single manic episode moderate
29603	Bipolar I disorder, single manic episode severe without mention of psychotic behavior
29604	Bipolar I disorder, single manic episode severe, specified as with psychotic behavior
29605	Bipolar I disorder, single manic episode, in partial or unspecified remission
29606	Bipolar I disorder, single manic episode, in full remission
29610	Manic disorder, recurrent episode, unspecified
29611	Manic disorder, recurrent episode, mild
29612	Manic disorder, recurrent episode, moderate
29613	Manic disorder, recurrent episode, severe without mention of psychotic behavior

Diagnosis Code	Description
29614	Manic disorder, recurrent episode severe, specified as with psychotic behavior
29615	Manic disorder, recurrent episode severe, in partial or unspecified remission
29616	Manic disorder, recurrent episode, in full remission
29620	Major depressive disorder, single episode, unspecified
29621	Major depressive disorder, single episode, mild
29622	Major depressive disorder, single episode, moderate
29623	Major depressive disorder, single episode, severe without mention of psychotic behavior
29624	Major depressive disorder, single episode, specified as with psychotic behavior
29625	Major depressive disorder, single episode, in partial or unspecified remission
29626	Major depressive disorder, single episode, in full remission
29630	Major depressive disorder, recurrent episode, unspecified
29631	Major depressive disorder, recurrent episode, mild
29632	Major depressive disorder, recurrent episode, moderate
29633	Major depressive disorder, recurrent episode, severe without mention of psychotic behavior
29634	Major depressive disorder, recurrent episode, specified as with psychotic behavior
29635	Major depressive disorder, recurrent episode, in partial or unspecified remission
29636	Major depressive disorder, recurrent episode, in full remission
29640	Bipolar I disorder, most recent episode (or current) manic, unspecified
29641	Bipolar I disorder, most recent episode (or current) manic, mild
29642	Bipolar I disorder, most recent episode (or current) manic, moderate
29643	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior

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Diagnosis Code	Description
29644	Bipolar I disorder, most recent episode (or current) manic, specified as with psychotic behavior
29645	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission
29646	Bipolar I disorder, most recent episode (or current) manic, in full remission
29650	Bipolar I disorder, most recent episode (or current) depressed, unspecified
29651	Bipolar I disorder, most recent episode (or current) depressed, mild
29652	Bipolar I disorder, most recent episode (or current) depressed, moderate
29653	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior
29654	Bipolar I disorder, most recent episode (or current) depressed, specified as with psychotic behavior
29655	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission
29656	Bipolar I disorder, most recent episode (or current) depressed, in full remission
29660	Bipolar I disorder, most recent episode (or current) mixed, unspecified
29661	Bipolar I disorder, most recent episode (or current) mixed, mild
29662	Bipolar I disorder, most recent episode (or current) mixed, moderate
29663	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior
29664	Bipolar I disorder, most recent episode (or current) mixed, specified as with psychotic behavior
29665	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified
29666	Bipolar I disorder, most recent episode (or current) mixed, in full remission
2967	Bipolar I disorder, most recent episode (or current) unspecified
29680	Bipolar disorder, unspecified
29681	Atypical manic disorder

Diagnosis Code	Description
29682	Atypical depressive disorder
29689	Other bipolar disorder
29690	Unspecified episodic mood disorder
29699	Other specified episodic mood disorder
2970	Paranoid state, simple
2971	Delusional disorder
2972	Paraphrenia
2973	Shared psychotic disorder
2978	Other specified paranoid states
2979	Unspecified paranoid state
2980	Depressive type psychosis
2981	Excitative type psychosis
2982	Reactive Confusion
2983	Acute paranoid reaction
2984	Psychogenic paranoid psychosis
2988	Other and unspecified reactive psychosis
2989	Unspecified psychosis
29900	Autistic disorder, current or active state
29901	Autistic disorder, residual state
29910	Childhood disintegrative disorder, current or active state
29911	Childhood disintegrative disorder, residual state
29980	Other specified pervasive developmental disorders, current or active state
29981	Other specified pervasive developmental disorders, residual state
29990	Unspecified pervasive developmental disorder, current or active state
29991	Unspecified pervasive developmental disorder, residual state
30000	Anxiety state, unspecified
30001	Panic disorder without agoraphobia
30002	Generalized anxiety disorder
30009	Other anxiety disorder
30010	Hysteria, unspecified
30011	Conversion disorder
30012	Dissociative amnesia
30013	Dissociative fugue
30014	Dissociative identity disorder
30015	Dissociative disorder or reaction, unspecified

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Diagnosis Code	Description
30016	Factitious disorder with predominantly psychological signs and symptoms
30019	Other and unspecified factitious illness
30020	Phobic, unspecified
30021	Agoraphobia with panic disorder
30022	Agoraphobia without mention of panic attacks
30023	Social phobia
30029	Other isolated or specific phobias
3003	Obsessive-compulsive disorders
3004	Neurotic depression
3006	Depersonalization syndrome
3007	Hypochondriasis
30081	Somatization disorder
30082	Undifferentiated somatoform disorder
30089	Other somatoform disorders
3009	Unspecified neurotic disorder
3010	Paranoid personality disorder
30110	Affective personality disorder
30120	Schizoid personality disorder
3013	Explosive personality disorder
3014	Compulsive personality disorder
30150	Histrionic personality disorder, unspecified
30151	Chronic factitious illness with physical symptoms
30159	Other histrionic personality disorder
3016	Dependent personality disorder
3017	Antisocial personality disorder
30181	Narcissistic personality disorder
30182	Avoidant personality disorder
30183	Borderline personality disorder
30184	Passive-aggressive personality
30189	Other personality disorders
3019	Unspecified personality disorder
3020	Ego-dystonic sexual orientation
3021	Zoophilia
3022	Pedophilia
3023	Transvestic fetishism
3024	Exhibitionism
30250	Trans-sexualism, with unspecified sexual history
30251	Trans-sexualism, with asexual history
30252	Trans-sexualism, with homosexual history
30253	Trans-sexualism, with heterosexual history
3026	Gender identity disorder in children
30270	Psychosexual dysfunction, unspecified
30271	Hypoactive sexual desire disorder
30272	With inhibited sexual excitement
30273	Female orgasmic disorder
30274	Male orgasmic disorder
30275	Premature ejaculation
30276	Dyspareunia, psychogenic
30279	With other specified psychosexual dysfunctions
30281	Fetishism
30282	Voyeurism
30283	Sexual masochism
30284	Sexual sadism
30285	Gender identity disorder in adolescents or adults
30289	Other specified psychosexual disorders
3029	Unspecified psychosexual disorder
30390	Other and unspecified alcohol dependence
30400	Drug dependence
30500	Alcohol abuse, unspecified
30501	Alcohol abuse, continuous
30502	Alcohol abuse, episodic
30503	Alcohol abuse, in remission
30520	Cannabis abuse, unspecified
30521	Cannabis abuse, continuous
30522	Cannabis abuse, episodic
30523	Cannabis abuse, in remission
30530	Hallucinogen abuse, unspecified
30531	Hallucinogen abuse, continuous
30532	Hallucinogen abuse, episodic
30533	Hallucinogen abuse, in remission
30540	Sedative, hypnotic or anxiolytic abuse, unspecified
30541	Sedative, hypnotic or anxiolytic abuse, continuous
30542	Sedative, hypnotic or anxiolytic abuse, episodic
30543	Sedative, hypnotic or anxiolytic abuse, in remission

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Diagnosis Code	Description
30550	Opioid abuse, unspecified
30551	Opioid abuse, continuous
30552	Opioid abuse, episodic
30553	Opioid abuse, in remission
30560	Cocaine abuse, unspecified
30561	Cocaine abuse, continuous
30562	Cocaine abuse, episodic
30563	Cocaine abuse, in remission
30570	Amphetamine abuse or related acting sympathomimetic abuse, unspecified
30571	Amphetamine abuse or related acting sympathomimetic abuse, continuous
30572	Amphetamine abuse or related acting sympathomimetic abuse, episodic
30573	Amphetamine abuse or related acting sympathomimetic abuse, in remission
30580	Antidepressant type abuse, unspecified
30581	Antidepressant type abuse, continuous
30582	Antidepressant type abuse, episodic
30583	Antidepressant type abuse, in remission
30591	Other, mixed, or unspecified drug abuse, continuous
30592	Other, mixed, or unspecified drug abuse, episodic
30593	Other, mixed, or unspecified drug abuse, in remission
3080	Predominant disturbance of emotions
3081	Predominant disturbance of consciousness
3082	Predominant psychomotor disturbance
3083	Other acute reactions to stress
3084	Mixed disorders as a reaction to stress
3089	Unspecified acute reaction to stress
3090	Adjustment disorder with depressed mood
3091	Prolonged depressive reaction
30921	Separation anxiety disorder
30922	Emancipation disorder of adolescents and early adult life
30923	Specific academic or work inhibition
30924	Adjustment disorder with anxiety
30928	Adjustment disorder with mixed anxiety
30929	Other
3093	Adjustment disorder with disturbance of conduct
3094	Adjustment disorder with mixed disturbance of emotions and conduct
30981	Posttrauma stress disorder
30982	Adjustment reaction with physical symptoms
30983	Adjustment reaction with withdrawal
30989	Other
3099	Unspecified adjustment reaction
3100	Frontal lobe syndrome
3101	Organic personality syndrome
3102	Postconcussion syndrome
3108	Other specified nonpsychotic mental disorders following organic brain damage
311	Depressive disorder, not elsewhere classified
31200	Undersocialized conduct disorder, aggressive type, unspecified
31201	Undersocialized conduct disorder, aggressive type, mild
31202	Undersocialized conduct disorder, aggressive type, moderate
31203	Undersocialized conduct disorder, aggressive type, severe
31210	Undersocialized conduct disorder, unaggressive type, unspecified
31211	Undersocialized conduct disorder, aggressive type, mild
31212	Undersocialized conduct disorder, aggressive type, moderate
31213	Undersocialized conduct disorder, aggressive type, severe
31220	Socialized conduct disorder, unspecified
31221	Socialized conduct disorder, mild
31222	Socialized conduct disorder, moderate
31223	Socialized conduct disorder, severe
31230	Impulse control disorder, unspecified
31231	Pathological gambling
31232	Kleptomania
31233	Pyromania
31234	Intermittent explosive disorder
31235	Isolated explosive disorder
31239	Other disorders of impulse control

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Diagnosis Code	Description
3124	Mixed disturbance of conduct and emotions
31281	Conduct disorder, childhood onset type
31282	Conduct disorder, adolescent onset type
31289	Other conduct disorder
3129	Unspecified disturbance of conduct
3130	Overanxious disorder
3131	Misery and unhappiness disorder
31321	Shyness disorder of childhood
31322	Introverted disorder of childhood
31323	Selective mutism
3133	Relationship problems
31381	Oppositional defiant disorder
31382	Identity disorder
31383	Academic underachievement disorder
31389	Other emotional disturbances of childhood or adolescence
3139	Unspecified emotional disturbance of childhood or adolescence
31400	Attention deficit disorder, without mention of hyperactivity
31401	Attention deficit disorder, with hyperactivity
3141	Hyperkinesis with developmental delay
3142	Hyperkinetic conduct disorder
3148	Other specified manifestations of hyperkinetic syndrome
3149	Unspecified hyperkinetic syndrome
31531	Expressive language disorder
31532	Mixed receptive-expressive language disorder
3154	Coordination disorder
3155	Mixed development disorder
3158	Other specified delays in development
3159	Unspecified delay in development
317	Mild mental retardation
3180	Moderate mental retardation
3181	Severe mental retardation
3182	Profound mental retardation
319	Unspecified mental retardation
3200	Hemophilus meningitis
3201	Pneumococcal meningitis
3202	Streptococcal meningitis

Diagnosis Code	Description
3203	Staphylococcal meningitis
3207	Meningitis in other bacterial diseases classified elsewhere
32081	Anaerobic meningitis
32082	Meningitis due to gram-negative bacteria, not elsewhere classified
32089	Meningitis due to other specified bacteria
3209	Meningitis due to unspecified bacterium
3210	Cryptococcal meningitis
3211	Meningitis in other fungal diseases
3212	Meningitis due to viruses not elsewhere classified
3213	Meningitis due to trypanosomiasis
3214	Meningitis in sarcoidosis
3218	Meningitis due to other nonbacterial organisms classified elsewhere
3220	Nonpyogenic meningitis
3221	Eosomophilic meningitis
3222	Chronic meningitis
3229	Meningitis, unspecified
32301	Encephalitis and encephalomyelitis in viral diseases classified elsewhere
32302	Myelitis in viral diseases classified elsewhere
3231	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere
3232	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere
32302	Myelitis in viral diseases classified elsewhere
32341	Other encephalitis and encephalomyelitis due to infection classified elsewhere
32342	Other myelitis due to infection classified elsewhere
32351	Encephalitis and encephalomyelitis following immunization procedures
32352	Myelitis following immunization procedures
32361	Infectious acute disseminated encephalomyelitis (ADEM)
32362	Other postinfectious encephalitis and encephalomyelitis
32363	Postinfectious myelitis
32371	Toxic encephalitis and encephalomyelitis

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Diagnosis Code	Description
32372	Toxic myelitis
32381	Other causes of encephalitis and encephalomyelitis
32382	Other causes of myelitis
3239	Unspecified causes of encephalitis, myelitis, and encephalomyelitis
3240	Intracranial abscess
3241	Intraspinal abscess
3249	Of unspecified site
3300	Leukodystrophy
3301	Cerebral lipidoses
3302	Cerebral degeneration in generalized lipidoses
3203	Cerebral degeneration of childhood in other diseases classified elsewhere
3308	Other specified cerebral degenerations in childhood
3309	Unspecified cerebral degeneration in childhood
3310	Alzheimer's disease
33111	Pick's disease
33119	Other frontotemporal dementia
3312	Senile degeneration of brain
3313	Communicating hydrocephalus
3314	Obstructive hydrocephalus
3317	Cerebral degeneration in diseases classified elsewhere
33181	Reye's syndrome
33182	Dementia with Lewy bodies
3319	Cerebral degeneration, unspecified
33392	Neuroleptic malignant syndrome
340	Multiple sclerosis
34500	Generalized nonconvulsive epilepsy, without mention of intractable epilepsy
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy
34510	Generalized convulsive epilepsy, without mention of intractable epilepsy
34511	Generalized convulsive epilepsy, with intractable epilepsy
3452	Petite mal status, epileptic
3453	Grand mal status, epileptic
34540	Partial epilepsy, with impairment of consciousness, without mention of intractable epilepsy

Diagnosis Code	Description
34541	Partial epilepsy, with impairment of consciousness, with intractable epilepsy
34550	Partial epilepsy, without mention of impairment of consciousness, without mention of intractable epilepsy
34551	Partial epilepsy, without mention of impairment of consciousness, with intractable epilepsy
34560	Infantile spasms, without mention of intractable epilepsy
34561	Infantile spasms, with intractable epilepsy
34570	Epilepsia partialis continua, without mention of intractable epilepsy
34571	Epilepsia partialis continua, with intractable epilepsy
34580	Other forms of epilepsy, without mention of intractable epilepsy
34581	Other forms of epilepsy, with intractable epilepsy
34590	Epilepsy, unspecified, without mention of intractable epilepsy
34591	Epilepsy, unspecified, with intractable epilepsy
3480	Cerebral cysts
3481	Anoxic brain damage
34830	Encephalopathy, unspecified
34831	Metabolic encephalopathy
34839	Other encephalopathy
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
4320	Nontraumatic extradural hemorrhage
4321	Subdural hemorrhage
4329	Unspecified intracranial hemorrhage
43300	Basilar artery, without mention of cerebral infarction
43301	Basilar artery, with cerebral infarction
43310	Carotid artery, without mention of cerebral infarction
43311	Carotid artery, with cerebral infarction
43320	Vertebral artery, without mention of cerebral infarction
43321	Vertebral artery, with cerebral infarction
43330	Multiple and bilateral, without mention of cerebral infarction
43331	Multiple and bilateral, with cerebral infarction

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Diagnosis Code	Description
43380	Other specified precerebral artery, without mention of cerebral infarction
43381	Other specified precerebral artery, with cerebral infarction
43390	Unspecified precerebral artery, without mention of cerebral infarction
43391	Unspecified precerebral artery, with cerebral infarction
43400	Cerebral thrombosis, without mention of cerebral infarction
43401	Cerebral thrombosis, with cerebral infarction
43410	Cerebral embolism, without mention of cerebral infarction
43411	Cerebral embolism, with cerebral infarction
43490	Cerebral artery occlusion, unspecified, without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified, with cerebral infarction
4350	Basilar artery syndrome
4351	Vertebral artery syndrome
4352	Subclavian steal syndrome
4353	Vertebrobasilar artery syndrome
4358	Other specified transient ischemia
4359	Unspecified transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
4370	Cerebral atherosclerosis
4371	Other generalized ischemic cerebrovascular disease
4372	Hypertensive encephalopathy
4373	Cerebral aneurysm, nonruptured
4374	Cerebral arteritis
4375	Moyamoya disease
4376	Nonpyogenic thrombosis of intracranial venous sinus
4377	Transient global amnesia
4378	Other and ill-defined cerebrovascular disease, other
4379	Other and ill-defined cerebrovascular disease, unspecified
4380	Cognitive deficits
43810	Speech and language deficits
43811	Aphasia
43812	Dysphasia
43819	Other speech and language deficits
43820	Hemiplegia affecting unspecified site
43821	Hemiplegia affecting dominant side
43822	Hemiplegia affecting nondominant side
43830	Monoplegia of upper limb affecting unspecified site
43831	Monoplegia of upper limb affecting dominant side
43832	Monoplegia of upper limb affecting nondominant side
43840	Monoplegia of lower limb affecting unspecified site
43841	Monoplegia of lower limb affecting dominant side
43842	Monoplegia of lower limb affecting nondominant side
43850	Other paralytic syndrome affecting unspecified side
43851	Other paralytic syndrome affecting dominant side
43852	Other paralytic syndrome affecting nondominant side
43853	Other paralytic syndrome, bilateral
4386	Alterations of sensations
4387	Disturbances of vision
43881	Other late effects of cerebrovascular disease, Apraxia
43882	Other late effects of cerebrovascular disease, Dysphagia
43883	Other late effects of cerebrovascular disease, Facial weakness
43884	Other late effects of cerebrovascular disease, Ataxia
43885	Other late effects of cerebrovascular disease, Vertigo
43889	Other late effects of cerebrovascular disease
4389	Unspecified late effects of cerebrovascular disease
7685	Severe birth asphyxia
7686	Mild or moderate birth asphyxia
77210	Intraventricular hemorrhage unspecified grade
77211	Intraventricular hemorrhage unspecified grade I
77212	Intraventricular hemorrhage unspecified grade II
77213	Intraventricular hemorrhage unspecified grade III

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Diagnosis Code	Description
77214	Intraventricular hemorrhage unspecified grade IV
7722	Subarachnoid hemorrhage
7790	Convulsions in newborn
78031	Febrile convulsions
78032	Complex febrile convulsions
78039	Other convulsions
79901	Asphyxia
79902	Hypoxemia
8500	Concussion, with loss of consciousness
85011	Concussion with brief loss of consciousness, with loss of consciousness of 30 minutes or less
85012	Concussion with brief loss of consciousness, with loss of consciousness from 31 to 59 minutes
8502	Concussion, with moderate loss of consciousness
8503	Concussion, with prolonged loss of consciousness and return to pre-existing conscious level
8504	Concussion, with prolonged loss of consciousness, without return to pre-existing conscious level
8505	Concussion, with loss of consciousness of unspecified duration
8509	Concussion, unspecified
85100	Cortex (cerebral) contusion without mention of open intracranial wound, unspecified state of consciousness
85101	Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified
85110	Cortex (cerebral) contusion with open intracranial wound, unspecified state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration
85119	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified
85120	Cortex (cerebral) laceration without mention of open cranial wound, unspecified state of consciousness
85121	Cortex (cerebral) laceration without mention of open cranial wound, with no loss of consciousness
85122	Cortex (cerebral) laceration without mention of open cranial wound, with brief (less than one hour) loss of consciousness
85123	Cortex (cerebral) laceration without mention of open cranial wound, with moderate (1-24 hours) loss of consciousness

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Diagnosis Code	Description
85124	Cortex (cerebral) laceration without mention of open cranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open cranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open cranial wound, with loss of consciousness of unappeased duration
85129	Cortex (cerebral) laceration without mention of open cranial wound, with concussion, unspecified
85130	Cortex (cerebral) laceration with open intracranial wound, unspecified state of consciousness
85131	Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified
85140	Cerebellar or brain stem contusions without mention of intracranial wound, unspecified state of consciousness
85141	Cerebellar or brain stem contusions without mention of intracranial wound, with no loss of consciousness
85142	Cerebellar or brain stem contusions without mention of intracranial wound, with brief (less than one hour) loss of consciousness
85143	Cerebellar or brain stem contusions without mention of intracranial wound, with moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusions without mention of intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusions without mention of intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusions without mention of intracranial wound, with loss of consciousness of unspecified duration
85149	Cerebellar or brain stem contusions without mention of intracranial wound, with concussion, unspecified
85150	Cerebellar or brain stem contusions with intracranial wound, unspecified state of consciousness
85151	Cerebellar or brain stem contusions with intracranial wound, with no loss of consciousness
85152	Cerebellar or brain stem contusions with intracranial wound, with brief (less than one hour) loss of consciousness
85153	Cerebellar or brain stem contusions with intracranial wound, with moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusions with intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85155	Cerebellar or brain stem contusions with intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusions with intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85159	Cerebellar or brain stem contusions with intracranial wound, with concussion, unspecified
85160	Cerebellar or brain stem laceration without mention of intracranial wound, unspecified state of consciousness
85161	Cerebellar or brain stem laceration without mention of intracranial wound, with no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of intracranial wound, with brief (less than one hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of intracranial wound, with moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of intracranial wound, with loss of consciousness of unspecified duration
85169	Cerebellar or brain stem laceration without mention of intracranial wound, with concussion, unspecified
85170	Cerebellar or brain stem laceration with intracranial wound, unspecified state of consciousness
85171	Cerebellar or brain stem laceration with intracranial wound, with no loss of consciousness
85172	Cerebellar or brain stem laceration with intracranial wound, with brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with intracranial wound, with moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with intracranial wound, with loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with intracranial wound, without mention of open intracranial wound, with concussion, unspecified
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, unspecified state of consciousness
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, unspecified state of consciousness

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Diagnosis Code	Description
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged {more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, c
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified
85200	Subarachnoid hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness
85201	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with no loss of consciousness
85202	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury without mention of open intracranial wound, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified duration
85206	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified duration
85209	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified
85210	Subarachnoid hemorrhage following injury with open intracranial wound, unspecified state of consciousness
85211	Subarachnoid hemorrhage following injury with open intracranial wound, with no loss of consciousness
85212	Subarachnoid hemorrhage following injury with open intracranial wound, with brief (less than one hour) loss of consciousness
85213	Subarachnoid hemorrhage following injury with open intracranial wound, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85214	Subarachnoid hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85215	Subarachnoid hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
85216	Subarachnoid hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury with open intracranial wound, with concussion, unspecified
85220	Subdural hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness
85221	Subdural hemorrhage following injury without mention of open intracranial wound, with no loss of consciousness

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Diagnosis Code	Description
85222	Subdural hemorrhage following injury without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85232	Subdural hemorrhage following injury without mention of open intracranial wound, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified duration
85226	Subdural hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified duration
85229	Subdural hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified
85230	Subdural hemorrhage following injury with open intracranial wound, unspecified state of consciousness
85231	Subdural hemorrhage following injury with open intracranial wound, with no loss of consciousness
85232	Subdural hemorrhage following injury with open intracranial wound, with brief (less than one hour) loss of consciousness
85233	Subdural hemorrhage following injury with open intracranial wound, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
85236	Subdural hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration

Diagnosis Code	Description
85239	Subdural hemorrhage following injury with open intracranial wound, with concussion, unspecified
85240	Extradural hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness
85241	Extradural hemorrhage following injury without mention of open intracranial wound, with no loss of consciousness
85242	Extradural hemorrhage following injury without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85243	Extradural hemorrhage following injury without mention of open intracranial wound, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85244	Extradural hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified duration
85246	Extradural hemorrhage following injury without mention of open intracranial wound, with loss of consciousness of unspecified duration
85249	Extradural hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified
85250	Extradural hemorrhage following injury with open intracranial wound, unspecified state of consciousness
85251	Extradural hemorrhage following injury with open intracranial wound, with no loss of consciousness
85252	Extradural hemorrhage following injury with open intracranial wound, with brief (less than one hour) loss of consciousness
85253	Extradural hemorrhage following injury with open intracranial wound, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85255	Extradural hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
85256	Extradural hemorrhage following injury with open intracranial wound, with loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury with open intracranial wound, with concussion, unspecified
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85305	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, unspecified state of consciousness

Diagnosis Code	Description
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, c
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85400	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, unspecified state of consciousness
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unappeased duration
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unappeased duration
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, Intracranial injury of other and unspecified nature, without mention of open intracranial wound
986	Toxic effect of carbon monoxide
9941	Drowning and nonfatal submersion
9947	Asphyxiation and strangulation
V110	Schizophrenia
V111	Affective Disorders
V112	Neurosis
V113	alcoholism
V170	Psychiatric condition
V401	Problems with communication (including speech)
V402	Other mental problems
V6282	Bereavement, uncomplicated
V6283	Counseling for perpetrator of physical/sexual abuse
V6284	Suicidal ideation
V695	Behavioral insomnia of childhood
V7101	Adult antisocial behavior
V7102	Childhood or adolescent antisocial behavior
V790	Depression
V791	Special screening for Alcoholism
V792	Mental retardation
V793	Developmental handicaps in early childhood
V798	Other specified mental disorders and developmental handicaps

If separate charges for an office visit and psychological testing or psychotherapy are billed on the same day, the office visit is denied as part of another procedure on the same day unless the diagnosis referenced to the office visit indicates a physical condition *unrelated* to the psychiatric diagnosis. In this instance the office visit is paid separately.

Report psychotherapy of less than 20 minutes duration using the appropriate E/M code.

Procedure codes 1-90801 and 1-90802 are limited to once per day per client, any provider, regardless of the number of professionals involved in the interview, and once per year per provider (same provider) in any setting.

An interactive interview (90802) may be covered to the extent it is medically necessary. Examples of medical necessity include, but are not limited to, clients whose ability to communicate is impaired by an expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.

A diagnostic interview (90801, 90802) may be incorporated into an evaluation and management service provided the required elements of the evaluation and management service are fulfilled. A diagnostic interview (90801 or 90802) will be denied as part of any evaluation and management service when billed for the same date of service by the same provider.

Procedure code 1-90802 billed on the same day as 1-90801 by the same provider is denied as part of another procedure billed on the same day.

If procedure code 1-90801 or 1-90802 is billed, the following psychiatric therapeutic procedure codes performed the same day by the same provider are denied as part of the initial psychiatric exam.

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90845	1-90847	1-90853
1-90865	1-90857	

If procedure code 1-90801 or 1-90802 is billed on the same day as 1-99221, 1-99222, and 1-99223 by the same provider, the initial hospital visit is denied as part of another procedure on the same day.

Documentation for diagnostic interview examinations (1-90801, 1-90802) must include:

- Reason for referral/presenting problem
- Prior History, including prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and mental status examinations
- Complete Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV) diagnosis
- Recommendations, including expected long term and short term benefits

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- For the interactive diagnostic interview (90802), the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques

Outpatient psychotherapy (1-90847, 1-90853, 1-90857, 1-90804) billed on the same date of service as narcosynthesis (1-90865) will be denied.

If the following psychotherapy or psychoanalysis codes are billed on the same day as a subsequent hospital visit (1-99231, 1-99232, 1-99233, and 1-99238) by the same provider, the subsequent hospital visit is denied as part of another procedure billed on the same day.

Procedure Codes		
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90845	1-90847	1-90853

A hospital visit subsequent care (1-99231, 1-99232, 1-99233, and 1-99238) is not separately payable on the same day as shock therapy. Hospital subsequent care for diagnoses unrelated to the EST will be considered on appeal.

Psychotherapy (with and without evaluation and management) is coded by the following:

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90847	1-90853	1-90857

Psychoanalysis should be coded 1-90845.

If the following psychotherapy procedure codes are billed on the same day as psychoanalysis (1-90845), psychotherapy is denied.

Procedure Codes		
1-90804	1-90805	1-90806
1-90807	1-90808	1-90809
1-90810	1-90811	1-90812
1-90813	1-90814	1-90815
1-90816	1-90817	1-90818
1-90819	1-90821	1-90822
1-90823	1-90824	1-90826
1-90827	1-90828	1-90829
1-90853	1-90857	

The following psychiatric services are *not* covered by the Texas Medicaid Program:

- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse (RN or licensed vocational nurse [LVN]), mental health worker, or psychological associate.
- Thermogenic therapy, recreational therapy, psychiatric day care, and biofeedback, music, or dance therapy
- Hypnosis
- *Adult activity* and *individual activity*. These services are payable only if guidelines of group therapy are met and termed “group therapy“

Medicare deductibles or coinsurance for inpatient stays in psychiatric hospitals are not payable for clients 22 to 64 years of age. This limitation does not apply to psychiatric services rendered in a general acute care hospital.

The following procedure codes are *not* reimbursed by the Texas Medicaid Program: 1-90846 and 1-90849.

When billing or providing family therapy/counseling services, note the following requirements for Medicaid reimbursement:

- The client must be present when family therapy/counseling services are provided.
- Family therapy/counseling is reimbursable only for one family member per session.

According to the definition of family provided by DADS Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of Temporary Assistance to Needy Families (formerly Aid to Families with Dependent Children [AFDC]) children. The following specific relatives are included in family counseling services:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

When individual, group, or family psychotherapy is billed by any provider on the same day, each type of session is paid. When multiples of each type of session are billed, the most inclusive code from each type of session is paid and the others are denied.

Refer to: “Request for Extended Outpatient Psychotherapy/Counseling Form” on page B-81.

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36.4.39.1 Documentation Required

Each client for whom services are billed must have the following documentation included in their record:

- All entries, clearly documented and legible to individuals other than the author, date (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times.
- All pertinent information on the patient's condition to substantiate the need for services, including, but not limited to:
    - The name of test(s) (e.g., WAIS-R, Rorschach, MMPI).
    - Background observations during the session.
    - Narrative descriptions of the test findings.
    - The diagnosis (symptoms, impressions).
    - The treatment plan and recommendations.
    - The explanation to substantiate the necessity of retesting, if testing is repeated.

In addition to these documentation requirements, the following must be a part of each client's record for which services are billed:

- Narrative description of the counseling session
- Narrative description of the assessment, treatment plan, and recommendations

36.4.39.2 Psychological and Neuropsychological Testing

Psychological testing (5-96101) and neuropsychological testing (5-96118) are limited to a total of four hours per day and eight hours per calendar year per client for any provider. Providers must maintain documentation supporting the medical necessity for each test in the client's record.

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours per calendar year, prior authorization is required. Additional documentation must be submitted that supports the medical necessity for the additional hours requested. This includes a record of all of the tests previously performed and a complete history that reflects the need for each test requested.

Each hour of examination, therapy, psychological and /or neuropsychological testing will count toward the 12 hours per day limitation as well as one visit/encounter towards the 30 visit/encounter limit.

Procedure codes 5-96101 and 5-96118 include the testing, interpretation, and report, and will not be reimbursed separately. Providers must bill the preponderance of each quarter hour of testing and indicate that number of units on the claim form. Document the number of hours in Block 24G of the CMS-1500 claim form.

Procedure code 5-96118 will be denied when billed on the same day as procedure code 5-96101 by any provider.

Procedure code 5-96101 or 5-96118 is payable on the same day as procedure code 1-90801 or 1-90802.

Advanced practice nurses are not eligible providers and will not be reimbursed for psychological and neuropsychological testing. Behavioral health testing may be performed during an assessment by an APN, and should be billed as part of another service.

Procedure codes 5-96101 and 5-96118 performed by a physician or psychologist are covered services only for the following diagnosis codes:

Diagnosis Code	Description
0360	Meningococcal meningitis
0361	Meningococcal encephalitis
0362	Meningococcemia
0363	Waterhouse-Friderichsen syndrome, meningococcal
03640	Meningococcal carditis, unspecified
03641	Meningococcal pericarditis
03642	Meningococcal endocarditis
03643	Meningococcal myocarditis
03681	Meningococcal optic neuritis
03682	Meningococcal arthropathy
03689	Other specified meningococcal infections
0369	Meningococcal infection, unspecified
04500	Acute paralytic poliomyelitis specified as bulbar, unspecified type of poliovirus
04501	Acute paralytic poliomyelitis specified as bulbar, poliovirus type I
04502	Acute paralytic poliomyelitis specified as bulbar, poliovirus type II
04503	Acute paralytic poliomyelitis specified as bulbar, poliovirus type III
04510	Acute poliomyelitis with other paralysis, unspecified type of poliovirus
04511	Acute poliomyelitis with other paralysis, poliovirus type I
04512	Acute poliomyelitis with other paralysis, poliovirus type II
04513	Acute poliomyelitis with other paralysis, poliovirus type III
04520	Acute nonparalytic poliomyelitis, unspecified type poliovirus
04521	Acute nonparalytic poliomyelitis, poliovirus type I
04522	Acute nonparalytic poliomyelitis, poliovirus type II
04523	Acute nonparalytic poliomyelitis, poliovirus type III

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Diagnosis Code	Description
04590	Unspecified acute poliomyelitis, unspecified type poliovirus
04591	Unspecified acute poliomyelitis, poliovirus type I
04592	Unspecified acute poliomyelitis, poliovirus type II
04593	Unspecified acute poliomyelitis, poliovirus type III
0460	Kuru
0461	Jakob-Creutzfeldt disease
0462	Subacute sclerosing panencephalitis
0463	Progressive multifocal leukoencephalopathy
0468	Other specified slow virus infection of central nervous system
0469	Unspecified slow virus infection of central nervous system
0470	Meningitis due to coxsackie virus
0471	Meningitis due to echo virus
0478	Other specified viral meningitis
0479	Unspecified viral meningitis
048	Other enterovirus diseases of central nervous system
0490	Non-arthopod borne lymphocytic choriomeningitis
0491	Non-arthopod borne meningitis due to adenovirus
0498	Other specified non-arthropod-borne viral diseases of central nervous system
0499	Unspecified non-arthropod-borne viral diseases of central nervous system
2900	Senile dementia, uncomplicated
29010	Presenile dementia, uncomplicated
29011	Presenile dementia with delirium
29012	Presenile dementia with delusional features
29013	Presenile dementia with depressive features
29020	Senile dementia with delusional features
29021	Senile dementia with depressive features
2903	Senile dementia with delirium
29040	Vascular dementia, uncomplicated
29041	Vascular dementia, with delirium
29042	Vascular dementia, with delusions

Diagnosis Code	Description
29043	Vascular dementia, with depressed mood
2908	Other specified senile psychotic conditions
2909	Unspecified senile psychotic condition
2910	Alcohol withdrawal delirium
2911	Alcohol-induced persisting amnestic disorder
2912	Alcohol-induced persisting dementia
2913	Alcohol-induced psychotic disorder with hallucinations
2914	Idiosyncratic alcohol intoxication
2915	Alcohol-induced psychotic disorder with delusions
29189	Other alcohol-induced mental disorders
2919	Unspecified alcohol-induced mental disorders
2920	Drug withdrawal
29211	Drug-induced psychotic disorder with delusions
29212	Drug-induced psychotic disorder with hallucinations
2922	Pathological drug intoxication
29281	Drug-induced delirium
29282	Drug-induced persisting dementia
29283	Drug-induced persisting amnestic disorder
29284	Drug-induced mood disorder
29285	Drug induced sleep disorders
29289	Other specified drug-induced mental disorders
2929	Unspecified drug-induced mental disorder
2930	Delirium due to conditions classified elsewhere
2931	Subacute delirium
29381	Psychotic disorder with delusions in conditions classified elsewhere
29382	Psychotic disorder with hallucinations in conditions classified elsewhere
23983	Mood disorder in conditions classified elsewhere
28384	Anxiety disorder in conditions classified elsewhere
29389	Other specified transient mental disorders due to conditions classified elsewhere, other

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Diagnosis Code	Description
2939	Unspecified transient mental disorder in conditions classified elsewhere
5940	Amnestic disorder in conditions classified elsewhere
29410	Dementia in conditions classified elsewhere without behavioral disturbance
29411	Dementia in conditions classified elsewhere with behavioral disturbance
2948	Other persistent mental disorders due to conditions classified elsewhere
2949	Unspecified persistent mental disorders due to conditions classified elsewhere
29500	Simple type schizophrenia, unspecified state
29501	Simple type schizophrenia, subchronic state
29502	Simple type schizophrenia, chronic state
29503	Simple type schizophrenia, subchronic state with acute exacerbation
29504	Simple type schizophrenia, chronic state with acute exacerbation
29505	Simple type schizophrenia, in remission
29510	Disorganized type schizophrenia, unspecified state
29511	Disorganized type schizophrenia, subchronic state
29512	Disorganized type schizophrenia, chronic state
29513	Disorganized type schizophrenia, subchronic state with acute exacerbation
29514	Disorganized type schizophrenia, chronic state with acute exacerbation
29515	Disorganized type schizophrenia, in remission
29520	Catatonic type schizophrenia, unspecified state
29521	Catatonic type schizophrenia, subchronic state
29522	Catatonic type schizophrenia, chronic state
29523	Catatonic type schizophrenia, subchronic state with acute exacerbation
29524	Catatonic type schizophrenia, chronic state with acute exacerbation
29525	Catatonic type schizophrenia, in remission
29530	Paranoid type schizophrenia, unspecified state
29531	Paranoid type schizophrenia, subchronic state
29532	Paranoid type schizophrenia, chronic state
29533	Paranoid type schizophrenia, subchronic state with acute exacerbation
29534	Paranoid type schizophrenia, chronic state with acute exacerbation
29535	Paranoid type schizophrenia, in remission
29540	Schizophreniform disorder, unspecified
29541	Schizophreniform disorder, subchronic
29542	Schizophreniform disorder, chronic
29543	Schizophreniform disorder, subchronic with acute exacerbation
29544	Schizophreniform disorder, chronic with acute exacerbation
29545	Schizophreniform disorder, in remission
29550	Latent schizophrenia, unspecified state
29551	Latent schizophrenia, subchronic state
29552	Latent schizophrenia, chronic state
29553	Latent schizophrenia, subchronic state with acute exacerbation
29554	Latent schizophrenia, chronic state with acute exacerbation
29555	Latent schizophrenia, in remission
29560	Schizophrenic disorders, residual type, unspecified
29561	Schizophrenic disorders, residual type, subchronic
29562	Schizophrenic disorders, residual type, chronic
29563	Schizophrenic disorders, residual type, subchronic with acute exacerbation
29564	Schizophrenic disorders, residual type, chronic with acute exacerbation
29570	Schizoaffective disorder, unspecified
29571	Schizoaffective disorder, subchronic

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Diagnosis Code	Description
29572	Schizoaffective disorder, chronic
29573	Schizoaffective disorder, subchronic with acute exacerbation
29574	Schizoaffective disorder, chronic with acute exacerbation
29575	Schizoaffective disorder, in remission
29580	Other specified types of schizophrenia, unspecified state
29581	Other specified types of schizophrenia, subchronic state
29582	Other specified types of schizophrenia, chronic state
29583	Other specified types of schizophrenia, subchronic state with acute exacerbation
29584	Other specified types of schizophrenia, chronic state with acute exacerbation
29585	Other specified types of schizophrenia, in remission
29590	Unspecified type schizophrenia, unspecified state
29591	Unspecified type schizophrenia, subchronic state
29592	Unspecified type schizophrenia, chronic state
29593	Unspecified type schizophrenia, subchronic state with acute exacerbation
29594	Unspecified type schizophrenia, chronic state with acute exacerbation
29595	Unspecified type schizophrenia, in remission
29600	Bipolar I disorder, single manic episode, unspecified
29601	Bipolar I disorder, single manic episode, mild
29602	Bipolar I disorder, single manic episode, moderate
29603	Bipolar I disorder, single manic episode, severe, without mention of psychotic behavior
29604	Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior
29605	Bipolar I disorder, single manic episode, in partial or unspecified remission
29606	Bipolar I disorder, single manic episode, in full remission

Diagnosis Code	Description
29610	Manic affective disorder, recurrent episode, unspecified degree
29611	Manic affective disorder, recurrent episode, mild degree
29612	Manic affective disorder, recurrent episode, moderate degree
29613	Manic affective disorder, recurrent episode, severe degree, without mention of psychotic behavior
29614	Manic affective disorder, recurrent episode, severe degree, specified as with psychotic behavior
29615	Manic affective disorder, recurrent episode, in partial or unspecified remission
29616	Manic affective disorder, recurrent episode, in full remission
29620	Major depressive affective disorder, single episode, unspecified degree
29621	Major depressive affective disorder, single episode, mild degree
29622	Major depressive affective disorder, single episode, moderate degree
29623	Major depressive affective disorder, single episode, severe degree, without mention of psychotic behavior
29624	Major depressive affective disorder, single episode, severe degree, specified as with psychotic behavior
29625	Major depressive affective disorder, single episode, in partial or unspecified remission
29626	Major depressive affective disorder, single episode, in full remission
29630	Major depressive affective disorder, recurrent episode, unspecified degree
29631	Major depressive affective disorder, recurrent episode, mild degree
29632	Major depressive affective disorder, recurrent episode, moderate degree
29633	Major depressive affective disorder, recurrent episode, severe degree, without mention of psychotic behavior
29634	Major depressive affective disorder, recurrent episode, severe degree, specified as with psychotic behavior
29635	Major depressive affective disorder, recurrent episode, in partial or unspecified remission

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Diagnosis Code	Description
29636	Major depressive affective disorder, recurrent episode, in full remission
29640	Bipolar I disorder, most recent episode (or current) manic, unspecified
29641	Bipolar I disorder, most recent episode (or current) manic, mild
29642	Bipolar I disorder, most recent episode (or current) manic, moderate
29643	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior
29644	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior
29645	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission
29646	Bipolar I disorder, most recent episode (or current) manic, in full remission
29650	Bipolar I disorder, most recent episode (or current) depressed, unspecified
29651	Bipolar I disorder, most recent episode (or current) depressed, mild
29652	Bipolar I disorder, most recent episode (or current) depressed, moderate
29653	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior
29654	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior
29655	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission
29656	Bipolar I disorder, most recent episode (or current) depressed, in full remission
29660	Bipolar I disorder, most recent episode (or current) mixed, unspecified
29661	Bipolar I disorder, most recent episode (or current) mixed, mild
29662	Bipolar I disorder, most recent episode (or current) mixed, moderate

Diagnosis Code	Description
29663	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior
29664	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior
29665	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission
29666	Bipolar I disorder, most recent episode (or current) mixed, in full remission
2967	Bipolar I disorder, most recent episode (or current) unspecified
29680	Bipolar disorder, unspecified
29681	Atypical manic disorder
29682	Atypical depressive disorder
29689	Other and unspecified bipolar disorders, other
29690	Unspecified episodic mood disorder
29699	Other specified episodic mood disorder
2970	Paranoid state, simple
2971	Delusional disorder
2972	Paraphrenia
2973	Shared psychotic disorder
2978	Other specified paranoid states
2979	Unspecified paranoid state
2980	Depressive type psychosis
2981	Excitative type psychosis
2982	Reactive confusion
2983	Acute paranoid reaction
2984	Psychogenic paranoid psychosis
2988	Other and unspecified reactive psychosis
2989	Unspecified psychosis
29900	Autistic disorder, current or active state
29901	Autistic disorder, residual state
29910	Childhood disintegrative disorder, current or active stat
29911	Childhood disintegrative disorder, residual state
29980	Other specified pervasive develop-mental disorders, current or active state
29981	Other specified pervasive develop-mental disorders, residual state

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Diagnosis Code	Description
29990	Unspecified pervasive developmental disorder, current or active state
29991	Unspecified pervasive developmental disorder, residual state
30000	Anxiety state, unspecified
30001	Panic disorder without agoraphobia
30002	Generalized anxiety disorder
30009	Other anxiety states
30010	Hysteria, unspecified
30011	Conversion disorder
30012	Dissociative amnesia
30013	Dissociative fugue
30014	Dissociative identity disorder
30015	Dissociative disorder or reaction, unspecified
30016	Factitious disorder with predominantly psychological signs and symptoms
30019	Other and unspecified factitious illness
30020	Phobia, unspecified
30021	Agoraphobia with panic disorder
30022	Agoraphobia without mention of panic attacks
30023	Social phobia
30029	Other isolated or specific phobias
3003	Obsessive-compulsive disorders
3004	Dysthymic disorder
3005	Neurasthenia
3006	Depersonalization disorder
3007	Hypochondriasis
30081	Somatization disorder
30082	Undifferentiated somatoform disorder
30089	Other somatoform disorders
3009	Unspecified nonpsychotic mental disorder
3010	Paranoid personality disorder
30100	Affective personality disorder, unspecified
30111	Chronic hypomanic personality disorder
30112	Chronic depressive personality disorder
30113	Cyclothymic disorder
30120	Schizoid personality disorder, unspecified

Diagnosis Code	Description
30121	Introverted personality
30122	Schizotypal personality disorder
3013	Explosive personality disorder
3014	Obsessive-compulsive personality disorder
30150	Histrionic personality disorder, unspecified
30151	Chronic factitious illness with physical symptoms
30159	Other histrionic personality disorder
3016	Dependent personality disorder
3017	Antisocial personality disorder
30181	Narcissistic personality disorder
30182	Avoidant personality disorder
30183	Borderline personality disorder
30184	Passive-aggressive personality
30189	Other personality disorders
3019	Unspecified personality disorder
3020	Ego-dystonic sexual orientation
3021	Zoophilia
3022	Pedophilia
3023	Transvestic fetishism
3024	Exhibitionism
30250	Trans-sexualism with unspecified sexual history
30251	Trans-sexualism with asexual history
30252	Trans-sexualism with homosexual history
30253	Trans-sexualism with heterosexual history
3026	Gender identity disorder in children
30270	Psychosexual dysfunction, unspecified
30271	Hypoactive sexual desire disorder
30272	Psychosexual dysfunction with inhibited sexual excitement
30273	Female orgasmic disorder
30274	Male orgasmic disorder
30275	Premature ejaculation
30276	Dyspareunia, psychogenic
30279	Psychosexual dysfunction with other specified psychosexual dysfunctions
30281	Fetishism
30282	Voyeurism
30283	Sexual masochism
30284	Sexual sadism

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Diagnosis Code	Description
30285	Gender identity disorder in adolescents or adults
30289	Other specified psychosexual disorders
3029	Alcohol dependence syndrome
30390	Other and unspecified alcohol dependence, unspecified drinking behavior
30391	Other and unspecified alcohol dependence, continuous drinking behavior
30392	Other and unspecified alcohol dependence, episodic drinking behavior
30393	Other and unspecified alcohol dependence, in remission
30400	Opioid type dependence, unspecified use
30401	Opioid type dependence, continuous use
30402	Opioid type dependence, episodic use
30403	Opioid type dependence, in remission
30410	Sedative, hypnotic or anxiolytic dependence, unspecified
30411	Sedative, hypnotic or anxiolytic dependence, continuous
30412	Sedative, hypnotic or anxiolytic dependence, episodic
30413	Sedative, hypnotic or anxiolytic dependence, in remission
30420	Cocaine dependence, unspecified use
30421	Cocaine dependence, continuous use
30422	Cocaine dependence, episodic use
30423	Cocaine dependence, in remission
30430	Cannabis dependence, unspecified use
30431	Cannabis dependence, continuous use
30432	Cannabis dependence, episodic use
30433	Cannabis dependence, in remission
30440	Amphetamine and other psychostimulant dependence, unspecified use
30441	Amphetamine and other psychostimulant dependence, continuous use
30442	Amphetamine and other psychostimulant dependence, episodic use
30443	Amphetamine and other psychostimulant dependence, in remission

Diagnosis Code	Description
30450	Hallucinogen dependence, unspecified use
30451	Hallucinogen dependence, continuous use
30452	Hallucinogen dependence, episodic use
30453	Hallucinogen dependence, in remission
30460	Other specified drug dependence, unspecified use
30461	Other specified drug dependence, continuous use
30462	Other specified drug dependence, episodic use
30463	Other specified drug dependence, in remission
30470	Combinations of opioid type drug with any other drug dependence, unspecified use
30471	Combinations of opioid type drug with any other drug dependence, continuous use
30472	Combinations of opioid type drug with any other drug dependence, episodic use
30473	Combinations of opioid type drug with any other drug dependence, in remission
30480	Combinations of drug dependence excluding opioid type drug, unspecified use
30481	Combinations of drug dependence excluding opioid type drug, continuous use
30482	Combinations of drug dependence excluding opioid type drug, episodic use
30483	Combinations of drug dependence excluding opioid type drug, in remission
30490	Unspecified drug dependence, unspecified use
20491	Unspecified drug dependence, continuous use
30492	Unspecified drug dependence, episodic use
30493	Unspecified drug dependence, in remission
30500	Nondependent alcohol abuse, unspecified drinking behavior
30501	Nondependent alcohol abuse, continuous drinking behavior

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Diagnosis Code	Description
30502	Nondependent alcohol abuse, episodic drinking behavior
30503	Nondependent alcohol abuse, in remission
30520	Nondependent cannabis abuse, unspecified use
30521	Nondependent cannabis abuse, continuous use
30522	Nondependent cannabis abuse, episodic use
30523	Nondependent cannabis abuse, in remission
30530	Nondependent hallucinogen abuse, unspecified use
30531	Nondependent hallucinogen abuse, continuous use
30532	Nondependent hallucinogen abuse, episodic use
30533	Nondependent hallucinogen abuse, in remission
30540	Sedative, hypnotic or anxiolytic abuse, unspecified
30541	Sedative, hypnotic or anxiolytic abuse, continuous
30542	Sedative, hypnotic or anxiolytic abuse, episodic
30543	Sedative, hypnotic or anxiolytic abuse, in remission
30550	Nondependent opioid abuse, unspecified use
30551	Nondependent opioid abuse, continuous use
30552	Nondependent opioid abuse, episodic use
30553	Nondependent opioid abuse, in remission
30560	Nondependent cocaine abuse, unspecified use
30561	Nondependent cocaine abuse, continuous use
30562	Nondependent cocaine abuse, episodic use
30563	Nondependent cocaine abuse, in remission
30570	Nondependent amphetamine or related acting sympathomimetic abuse, unspecified use
30571	Nondependent amphetamine or related acting sympathomimetic abuse, continuous use

Diagnosis Code	Description
30572	Nondependent amphetamine or related acting sympathomimetic abuse, episodic use
30573	Nondependent amphetamine or related acting sympathomimetic abuse, in remission
30580	Nondependent antidepressant type abuse, unspecified use
30581	Nondependent antidepressant type abuse, continuous use
30582	Nondependent antidepressant type abuse, episodic use
30583	Nondependent antidepressant type abuse, in remission
30590	Other, mixed, or unspecified drug abuse, unspecified use
30591	Nondependent other, mixed, or unspecified drug abuse, continuous use
30592	Nondependent other, mixed, or unspecified drug abuse, episodic use
30593	Nondependent other, mixed, or unspecified drug abuse, in remission
3080	Predominant disturbance of emotions
3081	Predominant disturbance of consciousness
3082	Predominant psychomotor disturbance
3083	Other acute reactions to stress
3084	Mixed disorders as reaction to stress
3089	Unspecified acute reaction to stress
3090	Adjustment disorder with depressed mood
3091	Adjustment reaction with prolonged depressive reaction
30921	Separation anxiety disorder
30922	Emancipation disorder of adolescence and early adult life
30923	Specific academic or work inhibition
30924	Adjustment disorder with anxiety
30928	Adjustment disorder with mixed anxiety and depressed mood
30929	Other adjustment reactions with predominant
3093	Adjustment disorder with disturbance of conduct
3094	Adjustment disorder with mixed disturbance of emotions and conduct
30981	Post-traumatic stress disorder

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Diagnosis Code	Description
30982	Adjustment reaction with physical symptoms
30983	Adjustment reaction with withdrawal
30989	Other specified adjustment reactions
3099	Unspecified adjustment reaction
3100	Frontal lobe syndrome
3101	Personality change due to conditions classified elsewhere
3102	Postconcussion syndrome
3108	Other specified nonpsychotic mental disorders following organic brain damage
311	Depressive disorder, not elsewhere classified
31200	Undersocialized conduct disorder, aggressive type, unspecified degree
31201	Undersocialized conduct disorder, aggressive type, mild degree
31202	Undersocialized conduct disorder, aggressive type, moderate degree
31203	Undersocialized conduct disorder, aggressive type, severe degree
31210	Undersocialized conduct disorder, unaggressive type, unspecified degree
31211	Undersocialized conduct disorder, unaggressive type, mild degree
31212	Undersocialized conduct disorder, unaggressive type, moderate degree
31213	Undersocialized conduct disorder, unaggressive type, severe degree
31220	Socialized conduct disorder, unspecified degree
31221	Socialized conduct disorder, mild degree
31222	Socialized conduct disorder, moderate degree
31223	Socialized conduct disorder, severe degree
31230	Impulse control disorder, unspecified
31231	Pathological gambling
31232	Kleptomania
31233	Pyromania
31234	Intermittent explosive disorder
31235	Isolated explosive disorder
31239	Other disorders of impulse control
3124	Mixed disturbance of conduct and emotions
31281	Conduct disorder, childhood onset type
31282	Conduct disorder, adolescent onset type
31289	Other specified conduct disorder, not elsewhere classified
3129	Unspecified disturbance of conduct
3130	Overanxious disorder specific to childhood and adolescence
3131	Misery and unhappiness disorder specific to childhood and adolescence
31321	Shyness disorder of childhood
31322	Introverted disorder of childhood
31323	Selective mutism
3133	Relationship problems specific to childhood and adolescence
31381	Oppositional defiant disorder
31382	Identity disorder of childhood or adolescence
31383	Academic underachievement disorder of childhood or adolescence
31389	Other emotional disturbances of childhood or adolescence
3139	Unspecified emotional disturbance of childhood or adolescence
31400	Attention deficit disorder of childhood without mention of hyperactivity
31401	Attention deficit disorder of childhood with hyperactivity
3141	Hyperkinesis of childhood with developmental delay
3142	Hyperkinetic conduct disorder of childhood
3148	Other specified manifestations of hyperkinetic syndrome of childhood
3149	Unspecified hyperkinetic syndrome of childhood
31500	Developmental reading disorder, unspecified
31501	Alexia
31502	Developmental dyslexia
31509	Other specific developmental reading disorder
3151	Mathematics disorder
3152	Other specific developmental learning difficulties
31531	Expressive language disorder

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Diagnosis Code	Description
31532	Mixed receptive-expressive language disorder
31539	Other developmental speech disorder
3154	Developmental coordination disorder
3155	Mixed development disorder
3158	Other specified delays in development
3159	Unspecified delay in development
317	Mild mental retardation
3180	Moderate mental retardation
3181	Severe mental retardation
3182	Profound mental retardation
319	Unspecified mental retardation
3200	Hemophilus meningitis
3201	Pneumococcal meningitis
3202	Streptococcal meningitis
3203	Staphylococcal meningitis
3207	Meningitis in other bacterial diseases classified elsewhere
32081	Anaerobic meningitis
32082	Meningitis due to gram-negative bacteria, not elsewhere classified
32089	Meningitis due to other specified bacteria
3209	Meningitis due to unspecified bacterium
3210	Cryptococcal meningitis
3211	Meningitis in other fungal diseases
3212	Meningitis due to viruses not elsewhere classified
3213	Meningitis due to trypanosomiasis
3214	Meningitis in sarcoidosis
3218	Meningitis due to other nonbacterial organisms classified elsewhere
3220	Nonpyogenic meningitis
3221	Eosinophilic meningitis
3222	Chronic meningitis
3229	Meningitis, unspecified
32301	Encephalitis and encephalomyelitis in viral diseases classified elsewhere
32302	Myelitis in viral diseases classified elsewhere
3231	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere
3232	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere
32341	Other encephalitis and encephalomyelitis due to infection classified elsewhere
32342	Other myelitis due to infection classified elsewhere
32351	Encephalitis and encephalomyelitis following immunization procedures
32352	Myelitis following immunization procedures
32361	Infectious acute disseminated encephalomyelitis (ADEM)
32362	Other postinfectious encephalitis and encephalomyelitis
32363	Postinfectious myelitis
32371	Toxic encephalitis and encephalomyelitis
32372	Toxic myelitis
32381	Other causes of encephalitis and encephalomyelitis
32382	Other causes of myelitis
3239	Unspecified causes of encephalitis, myelitis, and encephalomyelitis
3240	Intracranial abscess
3241	Intraspinal abscess
3249	Intracranial and intraspinal abscess of unspecified site
3300	Leukodystrophy
3301	Cerebral lipidoses
3302	Cerebral degeneration in generalized lipidoses
3303	Cerebral degeneration of childhood in other diseases classified elsewhere
3308	Other specified cerebral degenerations in childhood
3309	Unspecified cerebral degeneration in childhood
3310	Alzheimer’s disease
33111	Pick’s Disease
33119	Other frontotemporal dementia
3312	Senile degeneration of brain
3313	Communicating hydrocephalus
3314	Obstructive hydrocephalus
3317	Cerebral degeneration in diseases classified elsewhere
33181	Reye’s syndrome

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Diagnosis Code	Description
33182	Dementia with lewy bodies
33189	Other cerebral degeneration
3319	Cerebral degeneration, unspecified
33392	Neuroleptic malignant syndrome
340	Multiple sclerosis
34500	Generalized nonconvulsive epilepsy, without mention of intractable epilepsy
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy
34510	Generalized convulsive epilepsy, without mention of intractable epilepsy
34511	Generalized convulsive epilepsy, with intractable epilepsy
3452	Petit mal status, epileptic
3453	Grand mal status, epileptic
34540	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
34560	Infantile spasms, without mention of intractable epilepsy
34561	Infantile spasms, with intractable epilepsy
34570	Epilepsia partialis continua, without mention of intractable epilepsy
34571	Epilepsia partialis continua, with intractable epilepsy
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
34590	Epilepsy, unspecified, without mention of intractable epilepsy
3480	Cerebral cysts
3481	Anoxic brain damage
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
4320	Nontraumatic extradural hemorrhage
4321	Subdural hemorrhage
4329	Unspecified intracranial hemorrhage
43300	Occlusion and stenosis of basilar artery without mention of cerebral infarction
43301	Occlusion and stenosis of basilar artery with cerebral infarction
43310	Occlusion and stenosis of carotid artery without mention of cerebral infarction
43311	Occlusion and stenosis of carotid artery with cerebral infarction
43320	Occlusion and stenosis of vertebral artery without mention of cerebral infarction
43321	Occlusion and stenosis of vertebral artery with cerebral infarction
43330	Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction
43331	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
43380	Occlusion and stenosis of other specified precerebral artery without mention of cerebral infarction
43381	Occlusion and stenosis of other specified precerebral artery with cerebral infarction
43390	Occlusion and stenosis of unspecified precerebral artery without mention of cerebral infarction
43391	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction
43490	Cerebral artery occlusion, unspecified without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
4350	Basilar artery syndrome
4351	Vertebral artery syndrome
4352	Subclavian steal syndrome

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Diagnosis Code	Description
4353	Vertebrobasilar artery syndrome
4358	Other specified transient cerebral ischemias
4359	Unspecified transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
4370	Cerebral atherosclerosis
4371	Other generalized ischemic cerebrovascular disease
4372	Hypertensive encephalopathy
4373	Cerebral aneurysm, nonruptured
4374	Cerebral arteritis
4375	Moyamoya disease
4376	Nonpyogenic thrombosis of intracranial venous sinus
4377	Transient global amnesia
4378	Other ill-defined cerebrovascular disease
4379	Unspecified cerebrovascular disease
4380	Cognitive deficits
43810	Speech and language deficit, unspecified
43811	Aphasia
43812	Dysphasia
43819	Other speech and language deficits
42820	Hemiplegia affecting unspecified side
43821	Hemiplegia affecting dominant side
43822	Hemiplegia affecting nondominant side
43830	Monoplegia of upper limb affecting unspecified side
43831	Monoplegia of upper limb affecting dominant side
43832	Monoplegia of upper limb affecting nondominant side
43840	Monoplegia of lower limb affecting unspecified side
43841	Monoplegia of lower limb affecting dominant side
43842	Monoplegia of lower limb affecting nondominant side
43850	Other paralytic syndrome affecting unspecified side
43851	Other paralytic syndrome affecting dominant side
43852	Other paralytic syndrome affecting nondominant side

Diagnosis Code	Description
43853	Other paralytic syndrome, bilateral
4386	Alterations of sensations
4387	Disturbances of vision
43881	Apraxia
43882	Dysphagia
43884	Ataxia
43885	Vertigo
46889	Other late effects of cerebrovascular disease
4389	Unspecified late effects of cerebrovascular disease
7685	Severe birth asphyxia
7686	Mild or moderate birth asphyxia
77210	Intraventricular hemorrhage unspecified grade
77211	Intraventricular hemorrhage grade I
77212	Intraventricular hemorrhage grade II
7790	Convulsions in newborn
78031	Febrile convulsions (simple), unspecified
78039	Other convulsions
79901	Asphyxia
79902	Hypoxemia
8500	Concussion with no loss of consciousness
85011	Concussion, with loss of consciousness of 30 minutes or less
85012	Concussion, with loss of consciousness from 31 to 59 minutes
8502	Concussion with moderate loss of consciousness
8503	Concussion with prolonged loss of consciousness and return to pre-existing conscious level
8504	Concussion with prolonged loss of consciousness, without return to pre-existing conscious level
8505	Concussion with loss of consciousness of unspecified duration
8509	Concussion, unspecified
8510	Cortex (cerebral) contusion without mention of open intracranial wound
85100	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified

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Diagnosis Code	Description
85101	Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-exisiting conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified
85110	Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration

Diagnosis Code	Description
85119	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified
85120	Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified
85121	Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness
85122	Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85123	Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85124	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85129	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified
85130	Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified
85131	ortex (cerebral) laceration with open intracranial wound, with no loss of consciousness
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified
85140	Cerebellar or brain stem contusion without mention of open intracranial wound, with state of consciousness unspecified
84141	Cerebellar or brain stem contusion without mention of open intracranial wound, with no loss of consciousness
84142	Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85149	Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified
85150	Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified
85151	Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness

Diagnosis Code	Description
85152	Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85153	Cerebellar or brain stem contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85155	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration
85159	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified
85170	Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified
85171	Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness
85172	Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85086	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness

Diagnosis Code	Description
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85230	Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85231	Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85232	Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85233	Subdural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85236	Subdural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85239	Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85250	Extradural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85251	Extradural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85252	Extradural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85283	Extradural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85255	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85256	Extradural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial

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Diagnosis Code	Description
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
55310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
82313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness

Diagnosis Code	Description
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85400	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with state of consciousness unspecified
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with concussion, unspecified
986	Toxic effect of carbon monoxide
9941	Drowning and nonfatal submersion
9947	Asphyxiation and strangulation
V110	Personal history of schizophrenia
V111	Personal history of affective disorders
V112	Personal history of neurosis
V113	Personal history of alcoholism
V118	Personal history of other mental disorders
V119	Personal history of unspecified mental disorder
V401	Mental and behavioral problems with communication (including speech)
V402	Other mental problems
V403	Other behavioral problems
V409	Unspecified mental or behavioral problem
V6282	Bereavement, uncomplicated
V6283	Counseling for perpetrator of physical/sexual abuse
V6284	Suicidal ideation
V6289	Other psychological or physical stress, not elsewhere classified
V7101	Observation of adult antisocial behavior
V7102	Observation of childhood or adolescent antisocial behavior
V7109	Observation of other suspected mental condition
V790	Screening for depression
V791	Screening for alcoholism
V792	Screening for mental retardation
V793	Screening for developmental handicaps in early childhood
V798	Screening for other specified mental disorders and developmental handicaps
V799	Screening for unspecified mental disorder and developmental handicap

36.4.40 Radiation Therapy

Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as a distinct break has occurred in therapy sessions, and the fractions are of the character usually furnished on different days. Procedure code 6-77427 is also reported if three or four fractions are beyond a multiple of five at the end of a course of treatment. One or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consists of review of port films, review of dosimetry, dose delivery, and treatment parameters; review of patient treatment setup; and examination of the patient for medical E/M (e.g., assessment of the patient's response to treatment, coordination of care and treatment, and review of imaging and/or lab test results).

If a provider submits claims for dates of service that exceed five fractions in a seven-day period of time, the claim will suspend for manual review. If the provider has documented the dates/times the fractions were administered, supporting more than five fractions were provided in this seven-day period, the claim may be reimbursed. If the times are not supplied, the claim is denied for documentation of dates/times.

The professional component (TOS I) and the technical component (TOS T) are not reimbursed when billed with the total component (TOS 6). The total component includes the professional and technical components.

The following codes are payable as professional components only (TOS I) for services performed in POS 3 or 5 and as (TOS 6) for services performed in POS 1.

Radiation therapy (6-77427) may be reimbursed for the following provider types:

Provider Type	Description
19	Physician (DO)
20	Physician (MD)
21	Physician Group (DOS Only)
22	Physician Group (MDS Only and Multispeciality)
43	Radiation Treatment Centers
60	Hospital—Long Term, Limited, or Specialized Care
61	Hospital—Private Full Care
62	Hospital—Private, O/P Service/Emergency Care Only
79	Rural Health Clinic—Hospital Based

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36.4.40.1 Clinical Treatment Planning

The professional component (TOS I) is payable for services rendered in the freestanding radiation therapy facility (POS 5), outpatient hospital (POS 5), inpatient hospital (POS 3). Physicians billing for client services rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or their offices (POS 1) are reimbursed for total components (TOS 6).

Procedure Codes		
57155	58346	6/I-77261
6/I-77262	6/I-77263	6/I-77280
6/I-77285	6/I-77290	6/I-77295
6/I-77299	6/I/T-77301	

36.4.40.2 Clinical Treatment Management

Physicians billing for client services rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or their offices (POS 1) are reimbursed for the total component (TOS 6).

The following procedure codes are payable as the total component (TOS 6) for services performed in POS 1: 6-77427, 6-77431, and 6-77499.

36.4.40.3 Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services, and Proton Beam Treatment Delivery

Procedure Codes		
6/I-77300	6/I-77305	6/I-77310
6/I-77315	6/I-77326	6/I-77327
6/I-77328	6/I-77332	6/I-77333
6/I-77334	6/I-77399	6-77520
6-77522	6-77523	6-77525

36.4.40.4 Clinical Brachytherapy

Procedure Codes		
57155	58346	6/I-77750
6/I-77761	6/I-77762	6/I-77763
6/I-77776	6/I-77777	6/I-77778
6/I-77781	6/I-77782	6/I-77783
6/I-77784	6/I-77789	6/I-77799

Only the technical component (TOS T) is payable to physicians for the following services when rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or in the physician’s office (POS 1).

36.4.40.5 Radiation Treatment Delivery/Port Films

Procedure Codes		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	

36.4.40.6 Freestanding Radiation Therapy Facilities/Outpatient Facilities

Freestanding radiation therapy facilities (specialty 98) and outpatient hospitals are reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the following services:

Procedure Codes		
Clinical Treatment Planning		
T-77280	T-77285	T-77290
T-77295	T-77299	
Medical Radiation Physics, Dosimetry, Treatment Devices and Special Services		
T-77300	T-77305	T-77310
T-77315	T-77326	T-77327
T-77328	T-77332	T-77333
T-77334	T-77399	
Radiation Treatment Delivery/Port Films		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-77418
Clinical Brachytherapy		
T-77781	T-77782	T-77783
T-77784	T-77789	T-77799

The following services are not benefits of the Texas Medicaid Program:

Procedure Codes		
77321	77331	77336
77370	77470	77600
77605	77610	77615
77620	77790	

The following services are allowed once per day, unless documentation submitted with an appeal supports the need for the service to be provided more than once: therapeutic radiation treatment planning, therapeutic radiology simulation-aided field setting, teletherapy, brachytherapy isodose calculation, treatment devices, proton beam delivery/treatment, intracavity radioelement application,

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interstitial radioelement application, remote afterloading high intensity brachytherapy, radiation treatment delivery, localization, and radioisotope therapy.

The following clinical brachytherapy procedure codes include admission to the hospital and daily care. Initial and subsequent hospital care is denied on the same day that clinical brachytherapy services are billed.

Procedure Codes		
6/I-77750	6/I-77761	6/I-77762
6/I-77763	6/I-77776	6/I-77777
6/I-77778	6/I-77781	6/I-77782
6/I-77783	6/I-77784	6/I-77789
6/I-77799		

A consultation on the same day as clinical treatment planning and clinical brachytherapy is included in the therapeutic radiology procedure.

Laboratory and diagnostic radiologic services provided in an office (POS 1) are reimbursed to physicians as a total component. Freestanding radiation therapy facilities (specialty 98) will also be reimbursed for the total component for these services in POS 5. Injectable medications given during the course of therapy in any setting are reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service is denied. Medical services within program limitations may be paid on appeal when documentation supports the medical necessity of the visit because of services unrelated to the radiation treatment or radiation treatment complication. Procedure code 19298 is a benefit of the Texas Medicaid Program, effective for dates of service on or after January 1, 2005.

No separate payment is made for any of the following procedure codes provided on the same day as radiation therapy by the same provider:

Procedure Codes		
2-16000	2-16025	2/F-16030
2-36425	B-413	2-51701
2-51702	2-51703	1-99183
1-99211	1-99212	1-99213
1-99214	1-99215	3-99241
3-99242	3-99243	3-99244
3-99245	1-99281	1-99282
1-99283	1-99284	1-99285

No separate payment is made for established office (99211, 99212, 99213, 99214, and 99215) or outpatient visits (99281, 99282, 99283, 99284, and 99285) within 90 days after radiation treatment by the same provider.

Procedure code T-77295 (three-dimensional) is payable to freestanding therapy facilities (specialty 98) and outpatient hospitals (POS 5). Reimbursement for freestanding radiation treatment centers is at 28.32 RVUs. Outpatient hospitals are reimbursed at their reimbursement rate. This code is payable on Medicare crossover claims. T-77295 is payable once per day.

The following codes are denied when billed on the same day as T-77295: T-77305, T-77310, and T-77315.

Texas Medicaid Program benefits include payment for the technical portion of radiation therapy services provided in an inpatient setting. Covered services include clinical treatment planning and management, and clinical brachytherapy. Hospitals use revenue code 333, Radiation therapy, on the HCFA-1450 (UB-92) claim form when submitting charges for these services.

36.4.41 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their personal supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to the Texas Medicaid Program. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they personally supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same laboratory or radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation or procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist's office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the patient.

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Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Abdominal flat plates (AFP) or kidneys, ureters, bladder (KUB) codes 4-74000, 4-74010, and 4-74020 are frequently done as preliminary X-rays before other, more complicated X-ray procedures. If a physician bills separately for an AFP or KUB and more complicated procedures, the charges are combined and the more complex procedure may be paid. If, however, the claim specifically states the AFP or KUB was done first and the results required additional X-rays, each procedure may be paid separately.

Oral preparations for X-rays (for example, Oragrafin, X-prep, and Neloid) are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

36.4.41.1 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a covered benefit for the following diagnosis codes:

Diagnosis Code	Description
3526	Multiple cranial nerve palsies
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve, unspecified
41000	Acute myocardial infarction of anterolateral wall, episode of care unspecified
41001	Acute myocardial infarction of anterolateral wall, initial episode of care
41002	Acute myocardial infarction of anterolateral wall, subsequent episode of care
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care
41012	Acute myocardial infarction of other anterior wall, subsequent episode of care
41020	Acute myocardial infarction of inferolateral wall, episode of care unspecified
41021	Acute myocardial infarction of inferolateral wall, initial episode of care
41022	Acute myocardial infarction of inferolateral wall, subsequent episode of care
41030	Acute myocardial infarction of inferoposterior wall, episode of care unspecified
41031	Acute myocardial infarction of inferoposterior wall, initial episode of care
41032	Acute myocardial infarction of inferoposterior wall, initial episode of care
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41042	Acute myocardial infarction of other inferior wall, subsequent episode of care

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Diagnosis Code	Description
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41052	Acute myocardial infarction of other lateral wall, subsequent episode of care
41060	True posterior wall infarction, episode of care unspecified
41062	True posterior wall infarction, subsequent episode of care
41070	Subendocardial infarction, episode of care unspecified
41071	Subendocardial infarction, initial episode of care
41072	Subendocardial infarction, subsequent episode of care
41080	Acute myocardial infarction of other specified
41081	Acute myocardial infarction of other specified sites, initial episode of care
41082	Acute myocardial infarction of other specified sites, subsequent episode of care
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41092	Acute myocardial infarction of unspecified site, subsequent episode of care
4110	Postmyocardial infarction syndrome
4111	Intermediate coronary syndrome
41181	Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction
41189	Other acute and subacute forms of ischemic heart disease, other
412	Old myocardial infarction
4130	Angina decubitus
4131	Prinzmetal angina
4139	Other and unspecified angina pectoris
41400	Coronary atherosclerosis of unspecified type of vessel, native or graft
41401	Coronary atherosclerosis of native coronary artery
41402	Coronary atherosclerosis of autologous vein bypass graft
41403	Coronary atherosclerosis of nonautologous biological bypass graft
41404	Coronary atherosclerosis of artery bypass graft
41405	Coronary atherosclerosis of unspecified bypass graft
41406	Coronary atherosclerosis of native coronary artery of transplanted heart
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
41410	Aneurysm of heart (wall)
41411	Aneurysm of coronary vessels
41412	Dissection of coronary artery
41419	Other aneurysm of heart
4148	Other specified forms of chronic ischemic heart disease
4149	Chronic ischemic heart disease, unspecified
41511	Iatrogenic pulmonary embolism and infarction
41519	Other pulmonary embolism and infarction
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4168	Other chronic pulmonary heart diseases
4169	Chronic pulmonary heart disease, unspecified
4170	Arteriovenous fistula of pulmonary vessels
4171	Aneurysm of pulmonary artery
4178	Other specified diseases of pulmonary circulation
4179	Unspecified disease of pulmonary circulation
4200	Acute pericarditis in diseases classified elsewhere
42090	Acute pericarditis, unspecified
42091	Acute idiopathic pericarditis
42099	Other acute pericarditis
4210	Acute and subacute bacterial endocarditis
4211	Acute and subacute infective endocarditis in diseases classified elsewhere
4219	Acute endocarditis, unspecified
4220	Acute myocarditis in diseases classified elsewhere
42290	Acute myocarditis, unspecified
42291	Idiopathic myocarditis

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Diagnosis Code	Description
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Other acute myocarditis
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4238	Other specified diseases of pericardium
4239	Unspecified disease of pericardium
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of Africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4255	Alcoholic cardiomyopathy
4257	Nutritional and metabolic cardiomyopathy
4258	Cardiomyopathy in other diseases classified elsewhere
4259	Secondary cardiomyopathy, unspecified
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block
42652	Right bundle branch block and left anterior fascicular block
42653	Other bilateral bundle branch block

Diagnosis Code	Description
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-ganong-levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
72731	Atrial fibrillation
42732	Atrial flutter
42741	Ventricular fibrillation
42742	Ventricular flutter
4275	Cardiac arrest
42760	Premature beats, unspecified
42761	Supraventricular premature beats
42769	Other premature beats
42781	Sinoatrial node dysfunction
42789	Other specified cardiac dysrhythmias
4279	Cardiac dysrhythmia, unspecified
4280	Congestive heart failure
4281	Left heart failure
42810	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
4290	Myocarditis, unspecified
4291	Myocardial degeneration
4292	Cardiovascular disease, unspecified
4293	Cardiomegaly

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Diagnosis Code	Description
4294	Functional disturbances following cardiac surgery
4295	Rupture of chordae tendineae
4296	Rupture of papillary muscle
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other
42981	Other disorders of papillary muscle
42982	Hyperkinetic heart disease
42989	Other ill-defined heart diseases
4299	Heart disease, unspecified
7809	Other general symptoms
7813	Lack of coordination
78650	Unspecified chest pain
78651	Precordial pain
78652	Painful respiration
78659	Other chest pain
7991	Respiratory arrest
V4321	Organ or tissue replaced by other means, heart assist device
V4581	Postsurgical aortocoronary bypass status

36.4.41.2 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement; however, the following diagnosis codes are payable:

Diagnosis Code	Description
01100	Tuberculosis of lung, infiltrative, confirmation unspecified
01101	Tuberculosis of lung, infiltrative, bacteriological or histological examination not done
01102	Tuberculosis of lung, infiltrative, bacteriological or histological examination results unknown (at present)
01103	Tuberculosis of lung, infiltrative, tubercle bacilli found (in sputum) by microscopy
01104	Tuberculosis of lung, infiltrative, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
01105	Tuberculosis of lung, infiltrative, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01106	Tuberculosis of lung, infiltrative, tubercle bacilli not found bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01110	Tuberculosis of lung, nodular, unspecified examination
01111	Tuberculosis of lung, nodular, bacteriological or histological examination not done
01112	Tuberculosis of lung, nodular, bacteriological or histological examination results unknown (at present)
01113	Tuberculosis of lung, nodular, tubercle bacilli found (in sputum) by microscopy
01114	Tuberculosis of lung, nodular, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01115	Tuberculosis of lung, nodular, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01116	Tuberculosis of lung, nodular, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01120	Tuberculosis of lung with cavitation, unspecified examination
01121	Tuberculosis of lung with cavitation, bacteriological or histological examination not done
01122	Tuberculosis of lung with cavitation, bacteriological or histological examination results unknown (at present)
01123	Tuberculosis of lung with cavitation, tubercle bacilli found (in sputum) by microscopy
01124	Tuberculosis of lung with cavitation, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01125	Tuberculosis of lung with cavitation, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
01126	Tuberculosis of lung with cavitation, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01130	Tuberculosis of bronchus, unspecified examination
01131	Tuberculosis of bronchus, bacteriological or histological examination not done
01132	Tuberculosis of bronchus, bacteriological or histological examination results unknown (at present)
01133	Tuberculosis of bronchus, tubercle bacilli found (in sputum) by microscopy
01134	Tuberculosis of bronchus, tubercle bacilli not found (in sputum) by microscopy, but found in bacterial culture
01135	Tuberculosis of bronchus, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01136	Tuberculosis of bronchus, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01140	Tuberculous fibrosis of lung, unspecified examination
01141	Tuberculous fibrosis of lung, bacteriological or histological examination not done
01142	Tuberculous fibrosis of lung, bacteriological or histological examination unknown (at present)
01143	Tuberculous fibrosis of lung, tubercle bacilli found (in sputum) by microscopy
01144	Tuberculous fibrosis of lung, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01145	Tuberculous fibrosis of lung, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01146	Tuberculous fibrosis of lung, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
01150	Tuberculous bronchiectasis, unspecified examination
01151	Tuberculous bronchiectasis, bacteriological or histological examination not done
01152	Tuberculous bronchiectasis, bacteriological or histological examination results unknown (at present)
01153	Tuberculous bronchiectasis, tubercle bacilli found (in sputum) by microscopy
01154	Tuberculous bronchiectasis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01155	Tuberculous bronchiectasis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01156	Tuberculous bronchiectasis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01160	Tuberculous pneumonia (any form), unspecified examination
01161	Tuberculous pneumonia (any form), bacteriological or histological examination not done
01162	Tuberculous pneumonia (any form), bacteriological or histological examination results unknown (at present)
01163	Tuberculous pneumonia (any form), tubercle bacilli found (in sputum) by microscopy
01164	Tuberculous pneumonia (any form), tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01165	Tuberculous pneumonia (any form), tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01166	Tuberculous pneumonia (any form), tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01170	Tuberculous pneumothorax, unspecified examination

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Diagnosis Code	Description
01171	Tuberculous pneumothorax, bacteriological or histological examination not done
01172	Tuberculous pneumothorax, bacteriological or histological examination results unknown (at present)
01173	Tuberculous pneumothorax, tubercle bacilli found (in sputum) by microscopy
01174	Tuberculous pneumothorax, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01175	Tuberculous pneumothorax, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01176	Tuberculous pneumothorax, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01180	Other specified pulmonary tuberculosis, unspecified confirmation
01181	Other specified pulmonary tuberculosis, bacteriological or histological examination not done
01182	Other specified pulmonary tuberculosis, bacteriological or histological examination results unknown (at present)
01183	Other specified pulmonary tuberculosis, tubercle bacilli found (in sputum) by microscopy
01184	Other specified pulmonary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01185	Other specified pulmonary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01186	Other specified pulmonary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01190	Unspecified pulmonary tuberculosis, confirmation unspecified
01191	Unspecified pulmonary tuberculosis, bacteriological or histological examination not done

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
01192	Unspecified pulmonary tuberculosis, bacteriological or histological examination results unknown (at present)
01193	Unspecified pulmonary tuberculosis, tubercle bacilli found (in sputum) by microscopy
01194	Unspecified pulmonary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01195	Unspecified pulmonary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01196	Unspecified pulmonary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01200	Tuberculous pleurisy, confirmation unspecified
01201	Tuberculous pleurisy, bacteriological or histological examination not done
01202	Tuberculous pleurisy, bacteriological or histological examination results unknown (at present)
01203	Tuberculous pleurisy, tubercle bacilli found (in sputum) by microscopy
01204	Tuberculous pleurisy, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01205	Tuberculous pleurisy, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01206	Tuberculous pleurisy, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals
01210	Tuberculosis of intrathoracic lymph nodes, confirmation unspecified
01211	Tuberculosis of intrathoracic lymph nodes, bacteriological or histological examination not done
01212	Tuberculosis of intrathoracic lymph nodes, bacteriological or histological examination results unknown (at present)
01213	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli found (in sputum) by microscopy

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Diagnosis Code	Description
01214	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01215	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01216	Tuberculosis of intrathoracic lymph nodes, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01220	Isolated tracheal or bronchial tuberculosis, unspecified examination
01800	Acute miliary tuberculosis, unspecified examination
01801	Acute miliary tuberculosis, bacteriological or histological examination not done
01802	Acute miliary tuberculosis, bacteriological or histological examination results unknown (at present)
01803	Acute miliary tuberculosis, tubercle bacilli found (in sputum) by microscopy
01804	Acute miliary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01805	Acute miliary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01806	Acute miliary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01880	Other specified miliary tuberculosis, unspecified examination
01881	Other specified miliary tuberculosis, bacteriological or histological examination not done
01882	Other specified miliary tuberculosis, bacteriological or histological examination results unknown (at present)
01883	Other specified miliary tuberculosis, tubercle bacilli found (in sputum) by microscopy

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
01884	Other specified miliary tuberculosis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
01885	Other specified miliary tuberculosis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
01886	Other specified miliary tuberculosis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
01890	Unspecified miliary tuberculosis, unspecified examination
0310	Pulmonary diseases due to other mycobacteria
0330	Whooping cough due to bordetella pertussis (b. pertussis
0331	Whooping cough due to bordetella parapertussis (b. parapertussis)
0338	Whooping cough due to other specified organism
0339	Whooping cough, unspecified organism
042	Human immunodeficiency virus (HIV) disease
0551	Postmeasles pneumonia
07950	Retrovirus, unspecified
07951	Human t-cell lymphotrophic virus, type I (HTLV-I)
07952	Human t-cell lymphotrophic virus, type II (HTLV-II)
07953	Human immunodeficiency virus, type 2 (HIV-2)
07959	Other specified retrovirus
11144	Tuberculous fibrosis of lung, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
1124	Candidiasis of lung
135	Sarcoidosis
1363	Pneumocystosis
1620	Malignant neoplasm of trachea
1622	Malignant neoplasm of main bronchus
1623	Malignant neoplasm of upper lobe, bronchus or lung
1624	Malignant neoplasm of middle lobe, bronchus or lung

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
1625	Malignant neoplasm of lower lobe, bronchus or lung
1628	Malignant neoplasm of other parts of bronchus or lung
1629	Malignant neoplasm of bronchus and lung, unspecified
1630	Malignant neoplasm of parietal pleura
1631	Malignant neoplasm of visceral pleura
1638	Malignant neoplasm of other specified sites of pleura
1639	Malignant neoplasm of pleura, unspecified
1640	Malignant neoplasm of thymus
1641	Malignant neoplasm of heart
1642	Malignant neoplasm of anterior mediastinum
1643	Malignant neoplasm of posterior mediastinum
1648	Malignant neoplasm of other parts of mediastinum
1649	Malignant neoplasm of mediastinum, part unspecified
1650	Malignant neoplasm of upper respiratory tract, part unspecified
1658	Malignant neoplasm of other sites within the respiratory system and intrathoracic organs
1659	Malignant neoplasm of ill-defined sites within the respiratory system
1714	Malignant neoplasm of connective and other soft tissue of thorax
1740	Malignant neoplasm of nipple and areola of female breast
1741	Malignant neoplasm of central portion of female breast
1742	Malignant neoplasm of upper-inner quadrant of female breast
1743	Malignant neoplasm of lower-inner quadrant of female breast
1744	Malignant neoplasm of upper-outer quadrant of female breast
1745	Malignant neoplasm of lower-outer quadrant of female breast
1746	Malignant neoplasm of axillary tail of female breast
1748	Malignant neoplasm of other specified sites of female breast

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
1749	Malignant neoplasm of breast (female), unspecified site
1750	Malignant neoplasm of nipple and areola of male breast
1759	Malignant neoplasm of other and unspecified sites of male breast
1951	Malignant neoplasm of thorax
1961	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
1970	Secondary malignant neoplasm of lung
1971	Secondary malignant neoplasm of mediastinum
1972	Secondary malignant neoplasm of pleura
1973	Secondary malignant neoplasm of other respiratory organs
2310	Carcinoma in situ of larynx
2311	Carcinoma in situ of trachea
2312	Carcinoma in situ of bronchus and lung
2318	Carcinoma in situ of other specified parts of respiratory system
2319	Carcinoma in situ of respiratory system, part unspecified
2330	Carcinoma in situ of breast
2391	Neoplasm of unspecified nature of respiratory system
2393	Neoplasm of unspecified nature of breast
28262	HB-SS Disease with crisis
2959	Other and unspecified rheumatic aortic diseases
3061	Respiratory malfunction arising from mental factors
34400	Quadriplegia, unspecified
3530	Brachial plexus lesions
3910	Acute rheumatic pericarditis
3911	Acute rheumatic endocarditis
3912	Acute rheumatic myocarditis
3918	Other acute rheumatic heart disease
3919	Acute rheumatic heart disease, unspecified
3920	Rheumatic chorea with heart involvement
393	Chronic rheumatic pericarditis

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve unspecified
3980	Rheumatic myocarditis
39890	Rheumatic heart disease, unspecified
39891	Rheumatic heart failure (congestive)
39899	Other rheumatic heart diseases
4010	Malignant essential hypertension
4011	Benign essential hypertension
4019	Unspecified essential hypertension
40200	Malignant hypertensive heart disease without congestive heart failure
40201	Malignant hypertensive heart disease with congestive heart failure
40210	Benign hypertensive heart disease without congestive heart failure
40211	Benign hypertensive heart disease with congestive heart failure
40290	Unspecified hypertensive heart disease without congestive heart failure

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
40291	Unspecified hypertensive heart disease with congestive heart failure
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
40400	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40401	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
40410	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
40411	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40490	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40491	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
41000	Acute myocardial infarction of anterolateral wall, episode of care unspecified
41001	Acute myocardial infarction of anterolateral wall, initial episode of care
41002	Acute myocardial infarction of anterolateral wall, subsequent episode of care
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care
41012	Acute myocardial infarction of other anterior wall, subsequent episode of care

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Diagnosis Code	Description
41020	Acute myocardial infarction of infero-lateral wall, episode of care unspecified
41021	Acute myocardial infarction of infero-lateral wall, initial episode of care
41022	Acute myocardial infarction of infero-lateral wall, subsequent episode of care
41030	Acute myocardial infarction of infero-posterior wall, episode of care unspecified
41031	Acute myocardial infarction of infero-posterior wall, initial episode of care
41032	Acute myocardial infarction of infero-posterior wall, subsequent episode of care
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41042	Acute myocardial infarction of other inferior wall, subsequent episode of care
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41052	Acute myocardial infarction of other lateral wall, subsequent episode of care
41060	True posterior wall infarction, episode of care unspecified
41061	True posterior wall infarction, initial episode of care
41062	True posterior wall infarction, subsequent episode of care
41070	Subendocardial infarction, episode of care unspecified
41071	Subendocardial infarction, initial episode of car
41072	Subendocardial infarction, subsequent episode of care
41080	Acute myocardial infarction of other specified sites, episode of care unspecified
41081	Acute myocardial infarction of other specified sites, initial episode of care

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Diagnosis Code	Description
41082	Acute myocardial infarction of other specified sites, subsequent episode of care
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41092	Acute myocardial infarction of unspecified site, subsequent episode of care
4110	Postmyocardial infarction syndrome
4111	Intermediate coronary syndrome
41181	Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction
41189	Other acute and subacute forms of ischemic heart disease, other
412	Old myocardial infarction
4130	Angina decubitus
4131	Prinzmetal angina
4139	Other and unspecified angina pectoris
41400	Coronary atherosclerosis of unspecified type of vessel, native or graft
41401	Coronary atherosclerosis of native coronary artery
41402	Coronary atherosclerosis of autologous vein bypass graft
41403	Coronary atherosclerosis of nonautologous biological bypass graft
41404	Coronary atherosclerosis of artery bypass graft
41405	Coronary atherosclerosis of unspecified bypass graft
41406	Coronary atherosclerosis of native coronary artery of transplanted heart
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
41410	Aneurysm of heart (wall)
41411	Aneurysm of coronary vessels
41412	Dissection of coronary artery
41419	Other aneurysm of heart
4148	Other specified forms of chronic ischemic heart disease

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Diagnosis Code	Description
4149	Chronic ischemic heart disease, unspecified
4150	Acute cor pulmonale
41511	Iatrogenic pulmonary embolism and infarction
41519	Other pulmonary embolism and infarction
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4168	Other chronic pulmonary heart diseases
4169	Chronic pulmonary heart disease, unspecified
4170	Arteriovenous fistula of pulmonary vessels
4171	Aneurysm of pulmonary artery
4178	Other specified diseases of pulmonary circulation
4179	Unspecified disease of pulmonary circulation
4200	Acute pericarditis in diseases classified elsewher
42090	Acute pericarditis, unspecified
42091	Acute idiopathic pericarditis
42099	Other acute pericarditis
4210	Acute and subacute bacterial endocarditis
4211	Acute and subacute infective endocarditis in diseases classified elsewhere
4219	Acute endocarditis, unspecified
4220	Acute myocarditis in diseases classified elsewhere
42290	Acute myocarditis, unspecified
42291	Idiopathic myocarditis
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Other acute myocarditis
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4238	Other specified diseases of pericardium
4239	Unspecified disease of pericardium
4240	Mitral valve disorders
4241	Aortic valve disorders

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Diagnosis Code	Description
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of Africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4255	Alcoholic cardiomyopathy
4257	Nutritional and metabolic cardiomyopathy
4258	Cardiomyopathy in other diseases classified elsewhere
4259	Secondary cardiomyopathy, unspecified
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular bloc
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block
42652	Right bundle branch block and left anterior fascicular block
42653	Other bilateral bundle branch block
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-ganong-levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia

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Diagnosis Code	Description
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
42731	Atrial fibrillation
42732	Atrial flutter
42741	Ventricular fibrillation
42742	Ventricular flutter
4275	Cardiac arrest
42760	Premature beats, unspecified
42761	Supraventricular premature beats
42769	Other premature beats
42781	Sinoatrial node dysfunction
42789	Other specified cardiac dysrhythmias
4279	Cardiac dysrhythmia, unspecified
4280	Congestive heart failure
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
4290	Myocarditis, unspecified
4291	Myocardial degeneration
4292	Cardiovascular disease, unspecified
4293	Cardiomegaly
4294	Functional disturbances following cardiac surgery
4295	Rupture of chordae tendineae
4296	Rupture of papillary muscle
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect

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Diagnosis Code	Description
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other
42981	Other disorders of papillary muscle
42982	Hyperkinetic heart disease
42989	Other ill-defined heart diseases
4299	Heart disease, unspecified
43900	Estrinsic asthma, unspecified
44100	Dissection of aorta, unspecified site
44101	Dissection of aorta, thoracic
44102	Dissection of aorta, abdominal
44103	Dissection of aorta, thoracoabdominal
4411	Thoracic aneurysm, ruptured
4412	Thoracic aneurysm without mention of rupture
4416	Thoracoabdominal aneurysm, ruptured
4417	Thoracoabdominal aneurysm, without mention of rupture
4644	Croup
4660	Acute bronchitis
46611	Acute bronchiolitis
46619	Acute bronciolitis due to other infectious organisms
4800	Pneumonia due to adenovirus
4801	Pneumonia due to respiratory syncytial virus
4802	Pneumonia due to parainfluenza virus
4803	Pneumonia due to SARS-associated coronavirus
4808	Pneumonia due to other virus not elsewhere classified
4809	Viral pneumonia, unspecified
481	Pneumococcal pneumonia (streptococcus pneumoniae pneumonia)
4820	Pneumonia due to klebsiella pneumoniae
4821	Pneumonia due to pseudomonas
4822	Pneumonia due to hemophilus influenzae (H. influenzae)
48230	Pneumonia due to streptococcus, unspecified
48231	Pneumonia due to streptococcus, group A

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Diagnosis Code	Description
48232	Pneumonia due to streptococcus, group B
48239	Pneumonia due to other streptococcus
48240	Pneumonia due to staphylococcus, unspecified
48241	Pneumonia due to staphylococcus aureus
48249	Other staphylococcus pneumonia
48281	Pneumonia due to anaerobe
48282	Pneumonia due to escherichia coli (e.coli)
48283	Pneumonia due to other gram-negative bacteria
48284	Pneumonia due to Legionnaires' Disease
48289	Pneumonia due to other specified bacteria
4829	Bacterial pneumonia, unspecified
4830	Pneumonia due to mycoplasma pneumoniae
4831	Pneumonia due to chlamydia
4838	Pneumonia due to other specified organism
4841	Pneumonia in cytomegalic inclusion disease
4843	Pneumonia in whooping cough
4845	Pneumonia in anthrax
4846	Pneumonia in aspergillosis
4847	Pneumonia in other systemic mycoses
4848	Pneumonia in other infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
4870	Influenza with pneumonia
4871	Influenza with other respiratory manifestations
4878	Influenza with other manifestations
490	Bronchitis, not specified as acute or chronic
4910	Simple chronic bronchitis
4911	Mucopurulent chronic bronchitis
49120	Obstructive chronic bronchitis, without exacerbation

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Diagnosis Code	Description
49121	Obstructive chronic bronchitis, with (acute) exacerbation
49122	Obstructive chronic bronchitis with acute bronchitis
4918	Other chronic bronchitis
4919	Unspecified chronic bronchitis
4920	Emphysematous bleb
4928	Other emphysema
49300	Extrinsic asthma, unspecified
49301	Extrinsic asthma with status asthmaticus
49302	Extrinsic asthma with (acute) exacerbation
49310	Intrinsic asthma, unspecified
49311	Intrinsic asthma with status asthmaticus
49312	Intrinsic asthma, with (acute) exacerbation
49320	Chronic obstructive asthma, unspecified
49321	Chronic obstructive asthma with status asthmaticus
49322	Chronic obstructive asthma, with (acute) exacerbation)
49381	Exercise induced bronchospasm
49382	Cough varient asthma
49390	Asthma, unspecified type, unspecified
49391	Asthma, unspecified type, with status asthmaticus
49392	Asthma, unspecified type, with (acute) exacerbation
4940	Bronchiectasis without acute exacerbation
4941	Bronchiectasis with acute exacerbation
4950	Farmers' lung
4951	Bagassosis
4952	Bird-fanciers' lung
4953	Suberosis
4954	Malt workers' lung
4955	Mushroom workers' lung
4956	Maple bark-strippers' lung
4957	'Ventilation' pneumonitis
4958	Other specified allergic alveolitis and pneumonitis

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Diagnosis Code	Description
4959	Unspecified allergic alveolitis and pneumonitis
496	Chronic airway obstruction, not elsewhere classified
500	Coal workers' pneumoconiosis
501	Asbestosis
502	Pneumoconiosis due to other silica or silicates
503	Pneumoconiosis due to other inorganic dust
504	Pneumonopathy due to inhalation of other dust
505	Pneumoconiosis, unspecified
5060	Bronchitis and pneumonitis due to fumes and vapors
5061	Acute pulmonary edema due to fumes and vapors
5062	Upper respiratory inflammation due to fumes and vapors
5063	Other acute and subacute respiratory conditions due to fumes and vapors
5064	Chronic respiratory conditions due to fumes and vapors
5069	Unspecified respiratory conditions due to fumes and vapors
5070	Pneumonitis due to inhalation of food or vomitus
5071	Pneumonitis due to inhalation of oils and essences
5078	Pneumonitis due to other solids and liquids
5080	Acute pulmonary manifestations due to radiation
5081	Chronic and other pulmonary manifestations due to radiation
5088	Respiratory conditions due to other specified external agents
5089	Respiratory conditions due to unspecified external agent
5100	Empyema with fistula
5109	Empyema without mention of fistula
5110	Pleurisy without mention of effusion or current tuberculosis
5111	Pleurisy with effusion, with mention of a bacterial cause other than tuberculosis
5118	Other specified forms of pleural effusion, except tuberculous

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Diagnosis Code	Description
5119	Unspecified pleural effusion
5120	Spontaneous tension pneumothorax
5121	Iatrogenic pneumothorax
5128	Other spontaneous pneumothorax
5130	Abscess of lung
5131	Abscess of mediastinum
514	Pulmonary congestion and hypostasis
515	Postinflammatory pulmonary fibrosis
5160	Pulmonary alveolar proteinosis
5161	Idiopathic pulmonary hemosiderosis
5162	Pulmonary alveolar microlithiasis
5163	Idiopathic fibrosing alveolitis
5168	Other specified alveolar and parietoalveolar pneumonopathies
5169	Unspecified alveolar and parietoalveolar pneumonopathy
5171	Rheumatic pneumonia
5172	Lung involvement in systemic sclerosis
5173	Acute chest syndrome
5178	Lung involvement in other diseases classified elsewhere
5180	Pulmonary collapse
5181	Interstitial emphysema
5182	Compensatory emphysema
5183	Pulmonary eosinophilia
5184	Acute edema of lung, unspecified
5185	Pulmonary insufficiency following trauma and surgery
5186	Allergic bronchopulmonary aspergilliosis
51881	Acute respiratory failure
51882	Other pulmonary insufficiency, not elsewhere classified
51883	Chronic respiratory failure
51884	Acute and chronic respiratory failure
51889	Other diseases of lung, not elsewhere classified
51900	Tracheostomy complication, unspecified
51901	Infection of tracheostomy
51902	Mechanical complication of tracheostomy
51909	Other tracheostomy complications
51911	Acute bronchospasm

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Diagnosis Code	Description
51919	Other diseases of trachea and bronchus
5192	Mediastinitis
5193	Other diseases of mediastinum, not elsewhere classified
5194	Disorders of diaphragm
5198	Other diseases of respiratory system, not elsewhere classified
5199	Unspecified disease of respiratory system
5300	Achalasia and cardiospasm
53010	Esophagitis, unspecified
53011	Reflux esophagitis
53012	Acute esophagitis
53019	Other esophagitis
53020	Ulcer of esophagus without bleeding
53021	Ulcer of esophagus with bleeding
5303	Stricture and stenosis of esophagus
5304	Perforation of esophagus
5305	Dyskinesia of esophagus
5306	Diverticulum of esophagus, acquired
5307	Gastroesophageal laceration-hemorrhage syndrome
53081	Esophageal reflux
53082	Esophageal hemorrhage
53083	Esophageal leukoplakia
53084	Tracheoesophageal fistula
53085	Barrett's esophagus
53086	Infection of esophagostomy
53087	Mechanical complication of esophagostomy
53089	Other diseases of esophagus
5309	Unspecified disorder of esophagus
5533	Diaphragmatic hernia without mention of obstruction or gangrene
57400	Calculus of gallbladder with acute cholecystitis, without mention of obstruction
57401	Calculus of gallbladder with acute cholecystitis, with obstruction
57410	Calculus of gallbladder with other cholecystitis, without mention of obstruction
57411	Calculus of gallbladder with other cholecystitis, with obstruction

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Diagnosis Code	Description
57420	Calculus of gallbladder without mention of cholecystitis, without mention of obstruction
57421	Calculus of gallbladder without mention of cholecystitis, with obstruction
57430	Calculus of bile duct with acute cholecystitis without mention of obstruction
57431	Calculus of bile duct with acute cholecystitis, with obstruction
57440	Calculus of bile duct with other cholecystitis, without mention of obstruction
57441	Calculus of bile duct with other cholecystitis, with obstruction
57450	alculus of bile duct without mention of cholecystitis, without mention of obstruction
5770	Acute pancreatitis
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis
58281	Chronic glomerulonephritis in diseases classified elsewhere
58289	Other chronic glomerulonephritis with specified pathological lesion in kidney
5829	Chronic glomerulonephritis with unspecified pathological lesion in kidney
586	Renal failure, unspecified
66800	Pulmonary complications of anesthesia or other sedation in labor and delivery, unspecified as to episode of care
66801	Pulmonary complications of anesthesia or other sedation in labor and delivery, delivered

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Diagnosis Code	Description
66802	Pulmonary complications of anesthesia or other sedation in labor and delivery, delivered, with mention of postpartum complication
66803	Pulmonary complications of anesthesia or other sedation in labor and delivery, antepartum
66804	Pulmonary complications of anesthesia or other sedation in labor and delivery, postpartum
66810	Cardiac complications of anesthesia or other sedation in labor and delivery, unspecified as to episode of care
66811	Cardiac complications of anesthesia or other sedation in labor and delivery, delivered
66812	Cardiac complications of anesthesia or other sedation in labor and delivery, delivered, with mention of postpartum complication
66813	Cardiac complications of anesthesia or other sedation in labor and delivery, antepartum
66814	Cardiac complications of anesthesia or other sedation in labor and delivery, postpartum
7450	Common truncus
74510	Complete transposition of great vessels
74511	Double outlet right ventricle
74512	Corrected transposition of great vessels
74519	Other transposition of great vessels
7452	Tetralogy of fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
74560	Endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other endocardial cushion defects
7457	Cor biloculare
7458	Other bulbus cordis anomalies and anomalies of cardiac septal closure
7459	Unspecified defect of septal closure
74600	Congenital pulmonary valve anomaly, unspecified

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Diagnosis Code	Description
74601	Atresia of pulmonary valve, congenital
74602	Stenosis of pulmonary valve, congenital
74609	Other congenital anomalies of pulmonary valve
7461	Tricuspid atresia and stenosis, congenital
7462	Ebstein's anomaly
7463	Congenital stenosis of aortic valve
7464	Congenital insufficiency of aortic valve
7465	Congenital mitral stenosis
7466	Congenital mitral insufficiency
7467	Hypoplastic left heart syndrome
74681	Subaortic stenosis, congenital
74682	Cor triatriatum
74683	Infundibular pulmonic stenosis, congenital
74684	Congenital obstructive anomalies of heart, not elsewhere classified
74685	Coronary artery anomaly, congenital
74686	Congenital heart bloc
74687	Malposition of heart and cardiac apex
74689	Other specified congenital anomalies of heart
7469	Unspecified congenital anomaly of heart
7470	Patent ductus arteriosus
74710	Coarctation of aorta (preductal) (postductal)
74711	Interruption of aortic arch
74720	Congenital anomaly of aorta, unspecified
74721	Congenital anomalies of aortic arch
74722	Congenital atresia and stenosis of aorta
74729	Other congenital anomalies of aorta
7473	Congenital anomalies of pulmonary artery
74740	Congenital anomaly of great veins, unspecified
74741	Total anomalous pulmonary venous connection
74742	Partial anomalous pulmonary venous connection

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Diagnosis Code	Description
74749	Other anomalies of great veins
7483	Other congenital anomalies of larynx, trachea, and bronchus
7484	Congenital cystic lung
7485	Congenital agenesis, hypoplasia, and dysplasia of lung
74860	Congenital anomaly of lung, unspecified
74861	Congenital bronchiectasis
74869	Other congenital anomalies of lung
7488	Other specified congenital anomalies of respiratory system
7489	Unspecified congenital anomaly of respiratory system
7503	Congenital tracheoesophageal fistula, esophageal atresia and stenosis
7504	Other specified congenital anomalies of esophagus
7562	Cervical rib
7563	Other congenital anomalies of ribs and sternum
7566	Congenital anomalies of diaphragm
7682	Fetal distress before onset of labor, in liveborn infant
7683	Fetal distress first noted during labor, in liveborn infant
7684	Fetal distress, unspecified as to time of onset, in liveborn infant
7685	Severe birth asphyxia
7686	Mild or moderate birth asphyxia
7689	Unspecified severity of birth asphyxia in liveborn infant
769	Respiratory distress syndrome in newborn
7700	Congenital pneumonia
77010	Fetal and newborn aspiration, unspecified
77011	Meconium aspiration without respiratory symptoms
77012	Meconium aspiration with respiratory symptoms
77013	Aspiration of clear amniotic fluid without respiratory symptoms
77014	Aspiration of clear amniotic fluid with respiratory symptoms
77015	Aspiration of blood without respiratory symptoms

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Diagnosis Code	Description
77016	Aspiration of blood with respiratory symptoms
77017	Other fetal and newborn aspiration without respiratory symptoms
77018	Other fetal and newborn aspiration with respiratory symptoms
7702	Interstitial emphysema and related conditions of newborn
7703	Pulmonary hemorrhage of fetus or newborn
7704	Primary atelectasis of newborn
7705	Other and unspecified atelectasis of newborn
7706	Transitory tachypnea of newborn
7707	Chronic respiratory disease arising in the perinatal period
77081	Primary apnea of newborn
77082	Other apnea of newborn
77083	Cyanotic attacks of newborn
77084	Respiratory failure of newborn
77085	Aspiration of postnatal stomach contents without respiratory symptoms
77086	Aspiration of postnatal stomach contents with respiratory symptoms
77089	Other respiratory problems after birth
7709	Unspecified respiratory condition of fetus and newborn
78001	Coma
78002	Transient alteration of awareness
78009	Alteration of consciousness, other
7802	Syncope and collapse
78031*	Febrile convulsions (simple), unspecified
78039*	Other convulsions
78057	Unspecified sleep apnea
7806	Fever
78071	Chronic fatigue syndrome
78079	Other malaise and fatigue
7808	Generalized hyperhidrosis
7825	Cyanosis
7852	Undiagnosed cardiac murmurs
78600	Respiratory abnormality, unspecified
78601	Hyperventilation
78602	Orthopnea

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Diagnosis Code	Description
78603	Apnea
78604	Cheyne-Stokes respiration
78605	Shortness of breath
78606	Tachypnea
78607	Wheezing
78609	Other
7861	Stridor
7862	Cough
7863	Hemoptysis
7864	Abnormal sputum
78650	Unspecified chest pain
78651	Precordial pain
78652	Painful respiration
78659	Other chest pain
7866	Swelling, mass, or lump in chest
7867	Abnormal chest sounds
7868	Hiccough
7869	Other symptoms involving respiratory system and chest
78900*	Abdominal pain, unspecified site
7931	Nonspecific abnormal findings on radiological and other examination of lung field
7932	Nonspecific abnormal findings on radiological and other examination of other intrathoracic organs
7942	Nonspecific abnormal results of function study of pulmonary system
79430	Unspecified abnormal function study of cardiovascular system
79431	Nonspecific abnormal electrocardiogram (ECG) (EKG)
79439	Other nonspecific abnormal function study of cardiovascular system
7955	Shock without mention of trauma
79901	Asphyxia
79902	Hypoxemia
7991	Respiratory arrest
80700	Closed fracture of rib(s), unspecified
80701	Closed fracture of one rib
80702	Closed fracture of two ribs
80703	Closed fracture of three ribs
80704	Closed fracture of four ribs
80705	Closed fracture of five ribs
80706	Closed fracture of six ribs

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Diagnosis Code	Description
80707	Closed fracture of seven ribs
80708	Closed fracture of eight or more ribs
80709	Closed fracture of multiple ribs, unspecified
80710	Open fracture of rib(s), unspecified
80711	Open fracture of one rib
80712	Open fracture of two ribs
80713	Open fracture of three ribs
80714	Open fracture of four rib
80715	Open fracture of five ribs
80716	Open fracture of six ribs
80717	Open fracture of seven ribs
80718	Open fracture of eight or more ribs
80719	Open fracture of multiple ribs, unspecified
8072	Closed fracture of sternum
8073	Open fracture of sternum
8074	Flail chest
8075	Closed fracture of larynx and trachea
8076	Open fracture of larynx and trachea
81000	Closed fracture of clavicle, unspecified part
81001	Closed fracture of sternal end of clavicle
81002	Closed fracture of shaft of clavicle
81003	Closed fracture of acromial end of clavicle
81010	Open fracture of clavicle, unspecified part
81011	Open fracture of sternal end of clavicle
81012	Open fracture of shaft of clavicle
81013	Open fracture of acromial end of clavicle
8185	Pulmonary insufficiency following trauma and surgery
83130	Unspecified injury of lung with open wound into thorax
8600	Traumatic pneumothorax without mention of open wound into thorax
8601	Traumatic pneumothorax with open wound into thorax
8602	Traumatic hemothorax without mention of open wound into thorax
8603	Traumatic hemothorax with open wound into thorax

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Diagnosis Code	Description
8604	Traumatic pneumohemothorax without mention of open wound into thorax
8605	Traumatic pneumohemothorax with open wound into thorax
86100	Unspecified injury of heart without mention of open wound into thorax
86101	Contusion of heart without mention of open wound into thorax
86102	Laceration of heart without penetration of heart chambers or open wound into thorax
86103	Laceration of heart with penetration of heart chambers, without mention of open wound into thorax
86110	Unspecified injury of heart with open wound into thorax
86111	Contusion of heart with open wound into thorax
86112	Laceration of heart without penetration of heart chambers, with open wound into thorax
86113	Laceration of heart with penetration of heart chambers and open wound into thorax
86120	Unspecified injury of lung without open wound into thorax
86121	Contusion of lung without open wound into thorax
86122	Laceration of lung without open wound into thorax
86130	Unspecified injury of lung with open wound into thorax
86131	Contusion of lung with open wound into thorax
86132	Laceration of lung with open wound into thorax
8620	Injury to diaphragm without mention of open wound into cavity
8621	Injury to diaphragm with open wound into cavity
86221	Injury to bronchus without open wound into cavity
86222	Injury to esophagus without mention of open wound into cavity
86229	Injury to other specified intrathoracic organs without mention of open wound into cavity
86231	Injury to bronchus with open wound into cavity

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
86232	Injury to esophagus with open wound into cavity
86239	Injury to other specified intrathoracic organs with open wound into cavity
8628	Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity
8629	Injury to multiple and unspecified intrathoracic organs with open wound into cavity
8750	Open wound of chest (wall), without mention of complication
8751	Open wound of chest (wall), complicated
9192	Mediastinitis
9221	Contusion of chest wall
9228	Contusion of multiple sites of trunk
9248*	Contusion of multiple sites, not elsewhere classified
9340	Foreign body in trachea
9341	Foreign body in main bronchus
9348	Foreign body in other specified parts bronchus and lung
9349	Foreign body in respiratory tree, unspecified
9351	Foreign body in esophagus
9352	Foreign body in stomach
938	Foreign body in digestive system, unspecified
94100	Burn of unspecified degree of unspecified site of face and head
94101	Burn of unspecified degree of ear (any part)
94102	Burn of unspecified degree of eye (with other parts of face, head, and neck)
94103	Burn of unspecified degree of lip(s)
94104	Burn of unspecified degree of chin
94105	Burn of unspecified degree of nose (septum)
94106	Burn of unspecified degree of scalp (any part)
94107	Burn of unspecified degree of forehead and cheek
94108	Burn of unspecified degree of neck
94109	Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
94110	Erythema due to burn (first degree) of unspecified site of face and head
94111	Erythema due to burn (first degree) of ear (any part)
94112	Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
94113	Erythema due to burn (first degree) of lip(s)
94114	Erythema due to burn (first degree) of chin
94115	Erythema due to burn (first degree) of nose (septum)
94116	Erythema due to burn (first degree) of scalp (any part)
94117	Erythema due to burn (first degree) of forehead and cheek
94118	Erythema due to burn (first degree) of neck
94119	Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck
94120	Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site
94121	Blisters, with epidermal loss due to burn (second degree) of ear (any part)
94122	Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck
94123	Blisters, with epidermal loss due to burn (second degree) of lip(s)
94124	Blisters, with epidermal loss due to burn (second degree) of chin
94125	Blisters, with epidermal loss due to burn (second degree) of nose (septum)
94126	Blisters, with epidermal loss due to burn (second degree) of scalp (any part)
94127	Blisters, with epidermal loss due to burn (second degree) of forehead and cheek
94128	Blisters, with epidermal loss due to burn (second degree) of neck
94129	Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
94130	Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
94131	Full-thickness skin loss due to burn (third degree NOS) of ear (any part
94132	Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
94133	Full-thickness skin loss due to burn (third degree NOS) of lip(s)
94134	Full-thickness skin loss due to burn (third degree NOS) of chin
94135	Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
94136	Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
94137	Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
94138	Full-thickness skin loss due to burn (third degree NOS) of neck
94139	Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck
94140	Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part
94141	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear
94142	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part
94143	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)
94144	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin
94145	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
94146	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp
94147	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek
94148	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck
94149	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part
94150	Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part
94151	Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear
94152	Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part
94153	Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)
94154	Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin
94155	Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose
94156	Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp
94157	Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek
94158	Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck
94159	Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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Diagnosis Code	Description
9470	Burn of mouth and pharynx
9471	Burn of larynx, trachea, and lung
9472	Burn of esophagus
9473	Burn of gastrointestinal tract
9591	Other and unspecified injury to trunk
9598*	Other and unspecified injury to other specified
9651	Poisoning by salicylates
9711	Poisoning by parasympatholytics (anticholinergics and antimuscar-inics) and spasmolytics
9941	Drowning and nonfatal submersion
99550	Unspecified child abuse
99551	Child emotional/psychological abuse
99552	Child neglect (nutritional)
99553	Child sexual abuse
99554	Child physical abuse
99555	Shaken baby syndrome
99559	Other child abuse and neglect
99560	Anaphylactic shock due to unspec-ified food
99561	Anaphylactic shock due to peanuts
99562	Anaphylactic shock due to crustaceans
99563	Anaphylactic shock due to fruits and vegetables
99564	Anaphylactic shock due to tree nuts and seeds
99565	Anaphylactic shock due to fish
99566	Anaphylactic shock due to food additives
99567	Anaphylactic shock due to milk products
99568	Anaphylactic shock due to eggs
99569	Anaphylactic shock due to other specified food
9957	Other adverse food reactions, not elsewhere classified
99580	Unspecified adult maltreatment
99581	Adult physical abuse
99673	Other complications due to renal dialysis device, implant, and graft
9971	Cardiac complications, not elsewhere classified
9973	Respiratory complications, not elsewhere classified

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

Diagnosis Code	Description
9991	Air embolism as a complication of medical care, not elsewhere classified
V011	Contact with or exposure to tuberculosis
V103	Personal history of malignant neoplasm of breast
V420	Kidney replaced by transplant
V421	Heart replaced by transplant
V422	Heart valve replaced by transplant
V433	Heart valve replaced by other means
V451	Postsurgical renal dialysis status
V4581	Postsurgical aortocoronary bypass status
V460	Dependence on aspirator
V560	Aftercare involving extracorporeal dialysis
V568	Aftercare involving other dialysis
V711	Observation for suspected malignant neoplasm
V712	Observation for suspected tuberculosis
V760	Special screening for malignant neoplasms of the respiratory organ
V7610	Breast screening, unspecified

***Claims for clients 12 years of age and older may be appealed with documentation of medical necessity.**

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36.4.41.3 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms
- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and address or nine-digit provider identifier in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to the Texas Medicaid Program, baseline screening and/or comparison studies are not a benefit.

36.4.41.4 Contrast Materials/Radiopharmaceuticals

Reimbursement for radiological procedures, such as magnetic resonance imaging (MRI) or computed tomography (CT), with descriptions that specify "with contrast," include payment for high osmolar, low osmolar contrast material (LOCM) and paramagnetic contrast materials. These contrast materials will not be reimbursed separately.

Radiopharmaceuticals used for therapeutic treatment may be considered for separate reimbursement.

The following procedure codes may be billed for therapeutic radiopharmaceuticals:

Procedure Codes		
6/I/T-79403	9-A9517	9-A9532
9-A9543	9-A9545	9-A9699

36.4.41.5 Magnetic Resonance Angiography (MRA)

MRA is a technique that allows noninvasive visualization and study of blood vessels through either two- or three-dimensional image reconstruction. Although MRA in the study of the blood vessels of the heart, lungs, abdomen, pelvis, spine, and extremities is continuing to develop, it is most advanced in the evaluation of cerebrovascular disease especially in the assessment of arterial occlusive disease in patients at risk of stroke.

Refer to: Section 39, "Radiological and Physiological Laboratory and Portable X-Ray Supplier" on page 39-1, for authorization requirements.

MRA of the Head and Neck

Effective for dates of service on or after November 1, 2005, MRAs of the head, neck, and lower extremities will no longer have diagnosis restrictions for the Texas Medicaid Program.

MRAs of the chest, abdomen, and pelvis (procedure codes 4/I/T-70544, 4/I/T-70545, 4/I/T-70546, 4/I/T-70547, 4/I/T-70548, and 4/I/T-70549) may be reimbursed as a benefit of the Texas Medicaid Program.

MRA of Other Areas

The following MRA studies (with contrast materials) are a benefit of the Texas Medicaid Program:

MRA Studies	
4/I/T-71555	4/I/T-72159
4/I/T-72198	4/I/T-73225
4/I/T- 73725	4/I/T-74185

Refer to: The CPT and ICD-9-CM manuals for code descriptions.

36.4.41.6 Magnetic Resonance Imaging (MRI)

MRIs are reimbursed by the Texas Medicaid Program when medically necessary.

MRI procedures that specify *with contrast* include payment for para-magnetic contrast; therefore, LOCM is not reimbursed separately.

When an MRI and a CAT scan of the *same body area* are performed on the same day, the CAT scan is paid and the MRI is denied as part of an overlapping diagnostic procedure. Additional MRIs and/or CAT scans of *entirely different body areas* performed on the same day are paid with documentation of medical necessity.

A freestanding MRI facility may bill using the modifier TC for the technical portion only. The radiologist or neurologist who reads the MRI may bill using the modifier 26 for interpretation only whether the client is in the inpatient or outpatient setting.

Refer to: Section 39, "Radiological and Physiological Laboratory and Portable X-Ray Supplier" on page 39-1, for authorization requirements.

36.4.41.7 Technetium TC 99M-Tetrofosmin

Procedure code 9-A9502 is a benefit, without age restriction. It is payable in the office, inpatient, and outpatient settings.

Payable providers include:

- Physicians
- Radiation treatment centers
- Inpatient/outpatient hospitals

Inpatient settings are reimbursed under their DRG. Outpatient hospitals are reimbursed at their reimbursement rate. Physician offices and radiation treatment centers are reimbursed at a maximum fee of $112.46.

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36.4.42 Reduction Mammoplasties

Procedure code 2/8/F-19318 is the removal of breast tissue and is a benefit of the Texas Medicaid Program when prior authorized. At least one of the following criteria must be met:

- Evidence of a restrictive pulmonary defect
- Evidence of severe neck and/or back pain with incapacitation from the pain
- Evidence of ulnar pain/paresthesia from thoracic nerve root compression

In addition to the above criteria, documentation must indicate:

- A minimum of 500 grams of tissue is expected to be removed from each breast
- The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer

The following services are *not* a benefit of the Texas Medicaid Program:

- Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size)
- Reduction mammaplasty for gynecomastia (enlargement of breast tissue in the male)
- Augmentation mammaplasty to increase breast size

For prior authorization of reduction mammaplasty, the following documentation must be submitted:

- Referring letter from the client's primary care physician
- Completed Medicaid Certificate of Medical Necessity for Reduction Mammaplasty form, signed and dated by the physician (see "Medicaid Certificate of Medical Necessity for Reduction Mammaplasty" on page B-58.)
- Relevant documentation of the client's medical condition, including summaries of:
    - Pulmonary function studies
    - Failed treatments for neck/back/ulnar pain
    - Results of a weight reduction program with the amount of weight lost
- Preoperative photographs (front and lateral views)
- The estimated amount of tissue to be removed from each breast

The physician is required to maintain the following documentation in the client's clinical records:

- A complete history and physical
- Pulmonary function studies results
- Past treatments, therapies, and outcomes for pain control and weight reduction

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

Procedure code 2/8/F-19318 is to be used to bill for reduction mammaplasty.

When submitting for prior authorization, requests *must* be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty for traditional Medicaid and PCCM clients to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax 1-512-514-4213

36.4.43 Renal Disease

36.4.43.1 Cytogam

Procedure code 1-J0850 is reimbursable by the Texas Medicaid Program. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code V420, Status post kidney transplant. Cytogam is payable in POS 1 (office) and POS 5 (outpatient facility) only.

Refer to: "Organ/Tissue Transplant Services" on page 25-10 for information on kidney transplants.

36.4.43.2 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all places of service except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

Physician Supervision of Dialysis Patients

Use procedure codes 1-90918, 1-90919, 1-90920, 1-90921, 1-90922, 1-90923, 1-90924, or 1-90925 when billing for physician supervision for outpatient dialysis regardless of POS. The procedure codes should be billed as follows:

- When a full month of supervision has been provided, use procedure codes 1-90918, 1-90919, 1-90920, or 1-90921. The date of service must reflect the first day of the month that supervision was provided and the quantity is 1.
- When supervision is for less than a full month (for example, the patient is hospitalized or is out of the area), use procedure codes 1-90922, 1-90923, 1-90924, or 1-90925. This code represents a per day

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charge used to bill the supervision when a full month is not provided. The dates of service must indicate each day that supervision was provided and the quantity must be the same as the number of days listed for the month.

- Physician services during a dialysis session including supervisory services to the patient in connection with complicated and uncomplicated session (such as routine predialysis examination and physician attendance during a dialysis treatment where the patient has a serious ailment such as pulmonary edema).
- Office visits for the routine evaluation of patient progress, or for treatment of renal disease complications including evaluation of diagnostic tests and procedures.
- All physician services rendered by the attending physician in the course of office visits where the primary purpose is either the routine monitoring or the follow-up of complications of dialysis; follow up of complications includes services involved in prescribing therapy for illnesses unrelated to renal disease if the treatment occurs without increasing the number of physician-patient contacts beyond those occurring at dialysis, regular monitoring sessions, or visits for treatment of renal complications.

The following services may be provided in conjunction with dialysis but are considered nonroutine and may be billed separately:

- Declotting of shunts.
- *Physician services to inpatients.* The physician should bill procedure codes 1-90922, 1-90923, 1-90924, or 1-90925 for each date of outpatient supervision and bill the appropriate hospital E/M code for individual services provided on the hospitalized days.
- *Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP.* The physician must bill procedure codes 1-90922, 1-90923, 1-90924, or 1-90925 for each date supervision is provided. The physician may not bill for days that the patient dialyzed elsewhere.
- *Physician services beyond those that are related to the treatment of the patient's renal condition that cause the number of physician-patient contacts to increase.* 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.

Procedure Code	TMRM Payable (RVUs X Conversion Factor)
1-90918	$329.77
1-90919	$257.76
1-90920	$223.12
1-90921	$146.74
1-90922	$4.91
1-90923	$9.82
1-90924	$8.73
1-90925	$6.27

Use the following procedure codes for inpatient dialysis services when the physician is present during dialysis treatment. The nephrologist must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the nephrologist; hospital visit codes must be used for a cursory visit.

The following procedure codes are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician should bill the appropriate hospital visit code. The inpatient dialysis code should not be submitted for payment.

Hospital Evaluation and Management Codes

Procedure Codes		
1-90935	1-90937	1-90945
1-90947		

36.4.43.3 Epoetin Alfa (Erythropoietin; EPO)

EPO is a glycoprotein that stimulates red blood cell formation and production of the precursor red blood cells of bone marrow. EPO is indicated for anemia associated with chronic renal failure, including patients on dialysis (ESRD) and patients not on dialysis. In chronic ESRD patients, the increased BUN impairs the production of erythropoietin, leading to a chronic anemia.

EPO procedure codes used to bill for treatment of anemia associated with ESRD patients receiving dialysis are for a quantity of 1 for every 1,000 units. The exact dose should be stated on the claim.

Example: *If a client has an HCT of 34 percent with a diagnosis of ESRD and is given 5,000 units of EPO, bill a quantity of 5 with procedure code 1-J0886.*

EPO is limited to three injections per calendar week (Sunday through Saturday).

EPO is payable in the following places of service:

POS	Description
1	Office
2	Home
5	Outpatient hospital

36.4.43.4 Laboratory Services for Dialysis Patients

The Texas Medicaid Program provides reimbursement for laboratory services performed for dialysis patients.

Charges for *routine laboratory services* performed according to the established frequencies listed under "Laboratory and Radiology Services" on page 37-4 are included in the facility's dialysis charge billed to Medicaid

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regardless of where the tests were performed. Routine laboratory services performed by an outside laboratory are billed to the facility.

Nonroutine laboratory services for people dialyzing in a facility and all laboratory work for people on continuous ambulatory peritoneal dialysis (CAPD) may be billed separately from the dialysis charge.

36.4.43.5 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient's training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 1-90989 and 1-90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, procedure code 1-90989 is billed. Providers are to use modifier AT when using this procedure code.The date of service indicates the date training was completed, and the quantity is 1. The reimbursement is $507.50.
- When dialysis training is not completed, bill procedure code 1-90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided. The reimbursement is $380.63.

The amount of reimbursement of subsequent training is determined by prorating the physician's payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients
- Review of family and home status and environment, and counseling and training of family members
- Review of training progress

Initial Training

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications
- General support services (for example, arranging for supplies)

Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client's treatment machine to one the client had not been trained to use in the initial training course
- A change in setting
- A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of the Texas Medicaid Program, including the lease or purchase of dialysis machines and disposable supply kits.

36.4.44 Respiratory Care for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 1-94656 and 1-94657.

Use the ventilation assist and management subsequent code (1-94657) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

Procedure codes 1-94656 and 1-94657 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, initiation or maintenance of intravenous therapy or infusions, parenteral nutrition or hyperalimentation; arterial or venous punctures; interpretations of arterial blood gases; pulmonary function tests and management of the hemodynamic functions of the patient; intensive care visits; subsequent hospital visits; or any other hospital visit).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing–first day (1-94656) when respiratory support must be established for a patient. It is a *one-time charge* per hospitalization that may be paid under the following circumstances:

- The first day of ventilation assist and management when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (1-94657).
- When no anesthetic and/or major surgery is billed on the same day by the same provider. If major surgery is apparent, change initial ventilatory support (1-94656) to the subsequent day ventilatory support (1-94657).

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36.4.45 Speech-Language Therapy

Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. The assessments are usually performed before the initiation of speech therapy. Bill using procedure code 1-92506.

Procedure code 1-92506 is payable only once per six months, any payable speech therapy provider, same facility. Procedure code 1-92506 with modifier U4 as defined by each state (Reassessment), may be used for re-evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status, is payable once per month, any payable speech therapy provider, same facility. Procedure codes 1-92507 and 1-92508 are not payable on the same day as a speech evaluation or re-evaluation.

Speech-language pathology therapy is reimbursed only for acute or subacute pathological or traumatic conditions of the head or neck that would affect speech production. For clients younger than 21 years of age, therapy not covered by the Texas Medicaid Program is available through THSteps-CCP with documentation of the medical necessity/appropriateness.

To be covered under the Texas Medicaid Program, speech-language therapy must be prescribed by a physician, provided as an inpatient or outpatient hospital service, and billed by the hospital, or prescribed by a physician performed by or under the physician's personal supervision, and billed by the physician.

The therapy may be performed by either a speech-language pathologist or audiologist if they are on staff at the hospital or under the personal supervision of a physician. Speech evaluations and speech-language therapy billed directly by an independently practicing speech-language pathologist or audiologist are payable under THSteps-CCP to children younger than 21 years of age and eligible for Medicaid.

Use procedure code 1-92507 or 1-92508 for each half-hour session. If the claim does not state the amount of time spent on the session, a quantity of 1 is paid. Speech-language pathology sessions are limited to one hour per day.

Evaluation and treatment of swallowing and oral function for feeding is a benefit of the Texas Medicaid Program:

- For clients 0 to 21 years of age, the services are reimbursed through THSteps-CCP.
- For clients 21 years of age and older, the services are reimbursed through the traditional Medicaid program and must be limited to acute conditions or exacerbations of chronic conditions. The modifier AT must be used to indicate the necessity of an acute condition, and it must appear on the claim.
- For clients 21 years of age and older, the services must be either:
  - Prescribed by a physician, provided as an outpatient hospital service, and billed by the hospital.
  - Prescribed by a physician, performed by the physician or under the physician's personal supervision, and billed by the physician.
- The service is considered included in the DRG when provided in an inpatient and rehabilitation facility.

Procedure Codes	
1-92526	1-92610

Refer to: "Speech-Language Pathologists (THSteps-CCP Only)" on page 43-78.

36.4.45.1 Speech Therapy and Aural Rehabilitation Post Cochlear Implant

Cochlear implants are reimbursable for clients 18 months of age and older. Reimbursement for speech therapy and aural rehabilitation is made separately from the surgical fee for cochlear implants.

For clients 18 months to 21 years of age, speech therapy and aural rehabilitation are reimbursed through THSteps-CCP.

For clients 21 years of age and older, speech therapy and aural rehabilitation are reimbursed through the traditional Medicaid program when billed by the hospital or the physician. The traditional Medicaid program reimburses a maximum of 12 visits within a six-month period. Payment for speech therapy (1-92507) is included as part of the cochlear implant procedure (2-69930).

The speech therapy and aural rehabilitation should be prescribed by a physician, provided as an outpatient hospital service and billed by the hospital, or prescribed by a physician, performed by or under their personal supervision, and billed by the physician.

The service is considered included in the DRG when provided in an inpatient facility and rehabilitation setting.

Speech evaluations and speech therapy billed directly by an independently practicing speech pathologist or audiologist autodeny and are considered on appeal only by the TMHP Medical Director.

36.4.46 Surgeons and Surgery

36.4.46.1 Primary Surgery

A primary surgeon is reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.

If the same physician bills a surgical fee for one procedure (TOS 2) and an assistant surgeon's fee for the second procedure (TOS 8) on the same day, full allowed reimbursement is paid for the TOS 2 procedure and half the allowed reimbursement is paid for the TOS 8 procedure.

Regarding cosurgery, if a procedure code is not payable to an assistant surgeon (TOS 8), it is only payable to a primary surgeon (TOS 2).

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36.4.46.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. An exception to this policy is an epidural during labor and delivery.

Refer to: "Anesthesia" on page 36-24 for more information.

36.4.46.3 Assistant Surgeon

Assistant surgeons are reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. One of the following situations must be present and documented on the claim:

- No qualified resident was available (modifier 82 may be used to document this exception).
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).
- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is *recommended* that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 claim form the name and address *or* nine-digit provider identifier of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

> "I understand that section 1842(b)(6)(D) of the *Social Security Act* generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP."

A surgeon billing for a surgery and an assistant surgery fee on the same day (for the same client) may be reimbursed if two separate procedures are performed. Full payment is allowed for the surgery and the assisted surgical procedure is paid at half the allowed amount (16 percent of the TMRM fee for the surgical procedure performed).

Surgical procedures that do not ordinarily require the services of an assistant are denied when billed with a TOS 8 (assistant surgery). Procedures identified by Medicare as noncovered assisted surgical procedures are denied. One assistant surgeon is reimbursed for surgical procedures when appropriate. Two assistant surgeons are allowed for liver transplant surgery only.

Assistant surgeons must have the client's Medicaid number and when required the prior authorization number for claims payment. TMHP recommends that the surgeon provides this information to the assistant surgeon as soon as possible.

Physicians billing for assistant surgery on electronic and paper claims must include a facility provider identifier. When billing for assistant services, providers should bill with TOS 8, not TOS 2. The use of the TOS 2 with modifier 80 is paid incorrectly and is subject to recoupment.

PAs functioning as an assistant during surgery should be billed on the same claim as the surgery. Supervising physicians as defined by the Texas Medical Board bill Medicaid for services performed by the PA they supervise. Use modifier AS for assistant at surgery services rendered by the PA. The claim must include the PA's name and license number. Only procedures currently allowed for assistant surgeons are payable.

36.4.46.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

Procedure Code	Modifier
2/F-29405	LT
2/F-29405	RT

36.4.46.5 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

36.4.46.6 Capsulotomy

A capsulotomy is the incision of the fibrous tissues surrounding a joint. This procedure is considered part of the joint surgery.

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If a surgeon bills separate charges for a capsulotomy and another joint surgery on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

If a capsulotomy is billed alone, use the appropriate capsulotomy procedure code.

36.4.46.7 Cosurgery

Cosurgery (two surgeons) is reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons' separate contributions to the successful outcome of the procedure are considered to be of equal importance. Prior authorization is no longer required, nor will it be issued for cosurgery.

Note: *No additional reimbursement will be made for an assistant surgeon.*

When billing for services provided during a cosurgery, each surgeon (usually of different specialties) must bill using the same CPT code(s), along with CPT modifier 62, To be used when two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure. Each surgeon is reimbursed 58 percent of the highest paying procedure and 29 percent of each secondary procedure. No cosurgery payment is made for claims submitted without CPT modifier 62. In instances where the surgeons do not use CPT modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

36.4.46.8 Global Fees

The Texas Medicaid Program reimburses surgeons, assistant surgeons, and anesthesiologists based on a global fee concept. The global fee concept means that the fee paid for the surgical procedure includes *varying* preoperative and postoperative care based on the complexity of the procedure.

No distinction is made between emergency and nonemergency procedures because the required package of services is the same.

Surgical procedures are reimbursed as a comprehensive global fee for the performance of the procedure. The method of accomplishing the surgical procedure is the election of the surgeon, who may elect to incorporate new technology in the procedure because it offers advantages. However, the global fee remains the fee for the procedure, with additional payment not afforded because of surgeon preference as to the technology selected for completion of the procedure. Separate charges for the use of special equipment or other modifications during surgery are denied.

Important: *Consultations or visits denied within the pre-care of a surgery may be considered an appeal with documentation establishing the medical necessity for exceeding the global surgical fee limitations.*

The reimbursement for minor surgeries (for example, elbow arthroscopy, conjunctiva biopsy) include all routine care related to the surgery three days preoperatively and seven days postoperatively.

Major surgeries (for example, gastrostomy, hysterectomy, and cataract extraction) include all routine care pertaining to the surgery three days preoperatively including admissions and consultations and all routine postoperative care for six weeks in any POS.

Extensive surgical procedures (for example, total hip replacement) include all routine care related to the surgical procedure three days preoperatively and for a period of 180 days postoperatively regardless of the POS of the pre and postoperative procedures.

Simple diagnostic (for example, paracentesis) and minor surgical procedures (for example, repair of a superficial wound up to 2.5 cm) do not include any preoperative or postoperative care restrictions. If the procedure is performed in an inpatient hospital setting, a visit is not paid on the same day. If the procedure is performed in the office or home, visits are reimbursed in addition to the surgical procedure.

Postoperative complications necessitating readmission to the hospital during the postoperative package of service (that exceeds 72 hours of observation for a complication of the surgical procedure) may be reimbursed outside the package of service on appeal to the TMHP Medical Director. Documentation of the medical appropriateness of the protracted medical stay is required with submission of the appeal.

All supplies (trays, dressings, casting and splinting supplies, and local anesthetics) are considered part of the surgical procedure and should not be billed separately to Medicaid or the client.

Refer to: "Paper Appeals" on page 6-3 for information about submitting appeals.

36.4.46.9 Global Surgery Concurrent Care

Medicaid reimbursement for surgical procedures is based on the concept of a global fee for a package of services related to the surgical procedure. This package of services includes all preoperative and postoperative care. In situations where a single physician/surgeon does not provide the package of services, the following steps must be followed to ensure the accurate processing and reimbursement of services:

1) The preoperative care provided by the surgeon/anesthesiologist should not be billed separately because it is included in the reimbursement for the surgical procedure.
2) Surgeons who do not provide the postoperative care for a patient *must* bill the surgery code with modifier 54. This modifier allows reimbursement of the surgeon at 80 percent of the performing provider's allowed amount.
3) The physician who provides the postoperative care *without* having performed the surgery may bill the appropriate visit code but must use CPT modifier 55.

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CPT modifier 55 indicates that the physician did not perform the surgery and is only providing the preoperative or postoperative care.

4) Routine postoperative anesthesiology care by the anesthesiologist is included in the package of services by the anesthesiologist.

36.4.46.10 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
  - Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
  - Procedure code 2/8-58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
  - When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

36.4.46.11 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician's office). The medical necessity and/or special circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment.

Excision benign lesions	Excision malignant lesions	Manipulation (urethral)
2-11400	2-11600	2-53600
2-11401	2-11601	2-53601
2-11402	2-11602	2-53620
2-11403	2-11603	2-53621
2-11404	2-11604	2-53660
2-11420	2-11620	2-53661
2-11421	2-11621	
2-11422	2-11622	
2-11423	2-11623	
2-11440	2-11624	
2-11441	2-11640	
2-11442	2-11641	
2-11443	2-11642	
2-11444	2-11643	
	2-11644	
Simple repairs	**Endoscopy**	**Biopsy (tongue)**
2-28010	2-31505	2-41100
2-28011		
Lesions (penile)	**Lesions (eyelid)**	
2-54060	2-67801	

36.4.46.12 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon's global fee or the facility's payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post-operative care period.

36.4.46.13 Second Opinions

Texas Medicaid Program benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim should be coded with the appropriate office or hospital visit codes, and the notation "Client Initiated Second Opinion" should be identified in Block 24C of the CMS-1500 claim form.

Refer to: "Consultations" on page 36-11.

36.4.46.14 Team Surgery

Team surgery is no longer reimbursed by the Texas Medicaid Program. Surgeons and assistant surgeons participating in a team surgery procedure should bill for the procedure(s) personally performed and are reimbursed based on the multiple surgery guidelines.

In instances where one surgeon performs the approach procedure, another surgeon performs the definitive procedure, and another surgeon performs the recon-

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struction/repair procedure, each surgeon reports only the code for the specific procedure performed. Each procedure is reimbursed at full allowance.

Refer to: "Assistant Surgeon" on page 36-328.
"Multiple Surgeries" on page 36-330 for more information.

36.4.47 Suture of Wounds

Wounds are defined as a break or laceration of soft parts of body structures (i.e., skin) caused by violence or trauma to tissues. Wounds occur to all parts of the body and can be caused by accidents or under aseptic conditions, such as a surgical incision. The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures. Wound closures may use sutures, staples, and/or wound adhesives.

Wound closures should be billed using the following procedure codes:

Procedure Codes		
Repair Simple		
2-12001	2-12002	2-12004
2/F-12005	2/F-12006	2/F-12007
2-12011	2-12013	2-12014
2-12015	2/F-12016	2/F-12017
2/8/F-12018	2/F-12020	2/F-12021
Repair Intermediate		
2/F-12031	2/F-12032	2/F-12034
2/F-12035	2/F-12036	2/8/F-12037
2/F-12041	2/F-12042	2/F-12044
2/F-12045	2/F-12046	2/F-12047
2-12051	2-12052	2-12053
2/F-12054	2/F-12055	2/F-12056
2/8/F-12057		
Repair Complex		
2/F-13100	2/F-13101	2/8/F-13102
2/F-13120	2/F-13121	2/8/F-13122
2/F-13131	2/F-13132	2/8/F-13133
2/F-13150	2/F-13151	2/F-13152
2/8/F-13153	2/F-13160	

Multiple wounds on the same day will be paid the full-allowed amount for the major (largest) wound and one-half the allowed amount for each additional laceration.

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

For the hospital-based emergency department, see the policy on Supplies/Trays/Drugs.

36.4.48 Therapeutic Apheresis

Therapeutic apheresis does not require mandatory prior authorization. Payment for procedure code 2/F-36511, 2/F-36512, 2/F-36513, or 2/F-36514 is limited to the following diagnosis codes:

Diagnosis Code	Description
20300	Multiple myeloma, without mention of remission
20310	Plasma cell leukemia, without mention of remission
20311	Plasma cell leukemia, in remission
2038	Other immunoproliferative neoplasms
20380	Other immunoproliferative neoplasms, without mention of remission
20381	Other immunoproliferative neoplasms, in remission
20400	Lymphoid leukemia, acute, without mention of remission
20401	Lymphoid leukemia, acute, in remission
20410	Lymphoid leukemia, chronic, without mention of remission
20411	Lymphoid leukemia, chronic, in remission
20420	Lymphoid leukemia, subacute, without mention of remission
20421	Lymphoid leukemia, subacute, in remission
20480	Other lymphoid leukemia, without mention of remission
20481	Other lymphoid leukemia, in remission
20490	Unspecified lymphoid leukemia, without mention of remission
20491	Unspecified lymphoid leukemia, in remission
20500	Myeloid leukemia, acute, without mention of remission
20501	Myeloid leukemia, acute, in remission
20510	Myeloid leukemia, chronic, without mention of remission
20511	Myeloid leukemia, chronic, in remission
20520	Myeloid leukemia, subacute, without mention of remission

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Diagnosis Code	Description
20521	Myeloid leukemia, subacute, in remission
20530	Myeloid sarcoma, without mention of remission
20531	Myeloid sarcoma, in remission
20580	Other myeloid leukemia, without mention of remission
20581	Other myeloid leukemia, in remission
20590	Unspecified myeloid leukemia, without mention of remission
20591	Unspecified myeloid leukemia, in remission
20600	Monocytic leukemia, acute, without mention of remission
20601	Monocytic leukemia, acute, in remission
20610	Monocytic leukemia, chronic without mention of remission
20611	Monocytic leukemia, chronic, in remission
20620	Monocytic leukemia, subacute, without mention of remission
20621	Monocytic leukemia, subacute, in remission
20680	Other monocytic leukemia, without mention of remission
20681	Other monocytic leukemia, in remission
20690	Unspecified monocytic leukemia, without mention of remission
20691	Unspecified monocytic leukemia, in remission
20700	Acute erythremia and erythroleukemia, without mention of remission
20701	Acute erythremia and erythroleukemia, in remission
20710	Chronic erythremia, without mention of remission
20711	Chronic erythremia, in remission
20720	Megakaryocytic leukemia, without mention of remission
20721	Megakaryocytic leukemia, in remission
20780	Other specified leukemia, without mention of remission
20781	Other specified leukemia, in remission
20800	Leukemia of unspecified cell type, acute, without mention of remission
20801	Leukemia of unspecified cell type, acute, in remission

Diagnosis Code	Description
20810	Leukemia of unspecified cell type, chronic, without mention of remission
20811	Leukemia of unspecified cell type, chronic, in remission
20820	Leukemia of unspecified cell type, subacute, without mention of remission
20821	Leukemia of unspecified cell type, subacute, in remission
20880	Other leukemia of unspecified cell type, without mention of remission
20881	Other leukemia of unspecified cell type, in remission
20890	Unspecified leukemia, without mention of remission
20891	Unspecified leukemia, in remission
2384	Polycythemia vera
23871	Essential thrombocythemia
2720	Pure hypercholesterolemia
2730	Polyclonal hypergammaglobulinemia
2731	Monoclonal paraproteinemia
2733	Macroglobulinemia
28262	HB-SS Disease with crisis
2828	Other specified hereditary hemolytic anemias
2830	Autoimmune hemolytic anemias
28310	Non-autoimmune hemolytic anemia, unspecified
28311	Hemolytic-uremic syndrome
28319	Other non-autoimmune hemolytic anemias
2848	Other specified aplastic anemias
2863	Congenital deficiency of other clotting factors
2866	Defibrination syndrome
28730	Primary thrombocytopenia, unspecified
28731	Immune thrombocytopenic purpura
28732	Evans' syndrome
28733	Congenital and hereditary thrombocytopenic purpura
28739	Other primary thrombocytopenia
2884	Hemophagocytic syndromes
28869	Other elevated white blood cell count
2890	Polycythemia, secondary
28951	Chronic congestive splenomegaly
28952	Splenic sequestration
2896	Familial polycythemia

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Diagnosis Code	Description
2897	Methemoglobinemia
2898	Other specified diseases of blood and blood-forming organs
28981	Primary hypercoagulable state
28989	Other specified diseases of blood and blood-forming organs
2899	Unspecified diseases of blood and blood-forming organs
3570	Acute infective polyneuritis
3571	Polyneuropathy in collagen vascular disease
3572	Polyneuropathy in diabetes
3573	Polyneuropathy in malignant disease
3574	Polyneuropathy in other diseases classified elsewhere
3575	Alcoholic polyneuropathy
3576	Polyneuropathy due to drugs
3577	Polyneuropathy due to other toxic agents
3578	Other inflammatory and toxic neuropathies
3580	Myasthenia gravis
35800	Myasthenia gravis without (acute) exacerbation
35801	Myasthenia gravis with (acute) exacerbation
390	Rheumatic fever without mention of heart involvement
3918	Other acute rheumatic heart disease
44620	Hypersensitivity angiitis, unspecified
44621	Goodpasture's syndrome
44629	Other specified hypersensitivity angiitis
4466	Thrombotic microangiopathy
4476	Thrombotic microangiopathy
4478	Other specified disorders of arteries and arterioles
570	Acute and subacute necrosis of liver
5718	Other chronic nonalcoholic liver disease
5724	Hepatorenal syndrome
5731	Hepatitis in viral diseases classified elsewhere
5732	Hepatitis in other infectious diseases classified elsewhere
5733	Hepatitis, unspecified
57431	Calculus of bile duct with acute cholecystitis, with obstruction

Diagnosis Code	Description
57441	Calculus of bile duct with other cholecystitis, with obstruction
5800	Acute glomerulonephritis with lesion of proliferative glomerulonephritis
5804	Acute glomerulonephritis with lesion of rapidly progressive glomerulonephritis
5810	Nephrotic syndrome with lesion of proliferative glomerulonephritis
5811	Nephrotic syndrome with lesion of membranous glomerulonephritis
5812	Nephrotic syndrome with lesion of membranoproliferative glomerulonephritis
5813	Nephrotic syndrome with lesion of minimal change glomerulonephritis
58181	Nephrotic syndrome in diseases classified elsewhere
58189	Other nephrotic syndrome with specified pathological lesion in kidney
5819	Nephrotic syndrome with unspecified pathological lesion in kidney
5820	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis
5830	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis
5831	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis
5832	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis
5834	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis

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Diagnosis Code	Description
5836	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis
5837	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis
58381	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere
58389	Other nephritis and nephropathy, not specified as acute or chronic, with specified pathological lesion in kidney
5839	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney
6944	Pemphigus
6951	Erythema multiforme
7100	Systemic lupus erythematosus
701	Other hypertrophic and atrophic conditions of skin
7101	Systemic sclerosis
7103	Dermatomyositis
7104	Polymyositis
71430	Chronic or unspecified polyarticular juvenile rheumatoid arthritis
71431	Acute polyarticular juvenile rheumatoid arthritis
71432	Pauciarticular juvenile rheumatoid arthritis
71433	Monoarticular juvenile rheumatoid arthritis
7140	Rheumatoid arthritis
7141	Felty's syndrome
7142	Other rheumatoid arthritis with visceral or systemic involvement

Procedure codes 2/F-36515 and 2/F-36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber® LA 15) or the protein A immunoadsorption (such as Prosorba®) columns.

- The protein A immunoadsorption column is indicated for use in either of the following cases:
  - Clients who have a platelet count of less than 100,000 mm3.
  - Adult clients with signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, disease-modifying anti-rheumatic drugs (DMARDs).
- Therapeutic apheresis using the protein A immunoadsorption column may be reimbursed for the following diagnosis codes:

Diagnosis Code	Description
2720	Pure hypercholesterolemia
28730	Primary thrombocytopenia, unspecified
28731	Immune thrombocytopenic purpura
28732	Evans' syndrome
28733	Congenital and hereditary thrombocytopenic purpura
28739	Other primary thrombocytopenia
7140	Rheumatoid arthritis
7141	Felty's syndrome
7142	Other rheumatoid arthritis with visceral or systemic involvement

- The LDL apheresis column is indicated for use in clients with severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:
  - Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
  - Functional hypercholesterolemia heterozygotes with LDL-C $\geq$ 300 mg/dL.
  - Functional hypercholesterolemia heterozygotes with LDL-C $\geq$ 200 mg/dL and documented coronary heart disease.
- Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four- week period and should be within 10 percent of each other, indicating a stable condition.
- Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code 2720, Familial hypercholesterolemia.

This procedure represents one 30-minute time interval of personal physician involvement in the apheresis. Apheresis is limited to three 30-minute time intervals per procedure. The actual time must be reflected on the claim, or a unit of 1, 2, or 3 must be indicated. If the time (or unit) is not indicated, payment is based on one 30-minute time interval.

Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

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Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

36.4.49 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of the Texas Medicaid Program and may be billed using procedure code 1-99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

Diagnosis Code	Description
2384	Polycythemia vera
2750	Disorders of iron metabolism
2890	Polycythemia, secondary
2896	Familial polycythemia

Therapeutic phlebotomy will autodeny for all other diagnosis codes.

36.4.50 Ultrasonic Guidance for Intrauterine Fetal Transfusion, Cordocentesis

Payment for procedure codes 2-36460, 2-59012, or 4/I/T-76941 is limited to the diagnosis codes 65610, 65613, 65620,and 65623.

Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis should be billed using procedure code 4/I/T-76941. This service is reimbursable only when provided by a different physician from the one actually performing the fetal transfusion or cordocentesis. Procedure code 4/I/T-76941 is denied as part of 2-59012 or 2-36460 when both procedures are billed on the same day by the same provider.

36.5 Doctor of Dentistry Practicing as a Limited Physician

Claims Information for Doctor of Dentistry Practicing as a Limited Physician outlines guidelines for the Doctor of Dentistry Practicing as a Limited Physician. The THSteps dental program is *not* addressed in these guidelines.

36.5.1 Medicaid Managed Care Enrollment

Services provided by a Doctor of Dentistry Practicing as a Limited Physician must be billed to the member's health plan if the client is in the STAR or STAR+PLUS programs. Providers must enroll with each STAR and STAR+PLUS health plan to be reimbursed for services provided to STAR and STAR+PLUS program members.

Note: *To be reimbursed for services provided to STAR and STAR+PLUS Program members, genetic providers must enroll with each STAR and STAR+PLUS health plan in which their patients are enrolled*.

36.5.1.1 Mandatory Prior Authorization Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients 21 years of age and older (who do not reside in an ICF-MR facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. *Mandatory prior authorization is required* and the dental diagnoses *must* be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a *general dentist* who is enrolled as a *limited physician* are:

- Extractions
- Alveolectomies (in limited situations)
- Incision and drainage
- Curettement

Examples of dental procedures that may be authorized for an *oral and maxillofacial surgeon* who is enrolled as a *limited physician* are:

- Extractions
- Alveolectomies (in limited situations)
- Incision and drainage
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma
- Surgical corrections of craniofacial dysostosis

Note: *Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.*

36.5.2 Guidelines for Requesting Mandatory Prior Authorization

The *limited physician* dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition
- Narrative describing the current medical problem, client status, and medical need for requested services
- The client name and Medicaid number

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- The *limited physician* dentist's provider identifier
- The name and address of the facility
- CPT procedure codes
- The history and physical
- The *limited physician* dentist's signature

Note: *The "limited physician" dentist who will perform the procedure(s) must submit the request for prior authorization.*

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 512-514-4213

36.5.3 Reimbursement for Doctor of Dentistry Practicing as a Limited Physician

Services performed by a DMD or DDS practicing as a limited physician are reimbursed according to the TMRM in accordance with 1 TAC §355.8085. The TMRM is based on the resource-based relative value scale (RBRVS). TMRM is a flat fee structure applicable on a statewide basis, with *no* geographical or specialty differences. All the following information is required to bill *limited physician* services:

- CMS-1500 claim form
- Approved CPT procedure codes (refer to "CPT Procedure Codes" on page 36-341)
- Approved diagnosis codes (refer to "Diagnosis Codes" on page 36-336)
- *Limited physician* provider identifier
- Authorization number when prior authorization is required

For services provided to THSteps clients younger than 21 years of age, Doctor of Dentistry providers should first use American Dental Association (ADA) procedure codes, the ADA claim form, and the provider identifier. CPT codes may be used when an appropriate ADA procedure code is not available.

Refer to: "Reimbursement" on page 2-2

36.5.3.1 Benefits and Limitations

Services by a DDS or DMD are covered by the Texas Medicaid Program in accordance with the OBRA Act of 1987 (public law 100-203), if the services are furnished within the dentist's scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

36.5.3.2 Diagnosis Codes

The following table describes diagnosis codes (ICD-9-CM) that may be billed by a Doctor of Dentistry practicing as a Limited Physician:

Diagnosis Code	Description
0542	Herpetic gingivostomatitis
1120	Candidiasis of mouth
1400	Malignant neoplasm of upper lip vermilion border
1401	Malignant neoplasm of lower lip vermilion border
1403	Malignant neoplasm of upper lip, inner aspect
1404	Malignant neoplasm of lower lip, inner aspect
1405	Malignant neoplasm of lip, unspecified, inner aspect
1406	Malignant neoplasm of lip
1408	Malignant neoplasm of other sites of lip
1409	Malignant neoplasm of lip, unspecified, vermilion border
1410	Malignant neoplasm of base of tongue
1411	Malignant neoplasm of dorsal surface of tongue
1412	Malignant neoplasm of tip and lateral border of tongue
1413	Malignant neoplasm ventral of surface of tongue
1414	Malignant neoplasm of anterior two-thirds of tongue, part unspecified
1415	Malignant neoplasm of junctional zone of tongue
1416	Malignant neoplasm of lingual tonsil
1418	Malignant neoplasm of other sites of tongue
1419	Malignant neoplasm of tongue, unspecified
1420	Malignant neoplasm of parotid gland
1421	Malignant neoplasm of submandibular gland
1428	Malignant neoplasm of other major salivary glands
1429	Malignant neoplasm of salivary gland, unspecified
1430	Malignant neoplasm of upper gum
1431	Malignant neoplasm of lower gum
1438	Malignant neoplasm of other sites of gum

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Diagnosis Code	Description
1439	Malignant neoplasm of gum, unspecified
1440	Malignant neoplasm of anterior portion of floor of mouth
1441	Malignant neoplasm of lateral portion of floor of mouth
1448	Malignant neoplasm of other sites of floor of mouth
1449	Malignant neoplasm of floor of mouth, part unspecified
1450	Malignant neoplasm of cheek mucosa
1451	Malignant neoplasm of vestibule of mouth
1452	Malignant neoplasm of hard palate
1453	Malignant neoplasm of soft palate
1454	Malignant neoplasm of uvula
1455	Malignant neoplasm of palate, unspecified
1456	Malignant neoplasm of retromolar area
1458	Malignant neoplasm of other specified parts of mouth
1459	Malignant neoplasm of mouth, unspecified
1460	Malignant neoplasm of tonsil
1461	Malignant neoplasm of tonsillar fossa
1462	Malignant neoplasm of tonsillar pillars (anterior) (posterior)
1463	Malignant neoplasm of vallecula epiglottica
1464	Malignant neoplasm of anterior aspect of epiglottis
1465	Malignant neoplasm of junctional region of oropharynx
1466	Malignant neoplasm of lateral wall of oropharynx
1467	Malignant neoplasm of posterior wall of oropharynx
1468	Malignant neoplasm of other specified sites of oropharynx
1469	Malignant neoplasm of oropharynx, unspecified site
1490	Malignant neoplasm of pharynx, unspecified
1498	Malignant neoplasm of other sites within the lip and oral cavity
1602	Malignant neoplasm of maxillary sinus
1700	Malignant neoplasm of bones of skull and face, except mandible
1701	Malignant neoplasm of mandible

Diagnosis Code	Description
1730	Other malignant neoplasm of skin of lip
1733	Other malignant neoplasm of skin of other and unspecified parts of face
1950	Malignant neoplasm of head, face, and neck
2100	Benign neoplasm of lip
2101	Benign neoplasm of tongue
2102	Benign neoplasm of major salivary glands
2103	Benign neoplasm of floor of mouth
2104	Benign neoplasm of other and unspecified parts of mouth
2105	Benign neoplasm of tonsil
2106	Benign neoplasm of other parts of oropharynx
2107	Benign neoplasm of nasopharynx
2120	Benign neoplasm of nasal cavities, middle ear, and accessory sinuses
2130	Benign neoplasm of bones of skull and face
2131	Benign neoplasm of lower jaw bone
2160	Benign neoplasm of skin of lip
2163	Benign neoplasm of skin of other and unspecified parts of face
22801	Hemangioma of skin and subcutaneous tissue
2300	Carcinoma in situ of lip, oral cavity, and pharynx
2320	Carcinoma in situ of skin of lip
2323	Carcinoma in situ of skin of other and unspecified parts of face
2350	Neoplasm of uncertain behavior of major salivary glands
2351	Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
3501	Trigeminal neuralgia
3510	Bell's palsy
470	Deviated nasal septum
4730	Chronic maxillary sinusitis
4780	Hypertrophy of nasal turbinates
5225	Periapical abscess without sinus
5227	Periapical abscess with sinus
52400	Major anomalies of jaw size, unspecified anomaly
52401	Major anomalies of jaw size, maxillary hyperplasia
52402	Major anomalies of jaw size, mandibular hyperplasia

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Diagnosis Code	Description
52403	Major anomalies of jaw size, maxillary hypoplasia
52404	Major anomalies of jaw size, mandibular hypoplasia
52405	Major anomalies of jaw size, macrogenia
52406	Major anomalies of jaw size, microgenia
52409	Major anomalies of jaw size, other specified anomaly
52410	Anomalies of relationship of jaw to cranial base, unspecified anomaly
52411	Anomalies of relationship of jaw to cranial base, maxillary asymmetry
52412	Anomalies of relationship of jaw to cranial base, other jaw asymmetry
52419	Anomalies of relationship of jaw to cranial base, other specified anomaly
52420	Unspecified anomaly of dental arch relationship
52421	Malocclusion, Angle's class I
52422	Malocclusion, Angle's Class II
52423	Malocclusion, Angle's Class III
52424	Open anterior occlusal relationship
52425	Open posteriior occlusal relationship
52426	Excessive horizontal overlap
52427	Reverse articulation
52428	Anomalies of interarch disease
52429	Other anomolies of dental arch relationship
5242	Dental arch anomaly
5245	Dentofacial functional abnormalities
52450	Dentofacial functional abnormality, unspecified
52451	Abnormal jaw closure
52452	Limited mandibular range of motion
52453	Deviation in opening and closing of the mandible
52454	Insufficient anterior guidance
52455	Centric occlusion maximum intercus-pation descrepancy
52456	Non-working side interference
52457	Lack of posterior occlusal support
52459	Other dentofacial functional abnormalities
52460	Temporomandibular joint disorder, unspecified

Diagnosis Code	Description
52461	Temporomandibular joint disorders, adhesions and ankylosis (bony or fibrous)
52462	Temporomandibular joint disorders, arthralgia of temporomandibular joint
52463	Temporomandibular joint disorders, articular disc disorder (reducing or non-reducing)
52469	Temporomandibular joint disorders, other specified temporomandibular joint disorders
52470	Dental alveolar anomalies, unspec-ified alveolar anomaly
52471	Dental alveolar anomalies, alveolar maxillary hyperplasia
52472	Dental alveolar anomalies, alveolar mandibular hyperplasia
52473	Dental alveolar anomalies, alveolar maxillary hypoplasia
52474	Dental alveolar anomalies, alveolar mandibular hypoplasia
52479	Dental alveolar anomalies, other specified alveolar anomaly
52481	Anterior soft tissue impingement
52482	Posterior soft tissue impingement
52489	Other specified dentofacial anomalies
5249	Unspecified dentofacial anomalies
5260	Devel odontogenic cysts
5261	Fissural cysts of jaw
5262	Other cysts of jaws
5263	Central giant cell (reparative) granuloma
5264	Inflammatory conditions of jaw
5265	Alveolitis of jaw
52681	Exostosis of jaw
52689	Other specified diseases of the jaws
5269	Unspecified disease of the jaws
5272	Sialoadenitis
5273	Salivary gland abscess
5274	Salivary gland fistula
5275	Sialolithiasis
5276	Salivary gland mucocele
5277	Disturbance of salivary secretion
5278	Other specified diseases of salivary glands
5279	Unspecified disease of the salivary glands
5281	Cancrum oris

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Diagnosis Code	Description
5282	Oral aphthae
5283	Cellulitis and abscess of oral soft tissues
5284	Oral soft tissue cyst
5285	Diseases of lips
5286	Leukoplakia of oral mucosa, including tongue
5287	Other disturbances of oral epithelium, including tongue
52871	Minimal keratinized residual ridge mucosa
52872	Excessive keratinized residual ridge mucosa
52879	Other disturbances of oral epithlium, including tongue
5290	Glossitis
5291	Geographic tongue
5292	Median rhomboid glossitis
5293	Hypertrophy of tongue papillae
5294	Atrophy of tongue papillae
5295	Plicated tongue
5298	Other specified conditions of the tongue
6820	Cellulitis and abscess, face
6828	Cellulitis and abscess of other specified sites
6829	Cellulitis and abscess of unspecified sites
70900	Dyschromia, unspecified
71509	Osteoarthrosis, generalized, involving multiple sites
71518	Osteoarthrosis, localized, primary, involving other specified sites
71528	Osteoarthrosis, localized, secondary, involving other specified sites
71618	Traumatic arthropathy involving other specified sites
71690	Unspecified arthropathy, site unspecified
73810	Other acquired deformity of head, unspecified deformity
73811	Other acquired deformity of head, zygomatic hyperplasia
73812	Other acquired deformity of head, zygomatic hyperplasia
73819	Other acquired deformity of head, other specified deformity
74441	Branchial cleft sinus or fistula
74442	Branchial cleft cyst

Diagnosis Code	Description
74900	Cleft palate, unspecified
74901	Cleft palate, unilateral, complete
74902	Cleft palate, unilateral, incomplete
74903	Cleft palate, bilateral, complete
74904	Cleft palate, bilateral, incomplete
74910	Cleft lip, unspecified
74911	Cleft lip, unilateral, complete
74912	Cleft lip, unilateral, incomplete
74913	Cleft lip, bilateral, complete
74914	Cleft lip, bilateral, incomplete
74920	Cleft palate with cleft lip
74921	Cleft palate with cleft lip, unilateral, complete
74922	Cleft palate with cleft lip, unilateral, incomplete
74923	Cleft palate with cleft lip, bilateral, complete
74924	Cleft palate with cleft lip, bilateral, incomplete
74925	Other combinations of cleft palate with cleft lip
7500	Tongue tie
7810	Abnormal involuntary movements
78199	Other symptoms involving nervous and musculoskeletal systems
8020	Closed fracture of nasal bones
8021	Open fracture of nasal bones
80220	Closed fracture of unspecified site of mandible
80221	Closed fracture of condylar process of mandible
80222	Closed fracture of subcondylar process of mandible
80223	Closed fracture of coronoid process of mandible
80224	Closed fracture of unspecified part of ramus of mandible
80225	Closed fracture of angle of jaw
80226	Closed fracture of symphysis of body of mandible
80227	Closed fracture of alveolar border of body of mandible
80228	Closed fracture of other and unspecified part of body of mandible
80229	Closed fracture of multiple sites of mandible
80230	Open fracture of unspecified site of mandible

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Diagnosis Code	Description
80231	Open fracture of condylar process of mandible
80232	Open fracture of subcondylar process of mandible
80233	Open fracture of coronoid process of mandible
80234	Open fracture of unspecified part of ramus of mandible
80235	Open fracture of angle of jaw
80236	Open fracture of symphysis of body of mandible
80237	Open fracture of alveolar border of body of mandible
80238	Open fracture of body of mandible, other and unspecified
80239	Open fracture of multiple sites of mandible
8024	Closed fracture of malar and maxillary bones
8025	Open fracture of malar and maxillary bones
8026	Closed fracture of orbital floor (blow-out)
8027	Open fracture of orbital floor (blow-out)
8028	Closed fracture of other facial bones
8029	Open fracture of other facial bones
80300	Other closed skull fracture without mention of intracranial injury, with state of consciousness unspecified
80310	Other closed skull fracture with cerebral laceration and contusion, with state of consciousness unspecified
8300	Closed dislocation of jaw
8301	Open dislocation of jaw
8481	Sprain of jaw
87320	Open wound of nose, unspecified site, uncomplicated
87321	Open wound of nasal septum, uncomplicated
87322	Open wound of nasal cavity, uncomplicated
87323	Open wound of nasal sinus, uncomplicated
87329	Open wound of multiple sites, uncomplicated
87330	Open wound of nose, unspecified site, complicated
87331	Open wound of nasal septum, complicated

Diagnosis Code	Description
87332	Open wound of nasal cavity, complicated
87333	Open wound of nasal sinus, complicated
87339	Open wound of multiple sites, complicated
87340	Open wound of face, unspecified site, uncomplicated
87341	Open wound of cheek, uncomplicated
87342	Open wound of forehead, uncomplicated
87343	Open wound of lip, uncomplicated
87344	Open wound of jaw, uncomplicated
87349	Open wound of other and multiple sites, uncomplicated
87350	Open wound of face, unspecified site, complicated
87351	Open wound of cheek, complicated
87352	Open wound of forehead, complicated
87353	Open wound lip, complicated
87354	Open wound jaw, complicated
87359	Open wound of other and multiple sites, complicated
87360	Open wound of mouth, unspecified site, uncomplicated
87361	Open wound of buccal mucosa, uncomplicated
87362	Open wound of gum (alveolar process), uncomplicated
87363	Tooth (broken) (fractured) (due to trauma), without mention of complication
87364	Open wound of tongue and floor of mouth, uncomplicated
87365	Open wound of palate, uncomplicated
87369	Open wound of other and multiple sites, uncomplicated
87370	Open wound of mouth, unspecified site, complicated
87371	Open wound of buccal mucosa, complicated
87372	Open wound of gum (alveolar process), complicated
87373	Tooth (broken) (fractured) (due to trauma), complicated
87374	Open wound of tongue and floor of mouth, complicated
87375	pen wound of palate, complicated
87379	Open wound of other and multiple sites, complicated

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Diagnosis Code	Description
8738	Other and unspecified open wound of head without mention of complication
8739	Other and unspecified open wound of head, complicated
9062	Late effect of superficial injury
920	Contusion of scalp, face, and neck except eye(s)
9350	Foreign body in mouth
95909	Other and unspecified injury to face and neck

36.5.3.3 Evaluation and Management Procedure Codes

The following procedure codes listed in the "Evaluation and Management" section of the Physicians' CPT must be used with the appropriate ICD-9-CM codes listed in "Diagnosis Codes" on page 36-336.

Procedure Codes		
1-99201	1-99202	1-99203
1-99204	1-99205	1-99211
1-99212	1-99213	1-99214
1-99215	1-99217	1-99218
1-99219	1-99220	1-99221
1-99222	1-99223	1-99231
1-99232	1-99233	1-99234
1-99235	1-99236	1-99238
1-99239	1-99281	1-99282
1-99283	1-99284	1-99285
1-99291	1-99292	1-99293
1-99294	1-99295	1-99296
1-99297	1-99298	1-99299
1-99300	1-99304	1-99305
1-99306	1-99307	1-99308
1-99309	1-99310	1-99315
1-99316	1-99318	1-99324
1-99325	1-99326	1-99327
1-99328	1-99334	1-99335
1-99336	1-99337	1-99341
1-99342	1-99343	1-99344
1-99345	1-99347	1-99348
1-99349	1-99350	1-99354
1-99355	1-99356	1-99357
1-99401	1-99402	1-99429
1-99431	1-99432	1-99433
1-99435	1-99436	1-99440
1-99499		

36.5.3.4 CPT Procedure Codes

The following CPT procedure codes are a benefit when:

- Accompanied by the appropriate diagnosis code.
- The dentist is qualified and licensed to perform the procedures.

Important: *Descriptions of these codes can be found in the current edition of CPT.*

CPT Procedure Codes		
2-10060	2-10061	2-10120
2-10121	2-10140	2-10160
2-10180	2-11000	2-11001
2-11040	2-11041	2-11042
2-11043	2-11044	2-11440
2-11441	2-11442	2-11443
2-11444	2-11446	2-11640
2-11641	2-11642	2-11643
2-11644	2-11646	2-12011
2-12013	2-12014	2-12015
2-12016	2-12017	2-12018
2-12051	2-12053	2-12054
2-12055	2-12056	2-12057
2-13131	2-13132	2-13150
2-13151	2-13152	2-13133
2-13153	2-14040	2-14041
2-14060	2-14061	2-15000
2-15120	2-15121	2-15240
2-15241	2-15260	2-15261
2-15400	2-15850	2-15851
2-15852	2-20000	2-20005
2-20200	2-20220	2-20240
2-20520	2-20600	2-20605
2-20670	2-20680	2-20693
2-20694	2-20900	2-20902
2-20912	2-21015	2-21025
2-21026	2-21029	2-21030
2-21034	2-21040	2-21041
2-21044	2-21045	2-21070
2-21082*	2-21083*	2-21116
2-21310	2-21315	2-21320
2-21325	2-21330	2-21335
2-21336	2-21337	2-21338
2-21339	2-21340	2-21343
2-21344	2-21345	2-21346
2-21347	2-21348	2-21355
2-21356	2-21360	2-21365
*Code is not a benefit for clients 21 years of age and older.		

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CPT Procedure Codes		
2-21366	2-21385	2-21386
2-21387	2-21390	2-21395
2-21400	2-21401	2-21406
2-21407	2-21408	2-21421
2-21422	2-21423	2-21431
2-21432	2-21433	2-21435
2-21436	2-21440	2-21445
2-21450	2-21451	2-21452
2-21453	2-21454	2-21461
2-21462	2-21465	2-21470
2-21480	2-21485	2-21490
2-21499	2-29999	2-30130
2-30140	2-30400	2-30410
2-30420	2-30430	2-30435
2-30450	2-30520	2-30580
2-30600	2-30620	2-30630
2-30801	2-30802	2-30930
2-31020	2-31030	2-40490
2-40500	2-40510	2-40520
2-40525	2-40527	2-40530
2-40650	2-40652	2-40654
2-40700	2-40701	2-40702
2-40800	2-40801	2-40804
2-40805	2-40806	2-40808
2-40810	2-40812	2-40814
2-40816	2-40818	2-40819
2-40820	2-40830	2-40831
2-41000	2-41005	2-41006
2-41007	2-41008	2-41009
2-41010	2-41015	2-41016
2-41017	2-41018	2-41100
2-41105	2-41108	2-41110
2-41112	2-41113	2-41114
2-41115	2-41116	2-41120
2-41130	2-41250	2-41251
2-41252	2-41520	2-41800
2-41805	2-41806	2-41822
2-41823	2-41825	2-41826
2-41827	2-41830	2-41850
2-41899	2-42000	2-42100
2-42104	2-42106	2-42107
2-42120	2-42160	2-42280
2-42281	2-42200	2-42205
2-42210	2-42215	2-42220
2-42225	2-42226	2-42227
2-42235	2-42260	2-42280
2-42300	2-42305	2-42310
2-42320	2-42330	2-42335
2-42340	2-42400	2-42405
2-42408	2-42409	2-42410
2-42415	2-42420	2-42425
2-42440	2-42450	2-42500
2-42505	2-42550	2-42600
2-42650	2-42665	2-42700
2-42720	2-42725	2-42810
2-42900	2-42960	2-42961
2-42962	2-42970	2-61575
2-61576	2-64400	2-64600
2-64722	2-64736	2-64738
2-64740	2-92511	5-88305
5-88331	5-88332	
***Code is not a benefit for clients 21 years of age and older.**		

36.5.3.5 CPT Codes Requiring Mandatory Prior Authorization

The following CPT codes may be payable to an *oral and maxillofacial surgeon* when *mandatory prior authorization* is received from the TMHP Medical Director or designee. A narrative explaining medical necessity must be provided with the authorization request.

CPT Procedure Codes		
2-21010	2-21031	2-21032
2-21050	2-21060	2-21150
2-21151	2-21154	2-21155
2-21159	2-21206	2-21208
2-21209	2-21210	2-21215
2-21263	2-21267	2-21268
2-21270	2-21208	2-21275
2-21100*	2-21110*	2-21120
2-21121	2-21122	2-21123
2-21125	2-21127	2-21137
2-21138	2-21139	2-21145
2-21146	2-21147	2-21160
2-21172	2-21175	2-21179
2-21180	2-21181	2-21182
2-21183	2-21184	2-21188
2-21193	2-21194	2-21195
2-21196	2-21198	2-21199
2-21206	2-21230	2-21235

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CPT Procedure Codes		
2-21240	2-21242	2-21243
2-21244	2-21245	2-21246
2-21247	2-21255	2-21256
2-21260	2-21261	2-21280
2-21282	2-21295	2-21296
2-21299	2-29800	2-29804
2-40840	2-40842	2-40843
2-40844	2-40845	

Refer to: "Guidelines for Requesting Mandatory Prior Authorization" on page 36-335 for more instructions about submitting your request for prior authorization.

36.5.3.6 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement when accompanied by an appropriate diagnosis:

Procedure Codes		
4-70100	4-70110	4-70120
4-70130	4-70140	4-70150
4-70160	4-70170	4-70190
4-70200	4-70250	4-70260
4-70300	4-70310	4-70320
4-70328	4-70330	4-70332
4-70336	4-70350	4-70355
4-70370	4-70371	4-70380
4-70390	4-73100	

36.5.3.7 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§108.30 through 108.35, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services when accompanied by a payable diagnosis:

Procedure Codes		
7-00100	7-00102	7-00160
7-00162	7-00164	7-00170
7-00190	7-00192	1-99100
1-99116	1-99135	1-99140

36.5.4 Claims Information for Doctor of Dentistry Practicing as a Limited Physician

Claims for services by a Doctor of Dentistry Practicing as a Limited Physician must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form using the appropriate provider identifier. All THSteps and ICF-MR services by a dentist must be submitted on an ADA claim form or ADA electronic claim format. Providers must purchase ADA or CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

36.6 Procedure Codes Requiring Prior Authorization

The following list is *not all-inclusive* and is subject to change:

Procedure Codes		
7-00580	7-00796	K-00830
K-00831	K-00832	K-00833
K-00834	K-00835	K-00836
K-00837	K-00838	K-00844
7-00868	K-00870	K-00871
K-00872	K-00873	K-00874
K-00886	K-00887	K-02095
K-02491	K-02769	K-02773
K-02779	K-02940	K-03350
K-03360	K-03750	K-04100
K-04101	K-04102	K-04103
K-04104	K-04105	K-04106
K-04191	K-05051	K-05059
K-05561	K-05569	K-06494
K-06495	K-06496	K-06497
K-07631	K-07639	K-07641
K-07642	K-07643	K-07644
K-07645	K-07646	K-07650
K-07661	K-07662	K-07663
K-07664	K-07665	K-07666
K-07667	K-07668	K-07669
K-08530	K-08531	K-08532

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Procedure Codes		
K-08683	K-09979	2/F-15820
2/F-15821	2/8/F-15822	2/8/F-15823
2/F-15831	2/8/F-19318	2-21010
2/8-21031	2/8/F-21032	2/8/F-21050
2/8/F-21060	2/8-21100	2/8-21120
2/8/F-21121	2/8/F-21122	2/8/F-21123
2/8-21125	2/8/F-21127	2/8-21137
2/8-21138	2/8-21139	2/8-21141
2/8-21143	2/8-21145	2/8-21146
2/8-21147	2/8-21150	2/8-21151
2/8-21154	2/8-21155	2/8-21159
2/8-21160	2/8-21172	2/8-21175
2/8-21179	2/8-21180	2/8-21181
2/8-21182	2/8-21183	2/8-21184
2/8-21188	2/8-21193	2/8-21194
2/8-21195	2/8-21196	2/8-21198
2/8-21199	2/8-21206	2/8-21208
2/8-21209	2/8-21210	2/8-21215
2/8-21230	2/8-21235	2/8-21240
2/8-21241	2/8-21242	2/8-21243
2/8-21244	2/8-21245	2/8-21246
2/8-21247	2/8-21255	2/8-21256
2/8-21260	2/8-21261	2/8-21263
2/8-21267	2/8-21268	2/8-21270
2/8-21275	2/8-21280	2/8-21282
2/8-21295	2/8-21296	2/8-21299
2/8/F-29800	2/8/F-29804	2/8-32851
2/8-32852	2/8-32853	2/8-32854
2/8-33935	2/8-33945	2/8-38230
2/8-38240	2/8-38241	2/F-40840
2/F-40842	2/F-40843	2/F-40844
2/F-40845	2/8-41899	2/8-47135
2/8-47136	2/8-50360	2/8-50365
2/8-50380	2-62350	2-62360
2-62361	2-62362	2/8-63685
2/8-63688	2/8-64573	2/8-64585
2/8/F-67900	2/8/F-67901	2/8/F-67902
2/8/F-67903	2/8/F-67904	2/8/F-67906
2/8/F-67908	2/8/F-67909	2/8/F-67911
2/8/F-67961	8-67961	8/F-67966
8/F-67971	8/F-67973	8/F-67974
2/8/F-67975	2/8/F-69300	9-92326
1-99503	W-D3346	W-D3347
W-D3348	W-D5951	W-D5952

Procedure Codes		
W-D5953	W-D5954	W-D5955
W-D5958	W-D5959	W-D5960
W-D7260	W-D7280	W-D7286
W-D8080	W-D8110	W-D8120
W-D8999	W-D9930	5-Q0068
1-S9364	1-S9365	1-S9366
1-S9367	1-S9368	9-V2500
9-V2501	9-V2502	9-V2510
9-V2511	9-V2512	

Prior authorization is mandatory for these services (this list is noninclusive and subject to change):

- Abdominal lipectomies and panniculectomies
- Baclofen and/or morphine pump implantation/revision/replacement

Blepharochalasis/blepharoplasty/blepharoptosis repair (not required for procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, 2-67908, and 2-67909 for clients younger than 21 years of age with a diagnosis of 74361, 74362, or 7439). Procedure codes 2-67901, 2-67902, 2-67903, 2-67904, 2-67906, and 2-67908 do not require prior authorization for clients older than 21 years of age with diagnosis codes 37431, 37432, 37433, and 37434.

- Breast reduction
- Communication devices (CCP only)
- Contact lenses (except postsurgical prosthetic contact lenses or emergency corneal bandage lenses or for the diagnosis of aphakia)
- Corneal topography performed by an optometrist
- Corneal topography performed by an ophthalmologist
- Customized DME (CCP only)
- Freestanding psychiatric facility (CCP only)
- Freestanding rehabilitation facility (CCP only)
- Heart transplants
- Home delivery by a CNM
- In-home respiratory services provided by a certified respiratory care practitioner
- Kidney transplants
- Liver transplants
- Lung transplants
- Maxillofacial/craniofacial surgery (excludes procedure code 2-61550 for cosurgery)
- Most home health services
- Oral surgery—jaw deformities
- Orthodontic services
- Outpatient/in-home total parenteral nutrition (TPN)/hyperalimentation

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- Outpatient mental health services in excess of 30-encounters per client per calendar year to enrolled practitioners
- Private duty nursing (CCP only)
- Stem cell transplants
- Temporomandibular joint surgery
- Treatment of life-threatening oral infections
- Vagal nerve stimulator
- Vestibuloplasty

The following procedures do *not* require prior authorization:

- Cleft palate repair
- Cochlear implantation
- Contact lens(es) or replacement contact lens(es) for diagnosis of aphakia
- Implant of a dorsal column spinal cord stimulator inserted to treat chronic intractable pain
- Surgical removal of lesions, when medically necessary; use modifier KX, specific required documentation on file when excision/destruction is because of at least one of the following signs or symptoms: inflamed, growing, infected, bleeding, irritated, itching, limiting motion/function, or diagnosis 7020, actinic keratosis
- Home Health Services/DME supplies for in-home use require prior authorization through Home Health Services

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33
"Corneal Topography" on page 36-221.
"Certified Respiratory Care Practitioner (CRCP) Services" on page 16-1.
"Texas Medicaid (Title XIX) Home Health Services" on page 24-1.

36.7 Claims Information

Claims for physician and doctor services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

36.7.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
Example of CMS-1500 claim form	5-26
TMHP Electronic Claims Submission	5-10
State and Federal Offices Communication Guide	A-1
Abortion Certification Statements Form	B-4
Hysterectomy Acknowledgment Form	B-52
Request for Extended Outpatient Psycho-therapy/Counseling Form	B-81
Sterilization Consent Form (English)	B-92
Sterilization Consent Form (Spanish)	B-94
Sterilization Consent Form Instructions	B-96
Anesthesia Claim Example	D-5
Dialysis Training Claim Example	D-11
Office Visit with Lab and Radiology Claim Example	D-24
Radiation Therapy Claim Example	D-28
Surgery Claim Example	D-34
Acronym Dictionary	F-1

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Section

37

Physician Assistant (PA)

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37.1 Enrollment

To enroll in the Texas Medicaid Program, a physician assistant (PA) must be licensed and recognized as a PA by the Texas State Board of Physician Assistant Examiners. The Texas Medicaid Program accepts a signed letter of certification from the Texas State Board of Physician Assistant Examiners as acceptable documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA are not reimbursed for laboratory services.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

"CLIA Requirements" on page 26-2.

37.1.1 Enrollment in Texas Health Steps

PAs can enroll as Texas Health Steps (THSteps) providers. PAs should have expertise or additional education in the areas of comprehensive pediatric assessment.

Refer to: "Provider Enrollment" on page 43-5 for more information on enrollment procedures.

37.1.2 Medicaid Managed Care Enrollment

PAs may be eligible to enroll with Medicaid Managed Care as primary care providers. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1 for more information.

37.2 Reimbursement

According to Title 1 *Texas Administrative Code* (TAC) §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (Doctor of Medicine [MD] or Doctor of Osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The current fee schedule is available on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Procedures billed by PAs are reviewed retrospectively for appropriateness. Independently enrolled PAs with a valid Medicare provider number are eligible to receive payment of deductible and coinsurance amounts as appropriate on Medicare crossover claims.

Refer to: "Provider Enrollment" on page 1-2 for more information.

"TMHP Electronic Data Interchange (EDI)" on page 3-1 for information on how to obtain electronic fee schedules from the TMHP website.

37.3 Benefits and Limitations

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law
- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by the Texas Medicaid Program when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medicaid Program for their services if the billing results in duplicate payment for the same services.

Additional information about benefit limitation for services can be found in the Physician, Texas Health Steps medical (includes newborn exams), and Family Planning sections of this manual.

Note: *Payment to physicians for supplies is not a benefit of the Texas Medicaid Program. Costs of supplies are included in the reimbursement for office visits.*

Important: *Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and received within 95 days from the date of service.*

Refer to: "Family Planning Services" on page 20-1

"Physician" on page 36-1.

"THSteps Medical Checkup Facilities" on page 43-11.

37.4 Claims Information

Providers must submit PA services in an approved electronic format or on a CMS-1500 paper claim form. All services must be filed with modifier U7 on the claim detail(s) to indicate that the client was treated by a PA.

Refer to: "Claims Filing Instructions" on page 5-23 for paper claims completion instructions.

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37.4.1 Claim Filing Resources

Refer to the following sections or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
Use of the Family Planning 2017 Claim Form	20-5
Communication Guide	A-1
Family Planning Claim Form	D-13
Acronym Dictionary	F-1

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Psychologist

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38.1 Enrollment

To enroll in the Texas Medicaid Program, whether as an individual or as part of a group, a psychologist must be licensed by the Texas State Board of Examiners of Psychologists. Psychologists must also be enrolled in Medicare or obtain a pediatric practice exemption from TMHP Provider Enrollment. If a pediatric-based psychologist is enrolling as part of a Medicare-enrolled group, then the psychologist must also be enrolled in Medicare.

Psychologists cannot be enrolled if they have a license that is due to expire within 30 days. A current license must be submitted. The Texas Medicaid Program accepts temporary licenses for psychologists.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

38.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Psychologists who practice in the Dallas service area must be enrolled as a network provider in the NorthSTAR Behavioral Health Organization's (BHOs) network to provide services to NorthSTAR enrollees.

NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Providers must not bill TMHP for services rendered to NorthSTAR clients.

Refer to: "Managed Care" on page 7-1 for more information.

38.2 Reimbursement

The Medicaid rates for psychologists are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8081 and §355.8085. The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com. To request a copy, call the TMHP Contact Center at 1-800-925-9126.

A federally qualified health center (FQHC) is reimbursed for psychological services according to its specific Prospective Payment System (PPS) rate per visit calculated in accordance with 1 TAC §355.8261.

A freestanding psychiatric hospital/facility is reimbursed for psychological services in accordance with 1 TAC §355.8063.

Refer to: "Federally Qualified Health Center (FQHC)" on page 21-1 for more information.

"Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-71 for more information.

"Reimbursement Methodology" on page 2-2 for more information.

38.3 Benefits and Limitations

Psychologists licensed by the Texas State Board of Examiners of Psychologists and enrolled as Medicaid providers are authorized to perform counseling and testing for mental illness/debility. Treatment does *not* include the practice of medicine.

The services of a psychological associate (masters level psychologists), licensed chemical dependency counselor (LCDC), social worker, psychiatric nurse, or mental health worker are not covered by the Texas Medicaid Program and cannot be billed under a psychologist's provider identifier. Services provided by a licensed clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT) are reimbursable directly to the LCSW, LPC, or LMFT.

Psychologists must not bill for services performed by people under their supervision. For mental health services, only the licensed psychologist and Medicaid enrolled provider actually performing the service may bill Medicaid.

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) is also limited to a combined total of 12 hours.

Providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day. Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped. Documentation requirements for all services billed are listed for each individual specialty in this manual.

Outpatient mental health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31), regardless of provider, unless prior authorization is obtained. *This limitation includes encounters/visits by all providers.* An encounter/visit is defined as each hour of therapy or psychological and/or neuropsychological testing rendered per hour, per provider. Laboratory, radiology, and medication monitoring services do not count toward the 30-encounter/visit limitation. If a provider determines that additional services are medically necessary within the calendar year, prior authorization must be obtained before providing the 25th service.

It is anticipated that this limitation, which allows for six months of weekly therapy or 12 months of biweekly therapy, will be adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

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It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was unable to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to 10 encounters/visits per request and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and TPI
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number and type of services requested and the dates (based on the frequency of encounters/visits) that the services will be provided
- All areas of the request must be completed with the information required on the form. If additional room is needed providers may state "see attached." The attachment must contain the specific information required in that section of the form

Prior authorization is not granted to providers who have seen a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation addressing the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatments are mandated by the courts as court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Medicaid does not cover treatment for chronic diagnoses such as mental retardation and organic brain syndrome.

Psychiatric daycare is not a covered service.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement methodologies.

"Managed Care" on page 7-1.

"Request for Extended Outpatient Psychotherapy/Counseling Form" on page B-81.

"Licensed Clinical Social Worker (LCSW)" on page 28-1.

"Licensed Professional Counselor (LPC)" on page 30-1.

"Licensed Marriage and Family Therapist (LMFT)" on page 29-1 for more information.

38.3.1 Psychological and Neuropsychological Testing

Procedure codes 5-96101 and 5-96118 are covered services for the following diagnoses only:

Diagnosis Code	Description
0360	Meningococcal meningitis
0361	Meningococcal encephalitis
03681	Meningococcal optic neuritis
04503	Acute paralytic poliomyelitis specified as bulbar, polio virus type III
04510	Acute poliomyelitis with other paralysis, unspecified type of polio virus
04523	Acute nonparalytic poliomyelitis, polio virus type III
04593	Unspecified acute poliomyelitis, polio virus type III
0460	Kuru
0461	Jakob-Creutzfeldt disease
0462	Subacute sclerosing panencephalitis
0463	Progressive multifocal leukoencephalopathy
0468	Other specified slow virus infection of central nervous system
0469	Unspecified slow virus infection of central nervous system
0470	Meningitis due to coxsackie virus
0471	Meningitis due to echo virus
0478	Other specified viral meningitis

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Diagnosis Code	Description
0479	Unspecified viral meningitis
048	Other enterovirus diseases of central nervous system
0490	Non-arthopod borne lymphocytic choriomeningitis
0491	Non-arthopod borne meningitis due to adenovirus
0498	Other specified non-arthropod-borne viral diseases of central nervous system
0499	Unspecified non-arthropod-borne viral diseases of central nervous system
2900	Senile dementia, uncomplicated
29010	Presenile dementia, uncomplicated
29012	Presenile dementia with delusional features
29013	Presenile dementia with depressive features
29020	Senile dementia with delusional features
29021	Senile dementia with depressive features
2903	Senile dementia with delirium
29040	Vascular dementia, uncomplicated
29041	Vascular dementia, with delirium
29043	Vascular dementia, with depressed mood
2908	Other specified senile psychotic conditions
2909	Unspecified senile psychotic condition
2910	Alcohol withdrawal delirium
2911	Alcohol-induced persisting amnestic disorder
2912	Alcohol-induced persisting dementia
2915	Alcohol-induced psychotic disorder with delusions
29189	Other alcohol-induced mental disorders
2919	Unspecified alcohol-induced mental disorders
2920	Drug withdrawal
2921	Drug-induced psychotic disorders
2922	Pathological drug intoxication
29281	Drug-induced delirium
2929	Unspecified drug-induced mental disorder

Diagnosis Code	Description
2930	Delirium due to conditions classified elsewhere
2931	Subacute delirium
29381	Psychotic disorder with delusions in conditions classified elsewhere
29382	Psychotic disorder with hallucinations in conditions classified elsewhere
29384	Anxiety disorder in conditions classified elsewhere
29389	Other specified transient mental disorders due to conditions classified elsewhere, other
2939	Unspecified transient mental disorder in conditions classified elsewhere
2940	Amnestic disorder in conditions classified elsewhere
29410	Dementia in conditions classified elsewhere without behavioral disturbance
29411	Dementia in conditions classified elsewhere with behavioral disturbance
2948	Other persistent mental disorders due to conditions classified elsewhere
2949	Other persistent mental disorders due to conditions classified elsewhere
29500	Simple type schizophrenia, unspecified state
29501	Simple type schizophrenia, subchronic state
29502	Simple type schizophrenia, chronic state
29503	Simple type schizophrenia, subchronic state with acute exacerbation
29504	Simple type schizophrenia, chronic state with acute exacerbation
29505	Simple type schizophrenia, in remission
29510	Disorganized type schizophrenia, unspecified state
29511	Disorganized type schizophrenia, subchronic state
29512	Disorganized type schizophrenia, chronic state
29513	Disorganized type schizophrenia, subchronic state with acute exacerbation

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Diagnosis Code	Description
29514	Disorganized type schizophrenia, chronic state with acute exacerbation
29515	Disorganized type schizophrenia, in remission
29520	Catatonic type schizophrenia, unspecified state
29521	Catatonic type schizophrenia, subchronic state
29522	Catatonic type schizophrenia, chronic state
29523	Catatonic type schizophrenia, subchronic state with acute exacerbation
29524	Catatonic type schizophrenia, chronic state with acute exacerbation
29525	Catatonic type schizophrenia, in remission
29530	Paranoid type schizophrenia, unspecified state
29531	Paranoid type schizophrenia, subchronic state
29532	Paranoid type schizophrenia, chronic state
29533	Paranoid type schizophrenia, subchronic state with acute exacerbation
29534	Paranoid type schizophrenia, chronic state with acute exacerbation
29535	Paranoid type schizophrenia, in remission
29540	Schizophreniform disorder, unspecified
29541	Schizophreniform disorder, subchronic
29542	Schizophreniform disorder, chronic
29543	Schizophreniform disorder, subchronic with acute exacerbation
29544	Schizophreniform disorder, chronic with acute exacerbation
29545	Schizophreniform disorder, in remission
29550	Latent schizophrenia, unspecified state
29551	Latent schizophrenia, subchronic state
29552	Latent schizophrenia, chronic state
29553	Latent schizophrenia, subchronic state with acute exacerbation
29554	Latent schizophrenia, chronic state with acute exacerbation
29555	Latent schizophrenia, in remission
29560	Schizophrenic disorders, residual type, unspecified
29561	Schizophrenic disorders, residual type, subchronic
29562	Schizophrenic disorders, residual type, chronic
29563	Schizophrenic disorders, residual type, subchronic with acute exacerbation
29564	Schizophrenic disorders, residual type, chronic with acute exacerbation
29565	Schizophrenic disorders, residual type, in remission
29570	Schizoaffective disorder, unspecified
29571	Schizoaffective disorder, subchronic
29572	Schizoaffective disorder, chronic
29573	Schizoaffective disorder, subchronic with acute exacerbation
29574	Schizoaffective disorder, chronic with acute exacerbation
29575	Schizoaffective disorder, in remission
29580	Other specified types of schizophrenia, unspecified state
29581	Other specified types of schizophrenia, subchronic state
29582	Other specified types of schizophrenia, chronic state
29583	Other specified types of schizophrenia, subchronic state with acute exacerbation
29584	Other specified types of schizophrenia, chronic state with acute exacerbation
29585	Other specified types of schizophrenia, in remission
29590	Unspecified type schizophrenia, unspecified state
29591	Unspecified type schizophrenia, subchronic state
29592	Unspecified type schizophrenia, chronic state
29593	Unspecified type schizophrenia, subchronic state with acute exacerbation
29594	Unspecified type schizophrenia, chronic state with acute exacerbation

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Diagnosis Code	Description
29595	Unspecified type schizophrenia, in remission
29600	Bipolar I disorder, single manic episode, unspecified
29601	Bipolar I disorder, single manic episode, mild
29602	Bipolar I disorder, single manic episode, moderate
29603	Bipolar I disorder, single manic episode, severe, without mention of psychotic behavior
29604	Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior
29605	Bipolar I disorder, single manic episode, in partial or unspecified remission
29606	Bipolar I disorder, single manic episode, in full remission
29610	Manic affective disorder, recurrent episode, unspecified degree
29611	Manic affective disorder, recurrent episode, mild degree
29612	Manic affective disorder, recurrent episode, moderate degree
29613	Manic affective disorder, recurrent episode, severe degree, without mention of psychotic behavior
29614	Manic affective disorder, recurrent episode, severe degree, specified as with psychotic behavior
29615	Manic affective disorder, recurrent episode, in partial or unspecified remission
29616	Manic affective disorder, recurrent episode, in full remission
29620	Major depressive affective disorder, single episode, unspecified degree
29621	Major depressive affective disorder, single episode, mild degree
29622	Major depressive affective disorder, single episode, moderate degree
29623	Major depressive affective disorder, single episode, severe degree, without mention of psychotic behavior
29624	Major depressive affective disorder, single episode, severe degree, specified as with psychotic behavior
29625	Major depressive affective disorder, single episode, in partial or unspecified remission

Diagnosis Code	Description
29626	Major depressive affective disorder, single episode, in full remission
29630	Major depressive affective disorder, recurrent episode, unspecified degree
29631	Major depressive affective disorder, recurrent episode, mild degree
29632	Major depressive affective disorder, recurrent episode, moderate degree
29633	Major depressive affective disorder, recurrent episode, severe degree, without mention of psychotic behavior
29634	Major depressive affective disorder, recurrent episode, severe degree, specified as with psychotic behavior
29635	Major depressive affective disorder, recurrent episode, in partial or unspecified remission
29636	Major depressive affective disorder, recurrent episode, in full remission
29640	Bipolar I disorder, most recent episode (or current) manic, unspecified
29641	Bipolar I disorder, most recent episode (or current) manic, mild
29642	Bipolar I disorder, most recent episode (or current) manic, moderate
29643	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior
29644	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior
29645	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission
29646	Bipolar I disorder, most recent episode (or current) manic, in full remission
29650	Bipolar I disorder, most recent episode (or current) depressed, unspecified
29651	Bipolar I disorder, most recent episode (or current) depressed, mild
29652	Bipolar I disorder, most recent episode (or current) depressed, moderate

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Diagnosis Code	Description
29653	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior
29654	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior
29655	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission
29656	Bipolar I disorder, most recent episode (or current) depressed, in full remission
29660	Bipolar I disorder, most recent episode (or current) mixed, unspecified
29661	Bipolar I disorder, most recent episode (or current) mixed, mild
29662	Bipolar I disorder, most recent episode (or current) mixed, moderate
29663	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior
29664	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior
29665	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission
29666	Bipolar I disorder, most recent episode (or current) mixed, in full remission
2967	Bipolar I disorder, most recent episode (or current) unspecified
29680	Bipolar disorder, unspecified
29681	Atypical manic disorder
29682	Atypical depressive disorder
29689	Other and unspecified bipolar disorders, other
29690	Unspecified episodic mood disorder
29699	Other specified episodic mood disorder
2970	Paranoid state, simple
2971	Delusional disorder
2972	Paraphrenia
2973	Shared psychotic disorder
2978	Other specified paranoid states
2979	Unspecified paranoid state
2980	Depressive type psychosis

Diagnosis Code	Description
2981	Excitative type psychosis
2982	Reactive confusion
2983	Acute paranoid reaction
2984	Psychogenic paranoid psychosis
2988	Other and unspecified reactive psychosis
2989	Unspecified psychosis
29900	Autistic disorder, current or active state
29910	Childhood disintegrative disorder, current or active state
29980	Other specified pervasive developmental disorders, current or active state
29990	Unspecified pervasive developmental disorder, current or active state
30000	Anxiety state, unspecified
30001	Panic disorder without agoraphobia
30002	Generalized anxiety disorder
30009	Other anxiety states
30010	Hysteria, unspecified
30011	Conversion disorder
30012	Dissociative amnesia
30013	Dissociative fugue
30014	Dissociative identity disorder
30015	Dissociative disorder or reaction, unspecified
30016	Factitious disorder with predominantly psychological signs and symptoms
30019	Other and unspecified factitious illness
30020	Phobia, unspecified
30021	Agoraphobia with panic disorder
30022	Agoraphobia without mention of panic attacks
30023	Social phobia
30029	Other isolated or specific phobias
3003	Obsessive-compulsive disorders
3004	Dysthymic disorder
3006	Depersonalization disorder
3007	Hypochondriasis
30081	Somatization disorder
30082	Undifferentiated somatoform disorder
30089	Other somatoform disorders

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Diagnosis Code	Description
3009	Unspecified nonpsychotic mental disorder
3010	Paranoid personality disorder
30110	Affective personality disorder, unspecified
30111	Chronic hypomanic personality disorder
30112	Chronic depressive personality disorder
30113	Cyclothymic disorder
30120	Schizoid personality disorder, unspecified
30121	Introverted personality
30122	Schizotypal personality disorder
3013	Explosive personality disorder
3014	Obsessive-compulsive personality disorder
30150	Histrionic personality disorder, unspecified
30151	Chronic factitious illness with physical symptoms
30159	Other histrionic personality disorder
3016	Dependent personality disorder
3017	Antisocial personality disorder
30181	Narcissistic personality disorder
30182	Avoidant personality disorder
30183	Borderline personality disorder
30184	Passive-aggressive personality
30189	Other personality disorders
3019	Unspecified personality disorder
3020	Ego-dystonic sexual orientation
3021	Zoophilia
3022	Pedophilia
3023	Transvestic fetishism
3024	Exhibitionism
30250	Trans-sexualism with unspecified sexual history
30251	Trans-sexualism with asexual history
30252	Trans-sexualism with homosexual history
30253	Trans-sexualism with heterosexual history
3026	Gender identity disorder in children
30270	Psychosexual dysfunction, unspecified
30271	Hypoactive sexual desire disorder
30272	Psychosexual dysfunction with inhibited sexual excitement
30273	Female orgasmic disorder
30274	Male orgasmic disorder
30275	Premature ejaculation
30276	Dyspareunia, psychogenic
30279	Psychosexual dysfunction with other specified psychosexual dysfunctions
30281	Fetishism
30282	Voyeurism
30283	Sexual masochism
30284	Sexual sadism
30285	Gender identity disorder in adoles-cents or adults
30289	Other specified psychosexual disorders
3029	Unspecified psychosexual disorder
30390	Other and unspecified alcohol dependence, unspecified drinking behavior
30400	Opioid type dependence, unspecified use
30500	Nondependent alcohol abuse, unspecified drinking behavior
30501	Nondependent alcohol abuse, continuous drinking behavior
30502	Nondependent alcohol abuse, episodic drinking behavior
30503	Nondependent alcohol abuse, in remission
30520	Nondependent cannabis abuse, unspecified use
30521	Nondependent cannabis abuse, continuous use
30522	Nondependent cannabis abuse, episodic use
30523	Nondependent cannabis abuse, in remission
30530	Nondependent hallucinogen abuse, unspecified use
30531	Nondependent hallucinogen abuse, continuous use
30532	Nondependent hallucinogen abuse, episodic use
30533	Nondependent hallucinogen abuse, in remission
30540	Sedative, hypnotic or anxiolytic abuse, unspecified
30541	Sedative, hypnotic or anxiolytic abuse, continuous
30542	Sedative, hypnotic or anxiolytic abuse, episodic

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Diagnosis Code	Description
30543	Sedative, hypnotic or anxiolytic abuse, in remission
30550	Nondependent opioid abuse, unspecified use
30551	Nondependent opioid abuse, continuous use
30552	Nondependent opioid abuse, episodic use
30553	Nondependent opioid abuse, in remission
30560	Nondependent cocaine abuse, unspecified use
30561	Nondependent cocaine abuse, continuous use
30562	Nondependent cocaine abuse, episodic use
30563	Nondependent cocaine abuse, in remission
30570	Nondependent amphetamine or related acting sympathomimetic abuse, unspecified use
30571	Nondependent amphetamine or related acting sympathomimetic abuse, continuous use
30572	Nondependent amphetamine or related acting sympathomimetic abuse, episodic use
30573	Nondependent amphetamine or related acting sympathomimetic abuse, in remission
30580	Nondependent antidepressant type abuse, unspecified use
30581	Nondependent antidepressant type abuse, continuous use
30582	Nondependent antidepressant type abuse, episodic use
30583	Nondependent antidepressant type abuse, in remission
30591	Nondependent other, mixed, or unspecified drug abuse, continuous use
30592	Nondependent other, mixed, or unspecified drug abuse, episodic use
30593	Nondependent other, mixed, or unspecified drug abuse, in remission
3080	Predominant disturbance of emotions
3081	Predominant disturbance of consciousness
3082	Predominant psychomotor disturbance

Diagnosis Code	Description
3083	Other acute reactions to stress
3084	Mixed disorders as reaction to stress
3089	Unspecified acute reaction to stress
3090	Adjustment disorder with depressed mood
3091	Adjustment reaction with prolonged depressive reaction
30921	Separation anxiety disorder
30922	Emancipation disorder of adolescence and early adult life
30923	Specific academic or work inhibition
30924	Adjustment disorder with anxiety
30928	Adjustment disorder with mixed anxiety and depressed mood
30929	Other adjustment reactions with predominant disturbance of other emotions
3093	Adjustment disorder with disturbance of conduct
3094	Adjustment disorder with mixed disturbance of emotions and conduct
30981	Posttraumatic stress disorder
30982	Adjustment reaction with physical symptoms
30983	Adjustment reaction with withdrawal
3099	Unspecified adjustment reaction
3100	Frontal lobe syndrome
3101	Personality change due to conditions classified elsewhere
3102	Postconcussion syndrome
3108	Other specified nonpsychotic mental disorders following organic brain damage
311	Depressive disorder, not elsewhere classified
31200	Undersocialized conduct disorder, aggressive type, unspecified degree
31201	Undersocialized conduct disorder, aggressive type, mild degree
31202	Undersocialized conduct disorder, aggressive type, moderate degree
31203	Undersocialized conduct disorder, aggressive type, severe degree
31210	Undersocialized conduct disorder, unaggressive type, unspecified degree
31211	Undersocialized conduct disorder, unaggressive type, mild degree

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Diagnosis Code	Description
31212	Undersocialized conduct disorder, unaggressive type, moderate degree
31213	Undersocialized conduct disorder, unaggressive type, severe degree
31220	Socialized conduct disorder, unspecified degree
31221	Socialized conduct disorder, mild degree
31222	Socialized conduct disorder, moderate degree
31223	Socialized conduct disorder, severe degree
31230	Impulse control disorder, unspecified
31231	Pathological gambling
31232	Kleptomania
31233	Pyromania
31234	Intermittent explosive disorder
31235	Isolated explosive disorder
31239	Other disorders of impulse control
3124	Mixed disturbance of conduct and emotions
31281	Conduct disorder, childhood onset type
31282	Conduct disorder, adolescent onset type
31289	Other specified conduct disorder, not elsewhere classified
3130	Overanxious disorder specific to childhood and adolescence
3131	Misery and unhappiness disorder specific to childhood and adolescence
31321	Shyness disorder of childhood
31322	Introverted disorder of childhood
31323	Selective mutism
3133	Relationship problems specific to childhood and adolescence
31381	Oppositional defiant disorder
31382	Identity disorder of childhood or adolescence
31383	Academic underachievement disorder of childhood or adolescence
31389	Other emotional disturbances of childhood or adolescence
3139	Unspecified emotional disturbance of childhood or adolescence
31400	Attention deficit disorder of childhood without mention of hyperactivity

Diagnosis Code	Description
31401	Attention deficit disorder of childhood with hyperactivity
3141	Hyperkinesis of childhood with developmental delay
3142	Hyperkinetic conduct disorder of childhood
3148	Other specified manifestations of hyperkinetic syndrome of childhood
3149	Unspecified hyperkinetic syndrome of childhood
31531	Expressive language disorder
31532	Mixed receptive-expressive language disorder
3154	Developmental coordination disorder
3155	Mixed development disorder
3158	Other specified delays in development
3159	Unspecified delay in development
317	Mild mental retardation
3180	Moderate mental retardation
3181	Severe mental retardation
3182	Profound mental retardation
319	Unspecified mental retardation
320	Bacterial meningitis
3200	Hemophilus meningitis
3201	Pneumococcal meningitis
3202	Streptococcal meningitis
3203	Staphylococcal meningitis
3207	Meningitis in other bacterial diseases classified elsewhere
32081	Anaerobic meningitis
32082	Meningitis due to gram-negative bacteria, not elsewhere classified
32089	Meningitis due to other specified bacteria
3209	Meningitis due to unspecified bacterium
3210	Cryptococcal meningitis
3211	Meningitis in other fungal diseases
3212	Meningitis due to viruses not elsewhere classified
3213	Meningitis due to trypanosomiasis
3214	Meningitis in sarcoidosis
3218	Meningitis due to other nonbacterial organisms classified elsewhere
3220	Nonpyogenic meningitis
3221	Eosinophilic meningitis
3222	Chronic meningitis

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Diagnosis Code	Description
3229	Meningitis, unspecified
32301	Encephalitis and encephalomyelitis in viral diseases classified elsewhere
32302	Myelitis in viral diseases classified elsewhere
3231	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere
3232	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere
32341	Other encephalitis and encephalomyelitis due to infection classified elsewhere
32342	Other myelitis due to infection classified elsewhere
32351	Encephalitis and encephalomyelitis following immunization procedures
32352	Myelitis following immunization procedures
32361	Infectious acute disseminated encephalomyelitis (ADEM)
32362	Other postinfectious encephalitis and encephalomyelitis
32363	Postinfectious myelitis
32371	Toxic encephalitis and encephalomyelitis
32372	Toxic myelitis
32381	Other causes of encephalitis and encephalomyelitis
32382	Other causes of myelitis
3239	Unspecified causes of encephalitis, myelitis, and encephalomyelitis
3240	Intracranial abscess
3241	Intraspinal abscess
3249	Intracranial and intraspinal abscess of unspecified site
3300	Leukodystrophy
3301	Cerebral lipidoses
3302	Cerebral degeneration in generalized lipidoses
3303	Cerebral degeneration of childhood in other diseases classified elsewhere
3308	Other specified cerebral degenerations in childhood
3309	Unspecified cerebral degeneration in childhood
33111	Pick’s Disease

Diagnosis Code	Description
33119	Other frontotemporal dementia
3312	Senile degeneration of brain
3313	Communicating hydrocephalus
3314	Obstructive hydrocephalus
3317	Cerebral degeneration in diseases classified elsewhere
33181	Reye’s syndrome
33182	Dementia with lewy bodies
3319	Cerebral degeneration, unspecified
33392	Neuroleptic malignant syndrome
340	Multiple sclerosis
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy
34510	Generalized convulsive epilepsy, without mention of intractable epilepsy
34511	Generalized convulsive epilepsy, with intractable epilepsy
3452	Petit mal status, epileptic
3453	Grand mal status, epileptic
34540	Partial epilepsy, without mention of intractable epilepsy
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
34560	Infantile spasms, without mention of intractable epilepsy
34561	Infantile spasms, with intractable epilepsy
34570	Epilepsia partialis continua, without mention of intractable epilepsy
34571	Epilepsia partialis continua, with intractable epilepsy
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
34590	Epilepsy, unspecified, without mention of intractable epilepsy

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Diagnosis Code	Description
34591	Epilepsy, unspecified, with intractable epilepsy
3480	Cerebral cysts
3481	Anoxic brain damage
34830	Encephalopathy, unspecified
34831	Metabolic encephalopathy
34839	Other encephalopathy
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
43300	Occlusion and stenosis of basilar artery without mention of cerebral infarction
43301	Occlusion and stenosis of basilar artery with cerebral infarction
43311	Occlusion and stenosis of carotid artery with cerebral infarction
43321	Occlusion and stenosis of vertebral artery with cerebral infarction
43331	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction
43381	Occlusion and stenosis of other specified precerebral artery with cerebral infarction
43391	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43411	Cerebral embolism with cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
4350	Basilar artery syndrome
4351	Vertebral artery syndrome
4352	Subclavian steal syndrome
4353	Vertebrobasilar artery syndrome
4358	Other specified transient cerebral ischemias
4359	Unspecified transient cerebral ischemia
436	Acute, but ill-defined, cerebrovascular disease
4370	Cerebral atherosclerosis
4371	Other generalized ischemic cerebrovascular disease
4372	Hypertensive encephalopathy
4373	Cerebral aneurysm, nonruptured
4374	Cerebral arteritis

Diagnosis Code	Description
4375	Moyamoya disease
4376	Nonpyogenic thrombosis of intracranial venous sinus
4377	Transient global amnesia
4378	Other ill-defined cerebrovascular disease
4379	Unspecified cerebrovascular disease
4380	Cognitive deficits
43811	Aphasia
43812	Dysphasia
43819	Other speech and language deficits
43820	Hemiplegia affecting unspecified side
43821	Hemiplegia affecting dominant side
43822	Hemiplegia affecting nondominant side
43830	Monoplegia of upper limb affecting unspecified side
43831	Monoplegia of upper limb affecting dominant side
43832	Monoplegia of upper limb affecting nondominant side
43840	Monoplegia of lower limb affecting unspecified side
43841	Monoplegia of lower limb affecting dominant side
43842	Monoplegia of lower limb affecting nondominant side
43850	Other paralytic syndrome affecting unspecified side
43851	Other paralytic syndrome affecting dominant side
43852	Other paralytic syndrome affecting nondominant side
43853	Other paralytic syndrome, bilateral
43881	Apraxia
43882	Dysphagia
43883	Facial weakness
43884	Ataxia
43885	Vertigo
43889	Other late effects of cerebrovascular disease
4389	Unspecified late effects of cerebrovascular disease
7685	Severe birth asphyxia
7686	Mild or moderate birth asphyxia
77210	Intraventricular hemorrhage unspecified grade

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Diagnosis Code	Description
77211	Intraventricular hemorrhage grade I
77212	Intraventricular hemorrhage grade II
77213	Intraventricular hemorrhage grade III
77214	Intraventricular hemorrhage grade IV
7722	Subarachnoid hemorrhage of newborn
7790	Convulsions in newborn
78031	Febrile convulsions (simple), unspecified
78039	Other convulsions
7990	Asphyxia and hypoxemia
8500	Concussion with no loss of consciousness
85011	Concussion, with loss of consciousness of 30 minutes or less
85012	Concussion, with loss of consciousness from 31 to 59 minutes
8502	Concussion with moderate loss of consciousness
8503	Concussion with prolonged loss of consciousness and return to pre-existing conscious level
8504	Concussion with prolonged loss of consciousness, without return to pre-existing conscious level
8505	Concussion with loss of consciousness of unspecified duration
8509	Concussion, unspecified
85100	Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified
85101	Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness
85102	Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85103	Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85104	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85105	Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85106	Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85109	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified
85110	Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness
85111	Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness
85112	Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85113	Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85114	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85115	Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85116	Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration
85120	Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified
85121	Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness
85122	Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness

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Diagnosis Code	Description
85123	Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85124	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85125	Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85126	Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85129	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified
85130	Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified
85131	Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness
85132	Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85133	Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85134	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85135	Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85136	Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration
85139	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified

Diagnosis Code	Description
85140	Cerebellar or brain stem contusion without mention of open intracranial wound, with state of consciousness unspecified
85141	Cerebellar or brain stem contusion without mention of open intracranial wound, with no loss of consciousness
85142	Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85143	Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85144	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss consciousness and return to pre-existing conscious level
85145	Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85146	Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration
85149	Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified
85150	Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified
85151	Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness
85152	Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness
85153	Cerebellar or brain stem contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85154	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level

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Diagnosis Code	Description
85155	Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85156	Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration
85159	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified
85160	Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified
85161	Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness
85162	Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85163	Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85164	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85165	Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85166	Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration
85169	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified
85170	Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified
85171	Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness
85172	Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness
85173	Cerebellar or brain stem laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85174	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85175	Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85176	Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration
85179	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified
85180	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified
85181	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness
85182	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85183	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85184	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85185	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
85186	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85189	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified
85190	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified
85191	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness
85192	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness
85193	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85194	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85195	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85196	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration
85199	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified
85200	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85201	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness

Diagnosis Code	Description
85202	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85203	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85204	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85205	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85206	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85209	Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85210	Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85211	Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85212	Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85213	Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85214	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85215	Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level

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Diagnosis Code	Description
85216	Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85219	Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85220	Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85221	Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85222	Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85223	Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85224	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85225	Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85226	Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85229	Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85230	Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85231	Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85232	Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85233	Subdural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85234	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85235	Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85236	Subdural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85239	Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85240	Extradural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85241	Extradural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85242	Extradural hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness
85243	Extradural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85244	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85245	Extradural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85246	Extradural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85249	Extradural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85250	Extradural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85251	Extradural hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85252	Extradural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85253	Extradural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85254	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85255	Extradural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85256	Extradural hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration
85259	Extradural hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85300	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified
85301	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness
85302	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85303	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85304	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre- existing conscious level
85305	Other and unspecified intracranial hemorrhage following injury. without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85306	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85309	Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified
85310	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified
85311	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness
85312	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness
85313	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness
85314	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85315	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85316	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration

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Diagnosis Code	Description
85319	Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified
85400	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with state of consciousness unspecified
85401	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with no loss of consciousness
85402	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness
85403	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness
85404	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level
85405	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
85406	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness of unspecified duration
85409	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with concussion, unspecified
986	Toxic effect of carbon monoxide
9941	Drowning and nonfatal submersion
9947	Asphyxiation and strangulation
V110	Personal history of schizophrenia
V111	Personal history of affective disorders
V112	Personal history of neurosis
V113	Personal history of alcoholism
V170	Family history of psychiatric condition
V401	Mental and behavioral problems with communication (including speech)
V402	Other mental problems
V695	Behavioral insomnia of childhood
V7101	Observation of adult antisocial behavior
V7102	Observation of childhood or adolescent antisocial behavior
V790	Screening for depression
V791	Screening for alcoholism
V792	Screening for mental retardation
V793	Screening for developmental handicaps in early childhood
V798	Screening for other specified mental disorders and developmental handicaps

All claims for psychiatric procedure codes 1-90845, 1-90847, 1-90853, and 1-90857 referenced to the following diagnoses must include documentation that supports medical necessity.

Procedure code 1-90801 billed with the following diagnoses does not require documentation:

Diagnosis Code	Description
2940	Amnestic syndrome
29410	Dementia in condition classified elsewhere without behavioral disturbance
29411	Dementia in condition classified elsewhere with behavioral disturbance
2948	Organic brain syndrome NEC
2949	Organic brain syndrome NOS

Psychological testing (procedure code 5-96101) and neuropsychological testing (procedure code 5-96118) are limited to a total of four hours per day and eight hours per calendar year per client for any provider. Providers must maintain documentation in the client's chart that supports the medical necessity for each test.

If the client requires more than four hours of psychological or neuropsychological testing per day or more than eight hours per calendar year, prior authorization is required. Additional documentation must be submitted that supports the medical necessity for the additional hours requested. This includes a record of all of the tests that were previously performed and a complete history that reflects the need for each requested test.

Each hour of examination, therapy, psychological, and/or neuropsychological testing will count toward the 12 hours per day limitation and as one visit/encounter towards the 30 visit/encounter limit.

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Procedure codes 5-96101 and 5-96118 include the testing, interpretation, and report and will not be reimbursed separately. Providers must bill the preponderance of each quarter hour of testing and indicate that number of units on the claim form. Document the number of hours in Block 24G of the CMS-1500 claim form.

Procedure code 5-96118 will be denied when billed on the same day as procedure code 5-96101 by any provider.

Procedure code 5-96101 or 5-96118 is payable on the same day as procedure code 1-90801 or 1-90802.

The following is a list of psychiatric-related procedure codes:

Procedure Codes				
1-90801	1-90802	1-90804	1-90805	1-90806
1-90807	1-90808	1-90809	1-90810	1-90811
1-90812	1-90813	1-90814	1-90815	1-90816
1-90816	1-90817	1-90818	1-90819	1-90821
1-90822	1-90823	1-90824	1-90826	1-90827
1-90828	1-90829	1-90845	1-90847	1-90853
1-90857	1-90862	1-90865	1-90870	1-90899
1-96101				

38.3.2 Outpatient Behavioral Health Services

An interactive interview (procedure code 1-90802) may be covered to the extent it is medically necessary. Examples of medical necessity include, but are not limited to:

- Clients whose ability to communicate is impaired by an expressive or receptive language impairment from various causes, such as conductive or sensorineural hearing loss, deaf mutism, or aphasia.
- A diagnostic interview may be incorporated into an evaluation and management (E/M) service provided the required elements of the E/M service are fulfilled.
- A diagnostic interview examination (procedure codes 1-90801, 1-90802) will be denied as part of any E/M service when billed for the same date of service by the same provider.

Documentation for diagnostic interview examinations must include:

- Reason for referral/presenting problem
- Prior history, including prior treatment
- Other pertinent medical, social, and family history
- Clinical observations and mental status examinations
- Complete *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition* (DSM-IV) diagnosis
- Recommendations, including expected long term and short term benefits
- For the interactive diagnostic interview (procedure code 1-90802), the medical record must indicate the adaptations utilized in the session and the rationale for employing these interactive techniques

38.3.3 Therapy

When multiple counseling codes are billed by the same provider on the same day, only the most inclusive code will be paid.

If procedure code 1-90802 and 1-90801 are billed on the same day by the same provider, 1-90802 will be denied as part of another procedure billed on the same day. Procedure codes 1-90801 and 1-90802 are limited to once per day per client by any provider, regardless of the number of professionals involved in the interview, and once per year per provider (same provider) in any setting.

If procedure code 1-90801 or 1-90802 is billed, the following procedure codes will be denied as part of the initial psychiatric exam if billed on the same day by the same provider:

Procedure Codes				
1-90804	1-90806	1 90808	1-90810	1-90812
1-90814	1-90816	1 90818	1-90821	1-90823
1-90826	1-90828	1-90845	1-90847	1 90853
1-90857				

Procedure codes 1-90846 and 1-90849 are *not* reimbursed by the Texas Medicaid Program. Outpatient psychotherapy (procedure codes 1-90804, 1-90847, 1-90853, and 1-90857) billed on the same date of service as narcosynthesis (procedure code 1-90865) or psychoanalysis (procedure code 1-90845) will be denied.

When billing or providing procedure code 1-90847, note the following requirements for Medicaid reimbursement:

- The client must be present when family therapy/ counseling services are provided.
- Family therapy/counseling is only reimbursable for one family member per session.

Counseling billed by a licensed psychologist must be billed using the following procedure codes:

Procedure Codes				
1-90801	1-90802	1-90804	1 90806	1 90808
1-90810	1-90812	1-90814	1-90847	1-90853
1-90857				

Psychoanalysis must be billed using procedure code 1-90845.

Counseling will be denied if any of the procedure codes in the table below are billed on the same day as procedure code 1-90845.

Procedure Codes				
1 90804	1-90806	1-90808	1-90810	1-90812
1 90814	1-90816	1-90818	1-90821	1-90823
1 90826	1-90828	1-90847	1-90853	1-90857

When individual, group, or family counseling is billed by any provider on the same day, each type of session will be paid. When multiples of each type of session are billed, the most inclusive will be paid and the others will be denied.

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When billing for contracted therapy services provided to Medicaid clients who are younger than 21 years of age and reside in a residential treatment facility, use place of service (POS) 9 (other location).

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of Temporary Assistance for Needy Families. The following specific relatives are included in family counseling services:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

The following psychiatric services are not covered by the Texas Medicaid Program (except where specifically indicated in other sections):

- Services provided by an LCDC, psychiatric nurse, mental health worker, or psychologist assistant
- Thermogenic therapy, recreational therapy, psychiatric daycare, and biofeedback, music or dance therapy
- Hypnosis
- Adult activity and individual activity (these types of services would be payable only if guidelines of group therapy are met and are termed group therapy)

Procedure codes 1-90846 and 1-90849 are not covered benefits for Texas Medicaid for any provider.

38.4 Documentation Requirements

Services not supported by required documentation in the client's record and medical necessity will be subject to recoupment.

Each client for whom services are billed must have the following documentation (which meets the standards indicated) included in their record:

- All entries are clearly documented and legible to individuals other than the author, date (month/day/year), and signed by the performing provider.
- Notations of the beginning and ending session times for counseling and/or each test administered.
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
  - Name of test(s) (e.g., Wechsler Adult Intelligence Scale–Revised [WAIS-R], Rorschach, Minnesota Multiphasic Personality Inventory [MMPI])
  - Background and history of client and reason for testing
  - Behavioral observations during the session
  - Narrative description of the counseling session or test findings
  - Diagnosis (symptoms, impressions)
  - Treatment plan and recommendations
  - Explanation to substantiate the necessity of retesting, if applicable

38.5 Claims Information

Services provided by an independently practicing licensed psychologist must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice; TMHP does not supply them.

Providers must bill Medicare before Medicaid. Medicaid's responsibility for the coinsurance and/or deductible is determined in accordance with Medicaid benefits and limitations. Providers must check the client's Medicare card for Part B coverage before billing the Texas Medicaid Program. When Medicare is primary, it is inappropriate to bill Medicaid without first billing Medicare. The Texas Medicaid Program is responsible for the coinsurance and deductible of Medicare-allowed services on a crossover basis only.

Refer to: "Part B" on page 2-8.

"Medicare Part B Crossovers" on page 4-12.

38.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Psychiatric Hospital Inpatient Admission Form	B-74
Request for Extended Outpatient Psychotherapy/Counseling Form	B-81
Psychologist Claim Example	D-28
Acronym Dictionary	F-1

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Section

39

Radiological and Physiological Laboratory and Portable X-Ray Supplier

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39.1 Enrollment

To enroll in the Texas Medicaid Program, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC). Providers must submit a certificate containing their BRC certification number, dates of issue and expiration, type of service, and Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers. For more information, contact TMHP Provider Enrollment:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: 1-512-514-4214

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

39.1.1 Medicaid Managed Care Enrollment

Radiological, physiological laboratory, and portable X-ray suppliers may be eligible to enroll in the Medicaid Managed Care programs as primary care providers. Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Managed Care" on page 7-1

39.2 Reimbursement

The Medicaid rates for radiological and physiological laboratory and portable X-ray supplier providers are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8081 and §355.8085. The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website. These services are *not* payable when the client is in an inpatient setting, as they are included in the diagnosis related group (DRG) payment.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

39.3 Benefits and Limitations

Medicaid pays only up to the amount allowed for the total component for the same procedure, same client, same date of service, and any provider. Providers who perform the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component; those who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, and any provider are denied. Claims are paid based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical and/or interpretation component for the same procedure, same date of service, same client, and any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

The following procedure codes are payable to radiological laboratories, physiological laboratories, and portable X-ray suppliers.

Descriptions of the following procedure codes can be found in the *Physician's Common Procedural Terminology* (CPT) Manual:

Procedure Codes		
4/I/T-70030	4/I/T-70100	4/I/T-70110
4/I/T-70120	4/I/T-70130	4/I/T-70134
4/I/T-70140	4/I/T-70150	4/I/T-70160
4/I/T-70170	4/I/T-70190	4/I/T-70200
4/I/T-70210	4/I/T-70220	4/I/T-70240
4/I/T-70332	4/I/T-70336	4/I/T-70350
4/I/T-70355	4/I/T-70360	4/I/T-70370
4/I-70371	4/I/T-70373	4/I/T-70380
4/I/T-70390	4/I/T-70450	4/I/T-70480
4/I/T-70486	4/I/T-70490	4/I/T-70496
4/I/T-70498	4/I/T-70540	4/I/T-70542
4/I/T-70543	4/I/T-70544	4/I/T-70545
4/I/T-70546	4/I/T-70547	4/I/T-70548
4/I/T-70549	4/I/T-70551	4/I/T-70552
4/I/T-70553	4/I/T-71010	4/I/T-71015
4/I/T-71020	4/I/T-71021	4/I/T-71022
4/I/T-71023	4/I/T-71030	4/I/T-71034
4/I/T-71035	4/I/T-71100	4/I/T-71101
4/I/T-71110	4/I/T-71111	4/I/T-71120
4/I/T-71130	4/I/T-71250	4/I/T-71275
4/I/T-71550	4/I/T-71551	4/I/T-71552
4/I/T-72010	4/I/T-72020	4/I/T-72040
4/I/T-72050	4/I/T-72052	4/I/T-72069
4/I/T-72070	4/I/T-72072	4/I/T-72074
4/I/T-72080	4/I/T-72090	4/I/T-72100
4/I/T-72110	4/I/T-72114	4/I/T-72120
4/I/T-72125	4/I/T-72128	4/I/T-72131
4/I/T-72141	4/I/T-72146	4/I/T-72148
4/I/T-72156	4/I/T-72157	4/I/T-72158
4/I/T-72170	4/I/T-72190	4/I/T-72191
4/I/T-72192	4/I/T-72195	4/I/T-72196

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Procedure Codes		
4/I/T-72197	4/I/T-72198	4/I/T-72200
4/I/T-72202	4/I/T-72220	4/I/T-73000
4/I/T-73010	4/I/T-73020	4/I/T-73030
4/I/T-73050	4/I/T-73060	4/I/T-73070
4/I/T-73080	4/I/T-73090	4/I/T-73092
4/I/T-73100	4/I/T-73110	4/I/T-73120
4/I/T-73130	4/I/T-73140	4/I/T-73200
4/I/T-73206	4/I/T-73218	4/I/T-73219
4/I/T-73220	4/I/T-73221	4/I/T-73222
4/I/T-73223	4/I/T-73225	4/I/T-73500
4/I/T-73510	4/I/T-73520	4/I/T-73530
4/I/T-73540	4/I/T-73542	4/I/T-73550
4/I/T-73560	4/I/T-73562	4/I/T-73564
4/I/T-73565	4/I/T-73590	4/I/T-73592
4/I/T-73600	4/I/T-73610	4/I/T-73620
4/I/T-73630	4/I/T-73650	4/I/T-73660
4/I/T-73700	4/I/T-73706	4/I/T-73718
4/I/T-73719	4/I/T-73720	4/I/T-73721
4/I/T-73722	4/I/T-73723	4/I/T-73725
4/I/T-74000	4/I/T-74010	4/I/T-74020
4/I/T-74022	4/I/T-74150	4/I/T-74175
4/I/T-74181	4/I/T-74182	4/I/T-74183
4/I/T-74185	4/I/T-74190	4/I/T-74210
4/I/T-74220	4/I/T-74230	4/I/T-74240
4/I/T-74241	4/I/T-74245	4/I/T-74250
4/I/T-75635	4-75952	4/I/T-75989
4/I/T-76010	4/I/T-76012	4/I/T-76013
4/I/T-76020	4/I/T-76040	4/I/T-76061
4/I/T-76062	4/I/T-76065	4/I/T-76066
4/I/T-76090	4/I/T-76091	4/I/T-76092
4/I/T-76100	4/I/T-76101	4/I/T-76102
4/I/T-76350	4/I/T-76355	4/I/T-76360
4/I/T-76376	4/I/T-76377	4/I/T-76380
4/I/T-76390	4/I/T-76393	4/I/T-76400
4/I/T-76496	4/I/T-76497	4/I/T-76498
4/I/T-76499	4/I/T-76506	4/I/T-76510
4/I/T-76511	4/I/T-76512	4/I/T-76513
4/I/T-76516	4/I/T-76519	4/I/T-76529
4/I/T-76536	4/I/T-76604	4/I/T-76645
4/I/T-76700	4/I/T-76705	4/I/T-76770
4/I/T-76775	4/I/T-76778	4/I/T-76800
4/I/T-76801	4/I/T-76802	4/I/T-76805
4/I/T-76810	4/I/T-76811	4/I/T-76812
4/I/T-76815	4/I/T-76816	4/I/T-76817

Procedure Codes		
4/I/T-76818	4/I/T-76819	4/I/T-76820
4/I/T-76821	4/I/T-76825	4/I/T-76826
4/I/T-76827	4/I/T-76828	4/I/T-76830
4/I/T-76831	4/I/T-76856	4/I/T-76857
4/I/T-76870	4/I/T-76872	4/I/T-76873
4/I/T-76880	4/I/T-76940	4/I/T-76950
4/I/T-76965	4/I/T-76970	4/I/T-76975
4/I/T-76977	4/I/T-76991	4/I/T-76999
4/I/T-78070	4/I/T-78199	4/I/T-78299
4/I/T-78350	4/I/T-78473	4/I/T-78478
4/I/T-78480	4/I/T-78483	4/I/T-78499
4/I/T-78599	4/I/T-78999	5/I-91065
1/I/T-92135	1-92285	5/I/T-92542
1/I/T-92543	1/I/T-92544	1/I/T-92545
1/I/T-92546	5/I-92553	5/I-92555
5/I-92556	5/I-92557	5/I-92561
5/I-92562	5/I-92563	I-92564
5/I-92565	5/I-92568	5/I-92569
5/I-92571	5/I-92572	5/I-92573
5/I-92575	5/I-92577	5/I-92584
5-92586	T-93005	5-93012
5-93015	T-93017	I-93018
5-93040	T-93041	5-93224
T-93225	T-93226	5-93230
T-93231	T-93232	5-93235
T-93236	5-93268	5-93270
5-93271	5/I/T-93278	4/I/T-93307
4/I/T-93308	4/I/T-93312	4/I/T-93313
4/I/T-93314	4/I/T-93315	4/I/T-93316
4/I/T-93317	4/I/T-93318	4/I/T-93320
4/I/T-93321	4/I/T-93325	4/I/T-93350
5-93720	T-93721	5/I/T-93724
5/I/T-93731	5/I/T-93732	5/I/T-93733
5/I/T-93734	5/I/T-93735	5/I/T-93736
5/I/T-93799	4/I/T-93875	4/I/T-93880
4/I/T-93882	4/I/T-93886	4/I/T-93888
4/I/T-93890	4/I/T-93892	4/I/T-93893
4/I/T-93922	4/I/T-93923	4/I/T-93924
4/I/T-93925	4/I/T-93926	4/I/T-93930
4/I/T-93931	4/I/T-93965	4/I/T-93970
4/I/T-93971	4/I/T-93975	4/I/T-93976
4/I/T-93978	4/I/T-93979	4/I/T-93980
4/I/T-93981	5/I/T-94010	5-94014
5-94015	5-94016	5/I/T-94060

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Procedure Codes		
5/I/T-94070	5/I/T-94150	5/I/T-94200
5/I/T-94240	5/I/T-94250	5/I/T-94260
5/I/T-94350	5/I/T-94360	5/I/T-94370
5/I/T-94375	5/I/T-94400	5/I/T-94450
5/I/T-94620	5/I/T-94621	5/I/T-94680
5/I/T-94681	5/I/T-94690	5/I/T-94720
5/I/T-94725	5/I/T-94750	5/I/T-94772
5/I/T-94799	5/I/T-95805	5/I/T-95808
5/I/T-95810	5/I/T-95811	5/I/T-95812
5/I/T-95813	5/I/T-95816	5/I/T-95819
5/I/T-95822	5/I/T-95824	5/I/T-95827
5/I/T-95860	5/I/T-95861	5/I/T-95863
5/I/T-95864	5/I/T-95865	5/I/T-95866
5/I/T-95867	5/I/T-95868	5/I/T-95870
5/I/T-95872	5/I/T-95900	5/I/T-95903
5/I/T-95904	5/I/T-95925	5/I/T-95926
5/I/T-95927	5/I/T-95933	5/I/T-95934
5/I/T-95936	5/I/T-95937	5/I/T-95950
5/I/T-95951	5/I/T-95953	5/I/T-95956
5/I/T-95958		

39.3.1 Magnetic Resonance Angiography (MRA)

MRA is a technique which allows the noninvasive visualization and study of blood vessels through either two-dimensional (2-D) or three-dimensional (3-D) image reconstruction. The advantages of this noninvasive radiologic test include its safety, large field of view, and the ability to demonstrate complicated 3-D relationships without the need for nephrotoxic contrast media.

MRA of the head and neck may be considered for reimbursement when indicated and utilized for the visualization and ruling out of cerebrovascular disease, subarachnoid and intracerebral hemorrhage, and occlusion and stenosis of intracranial vessels. Procedure codes 4/I/T-70544, 4/I/T-70545, 4/I/T-70546, 4/I/T-70547, 4/I/T-70548, and 4/I/T-70549 will be denied for all other diagnoses.

The following procedure codes are a benefit of the Texas Medicaid Program:

Procedure Codes		
4/I/T-70544	4/I/T-70545	4/I/T-70546
4/I/T-70547	4/I/T-70548	4/I/T-70549
4/I/T-71555	4/I/T-72159	4/I/T-72198
4/I/T-73225	4/I/T-74185	

MRA of the chest (procedure code 4/I/T-71555) may be indicated and considered for reimbursement for the evaluation of coronary artery disease or anomalous arterio-pulmonary systems. It may be utilized to identify thoracic aneurysms or pulmonary emboli in cases where contrast material is contraindicated. MRAs are also indicated to evaluate the coronary vessels in coronary artery disease, vasculitis, or vessel patency postoperatively.

MRA of the abdomen (procedure code 4/I/T-74185) may be considered for reimbursement when indicated to assess the main renal arteries, for the evaluation of renal artery stenosis, abdominal aortic aneurysm or dissection, and/or associated veno-occlusive disease.

MRA of the pelvis (procedure code 4/I/T-72198) may be considered for reimbursement for evaluation of pelvic arteries for stenosis and the detection, grading, and differentiation of renovascular disease.

MRA of the lower extremities (procedure code (procedure code 4/I/T-73725) may be considered for reimbursement 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.

39.3.2 Magnetic Resonance Imaging (MRI)

MRI is a noninvasive nuclear procedure for imaging tissues of high fat and water content, which are poorly seen with other radiologic techniques. MRI is a covered benefit of the Medicaid Program when medically indicated.

When a computerized axial tomography (CAT) scan and an MRI of the *same* body area are performed on the same day, the CAT scan will be paid and the MRI will be denied as part of an overlapping diagnostic procedure. Additional MRIs or CAT scans of entirely different body areas performed on the same day will be paid with documentation of medical necessity.

MRI procedures that specify "with contrast" include payment for paramagnetic contrast, therefore, low osmolar contrast material is not reimbursed separately.

MRI of the breast (procedure codes 4/I/T-76093 and 4/I/T-76094) will be reimbursed by the Texas Medicaid program, when billed for the following diagnosis codes:

Diagnosis Code	Description
99654	Mechanical complication of breast prosthesis
99669	Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft
99679	Other complications due to other internal prosthetic device, implant, and graft

Procedure codes 4/I/T-76093 and 4/I/T-76094 will be denied for all other diagnoses.

A freestanding MRI facility may bill type of service (TOS) T for the technical portion only. The radiologist or neurologist who then reads the MRI may bill using TOS I for

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interpretation only. Additionally, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill using TOS I for interpretation.

Refer to: "Hospital (Medical/Surgical Acute Care Facility)" on page 25-1.
"Physician" on page 36-1 for more information on MRI and contrast material.

39.3.3 Positron-Emission Tomography (PET) Scans

A PET scan is a noninvasive nuclear medicine procedure that images the chemical activity of body organs and tissues. The PET scan uses electronic detection of short-lived positron-emitting radiopharmaceuticals to measure metabolic, biochemical, and functional activity in tissue. A scanner then measures radioactivity as it is dispersed throughout the body, creating three-dimensional pictures of tissue function.

The following procedure codes are a benefit of the Texas Medicaid Program. Prior authorization is required with documentation of medical necessity.

Procedure Codes		
4/I/T-78608	4/I/T-78609	4/I/T-78811
4/I/T-78812	4/I/T-78813	4/I/T-78814
4/I/T-78815	4/I/T-78816	

39.3.3.1 Brain Imaging

Brain imaging PET scans are a benefit when either of the following is true:

- "When used as part of a pre-surgical evaluation to localize a focus of refractory seizure activity with documentation of a history of seizures that are not controlled through medications"
- "When differentiating recurrent brain tumors from scar tissue with documentation of a history of a primary brain tumor and a plan of treatment"

39.3.3.2 Tumor Imaging

Tumor-imaging PET scans are a benefit and are limited to staging and restaging of recurrent tumors in which the PET scan may assist in determining the optimal clinical management of the client.

Procedure codes 78459, 78491, and 78492 are *not* a benefit of the Texas Medicaid Program.

When requesting prior authorization for tumor-imaging PET scans, the provider must submit supporting documentation which indicates that standard imaging was not conclusive and that the provider's rationale for this procedure supports medical necessity.

39.3.4 Computerized Axial Tomography (CAT) Scan

The Texas Medicaid Program pays for CAT scans for specific diagnoses.

When a CAT scan and an MRI of the *same* body area are performed on the same day, the CAT scan will be paid and the MRI will be denied as part of an overlapping diagnostic procedure. Additional MRIs and/or CAT scans of entirely different body areas performed on the same day will be paid with documentation of medical necessity.

Freestanding facilities may bill for CAT scans using TOS T for technical component only. The radiologist or neurologist who then reads the scan bills TOS I for interpretation only.

39.3.5 Prior Authorization for Radiology Services

Traditional Medicaid and PCCM require prior authorization or retrospective authorization for:

- MRI
- MRA
- Computed Tomography Imaging (CT)
- Computed Tomography Angiography (CTA)

Authorization is not required for emergency department or inpatient hospital MRI, MRA, CT, or CTA.

Prior authorization is required for all outpatient nonemergent CT, CTA, MRI, and MRA studies (e.g., those that are preplanned or scheduled) before services are rendered. Retrospective authorization is required for outpatient emergent studies when the physician determines that a medical emergency that imminently threatens life or limb exists, and the medical emergency requires advanced diagnostic imaging (CT, CTA, MRI, or MRA). Additional studies may be conducted at the time of the test if they are medically indicated by the radiologist. Providers must submit a retrospective authorization request no later than seven calendar days after the study has been completed. A copy should be maintained in the client's medical record. If radiology services are ordered by a referring physician who is not a Medicaid-enrolled provider in places of service, such as teaching facilities, federally qualified health care centers, and rural health clinics, the Radiology Prior Authorization Request Form must be signed by the referring physician and must include the group or supervising physician's provider identifier.

The addition of post 3-D reconstruction (procedure codes 4/I/T-76376 and 4/I/T-76377) CT and MR studies must be prior authorized. No additional payment will be made without prior authorization.

Providers and facilities are required to use the lowest possible radiation dose that is consistent with acceptable image quality for CT examinations of children. It is recommended that providers and facilities utilize national standards for CT imaging, such as those in the *Practice Guidelines for Performing and Interpreting Diagnostic CT examinations*, which was created by the American College of Radiology.

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Nationally-accepted guidelines and radiology protocols that are based on medical literature are utilized in the authorization processes for both emergent and nonemergent studies.

The medical literature includes the works of the: American College of Radiology (specifically, the Appropriateness Criteria), American Academy of Neurology, American Academy of Orthopedic Surgeons, American College of Cardiology, American Heart Association, and National Comprehensive Cancer Care Network.

Prior authorization of nonemergent and emergent retrospective authorization of CT, CTA, MRI, and MRA studies are considered on an individual basis using standard evidence-based guidelines to evaluate the request. Documentation must support medical necessity for the study.

Providers may request prior or retrospective authorization by calling the TMHP Radiology Services Prior Authorization Line at 1-800-572-2116, by fax to 1-888-693-3210, or by mail to:

Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

Please be prepared to provide the following patient information for all requests:

- Diagnosis
- Treatment history
- Treatment plan
- Medications
- Previous imaging results

Providers may be requested to provide additional documentation. Requests that are faxed or mailed must be accompanied by a Radiology Prior Authorization Form. The Radiology Prior Authorization Form must be completed, signed, and dated by the ordering physician before submitting the request for authorization of CT, CTA, MRI, or MRA studies, regardless of the method of request for authorization. The physician's signature must be current, unaltered, original, and handwritten. A computerized or stamped signature will not be accepted. The physician who ordered the test(s) must keep the completed form with original signature in the client's medical record. In addition, medical record documentation must support the medical necessity of the study. Authorization requirements for both nonemergent and emergent studies must be met in order to be considered for reimbursement. In the absence of authorization, both the technical and professional interpretation components will be denied.

Claims for emergency CT, CTA, MRI, and MRA studies provided in the emergency department must be submitted with modifier U6 and must have the appropriate corresponding emergency services revenue code.

If two CTs, CTAs, MRAs, or MRIs are performed in the emergency room or in an out patient setting on the same day without an authorization on file, the second procedure will be denied. Providers may submit additional medical necessity documentation for payment reconsideration.

The following procedure codes require authorization:

Procedure Codes		
B-350	B-351	B-352
B-359	B-610	B-611
B-612	B-619	4/I/T-70336
4/I/T-70450	4/I/T-70460	4/I/T-70470
4/I/T-70480	4/I/T-70481	4/I/T-70482
4/I/T-70486	4/I/T-70487	4/I/T-70488
4/I/T-70490	4/I/T-70491	4/I/T-70492
4/I/T-70496	4/I/T-70498	4/I/T-70540
4/I/T-70543	4/I/T-70544	4/I/T-70545
4/I/T-70546	4/I/T-70547	4/I/T-70542
4/I/T-70548	4/I/T-70549	4/I/T-70551
4/I/T-70552	4/I/T-70553	4/I/T-71250
4/I/T-71260	4/I/T-71270	4/I/T-71275
4/I/T-71551	4/I/T-71552	4/I/T-71555
4/I/T-72125	4/I/T-71550	4/I/T-72126
4/I/T-72127	4/I/T-72128	4/I/T-72129
4/I/T-72130	4/I/T-72132	4/I/T-72133
4/I/T-72141	4/I/T-72142	4/I/T-72131
4/I/T-72147	4/I/T-72148	4/I/T-72149
4/I/T-72156	4/I/T-72146	4/I/T-72158
4/I/T-72159	4/I/T-72191	4/I/T-72192
4/I/T-72157	4/I/T-72194	4/I/T-72195
4/I/T-72196	4/I/T-72197	4/I/T-72193
4/I/T-73200	4/I/T-73201	4/I/T-73202
4/I/T-73206	4/I/T-72198	4/I/T-73219
4/I/T-73220	4/I/T-73221	4/I/T-73222
4/I/T-73218	4/I/T-73225	4/I/T-73700
4/I/T-73701	4/I/T-73702	4/I/T-73223
4/I/T-73718	4/I/T-73719	4/I/T-73720
4/I/T-73721	4/I/T-73706	4/I/T-73723
4/I/T-73725	4/I/T-74150	4/I/T-74160
4/I/T-73722	4/I/T-74175	4/I/T-74181
4/I/T-74182	4/I/T-74183	4/I/T-74170
4/I/T-75552	4/I/T-75553	4/I/T-75554
4/I/T-75555	4/I/T-74185	4/I/T-75635
4/I/T-76093	4/I/T-76094	4/I/T-76355
4/I/T-75556	4/I/T-76377	4/I/T-76380
4/I/T-76390	4/I/T-76400	4/I/T-76376

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39.3.6 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (procedure codes 4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a covered benefit for the following diagnosis codes:

Diagnosis Code	Description
3526	Multiple cranial nerve palsies
3940	Mitral stenosis
3941	Rheumatic mitral insufficiency
3942	Mitral stenosis with insufficiency
3949	Other and unspecified mitral valve diseases
3950	Rheumatic aortic stenosis
3951	Rheumatic aortic insufficiency
3952	Rheumatic aortic stenosis with insufficiency
3959	Other and unspecified rheumatic aortic diseases
3960	Mitral valve stenosis and aortic valve stenosis
3961	Mitral valve stenosis and aortic valve insufficiency
3962	Mitral valve insufficiency and aortic valve stenosis
3963	Mitral valve insufficiency and aortic valve insufficiency
3968	Multiple involvement of mitral and aortic valves
3969	Mitral and aortic valve diseases, unspecified
3970	Diseases of tricuspid valve
3971	Rheumatic diseases of pulmonary valve
3979	Rheumatic diseases of endocardium, valve unspecified
41000	Acute myocardial infarction of anterolateral wall, episode of care unspecified
41001	Acute myocardial infarction of anterolateral wall, initial episode of care
41002	Acute myocardial infarction of anterolateral wall, subsequent episode of care
41010	Acute myocardial infarction of other anterior wall, episode of care unspecified
41011	Acute myocardial infarction of other anterior wall, initial episode of care
41012	Acute myocardial infarction of other anterior wall, subsequent episode of care
41020	Acute myocardial infarction of inferolateral wall, episode of care unspecified
41021	Acute myocardial infarction of inferolateral wall, initial episode of care
41022	Acute myocardial infarction of inferolateral wall, subsequent episode of care
41030	Acute myocardial infarction of inferoposterior wall, episode of care unspecified
41031	Acute myocardial infarction of inferoposterior wall, initial episode of care
41032	Acute myocardial infarction of inferoposterior wall, subsequent episode of care
41040	Acute myocardial infarction of other inferior wall, episode of care unspecified
41041	Acute myocardial infarction of other inferior wall, initial episode of care
41042	Acute myocardial infarction of other inferior wall, subsequent episode of care
41050	Acute myocardial infarction of other lateral wall, episode of care unspecified
41051	Acute myocardial infarction of other lateral wall, initial episode of care
41052	Acute myocardial infarction of other lateral wall, subsequent episode of care
41060	True posterior wall infarction, episode of care unspecified
41061	True posterior wall infarction, initial episode of care
41062	True posterior wall infarction, subsequent episode of care
41070	Subendocardial infarction, episode of care unspecified
41071	Subendocardial infarction, initial episode of care
41072	Subendocardial infarction, subsequent episode of care
41080	Acute myocardial infarction of other specified sites, episode of care unspecified
41081	Acute myocardial infarction of other specified sites, initial episode of care

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Diagnosis Code	Description
41082	Acute myocardial infarction of other specified sites, subsequent episode of care
41090	Acute myocardial infarction of unspecified site, episode of care unspecified
41091	Acute myocardial infarction of unspecified site, initial episode of care
41092	Acute myocardial infarction of unspecified site, subsequent episode of care
4110	Postmyocardial infarction syndrome
4111	Intermediate coronary syndrome
41181	Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction
41189	Other acute and subacute forms of ischemic heart disease, other
412	Old myocardial infarction
4130	Angina decubitus
4131	Prinzmetal angina
4139	Other and unspecified angina pectoris
41400	Coronary atherosclerosis of unspecified type of vessel, native or graft
41401	Coronary atherosclerosis of native coronary artery
41402	Coronary atherosclerosis of autol-ogous vein bypass graft
41403	Coronary atherosclerosis of nonau-tologous biological bypass graft
41404	Coronary atherosclerosis of artery bypass graft
41405	Coronary atherosclerosis of unspecified bypass graft
41406	Coronary atherosclerosis of native coronary artery of transplanted hearts
41407	Coronary atherosclerosis, of bypass graft (artery) (vein) of trans-planted heart
41410	Aneurysm of heart (wall)
41411	Aneurysm of coronary vessels
41412	Dissection of coronary artery
41419	Other aneurysm of heart
4148	Other specified forms of chronic ischemic heart disease

Diagnosis Code	Description
4149	Chronic ischemic heart disease, unspecified
4150	Acute cor pulmonale
41511	Iatrogenic pulmonary embolism and infarction
41519	Other pulmonary embolism and infarction
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4168	Other chronic pulmonary heart diseases
4169	Chronic pulmonary heart disease, unspecified
4170	Arteriovenous fistula of pulmonary vessels
4171	Aneurysm of pulmonary artery
4178	Other specified diseases of pulmonary circulation
4179	Unspecified disease of pulmonary circulation
4200	Acute pericarditis in diseases classified elsewhere
42090	Acute pericarditis, unspecified
42091	Acute idiopathic pericarditis
42099	Other acute pericarditis
4210	Acute and subacute bacterial endocarditis
4211	Acute and subacute infective endocarditis in diseases classified elsewhere
4219	Acute endocarditis, unspecified
4220	Acute myocarditis in diseases classified elsewhere
42290	Acute myocarditis, unspecified
42291	Idiopathic myocarditis
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Other acute myocarditis
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4238	Other specified diseases of pericardium
4239	Unspecified disease of pericardium
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic

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Diagnosis Code	Description
4243	Pulmonary valve disorders
42490	Endocarditis, valve unspecified, unspecified cause
42491	Endocarditis in diseases classified elsewhere
42499	Other endocarditis, valve unspecified
4250	Endomyocardial fibrosis
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4255	Alcoholic cardiomyopathy
4257	Nutritional and metabolic cardiomyopathy
4258	Cardiomyopathy in other diseases classified elsewhere
4259	Secondary cardiomyopathy, unspecified
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) ii atrioventricular block
42613	Other second degree atrioven-tricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block
42652	Right bundle branch block and left anterior fascicular block
42653	Other bilateral bundle branch block
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-ganong-levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
42731	Atrial fibrillation
42732	Atrial flutter
42741	Ventricular fibrillation
42742	Ventricular flutter
4275	Cardiac arrest
42760	Premature beats, unspecified
42761	Supraventricular premature beats
42769	Other premature beats
42781	Sinoatrial node dysfunction
42789	Other specified cardiac dysrhythmias
4279	Cardiac dysrhythmia, unspecified
4280	Congestive heart failure
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
4290	Myocarditis, unspecified
4291	Myocardial degeneration
4292	Cardiovascular disease, unspecified
4293	Cardiomegaly
4294	Functional disturbances following cardiac surgery
4295	Rupture of chordae tendineae
4296	Rupture of papillary muscle
42971	Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect

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Diagnosis Code	Description
42979	Certain sequelae of myocardial infarction, not elsewhere classified, other
42981	Other disorders of papillary muscle
42982	Hyperkinetic heart disease
42989	Other ill-defined heart diseases
4299	Heart disease, unspecified
7813	Lack of coordination
78650	Unspecified chest pain
78651	Precordial pain
78652	Painful respiration
78659	Other chest pain
7991	Respiratory arrest
V4321	Organ or tissue replaced by other means, heart assist device
V4581	Postsurgical aortocoronary bypass status

39.3.7 Myocardial Perfusion Imaging

Myocardial perfusion imaging, which uses radionuclides, is a noninvasive stress test that measures coronary blood flow (perfusion), especially to the left ventricle.

Myocardial perfusion imaging is a covered benefit of the Texas Medicaid Program when it is medically indicated.

Myocardial perfusion imaging studies will be limited to one study per day, including, but not limited to, the following procedure codes: 4/I/T-78460, 4/I/T-78461, 4/I/T-78464, and 4/I/T-78465.

When multiple procedure codes are billed, the most inclusive code will be paid and all other codes will be denied.

Myocardial perfusion imaging may be performed at rest and/or during stress using physical exercise or pharmacologicals. The following procedure codes may be used to bill for cardiovascular stress testing: 5-93015, T-93017, and I-93018.

39.3.8 Ambulatory Electroencephalogram

Epilepsy is a clinical diagnosis which, in the overwhelming majority of cases, can be characterized with a standard electroencephalogram, a detailed history, a detailed physical examination that includes a comprehensive neurological examination, and an accurate description of the patient's epileptic phenomenon (because a positive interictal pattern of the EEG does not confirm the diagnosis beyond doubt).

There are some studies that show an advantage for intensive ambulatory electroencephalographic (A/EEG) monitoring in some cases where it has not been possible to confirm or support a diagnosis of epilepsy or to confirm or support the differential diagnosis of epilepsy from pseudoconvulsive episodes associated with transient cerebral ischemia from variable causes other than epilepsy.

A/EEG testing is a benefit of the Texas Medicaid Program. A 24-hour A/EEG may be covered for clients in whom:

- A seizure diathesis is suspected but is not defined by history, physical examinations, or resting EEG.
- Syncope or transient ischemic attacks have not been explained by conventional studies.

The monitoring unit is 24 hours. Benefits are limited to two units for each physician for the same patient per six months when it is medically necessary.

A/EEG should be billed using procedure codes 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, or 5/I/T-95956.

Procedure codes 5/I/T-95950, 5/I/T-95951, 5/I/T-95953, and 5/I/T-95956 are related codes. If multiple procedure codes are billed on the same day, the most inclusive code will be paid, and all other codes will be denied.

Procedure codes 4/I/T-95950, 4/I/T-95951, 4/I/T-95953, and 4/I/T-95956 are automatically payable when billed with the following International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes or their equivalent narrative description listed below.

Request for payment of codes 4/I/T-95950, 4/I/T-95951, 4/I/T-95953, and 4/I/T-95956 in any place of service without the enumerated ICD-9-CM codes or their equivalent narrative description will be denied as an inappropriate service for the diagnosis. Upon appeal to the associate medical director, codes 4/I/T-95950, 4/I/T-95951, 4/I/T-95953, and 4/I/T-95956 may be paid with other related procedure codes when the submitted documentation establishes the medical necessity of the service.

Diagnosis Code	Description
2390	Delirium due to conditions classified elsewhere
2948	Other persistent mental disorders due to conditions classified elsewhere
3332	Myoclonus
34500	Generalized nonconvulsive epilepsy, without mention of intractable epilepsy
34501	Generalized nonconvulsive epilepsy, with intractable epilepsy
34510	Generalized convulsive epilepsy, without mention of intractable epilepsy
34511	Generalized convulsive epilepsy, with intractable epilepsy
3452	Petit mal status, epileptic
3453	Grand mal status, epileptic

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Diagnosis Code	Description
34540	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy
34541	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
34550	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy
34551	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy
34560	Infantile spasms, without mention of intractable epilepsy
34561	Infantile spasms, with intractable epilepsy
34570	Epilepsia partialis continua, without mention of intractable epilepsy
34571	Epilepsia partialis continua, with intractable epilepsy
34580	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy
34581	Other forms of epilepsy and recurrent seizures, with intractable epilepsy
34590	Epilepsy, unspecified, without mention of intractable epilepsy
34591	Epilepsy, unspecified, with intractable epilepsy

39.3.9 Diagnosis Requirements for Other Services

A diagnosis is not required with a provider's request for payment except when providing the following services: ambulatory electroencephalograms (A/EEGs), arteriograms, cardiac blood pool imaging, chest X-rays, CAT scans, echography, electrocardiograms (EKGs), magnetic resonance angiographies (MRAs), MRIs, mammographies, noninvasive diagnostic studies, polysomnographies, and venographies.

Claims for all services provided to clients eligible for "Emergency Care Only" *must* have a diagnosis to be considered for reimbursement. As with all procedures billed to the Texas Medicaid Program, most baseline screening or comparison studies are not a benefit.

Refer to: "Physician" on page 36-1 for more information about these services.

39.3.10 Radiation Therapy

Radiation treatment management will be considered for reimbursement as defined in the paragraphs of the CPT Manual under the heading of "Radiation Treatment Management." Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Procedure code 6-77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consists of:

- Review of port films
- Review of dosimetry, dose delivery, and treatment parameters
- Review of patient treatment set-up
- Examination of patient for medical evaluation and management (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results)

39.3.11 Stereotactic Radiosurgery

Stereotactic radiosurgery is a system used to verify tumor location with precise mapping using live radiographic images throughout the procedure. The linear accelerator attached to a robotic arm delivers multiple, highly focused radiation beams. This high dose radiation can treat multiple sites at one treatment session. A multidisciplinary team consisting of a neurosurgeon, a radiation oncologist, and a radiation physicist accomplishes treatment with the patient as the central focus. Stereotactic radiosurgery is a benefit of the Texas Medicaid Program.

Procedure codes 6/I/T-G0338, T-G0339, and T-G0340 may be considered for reimbursement.

Physicians, radiation treatment centers, and outpatient facilities may bill the technical component only for procedure codes T-G0339 and T-G0340 in either the office (POS 1) or outpatient setting (POS 5) for stereotactic radiosurgery therapeutic delivery sessions.

The professional component (TOS I) and the technical component (TOS T) are not reimbursed when billed with the total component (TOS 6). The total component includes the professional and the technical components.

The professional component (TOS I) is payable for services that are rendered in an inpatient hospital (POS 3), a radiation treatment center (POS 5), or an outpatient hospital (POS 5). Physicians who bill for client services that are rendered in a facility recognized by

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Medicaid as a radiation treatment center (POS 1) or in their offices (POS 1) will be reimbursed for the total component (TOS 6).

Prior authorization requirements for stereotactic radiosurgery may include, but are not limited to, diagnoses that indicate 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
- Other diagnoses may be considered after a review of the documentation of medical necessity and a review of current literature that supports the requested use (e.g., trigeminal neuralgia)

The following documentation must be submitted to request prior authorization for stereotactic radiosurgery services:

- A brief history and physical evaluation
- Description of tumor types, sizes, and locations
- Supporting documentation of medical necessity
- ICD-9-CM diagnosis codes
- The physician's provider identifier
- The name and address of the facility where services will be performed

39.3.11.1 Radiation Treatment Planning

The following procedure codes are a benefit of the Texas Medicaid Program:

Procedure Codes		
6/I-77261	6/I-77262	6/I-77263
6/I-77280	6/I-77285	6/I-77290
6/I-77295	6/I-77299	6/I/T-77301

Procedure codes 6-77421, 6-77427, and 6-77499 are payable as the total component (TOS 6) for services performed in POS 1 (office or a facility recognized by Medicaid as a radiation treatment center), POS 3 (inpatient hospital), and POS 5 (outpatient hospital or a radiation treatment center).

39.3.11.2 Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services, and Proton Beam Treatment Delivery

The following procedure codes are a benefit of the Texas Medicaid Program:

Procedure Codes		
6/I-77300	6/I-77305	6/I-77310
6/I-77315	6/I-77326	6/I-77327
6/I-77328	6/I-77332	6/I-77333
6/I-77334	6/I-77399	6-77520
6-77522	6-77523	6-77525

39.3.11.3 Clinical Brachytherapy

Brachytherapy (short distance or close treatment) is used to describe the use of radioactive isotopes in the treatment of cancer and benign diseases. Brachytherapy involves placement of radioactive sources, such as “seeds” or wires either in tumors (interstitial implants) or near tumors (intracavitary therapy and mold therapy).

The following procedure codes are a benefit of the Texas Medicaid Program:

Procedure Codes		
2/F-57155	2/F-58346	6/I-77750
6/I-77761	6/I-77762	6/I-77763
6/I-77776	6/I-77777	6/I-77778
6/I-77781	6/I-77782	6/I-77783
6/I-77784	6/I-77789	6/I-77799

39.3.12 Technical Services (Radiation Treatment Delivery/Port Films)

Only the technical component (TOS T) is payable to physicians for the following services when they are rendered in a facility recognized by Medicaid as a radiation treatment center (POS 1) or in the physician's office (POS 1).

Procedure Codes		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-77418
T-77421	T-77422	T-77423

39.3.13 Radiation Treatment Centers/ Outpatient Facilities

Radiation treatment centers and outpatient hospitals will be reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the following services:

Procedure Codes		
Radiation Treatment Planning		
T-77280	T-77285	T-77290
T-77295	T-77299	
Medical Radiation Physics, Dosimetry, Treatment Devices and Special Services		
T-77300	T-77305	T-77310
T-77315	T-77326	T-77327
T-77328	T-77332	T-77333
T-77334	T-77399	
Radiation Treatment Delivery/Port Films		
T-77401	T-77402	T-77403
T-77404	T-77406	T-77407

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Procedure Codes		
T-77408	T-77409	T-77411
T-77412	T-77413	T-77414
T-77416	T-77417	T-77421
T-77422	T-77423	
Clinical Brachytherapy		
2/F-57155	2/F-58346	T-77781
T-77782	T-77783	T-77784
T-77789	T-77799	

The following clinical brachytherapy services procedure codes include admission to the hospital and daily care. Initial and subsequent hospital care will be denied on the same day that clinical brachytherapy services are billed.

Procedure Codes		
6/I-77750	6/I-77761	6/I-77762
6/I-77763	6/I-77776	6/I-77777
6/I/T-77781	6/I/T-77782	6/I/T-77783
6/I/T-77784	6/I/T-77789	6/I/T-77799

The following services will be allowed once per day, unless an appeal is submitted with documentation that supports the need for the service to be provided more than once:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavity radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

A consultation on the same day as clinical treatment planning and clinical brachytherapy is included in the therapeutic radiology procedure.

Laboratory and diagnostic radiologic services provided in an office (POS 1) will be reimbursed to physicians as a total component. Radiation treatment centers will also be reimbursed for the total component for these services in POS 5. Injectable medications given during the course of therapy in any setting will be reimbursed separately.

Normal follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be paid on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

Procedure code 2/8-19298 is a benefit of the Texas Medicaid Program.

No separate payment will be made for any of the following procedure codes provided on the same day as radiation therapy by the same provider:

Procedure Codes		
2-16000	2-16020	2-16025
2/F-16030	2-36425	1-99050
1-99211	1-99212	1-99213
1-99214	1-99215	1-99241
1-99242	1-99243	1-99244
1-99245	1-99183	1-99281
1-99282	1-99283	1-99284
1-99285		

No separate payment will be made for established office or outpatient visits within 90 days after radiation treatment by the same provider.

Procedure Codes		
1-99211	1-99212	1-99213
1-99214	1-99215	1-99281
1-99282	1-99283	1-99284
1-99285		

High energy neutron beam radiation therapy (procedure codes 6/I/T-77422 and 6/I/T-77423) are only payable for the following diagnosis codes:

Diagnosis Code	Description
1420	Malignant neoplasm of parotid gland
1421	Malignant neoplasm of submandibular gland
1422	Malignant neoplasm of sublingual gland
1428	Malignant neoplasm of other major salivary glands
1429	Malignant neoplasm of salivary gland, unspecified

39.4 Claims Information

Submit radiological and physiological laboratory services and portable X-ray supplier services to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them. Providers must identify the referring/ordering provider by full name and address or nine-digit TPI in Block 17 and 17a of the CMS-1500 claim form.

Important: *Electronic billers must submit the referring/ordering TPI within the electronic claim format. Consult your software vendor for location of the field for your software.*

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39.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Radiological/Physiological Laboratory and Portable X-Ray Supplier Claim Example	D-29
Acronym Dictionary	F-1

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Section

40

Renal Dialysis Facility

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40.1 Enrollment

To enroll in the Texas Medicaid Program, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: “Provider Enrollment” on page 1-2 for more information.
“Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2.

40.1.1 Medicaid Managed Care Enrollment

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

Refer to: “Managed Care” on page 7-1

40.2 Reimbursement

The Medicaid rates for renal dialysis facilities are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS). The applicable Medicaid rates are listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com.

Refer to: “Reimbursement” on page 2-2 for more information about reimbursement.

40.3 Benefits and Limitations

Renal dialysis services are available for Medicaid clients with one of the following diagnoses:

- *Acute renal disease.* A renal disease with a relatively short course, usually correctable.
- *Chronic renal disease (CRD) (end stage renal disease [ESRD]).* A stage of renal disease that requires continuing dialysis or kidney transplantation to maintain life or health.

40.3.1 Renal Dialysis

Medicaid coverage of renal dialysis patients who may have Medicare coverage begins with the original onset date of dialysis treatments and may continue for a period of three months. During this period, TMHP pursues Medicare eligibility through HHSC. If HHSC discovers that the client is Medicare-eligible, Medicaid coverage begins with the original onset date and continues until Medicare coverage begins. If HHSC determines that the client is not eligible for Medicare, Medicaid coverage of eligible clients begins with the original onset date and continues as long as the dialysis treatments are medically necessary, and the client is eligible for Medicaid.

In the case of a client who participates in self-dialysis training before the beginning of the third month, the Medicare waiting period is waived. The waiver is for Medicaid clients who can reasonably be expected to complete the training program and, upon completion, enter a self-dialysis setting.

40.3.2 Kidney Transplants

Medicare coverage of a client who requires a kidney transplant can begin as early as the month in which a patient is hospitalized for transplantation, provided the surgery takes place in that month or in the following two months. Medicare coverage of a client who receives a successful kidney transplant ends with the thirty-sixth month after the transplant. *At that time, Medicaid resumes full coverage of the client's claims for services covered under the Texas Medicaid Program, if the client remains eligible for Texas Medicaid.*

If HHSC verifies that a Medicaid client is not eligible for Medicare coverage of a transplant, the Texas Medicaid Program pays for the transplantation services. Medicaid does not pay for donor expenses. Facility expenses for kidney procurement, tissue matching, or the cost of maintaining a kidney before transplantation are included in the diagnosis related group (DRG) reimbursement.

Medicare benefits for qualified clients include all covered Part A and B items and services. Coverage is not limited to items and services associated with renal disease. *Medicaid coverage of Medicare clients extends to the Medicare deductible and coinsurance.* Medicaid may pay the Medicare deductible and coinsurance for clients who are eligible.

Refer to: “Organ/Tissue Transplants” on page 36-235 and “Organ/Tissue Transplant Services” on page 25-10 for information on organ transplant and facility services.

40.3.3 Facility Services

The facility bills an amount that represents the charge for the facility's service to the dialysis patient. The facility's charge must not include the charge for the physician's routine supervision.

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40.3.3.1 Facility Revenue Codes

Service	Revenue Code	Description
Maintenance	B-821	Hemodialysis (outpatient/home)–composite
	B-831	Peritoneal Dialysis (outpatient/home)–composite
	B-841	Continuous ambulatory peritoneal dialysis (CAPD) (outpatient/home)–composite
	B-851	continuous cycling peritoneal dialysis (CCPD) (outpatient/home)–composite
Training	B-829	Hemodialysis (outpatient/home)–other
	B-839	Peritoneal Dialysis (outpatient/home)–other
	B-849	CAPD (outpatient/home)–other
	B-859	CCPD (outpatient/home)–other
Support	B-845	CAPD (outpatient/home)–support services
	B-855	CCPD (outpatient/home)–support services

40.3.3.2 Maintenance Hemodialysis

The facility payment applies when a CRD patient receives hemodialysis in an approved renal dialysis facility. Payment is based on the facility's per-treatment composite rate, as calculated by Medicare. Services included in the facility's charge are routine laboratory tests, personnel services, equipment, supplies, and other services associated with the treatment.

For hospitals to be reimbursed for maintenance hemodialysis, they must be enrolled as an approved dialysis facility with the appropriate provider identifier.

40.3.3.3 Maintenance Intermittent Peritoneal Dialysis (IPD)

Maintenance IPD is usually performed in sessions of 10 to 12 hours duration, 3 times per week. However, it is sometimes performed in fewer sessions of longer duration. If more than three sessions occur in one week, the provider must supply documentation of medical necessity with the claim.

40.3.3.4 CAPD and CCPD Support

Support services furnished to maintenance home CAPD/CCPD clients are payable to dialysis facilities. Home dialysis support services must be furnished by the facility in either the home or the facility. Use revenue codes B-845 or B-855 (CAPD and CCPD) when billing such services.

CAPD/CCPD support services include, but are not limited to, the following:

- Changing the connecting tube ("administration set")
- Watching the patient perform CAPD/CCPD, and ensuring that it is done correctly. The observation includes reviewing any aspects of the technique they may have forgotten or informing the patient of modifications in apparatus or technique
- Documenting whether the patient has or had peritonitis that requires physician intervention or patient hospitalization
- Inspecting the catheter site

Routine laboratory services are not included in the support services and are reimbursed separately.

Equipment and supplies are not payable separately.

A client with Medicaid coverage may receive CAPD/CCPD support services furnished by the facility once per month. Charges for support services in excess of once per month must include documentation of medical necessity.

40.3.3.5 Hemodialysis, IPD, CCPD, and CAPD Training

Most self-dialysis training is given in an outpatient setting. While CAPD training itself usually does not justify inpatient status, CAPD training is covered when provided to an inpatient. It is reimbursed at the same rate as the facility's outpatient CAPD training rate. Payment for B-829, B-839, or B-859 consists of the facility's composite rate plus $20 per training session.

A client who is eligible for Medicaid may receive up to 18 days of training. Additional days of CAPD training (B-849) may be paid only when medical necessity is documented. Payment consists of the facility's composite rate plus $12 per training session.

CAPD training services and supplies provided by the dialysis facility include personnel services, parenteral items routinely used in dialysis, training manuals and materials, and routine CAPD laboratory tests.

No frequency limitation is applied to routine laboratory tests during the training period because these tests commonly are given during each day of training. Nonroutine laboratory tests performed during the training period require documentation of medical necessity.

It may be necessary to supplement the patient's dialysis during CAPD training with IPD or hemodialysis because the patient has not mastered the CAPD technique.

Three supplemental dialysis sessions are covered routinely. If more than three sessions are billed during the training, the claims must document the medical necessity.

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40.3.4 Laboratory and Radiology Services

40.3.4.1 In-Facility Dialysis–Routine Laboratory

Laboratory services may be performed in the CRD facility or by an outside laboratory. Charges for routine laboratory tests performed according to the established frequencies in the following tables are included in the facility's dialysis charge billed to Medicaid regardless of where tests were performed. Routine laboratory services performed by an outside laboratory are billed to the facility.

Per Dialysis

Procedure Codes	
5-85014	5-85345
5-85347	

Per Week

Procedure Codes	
5-82565	5-84520
5-85610	

Per Month

Procedure Codes	
5-82040	5-82310
5-82374	5-82435
5-83615	5-84075
5-84100	5-84132
5-84155	5-84450

The routine tests listed in the tables above are frequently performed as an automated battery of tests such as the SMAC-12. These tests are considered routine and are included in the charge for dialysis, unless there is an additional diagnosis to document medical necessity for performing the tests in excess of the recommended frequencies.

If it is medically necessary to perform a routine laboratory test beyond the established frequency, payment may be made if the test is indicated on the claim form along with documentation of medical necessity.

Refer to: "Laboratory Paneling" on page 26-5 for more information about laboratory paneling procedures.

40.3.4.2 In-Facility Dialysis—Nonroutine Laboratory

The following are considered necessary, nonroutine tests. They must be billed separately from the dialysis charge when performed in the CRD facility or by an outside laboratory that bills the facility for laboratory services. All nonroutine laboratory and radiology tests beyond the recommended frequencies require medical justification.

Procedure code 1-99001 for nonroutine laboratory services may be billed to the Texas Medicaid Program *only* if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The claim form must document that the handling fee is for nonroutine laboratory services.

Once a Month

Procedure Code
5-87340

Every Three Months

Procedure Code
T-93005

Every Six Months

Procedure Codes	
4-71010	4-71020
5-95900	

Annually

Procedure Code	
4-78300	4-78305
4-78306	

40.3.4.3 Continuous Ambulatory Peritoneal Dialysis

The following laboratory tests are routine for home maintenance CAPD patients when performed according to the indicated frequency. When the patient is dialyzing in the home and is not undergoing IPD or hemodialysis in the facility, payment may be made. The provider must indicate the patient's diagnosis and the type of dialysis on the claim form.

Important: *Tests in excess of this frequency or tests not listed in the tables, require documentation of medical necessity for payment to be made.*

Every Month

Laboratory Tests for Routine Home Maintenance CAPD Patients	
BUN	Total protein
Creatinine	Albumin
Sodium	Alkaline phosphatase
Potassium	LDH
Carbon dioxide	SGOT
Calcium	Hct
Magnesium	Hgb
Phosphate	Dialysate protein

Every Three Months

Laboratory Tests for Routine Home Maintenance CAPD Patients
WBC
RBC
Platelet count

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Every Six Months

Laboratory Tests for Routine Home Maintenance CAPD Patients	
Residual renal function	Bone mineral density
24-hour urine volume	MNCV
Chest X-ray	Electrocardiogram (EKG)

40.3.4.4 Erythropoietin Alfa (EPO)

Medicaid reimbursement is allowed for EPO injections administered to chronic renal disease patients, chronic end-stage renal disease predialysis patients who have an anemia with a Hematocrit of 36 percent or less, and for patients with HIV infection who are being treated with Retrovir (AZT). Payment is limited to the end-stage renal dialysis facility and the physician in the office. Only three injections are allowed per seven days.

When billing for EPO with a diagnosis of HIV, providers may use diagnosis code 042, Human Immunodeficiency Virus (HIV) disease. The following diagnoses are payable for EPO:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
20300	Multiple myeloma, without mention of remission
20301	Multiple myeloma, in remission
23872	Low grade myelodysplastic syndrome lesions
23873	High grade myelodysplastic syndrome lesions
23874	Myelodysplastic syndrome with 5q deletion
23875	Myelodysplastic syndrome, unspecified
23876	Myelofibrosis with myeloid metaplasia
23879	Other lymphatic and hematopoietic tissues
2733	Macroglobulinemia
2800	Iron deficiency anemia secondary to blood loss (chronic)
2801	Iron deficiency anemia secondary to inadequate dietary iron intake
2808	Other specified iron deficiency anemias
2809	Iron deficiency anemia, unspecified
2810	Pernicious anemia
2811	Other vitamin B12 deficiency anemia
2812	Folate-deficiency anemia
2813	Other specified megaloblastic anemias not elsewhere classified
2814	Protein-deficiency anemia
2818	Anemia associated with other specified nutritional deficiency
2819	Unspecified deficiency anemia
2820	Hereditary spherocytosis
2821	Hereditary elliptocytosis
2822	Anemias due to disorders of glutathione metabolism
2823	Other hemolytic anemias due to enzyme deficiency
28241	Sickle-cell thalassemia without crisis
28242	Sickle-cell thalassemia with crisis
28249	Other thalassemia
2825	Sickle-cell trait
2826	Sickle-cell disease
28260	Sickle-cell disease, unspecified
28261	HB-SS disease without crisis
28262	HB-SS disease with crisis
28263	Sickle-cell/HB-C disease without crisis
28264	Sickle-cell/HB-C disease with crisis
28268	Other sickle-cell disease without crisis
28269	Other sickle-cell disease with crisis
2827	Other hemoglobinopathies
2828	Other specified hereditary hemolytic anemias
2829	Hereditary hemolytic anemia, unspecified
2830	Autoimmune hemolytic anemias
28310	Non-autoimmune hemolytic anemia, unspecified
28311	Hemolytic-uremic syndrome
28319	Other non-autoimmune hemolytic anemias
2832	Hemoglobinuria due to hemolysis from external causes
2839	Acquired hemolytic anemia, unspecified
28409	Other constitutional aplastic anemia
2848	Other specified aplastic anemias
2849	Aplastic anemia, unspecified
2850	Sideroblastic anemia
2851	Acute posthemorrhagic anemia
28521	Anemia in chronic kidney disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic disease
2858	Other specified anemias
2859	Anemia, unspecified

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Diagnosis Code	Description
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
5820	Chronic glomerulonephritis, with lesion of proliferative glomerulonephritis
5821	Chronic glomerulonephritis, with lesion of membranous glomerulonephritis
5822	Chronic glomerulonephritis, with lesion of membranoproliferative glomerulonephritis
5824	Chronic glomerulonephritis, with lesion of rapidly progressive glomerulonephritis
58281	Chronic glomerulonephritis in diseases classified elsewhere
58289	Other chronic glomerulonephritis with specified pathological lesion in kidney
5829	Chronic glomerulonephritis with unspecified pathological lesion in kidney
5851	Chronic kidney disease, stage I
5852	Chronic kidney disease, Stage II (mild)
5853	Chronic kidney disease, Stage III (moderate)
5854	Chronic kidney disease, Stage IV (severe)
5855	Chronic kidney disease, Stage V
5856	End stage renal disease
5859	Chronic kidney disease, unspecified
586	Renal failure, unspecified
7140	Rheumatoid arthritis
79001	Precipitous drop in hematocrit
99680	Complications of transplanted organ, unspecified
99811	Hemorrhage complicating a procedure
V5811	Encounter for antineoplastic chemotherapy
V5812	Encounter for immunotherapy for neoplastic condition

The procedure codes used when billing for EPO remain unchanged.

When billing for EPO, procedure code 1-J0885 is considered for reimbursement with a covered diagnosis.

EPO coverage is limited to three injections per calendar week (Sunday through Saturday).

Example: *If a client with end-stage renal disease has a hematocrit of 34 percent and is given 5,000 units of EPO, bill a quantity of 5, using code J0886. The client may receive three payable injections per calendar week (Sunday through Saturday).*

Important: *EPO given for a Hematocrit of 37 percent or above is not a benefit of the Texas Medicaid Program.*

40.3.4.5 Blood Transfusions

Payment of whole blood for transfusions billed by dialysis facilities is a covered service when medically indicated for a client eligible for Medicaid. The administration of blood transfusion is not payable to dialysis facilities and must be billed by the medical professional.

Use the following procedure codes when billing for blood:

Procedure Code	Maximum Fee
0-P9010	$45.00
0-P9011	$89.37
9-P9021	$66.19

Important: *Blood administration is considered a professional service and is not payable to dialysis facilities.*

40.4 Claims Information

Submit all renal dialysis facility services to TMHP in an approved electronic claims format or on a HCFA-1450 (UB-92) claim form. Providers must purchase HCFA-1450 (UB-92) claim forms from the vendor of their choice. TMHP does not supply them.

Reminder: *The original onset date must be included on the claim form to prevent claim denial. The original onset date must be the same date entered on Form CMS-2728 sent to the Social Security office.*

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40.4.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
HCFA-1450 Claim Filing Instructions	5-32
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Renal Dialysis Facility CAPD Training	D-30
Renal Dialysis Facility CAPD/CCPD	D-30
Acronym Dictionary	F-1

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Section

41

Rural Health Clinics (RHCs)

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41.1 Enrollment

To enroll in the Texas Medicaid Program and qualify for participation as a Title XIX rural health clinic (RHC), RHCs must be enrolled in Medicare.

A nine-digit provider identifier is issued to the rural health clinic after a certification letter from Medicare is received, stating that the clinic qualifies for Medicaid participation.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: "Provider Enrollment" on page 1-2 for more information.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

41.1.1 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid managed care clients. Contact the individual Medicaid Managed Care health plan for enrollment information.

Refer to: "Managed Care" on page 7-1

41.2 Record Retention

Freestanding RHCs must retain their records for a minimum of six years. Hospital-based RHCs must retain their records for a minimum of ten years.

41.3 Reimbursement

Freestanding and hospital-based RHCs are reimbursed provider-specific per visit rates calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8101.

41.4 Benefits and Limitations

41.4.1 Telemedicine Services

Remote site providers are limited to physicians (Doctors of Medicine [MDs] and Doctors of Osteopathy [DOs]), physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), federally qualified health centers (FQHCs), and RHCs.

RHC telemedicine providers must submit their claims using the appropriate encounter code and modifiers. Modifier U7, AM, or SA is to be used in the first modifier field on the claim form together with the modifier GT in the second modifier field on the claim form.

Refer to: "Physician" on page 36-1 for more information.

41.4.2 Freestanding and Hospital-Based RHC Services

An RHC must be located in an area designated by the federal government as a health care shortage area.

The following services are benefits of RHCs under the Texas Medicaid Program:

- Physician services
- Services and supplies furnished as incidental to physician services
- Services provided by an NP, a CNS, a CNM, a clinical social worker, or physician assistant services
- Services and supplies furnished as incidental to the nurse practitioner or physician assistant's services
- Visiting nurse services on a part time or intermittent basis to homebound clients in areas determined to have a shortage of home health agencies. A homebound client is someone who is permanently or temporarily confined to his place of residence, not including a hospital or a skilled nursing facility, because of a medical condition

  Important: *When an RHC bills for visiting nurse services, the written plan of treatment to be used for the visiting nurse must be developed by the RHC supervising physician. It must be approved and ordered by the client's treating physician if different from the supervising physician. The plan of treatment must be reviewed and approved at least every 60 days by the supervising physician of the clinic.*

A *visit* is a face-to-face encounter between an RHC client and a physician, PA, NP, CNS, CNM, visiting nurse, or clinical nurse practitioner. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one or the other of the following conditions exists:

- After the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment.
- The RHC client has a medical visit and an *other* health visit.

An *other* health visit includes, but is not limited to, a face-to-face encounter between an RHC client and a clinical social worker.

For freestanding RHCs, all laboratory services provided in the RHC's laboratory are included in the encounter. This includes the basic laboratory tests as well as any other laboratory tests provided in the RHC laboratory. Consequently, there is no separate billing for laboratory services. However, if the RHC laboratory becomes a certified Medicare laboratory with its own supplier number, and enrolls in Medicaid as an independent laboratory, all laboratory tests (except the basic laboratory tests) performed for RHC and non-RHC clients can be billed to Medicaid. The claim should be filed under their independent laboratory Medicaid provider identifier and using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

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41.4.2.1 Freestanding Rural Health Clinic Services

The services listed below cannot be reimbursed to freestanding RHCs using the RHC nine-digit provider identifier. Use of the RHC provider identifier for billing these services causes claims to deny. Services in any of these four categories must be billed using the appropriate practitioner's group/individual, Texas Health Steps (THSteps), or family planning agency Medicaid nine-digit provider identifier:

- THSteps medical checkups
- THSteps dental services
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations, unless they are billed outside of a THSteps medical checkup

These services (except for THSteps dental) must be billed with an AJ, AM, SA, or U7 modifier if performed in an RHC setting. Claims are paid under the Prospective Payment System (PPS) reimbursement methodology. When billing on the CMS-1500 claim form, use the appropriate national place of service code (72) for an RHC setting.

Important: *Payment to physicians for supplies is not a benefit of the Texas Medicaid Program. Costs of supplies are included in the reimbursement for office visits.*

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician Medicaid nine-digit provider identifier.

Exception: *If later in the same day the client suffers an additional illness or injury requiring diagnosis or treatment, the clinic may bill for a second visit.*

Freestanding RHCs bill an all-inclusive encounter for services provided.

All services provided that are incidental to the encounter must be included in the total charge for the encounter. They are not billable as a separate encounter.

Exception: *When billing for immunizations outside of a THSteps medical checkup, procedure codes given in the THSteps section of this manual should be used. This is the only circumstance in which a freestanding RHC can bill for a procedure other than 1-T1015.*

All services provided during a freestanding RHC encounter must be billed using procedure code 1-T1015. The total billed amount should be the combined charges for all services provided during that encounter.

One of the following modifiers must be reported with procedure code 1-T1015 to designate the health care professional providing the services: AJ, AM, or SA with place of service (POS) 2, TH, or U7.

Reminder: *The primary* initial contact *is defined as "the health care professional who spends the greatest amount of time with the client during that encounter."*

If more than one health care professional is seen during the encounter, the modifier (if appropriate) must indicate the primary contact. For example, if an NP, CNS, or PA performs an antepartum exam, modifiers SA or U7, and TH, must be entered. A maximum of two modifiers may be reported with each encounter.

If the encounter is for antepartum or postpartum care, use modifier TH.

41.4.2.2 Hospital-Based Rural Health Clinic Services

Hospital-based RHCs must use the encounter code 1-T1015. A hospital-based RHC is paid based on an all-inclusive encounter rate.

One of the following modifiers must be billed for general medical services: AJ, AM, or SA with POS 2, or U7.

The services listed below cannot be reimbursed to hospital-based RHCs using the RHC nine-digit provider identifier. Use of the RHC nine-digit provider identifier for billing these services causes claims to deny. Services in any of these four categories must be billed using the appropriate practitioner's group/individual, THSteps, or family planning agency provider identifier:

- THSteps medical checkups
- THSteps dental
- Family planning services (including implantable contraceptive capsules provision, insertion, or removal)
- Immunizations provided in hospital-based RHCs

These services must be billed with an AM, U7, or SA modifier if performed in an RHC setting. Claims are paid under the PPS reimbursement methodology. When billing on the CMS-1500 claim form, use the appropriate national place of service code (72) for an RHC setting.

Outpatient hospital services (including emergency room services) and inpatient hospital services provided outside the RHC setting are to be billed using the individual or group physician provider identifier.

Hospital-based RHCs should bill pneumococcal and influenza vaccines as non-RHC services, under their hospital provider identifier.

41.5 Cost Settlement

41.5.1 Freestanding RHCs and Hospital-Based RHCs

Effective for dates of service on or after January 1, 2001, a cost settlement for RHCs does not exist.

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41.5.2 Cost Report Submission

All RHCs are required to submit a copy of their Medicare audited cost report within 15 days of receipt from Medicare for fiscal years ending on or after January 1, 2001, to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

41.6 Claims Information

Submit freestanding and hospital-based RHC services to TMHP on a HCFA-1450 (UB-92) claim form or the approved equivalent electronic format.

41.6.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
HCFA-1450 Claim Filing Instructions	5-32
TMHP Electronic Claims Submission	5-10
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Section

42

School Health and Related Services (SHARS)

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42.1 Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allow local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services documented in a student's Individualized Education Program (IEP). SHARS are provided to students who meet all of the following requirements:

- Are under 21 years of age and Medicaid-eligible
- Meet eligibility requirements for special education described in the *Individuals with Disabilities Education Act* (IDEA)
- Have IEPs that prescribe the needed services

Covered SHARS include:

- Audiology services
- Counseling
- Nursing services
- Physician services
- Occupational therapy (OT)
- Physical therapy (PT)
- Psychological services, including assessments (1-96101)
- Speech therapy services
- Personal care services
- Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district. Furthermore, the school district must be enrolled as a SHARS Medicaid provider in order to bill Medicaid for these services.

42.2 School Enrollment

To enroll in the Texas Medicaid Program as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select "public entity" on the enrollment application.

SHARS providers are required to notify parents/guardians of their rights to a "freedom of choice of providers" (42 *Code of Federal Regulations* [CFR] §431.51) under the Texas Medicaid Program. Most SHARS providers currently provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider (school district) provide a required service listed in the student's IEP, the SHARS provider must make a good faith effort to comply with the parent's request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services. If the SHARS provider and the requested provider do not agree on a contract, the parties can determine whether a nonschool SHARS relationship in accordance with 42 CFR §431.51 is possible. If the parties do not agree to a nonschool SHARS relationship, the SHARS provider is responsible for providing the required services and must notify the parent that no contracted or nonschool SHARS relationship could be established with the requested provider.

Refer to: "Reimbursement" on page 2–2.

42.2.1 Nonschool SHARS Provider Enrollment

A nonschool SHARS provider must have either a current provider identifier as a Texas Medicaid provider of the IEP service or meet all of the eligibility requirements to obtain a provider identifier as a Texas Medicaid provider of the IEP service. For example, a nonschool SHARS provider of speech therapy must meet all provider criteria to provide Medicaid fee-for-service speech therapy and cannot hold only a state education certificate as a speech therapist.

To be enrolled in the Texas Medicaid Program as a nonschool SHARS provider, the enrollment packet must contain an affiliation letter that:

- Is written on school district letterhead.
- Is signed by the school district superintendent or designee.
- Contains assurances that the school district will reimburse the state share to HHSC for any Texas Medicaid payments made to the nonschool SHARS provider for the listed student and service.
- Lists the Medicaid number and Social Security number of the student to be served and notes the type of IEP SHARS service to be provided.
- Acknowledges that the nonschool SHARS provider has agreed in writing to:
  - Provide the listed SHARS service shown in the student's IEP.
  - Provide the listed SHARS service in the least restrictive environment as set forth in the IEP.
  - Maintain and submit all records and reports required by the school district to ensure compliance with the IEP and compliance with IEP and documentation/billing requirements.
- States the effective period for this nonschool SHARS provider arrangement.

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A separate affiliation letter is required for each Texas Medicaid client to be served by the nonschool SHARS provider. A nonschool SHARS provider is required to have a separate two-digit suffix for each school district with which it is affiliated. For example, if a nonschool SHARS provider has written agreements with Anywhere Independent School District (ISD) for two students and with Somewhere ISD for one student, then the nonschool SHARS provider would submit its claims for the two students from Anywhere ISD under provider identifier 1234567-01 and its claims for the one student from Somewhere ISD under provider identifier 1234567-02. The nonschool SHARS provider would submit two affiliation letters from Anywhere ISD to TMHP Provider Enrollment (one for each student served) and one affiliation letter from Somewhere ISD.

Since nonschool SHARS providers are private, nonpublic entities, they should select "private entity" on the enrollment application.

Nonschool SHARS services include audiology services, counseling services, nursing services, OT, PT, speech therapy services, and psychological services delivered in an individual setting. Nonschool SHARS services do not include evaluation/assessment, physician services, personal care services, or transportation.

42.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider or as a nonschool SHARS provider.

42.2.3 Medicaid Managed Care Enrollment

SHARS providers do not enroll with the Medicaid Managed Care health plans. SHARS providers deliver services to all eligible Medicaid SHARS clients, including clients of the Medicaid Managed Care health plans. SHARS services are not covered by the Medicaid Managed Care health plans. SHARS services that are rendered to clients of Medicaid Managed Care are covered and reimbursed by TMHP. Students who are under 21 years of age and on a Medicaid 1915(c) waiver program are covered and reimbursed by TMHP.

SHARS providers should use program code 200 to bill for Primary Care Case Management (PCCM). SHARS providers should use program code 100 to bill for fee-for-service.

42.3 Reimbursement and Certification of Funds

42.3.1 Reimbursement

Effective for dates of service on or after September 1, 2006, SHARS providers are reimbursed on an interim basis for covered services at either the lesser of the provider's billed charges or the provider's district-specific interim rate. SHARS providers receive Medicaid payments equal to the federal share and fund the state matching share through certification of public expenditures. The federal share is the applicable federal Medicaid assistance percentage (FMAP) in accordance with guidelines from the Centers for Medicare & Medicaid Services (CMS).

CMS requires the implementation of annual cost reporting, cost reconciliation, and cost settlement processes for all such Medicaid services delivered by school districts. Recent changes from CMS require that school districts, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned district-specific interim rates that are as close as possible to each district's estimated Medicaid-allowable costs for providing each service. School districts can access their district-specific interim rates on the HHSC website at www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/Shars/Shars.html.

Payments for services delivered by a nonschool SHARS provider are limited to either the lower of the nonschool SHARS provider's billed charges or the district-specific interim rate for the school district in which the student is enrolled and for the specific covered service provided. The school district with whom the nonschool SHARS provider is affiliated is required to pay HHSC the state portion of Medicaid payments made to the nonschool SHARS provider. Invoices for the state portion of Medicaid payments to nonschool SHARS providers are sent to the affiliated SHARS school districts on a quarterly basis.

Refer to: "Reimbursement" on page 2–2 for more information about reimbursement and "Federal Financial Participation (FFP) Rate" on page 2–8.

42.3.1.1 Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds letter to SHARS providers at the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the letter is to verify that the school district incurred allowable costs/expenditures on the dates of service that were funded from state/local funds in an amount equal to or greater than the combined total of its interim rates times the paid units of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

The Certification of Funds letter includes a report which shows that quarter's combined total payments for Medicaid fee-for-service claims and Medicaid primary care case management (PCCM) claims. For help balancing the

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amounts in the letter, providers can contact their Provider Relations representative or the TMHP Contact Center at 1-800-925-9126.

Refer to: "TMHP Provider Relations" on page -xiii for more information about provider relations representatives.

The Certification of Funds letter *must* be:

Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.

- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider's payments until the signed Certification of Funds letter is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126, if they do not receive their Certification of Funds letter.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred allowable costs/expenditures, including the federal share and the nonfederal share.

42.3.1.2 Cost Reporting

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous state fiscal year (September 1 through August 31). The cost report is due on or before March 1 of the year following the reporting period. The first SHARS cost report will cover September 1, 2006, through August 31, 2007, and is due on or before March 1, 2008.

The primary purpose of the cost report is to document the provider's costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider's interim payments for SHARS with its actual, total, Medicaid-allowable costs. The annual SHARS cost report includes a certification of funds statement which must be completed to certify the provider's actual, incurred costs/expenditures. All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

42.3.1.3 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation. The SHARS cost report is due on or before March 1, 2008, with the cost reconciliation and settlement processes completed no later than August 31, 2009.

If a provider's interim payments exceed the actual, certified, Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered
- Recoup an agreed upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year
- Recoup an agreed upon dollar amount from future claims payments to ensure recovery of the overpayment within one year

If the actual, certified, Medicaid-allowable costs of a provider for SHARS exceed the provider's interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC shall issue a notice of settlement that denotes the amount due to or from the provider.

42.4 Record Retention

Student-specific records that are required for SHARS become part of the student's educational records and must be maintained for seven years rather than the five years required by Medicaid. All records that are pertinent to SHARS billings must be maintained until all audit questions, appeal hearings, investigations, or court cases are resolved. Records should be stored in a readily accessible location and format and must be available for state and/or federal audit.

The following is a checklist of the minimum documents to collect and maintain:

- IEP
- Current provider qualifications (licenses or TEA or State Board for Educator Certification [SBEC] certificates)
- Attendance records
- Prescriptions/referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories
- If applicable, nonschool SHARS provider's affiliation letter and signed agreement with the district

42.5 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through TMHP electronic data interchange (EDI) with TDHconnect software.
    - School districts may inquire about the eligibility

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of a student by submitting the student's Medicaid number or two of the following: name, date of birth, or Social Security number.

- A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.

- Contact the Automated Inquiry System (AIS) at 1-800-925-9126.
- Contact the TMHP Contact Center at 1-800-925-9126.

42.6 Benefits and Limitations

All of the SHARS procedures listed in the following sections require a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. SHARS include audiology services, counseling, physician services, nursing services, occupational therapy, physical therapy, psychological services, speech therapy services, personal care services, and transportation.

Reminder: *SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and under 21 years of age receive the benefits accorded to them by federal and state law in order to participate in the educational program.*

42.6.1 Audiology

Audiology evaluation services include:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the habilitation of hearing
- Determination of the child's need for group and individual amplification

Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

Audiology services must be provided by a professional who holds a valid state license as an audiologist or by an audiology assistant who is licensed by the state when the assistant is acting under the supervision or direction of a qualified audiologist. State licensure requirements are equal to American Speech-Language Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (1-92506) basis only. Audiology therapy is billable on an individual (1-92507) and group (1-92508) basis. Only the time spent with the student present is billable; time spent without the student present is not billable. Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation). Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.1.1 Audiology Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Assistant
1,2, or 9	1-92506	Individual	Licensed therapist
1,2, or 9	1-92507 with modifier GN-U8	Individual	Licensed therapist
1,2, or 9	1-92507 with modifier GN-U1	Individual	Licensed/ certified assistant
1,2, or 9	1-92508 with modifier GN-U8	Group	Licensed therapist
1,2, or 9	1-92508 with modifier GN-U1	Group	Licensed/ certified assistant
*Place of Service: 1=office/school; 2=home; 9=other locations			

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable time for audiology evaluation is four hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (group and/or individual) is two hours per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to:

- Assisting the child and/or parents in understanding the nature of the child's disability
- Assisting the child and/or parents in understanding the special needs of the child
- Assisting the child and/or parents in understanding the child's development
- Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
- Assessing the need for specific counseling services

Counseling services must be provided by a professional who has one of the following certifications or licensures: a Licensed Professional Counselor (LPC), a Licensed

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Clinical Social Worker (LCSW, formerly LMSW-ACP), a Licensed Marriage and Family Therapist (LMFT), or a Licensed Psychologist.

Counseling services are billable on an individual (1-96152) or group (1-96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student's IEP includes a behavior improvement plan that documents the need for emergency services.

42.6.2.1 Counseling Services Billing Table

POS*	Procedure Code	Individual or Group
1, 2, or 9	1-96152 with modifier GN	Individual
1, 2, or 9	1-96153 with modifier GN	Group
*Place of Service: 1 = Office/School; 2 = Home; 9 = Other Locations		

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable time is two hours per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.3 Physician Services

Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (Doctor of Medicine [MD] or Doctor of Osteopathy [DO]). A physician prescription is required before PT or OT services can be reimbursed under SHARS. Speech therapy services require either a physician prescription or a referral from a licensed speech language pathologist (SLP) before the speech therapy services can be reimbursed under the SHARS program. The school district must maintain the prescription/referral. The prescription/referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription/referral, the prescription/referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician's designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student's records is left up to the professional judgment of the provider. Therefore, billable time includes:

- The diagnosis/evaluation time spent with the student present
- The time spent without the student present reviewing the student's records for the purpose of writing a prescription/referral for specific SHARS services
- The diagnosis/evaluation time spent with the student present, and/or the time spent without the student present reviewing the student's records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription/referral for that service

Session notes are not required for procedure code 1-99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

42.6.3.1 Physician Services Billing Table

POS*	Procedure Code
1, 2, or 9	1-99499
*Place of Service: 1 = Office/School; 2 = Home; 9 = Other Locations	

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable time is one hour per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.4 Nursing Services

Nursing services are skilled nursing tasks, as defined by the Board of Nurse Examiners (BNE), that are included in the student's IEP. Nursing services may be direct nursing care or medication administration. Examples of reimbursable nursing services include, but are not limited to:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care
- Gastrostomy care
- Ileostomy care
- Catheterization
- Tube feeding
- Suctioning
- Client training
- Assessment of a student's nursing and personal care services needs

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The registered nurse (RN) or advanced

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practice nurse (APN) determines whether these services must be billed as direct nursing care or medication administration.

Nursing services must be provided by an RN, an APN (including nurse practitioners [NPs] and clinical nurse specialists [CNSs]), licensed vocational nurse/licensed practical nurse (LVN/LPN), or a school health aide or other trained, unlicensed assistive person delegated by an RN or APN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.

POS*	Procedure Code	Individual or Group	Unit of Service
1,2, or 9	1-T1002 with modifier TD	Individual	15 minutes
1,2, or 9	1-T1002 with modifier TD-UD	Group	15 minutes
1,2, or 9	1-T1502 with modifier TD		Medication administration, per visit
1,2, or 9	1-T1002 with modifier U7	Delegation, individual	15 minutes
1,2, or 9	1-T1002 with modifier U7-UD	Delegation, group	15 minutes
1,2, or 9	1-T1502 with modifier U7		Delegation, medication, administration per visit
*Place of Service: 1=office/school; 2=home; 9=other locations			

While the procedure code descriptions specifically state “up to 15 minutes,” the Medicaid-allowable fee is determined based on 15-minute increments. Therefore, providers must use a 15-minute unit of service for billing.

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service. Do not convert minutes of nursing services separately for each nursing task that was performed.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day’s minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: “Billing Units Based on 15 minutes” on page 42–12

Important: *The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure codes 1-T1002 with modifier TD or 1-T1502 with modifier U7 are a cumulative of four per visit medication administrations per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.5 Occupational Therapy

In order for a student to receive OT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.

Occupational evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

OT includes:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a certified occupational therapist assistant (COTA) acting under the supervision or direction of a qualified occupational therapist.

OT evaluation is billable on an individual (1-97003) basis only. OT is billable on an individual (1-97530) or group (1-97150) basis. The occupational therapist or COTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology. Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment, is not billable. Session notes are not required for procedure code 1-97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation). Session notes are required for procedure codes 1-97530 and 1-97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

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42.6.5.1 Occupational Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1,2, or 9	1-97003	Individual	Licensed therapist
1,2, or 9	1-97530 with modifier GO	Individual	Licensed therapist
1,2, or 9	1-97530 with modifier GO-U1	Individual	Licensed/certified assistant
1,2, or 9	1-97150 with modifier GO	Group	Licensed therapist
1,2, or 9	1-97150 with modifier GO-U1	Group	Licensed/certified assistant
*Place of Service: 1=office/school; 2=home; 9=other locations			

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable time for OT evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a cumulative of two hours per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.6 Physical Therapy

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

PT evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision or direction of a qualified physical therapist.

PT evaluation is billable on an individual (1-97001) basis only. PT is billable on an individual (1-97110) or group (1-97150) basis. The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology. Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable. Session notes are not required for procedure code 1-97001; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 1-97110 and 1-97150. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.6.1 Physical Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/ Certified Assistant
1,2, or 9	1-97001	Individual	Licensed therapist
1,2, or 9	1-97110 with modifier GP	Individual	Licensed therapist
1,2, or 9	1-97110 with modifier GP-U1	Individual	Licensed/certified assistant
1,2, or 9	1-97150 with modifier GP	Group	Licensed therapist
1,2, or 9	1-97150 with modifier GP-U1	Group	Licensed/certified assistant
*Place of Service: 1=office/school; 2=home; 9=other locations			

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable time for PT evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a cumulative of two hours per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.7 Speech Therapy

42.6.7.1 Referral

The name and complete address or the provider identifier or license number of the referring licensed physician or licensed SLP is required before speech therapy services can be billed under SHARS. A licensed SLP's evaluation and recommendation for the frequency, location, and duration of speech therapy serves as the speech referral.

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42.6.7.2 Description of Services

Speech evaluation services include the identification of children with speech and/or language disorders and the diagnosis and appraisal of specific speech and language disorders. Speech therapy services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

Speech evaluation is billable on an individual (1-92506) basis only. Speech therapy is billable on an individual (1-92507) or group (1-92508) basis. Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology. Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable. Session notes are not required for procedure code 1-92506; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation). Session notes are required for procedure codes 1-92507 and 1-92508. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

42.6.7.3 Provider and Supervision Requirements

Speech therapy services are eligible for reimbursement when they are provided by an ASHA-certified SLP who holds a Texas license or an ASHA-equivalent SLP (has a master's degree in the field of speech language pathology and a Texas license). Speech therapy services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, and a grandfathered SLP who is acting under the supervision or direction of an SLP.

The supervision must meet the following provisions:

- The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.
- The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.
- The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets "under the direction of a speech-language pathologist," as a speech-language pathologist who:

- Is directly involved with the individual under his direction.
- Accepts professional responsibility for the actions of the personnel he agrees to direct.
- Sees each student at least once.
- Has input about the type of care provided.
- Reviews the student's speech records after the therapy begins.
- Assumes professional responsibility for the services provided.

42.6.7.4 Speech Therapy Billing Table

POS*	Procedure Code	Individual or Group	Therapist or Licensed/Certified Assistant
1,2, or 9	1-92506 with modifier GN	Individual	Licensed therapist
1,2, or 9	1-92507 with modifier GN-U8	Individual	Licensed therapist
1,2, or 9	1-92507 with modifier GN-U1	Individual	Licensed/certified assistant acting under the supervision or direction of a SLP
1,2, or 9	1-92508 with modifier GP-U8	Group	Licensed therapist
1,2, or 9	1-92508 with modifier GP-U1	Group	Licensed/certified assistant acting under the supervision or direction of a SLP
*Place of Service: 1=office/school; 2=home; 9=other locations			

Providers must use a 15-minute unit of service for billing.

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a cumulative of two hours per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.8 Evaluation/Assessment and Psychological Services

42.6.8.1 Evaluation/Assessment

Evaluations/assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation/assessment is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is under 21 years of age, whether or not the IEP includes SHARS.

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Evaluations/assessments (1-96101) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with Title 19 Texas Administrative Code (TAC) §89.1040(b)(1) and 34 CFR §300.136(a)(1).

Evaluation/assessment billable time includes:

- Psychological, educational, or intellectual testing time spent with the student present.
- Necessary observation of the student associated with testing.
- A parent/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities.
- Time spent without the student present for the interpretation of testing results.

Time spent gathering information without the student present or observing a student is not billable evaluation/assessment time.

Occupational therapists, physical therapists, audiologists, and SLPs who perform an evaluation should bill for their time under their individual procedure codes (1-97003, 1-97001, and 1-92506, with modifier U9, or 1-92506, with modifier GN).

Assessments for visual impairment that are performed by a licensed physician can only be billed under the medical services procedure code 1-99499. State-mandated vision and hearing screenings are not billable under SHARS.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

Evaluation/Assessment Billing Table

POS*	Procedure Code	Individual/ Group	Unit of Service
1,2, or 9	1-96101	Individual	1 hour
*Place of Service: 1=office/school; 2=home; 9=other locations			

Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.

Refer to: “Billing Units Based on an Hour” on page 42–12

Important: *The recommended maximum billable time is eight hours over several days. Time spent for the interpretation of testing results without the student present is billable time. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.8.2 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP. Nothing in this rule prohibits public schools from contracting with licensed psychologists and licensed psychological associates who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. School districts may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the school district. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(1)(B).

All psychological services are billable on an individual (1-96152) or group (1-96153) basis. Session notes are required. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency psychological services as long as the student’s IEP includes a behavior improvement plan that documents the need for the emergency services.

Psychological Services Billing Table

POS*	Procedure Code	Individual/Group
1,2, or 9	1-96152 with modifier AH	Individual
1,2, or 9	1-96153 with modifier AH	Group
*Place of Service: 1=office/school; 2=home; 9=other locations		

Providers must use a 15-minute unit of service for billing.

Refer to: “Billing Units Based on 15 minutes” on page 42–12

Important: *The recommended maximum billable time for direct psychological therapy (group and/or individual) is a cumulative of two hours per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.*

42.6.9 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing activities of daily living (ADLs) and instrumental ADLs (IADLs) but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment. For personal care services to be billable, they must be listed in the student’s IEP. Personal care services are billable on an individual (1-T1019 with modifier U5 or U6) or group (1-T1019 with modifier U5-UD or U6-UD) basis. Session notes are not required for procedure codes 1-T1019 with modifier U5 or

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1-T1019 with modifier U5-UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed. Procedure codes 1-T1019 with modifier U6 and 1-T1019 with modifier U6-UD are billed using a one-way trip unit of service.

42.6.9.1 Personal Care Services Billing Table

POS*	Procedure Code	Individual or Group	Unit of Service
1,2, or 9	T1019 with modifier U5	Individual, school	15 minutes
1,2, or 9	T1019 with modifier U5-UD	Group, school	15 minutes
1,2, or 9	T1019 with modifier U6	Individual, bus	Per one-way trip
1,2, or 9	T1019 with modifier U6-UD	Group, bus	Per one-way trip
*Place of Service: 1=office/school; 2=home; 9=other locations			

Refer to: "Billing Units Based on 15 minutes" on page 42–12

Important: *The recommended maximum billable units for 1-T1019 with modifier U6 or 1-T1019 with modifier U6-UD is a cumulative of four one-way trips per day. Providers must maintain documentation of the reasons for the additional time, if more than the recommended one-way trips are billed.*

42.6.10 Transportation Services in a School Setting

Transportation services in a school setting are reimbursed when they are provided on a specially-adapted vehicle and if the following criteria are met:

- Provided to and/or from a Medicaid-covered service on the day for which the claim is made.
- A child requires transportation in a specially-adapted vehicle to serve the needs of the disabled.
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school.
- The Medicaid-covered SHARS is included in the student's IEP.
- The special transportation service is included in the student's IEP.

A specially-adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of seatbelts or harnesses, addition of child protective seating, or addition of air conditioning). In addition, a bus monitor does not meet the criteria for special adaptation. Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS.

Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting would be reimbursed for them.

Reimbursement for covered transportation services is on a student one-way trip basis. The following one-way trips may be billed if the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school's specially adapted vehicle from:

- The student's residence to school.
- The school to the student's residence.
- The student's residence to a provider's office that is contracted with the district.
- A provider's office that is contracted with the district to the student's residence.
- The school to a provider's office that is contracted with the district.
- A provider's office that is contracted with the district to the student's school.
- The school to another campus to receive a billable SHARS service.
- The campus where the student received a billable SHARS service back to the student's school.

Covered transportation services from a child's residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive a Medicaid-covered SHARS service (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially-adapted bus.

42.6.10.1 Transportation Services in a School Setting Billing Table

POS*	Procedure Code	Unit of Service
1,2, or 9	1-T1003	Per one-way trip
*Place of Service: 1=office/school; 2=home; 9=other locations		

42.7 Claims Information

42.7.1 Other Insurance

Medicaid guidelines state that other insurance carriers must be billed before billing Medicaid. If the SHARS student has other insurance, the SHARS provider can call the other insurance company to inquire whether the service is covered under the student's insurance plan. If the service is not covered under the student's insurance plan, the SHARS provider can obtain from the other insurance company an oral denial without ever billing the other insurance carrier.

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To appeal a Medicaid claim that was denied for other insurance using an oral denial from the other insurance company, the SHARS provider should submit the following information:

- The date of the telephone call with the other insurance company
- The name and telephone number of the insurance carrier
- The name of the insurance representative
- Policy and group holder information
- The specific reason for denial

Include the client's type of coverage to enhance the accuracy of future claims processing.

If the SHARS provider learns that the other insurance policy does cover the service, the SHARS provider must obtain parental permission to bill the other insurance carrier. If parental permission is not received or the SHARS provider does not wish to pursue payment through the other insurance carrier, the SHARS provider cannot bill Medicaid by submitting claims for the services to TMHP.

42.7.2 Claims Information

Claims for SHARS must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

42.7.3 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
School Health and Related Services (SHARS) Claim Example	D-33
Acronym Dictionary	F-1

42.7.4 Billing Units Based on 15 minutes

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

Reminder: *Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information will be reimbursed as a unit of 1.*

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or less minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Examples:

- 0 min–7 mins = 0 units
- 8 mins–22 mins = 1 unit
- 23 mins–37 mins = 2 units
- 38 mins–52 mins = 3 units
- 53 mins–67 mins = 4 units
- 68 mins–82 mins = 5 units

42.7.5 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units should be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Reminder: *Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information will be reimbursed as a unit of 1.*

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

- 0 mins–3 mins = 0 units
- 4 mins–9 mins = 0.1 unit
- 10 mins–15 mins = 0.2 unit
- 16 mins–21 mins = 0.3 unit
- 22 mins–27 mins = 0.4 unit
- 28 mins–33 mins = 0.5 unit
- 34 mins–40 mins = 0.6 unit
- 42 mins–48 mins = 0.7 unit
- 49 mins–54 mins = 0.8 unit
- 55 mins–57 mins = 0.9 unit

Other examples:

- 58 mins–63 mins = 1 unit
- 64 mins–70 mins = 1.1 units
- 71 mins–77 mins = 1.2 units
- 78 mins–84 mins = 1.4 units
- 85 mins–91 mins = 1.5 units

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Section

43

Texas Health Steps (THSteps)

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43.1 THSteps Medical and Dental Administrative Information

This section describes the administrative requirements for the Texas Health Steps (THSteps) Program, including provider requirements, client eligibility requirements, and billing and claims processing information. "Clinical Information" on page 43-14 contains information for medical and dental services provided under THSteps. Providers needing additional information, may call 1-877-847-8377 or refer to the "THSteps Quick Reference Guide" on page M-1 for a more specific list of resources and telephone numbers. Providers may also contact the DSHS THSteps Provider Relations staff in the DSHS regional office by calling the appropriate regional office as listed in "DSHS Health Service Region Contacts" on page A-8.

43.1.1 Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service for individuals younger than 21 years of age. In Texas EPSDT is known as the THSteps program. EPSDT was defined by federal law as part of the *Omnibus Budget Reconciliation Act* (OBRA) of 1989 legislation and includes periodic screening, vision, hearing, and dental preventive and treatment services. In addition, Section 1905(r)(5) of the *Social Security Act* requires that any medically necessary health care service listed in the Act be provided to THSteps (EPSDT) clients even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. These additional services are available through the Comprehensive Care Program (CCP). THSteps-CCP services are the diagnosis and treatment components of THSteps.

43.1.2 Statutory Requirements

Several specific legislative requirements affect the THSteps program and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Blood Screening, *Health and Safety Code*, Chapter 33.
- Parental Accompaniment, as outlined in Appendix K, THSteps Statutory Requirements, "Parental Accompaniment" on page K-2.
- Requirements for Reporting Abuse or Neglect, as outlined in "Compliance with Texas Family Code" on page 1-4.
- Simplified Enrollment, *Texas Human Resources Code*, §32.025.
- Early Childhood Intervention (ECI), 34 *Code of Federal Regulations* (CFR) Part 303; Chapter 73, *Texas Human Resources Code,* and Title 40 *Texas Administrative Code* (TAC), Chapter 108.
- Newborn Hearing Screening, *Health and Safety Code*, Chapter 47.
- Teen Confidentiality Issues. There are many state statutes that may affect consent to medical care for a minor, depending on the facts of the situation. Among the relevant statutes are Chapters 32, 33, 153, and 266 of the *Texas Family Code*. Providers may want to consult an attorney, their licensing board, or professional organization if guidance is needed or questions arise on matters of medical consent.

Refer to: "Texas Health Steps Statutory State Requirements" on page K-1 for more information.

43.1.3 Medical Transportation Program

On request by the client, the Texas Department of Transportation Medical Transportation Program (MTP) can assist the client with scheduling transportation for THSteps medical and dental checkups.

Refer to: "Medical Transportation" on page I-1 for more information.

43.1.4 Provider Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application. Facility providers must submit a current copy of the supervising practitioner's license.

To enroll in the THSteps program, providers must be enrolled in the Texas Medicaid Program, in addition to one of the following:

- Physicians (doctor of medicine [MD] and doctor of osteopathy [DO]) currently licensed in the state where the service is provided.
- Health care providers or facilities (public or private) capable of performing the required medical checkup procedures under a physician's direction, such as regional and local health departments, family planning clinics, migrant health clinics, community-based hospitals and clinics, maternity clinics (MSCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), home health agencies (HHAs), school districts, and family or pediatric nurse practitioners. In the case of a clinic, a physician is not required to be present in the clinic at all times during the hours of operation; however, a physician must assume responsibility for the clinic's operation.
- Family and pediatric nurse practitioners enrolled independently.
- Certified nurse-midwives (CNM) enrolled as providers of THSteps medical checkups for newborns younger than 2 months of age and adolescent females.
- Women's health care nurse practitioners enrolled as providers of THSteps medical checkups for adolescent females.
- Adult nurse practitioners (ANP) enrolled as providers of THSteps checkups for adolescents.

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- Effective July 1, 2006, physician assistants (PAs) may enroll independently as THSteps medical providers. It is recommended that PAs have expertise or additional education in the areas of comprehensive pediatric assessment.

Residents may provide medical checkups in a teaching facility under the personal guidance of the attending staff as long as the facility's medical staff by-laws and requirements of the Graduate Medical Education (GME) Program are met, and the attending physician has determined the intern or resident to be competent in performing these functions. THSteps does not require the supervising physician to examine the patient as long as these conditions are met.

A registered nurse (RN) may not enroll independently, but may perform THSteps medical checkups only under the supervision of a physician. The physician ensures that the RN or PA has appropriate training and adequate skills for performing the procedures for which they are responsible.

Refer to: "Provider Enrollment" on page 1-2 for information about enrollment procedures.

43.1.4.1 Additional Education Requirements for Registered Nurses (RNs)

All RNs performing THSteps medical checkups must receive special training in comprehensive pediatric assessment. To be qualified to conduct a THSteps physical examination, RNs must have completed courses in pediatric assessment after graduation from nursing school, which includes the following components: physical, developmental/mental health, nutrition assessment, and anticipatory guidance. This education may be obtained through credit hours at an accredited college or university or through courses approved for continuing education units.

If the pediatric course(s) do not include a formal preceptorship (observation by course faculty or their designee of the individual's skills over a period of time), the RN should receive personal supervision by a physician (or family or pediatric nurse practitioner) until the physician (or family or pediatric nurse practitioner) determines the RN to be competent to perform these functions.

Documentation of the required special training should be included in the employee's personnel file.

It is recommended that PAs have expertise or additional education in the areas of comprehensive pediatric assessment. Courses offered by the Texas Nurses Association (TNA) are available for PAs and provide continuing education units for PAs and RNs.

The courses are:

- *Comprehensive Pediatric Assessment.* The curriculum includes an overview of THSteps family medical history, pediatric physical assessment, nutrition, developmental and mental health assessments, case management, and anticipatory guidance. A clinical preceptorship with a physician or advanced practice nurse (APN) is part of this training.
- *Adolescence* (web-based). This course gives health care providers (including PAs, nurse practitioners (NPs), clinical nurse specialists (CNSs), RNs, social workers, nutritionists, and dietitians) information that can assist them in relating to and providing care for adolescents.
- T*exas Health Steps Adolescent Checkup (web-based). This course* provides the RN with recommended guidelines and necessary forms for conducting a THSteps adolescent checkup.

For more information, nurses can contact TNA at www.texasnurses.org/thsteps/thsteps.htm or by telephone at 1-512-452-0645, or call THSteps at 1-512-458-7745.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.1.4.2 Medicaid Managed Care Enrollment

The Medicaid Managed Care Program consists of two types of health care delivery systems, Primary Care Case Management (PCCM) and health maintenance organization (HMO). THSteps medical providers do not have to enroll with PCCM to be reimbursed for medical checkup services provided to PCCM clients. Bills are submitted directly to TMHP, and PCCM clients are free to choose the physician who will perform their THSteps medical checkups.

Under HMOs this same freedom of choice exists; however, providers bill the HMO rather than TMHP.

While preventive services are available in managed care, those provided to clients from birth to 21 years of age must be completed as THSteps medical checkups, meet program requirements, and be submitted with appropriate THSteps procedure codes and THSteps provider identifiers.

Note: *Diagnosis and treatment of problems must be provided either by the client's primary care provider or by a provider referred by the client's primary care provider. If a THSteps medical checkup is performed by a provider who is not the client's primary care provider, the results of the medical checkup should be forwarded to the client's primary care provider so that the client's medical record can be updated, in keeping with the medical home concept*

If an enrolled medical checkup provider wants to discontinue participation, the provider must send written notification to the managed care health plan, as well as to TMHP at the following address:

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

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment.

"Managed Care" on page 7-1.

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43.1.5 Eligibility for a Medical Checkup

Through outreach THSteps staff (the Department of State Health Services [DSHS], the Texas Health and Human Services Commission [HHSC], or contractors) encourage clients to use THSteps preventive medical checkup services when they first become eligible for Medicaid and each time thereafter when they are periodically due or overdue for their next medical checkup.

Providers are encouraged to perform checkups on any client they identify as eligible for medical checkups. They also are encouraged to notify clients when they are due for the next checkup according to the THSteps periodicity schedule.

The client is periodically eligible for medical checkup services based on the THSteps Periodicity Schedule. A THSteps statement under the client's name on the regular client Medicaid Identification (Form H3087) and the State of Texas Access Reform (STAR) Identification (Form H3087 STAR) indicates the THSteps services for which the client is currently eligible. A check mark on the Medicaid Identification (Form H3087) and the STAR Identification (Form H3087 STAR) indicates eligibility for the particular service, such as eye exam, eye glasses, hearing aid, intermediate care facility for the mentally retarded (ICF-MR) dental, prescriptions, and medical services. A blank space denotes that the client is not eligible for the particular service based on available data.

Checkups provided when a THSteps statement does not indicate a medical checkup is due must be billed as an exception to the periodicity schedule.

Refer to: "Exceptions to Periodicity" on page 43-9 for further details about billing for a checkup performed as an exception to periodicity.

Although the Medicaid Eligibility Verification (Form H1027) identifies eligible clients when the client Medicaid Identification (Form H3087) is lost or has not yet been issued, Form H1027 does not indicate periodic eligibility for medical checkup services. Providers can call the TMHP Contact Center at 1-800-925-9126 or check the TMHP website at www.tmhp.com, to verify a client's periodic eligibility for medical checkup services.

43.1.5.1 Newborn Eligibility

A newborn child may be eligible for Medicaid for up to one year if the child's mother is:

- Receiving Medicaid at the time of the child's birth
- Eligible for Medicaid or would be eligible if pregnant
- Living with the child

If the newborn has Medicaid coverage, it is *not* acceptable for a provider to require a deposit for newborn care from the guardian. The child's eligibility ends if the child's mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother's household. The hospital or birthing center must report the birth to HHSC Eligibility Services at the time of the birth.

If the hospital or birthing center notifies HHSC Eligibility Services that a newborn child was born to a Medicaid-eligible mother, then the hospital caseworker, mother, and attending physician (if identified) should receive a Medicaid Eligibility Verification (Form H1027) from HHSC a few weeks after the child's birth. The H1027 form includes the child's Medicaid number and effective date of coverage. After the child has been added to the HHSC eligibility file, a client Medicaid Identification (Form H3087) is issued.

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

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

Refer to: "Medicaid Identification Form H3087" on page 4-18.

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43.1.6 Reimbursement

Physicians are reimbursed for THSteps medical checkups and administration of immunizations in accordance with 1 TAC §355.8085. High volume payments to physicians are detailed in "Additional Payments to High-Volume Providers" on page 2-6 of this manual. THSteps medical checkups provided in an FQHC are reimbursed in accordance with 1 TAC §355.8261.

THSteps medical checkups may be billed electronically or on a CMS-1500 claim form. Providers may request information about electronic billing or the claim form by contacting the TMHP THSteps Contact Center at 1-800-757-5691.

Only services provided are considered for reimbursement. In accordance with federal policy, the Texas Medicaid Program and Medicaid clients cannot be charged when a client does not keep an appointment.

The $70 THSteps medical checkup fee includes payment for tuberculosis (TB) skin tests and collecting the blood specimens for all required laboratory services included on the checkup periodicity schedules. Vaccines, TB skin tests and supplies, laboratory supplies, and laboratory testing are made available free of charge to medical checkup providers through DSHS.

THSteps visits will not be reimbursed if performed through telemedicine.

A $5 reimbursement is made for each immunization administered during the medical checkup visit. Combined antigen vaccines (e.g., DTaP or MMR) are reimbursed as one dose. Vaccines that are available through the DSHS Texas Vaccine for Children (TVFC) Program (from birth through 18 years of age) will not be reimbursed. No reimbursement is made for performing the TB skin test, but all clients should be brought back to the provider's office for a THSteps follow-up visit to read the skin test.

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43.1.6.1 Medical Checkup

A complete THSteps medical checkup is reimbursed at a maximum fee of $70 for children covered under the traditional fee-for-service Medicaid Program. Except for PCCM, reimbursement for THSteps medical checkups for children enrolled in the Medicaid Managed Care Program must be contractually negotiated between the provider and the child's or adolescent's managed care organization (MCO). PCCM providers are reimbursed at the traditional fee-for-service rate of $70. Providers in areas of the state covered by Medicaid Managed Care should refer to "Managed Care" on page 7-1 for more information about reimbursement and referrals.

All components of the THSteps medical checkup are included in the reimbursement for the visit. A provider's billing for services is acknowledging the completion of a comprehensive medical checkup in accordance with THSteps policy. The visit is a comprehensive medical checkup and must include all age-appropriate assessments, screenings, immunizations, and laboratory tests as indicated on the periodicity schedule. Specifically, a component with an available Current Procedural Terminology (CPT) code is not reimbursed separately on the same day as a medical checkup.

Information concerning the components required at specific ages can be found on pages 43-16 and 43-17 for birth through 20 years of age.

Services performed in an FQHC or RHC setting are paid an all-inclusive rate per visit. For services performed in an RHC, providers must use the appropriate national place of service code (POS) 72 for an RHC setting. An FQHC provider must bill all THSteps visits with modifier EP in addition to the modifiers used to identify who performed the medical checkup.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-24 for billing instructions.

Reminder: *A complete checkup is an assessment provided in accordance with mandated procedures and the narrative standards outlined for each procedure. Incomplete medical checkups are not reimbursed.*

Providers may bill up to nine visits, regardless of the date of the last medical checkup, in the first two years of life. All of the checkups listed on the periodicity schedule have been developed based on recommendations of the American Academy of Pediatrics (AAP). In Texas, the THSteps program has modified the AAP periodicity schedule based on the scheduling of a test in federal EPSDT regulations or other programs or to meet the population's needs.

When the THSteps provider who performs the checkup determines that a referral for diagnosis and treatment is necessary for a condition found during the checkup, the referral should be made to a provider who is qualified to perform diagnostic or treatment services.

If the provider performing the medical checkup can provide treatment for the identified condition, a separate claim for an established patient office visit may be submitted on the same day as the checkup with an appropriate established patient CPT code for the diagnosis and treatment of the identified problem.

Exception: *Medicaid Managed Care clients must be referred to their designated primary care provider for further treatment or referral.*

Refer to: "Referrals for Medicaid-Covered Services" on page 43-13 for information about treatment or acute care visits on the same day as a medical checkup or other referral information.

For the acute care claim, providers must bill the CPT codes for evaluation and management of *established* patients with an appropriate diagnosis documented. Often minor illnesses or conditions (e.g., follow-up of a mild upper respiratory infection) during the THSteps medical checkup do not warrant additional billing.

43.1.6.2 Newborn Examination

Inpatient newborn examinations billed with procedure codes 1-99431 and 1-99432 are counted as THSteps medical checkups and must include all the necessary components.

The required components of the initial THSteps newborn checkup must meet THSteps requirements and must include the following documentation:

- History and physical examination
- Length, height, weight, and head circumference
- Sensory screening (vision and hearing appropriate to age)
- Hepatitis B immunization
- Mandated initial newborn screen at 24–48 hours of age
- Health education with the parents or a responsible adult who is familiar with the child's medical history. Health education by the nursing staff, individually or in a class, is acceptable

Note: *In Texas the newborn hearing screening is included in the in-hospital newborn exam.*

Providers must include and document the required components when billing procedure codes 1-99431 or 1-99432 to the Texas Medicaid Program.

If the provider chooses to do a brief examination (not including all the above components), the provider may bill procedure code 1-99431 or 1-99432 with modifier 52, which does not count as a THSteps checkup.

Providers billing these newborn codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. TMHP encourages THSteps enrollment for all providers that offer a medical home for clients and provide them with well-child care and immunizations. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled at 1 to 2 weeks of age and that regular checkups should be scheduled during the first year.

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43.1.6.3 Medical Checkup, First 6 Days of Life

To encourage early checkups for high-risk but healthy newborns, providers may bill a THSteps medical checkup in the first six days of life as an exception to periodicity. A physical examination is important if the child has been discharged early from the hospital or if the infant was born outside of a hospital. A home visit may be especially helpful for first-time mothers. The first regular checkup should still be scheduled at 1 to 2 weeks of age, is also reimbursable, and should include the second newborn screen.

The exception-to-periodicity checkup performed in the first six days of life may be performed in a clinic, provider's office, or the family's home. If the checkup is performed in the home, the provider must be designated by the discharging physician or the medical home physician before discharge and must provide a timely report of findings and recommendations to the infant's medical home.

Refer to: "Medical Home Concept" on page 43-11.

A THSteps medical checkup in the first six days of life, billed as an exception to periodicity, must include the following:

- Neonatal and family history
- Review of systems
- Height, weight, and head circumference
- Physical and nutritional assessment
- Vision and hearing screening
- Age-appropriate immunization
- Assessment of the mental health status of the infant and mother
- Anticipatory guidance

The metabolic screening should only be obtained if not obtained before discharge from the hospital. The repeat metabolic screening should be completed at the one- or two-week visit. If a potential or confirmed medical problem requires monitoring, it is recommended that the infant be seen in a clinic or medical provider's office, and Medicaid should be billed using codes for a sick child.

43.1.6.4 Exceptions to Periodicity

Payment is made for medical checkups that are exceptions to the periodicity schedule to allow for services under the following categories:

- Medically necessary (such as developmental delay or suspected abuse)
- Environmental high-risk (such as sibling of a child with elevated blood lead)
- Required to meet state or federal exam requirements for Head Start, daycare, foster care, or pre-adoption
- Required for dental services provided under general anesthesia
- Medically necessary checkup in the first six days of life

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-24 for billing instructions.

THSteps medical exception to periodicity services must be billed with the same procedure codes, provider type, modifier, and condition indicators as a medical checkup. Additionally, providers must use modifiers SC, 23, and 32 to indicate the exception.

Note: *Modifier 23 refers to children receiving a medical checkup prior to general anesthesia related to dental procedures.*

Note: *The visit is not required to be billed as an exception when the child is eligible for Medicaid or the child is new to Medicaid and the checkup will be the initial medical checkup. If an exception is not required, the claim should be submitted without the use of the modifiers.*

43.1.6.5 Follow-up Medical Checkup Visit

A follow-up checkup visit is reimbursed at a maximum fee of $6 except for services performed in an RHC or FQHC setting. Follow-up checkups may be needed when required to complete necessary procedures related to the THSteps checkup (e.g., to read a TB skin test, transportation and outreach work required by the provider to read a TB skin test, administering immunizations in cases where the child's immunizations were not up-to-date or medically contraindicated on the initial visit, and repeating laboratory work). An additional $5 administrative fee is paid for each immunization (injection), except for services performed in an RHC or FQHC setting. Combined antigen vaccines (e.g., DTaP or MMR) are reimbursed as one dose. A return visit to follow up on treatment initiated during the screen or to make a referral is not to be filed as a follow-up visit.

Follow-up visits may not be billed on the same day as a THSteps visit.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-24.

A THSteps medical checkup follow-up visit must be billed with a THSteps provider identifier to be considered a THSteps visit. FQHCs must bill the same procedure with modifier EP.

When billing for a THSteps medical checkup follow-up visit, providers must use national procedure code S-99211. Usually, the necessary components are minimal and may not require the presence of a physician. Typically, five minutes are spent performing or supervising these services.

43.1.7 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a CMS-1500 claim form as soon as possible after the date of service, as the paid claim updates client information, including the Medicaid Identification.

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The second source of acceptable verification is a physician's written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the child's name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

If neither the first nor the second source of verification is available, a THSteps staff member may contact the provider's office for verification.

43.1.8 Claims Information

43.1.8.1 Procedure Coding for THSteps Medical Checkups

THSteps medical checkups must be billed with the appropriate procedure codes (S-99381, S-99382, S-99383, S-99384, S-99385, S-99391, S-99392, S-99393, S-99394, and S-99395). Procedure codes S-99385 and S-99395 are restricted to clients 18 through 20 years of age for a THSteps medical checkup.

Condition indicators must be used to describe the results of the checkup. A condition indicator must be entered on the claim with the periodic medical checkup visit procedure code. Additional indicators are required based on whether a referral was made or not.

If a referral was made, providers must use the Y referral indicator. If no referral is made, providers must use the N referral indicator.

Procedure Codes for THSteps Medical Checkups

The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.

Providers must use type of service (TOS) S when billing for the following THSteps medical checkup services:

TOS	Procedure Codes	Referral Indicator	Condition Indicator
S	S-99381, S-99382, S-99383, S-99384, and S-99385 (New client preventive visit) *or* S-99391, S-99392, S-99393, S-99394, and S-99395 (Established client preventive visit)	N (No referral given)	NU (Not used)
S	S-99381, S-99382, S-99383, S-99384, and S-99385 (New client preventive visit) *or* S-99391, S-99392, S-99393, S-99394, and S-99395 (Established client preventive visit)	Y (Yes THSteps/ EPSDT referral was given to the client)	S2 (Under treatment) *or* ST (New services requested)

Modifiers AM, SA, TD, and U7 must be used to indicate the practitioner who performed the unclothed physical examination on the medical screen.

Services performed in an FQHC or RHC setting are paid an all-inclusive rate per visit. If services are performed in an RHC, providers must use the appropriate national place of service code (72) for an RHC setting. *An FQHC provider must bill all THSteps visits with modifier EP in addition to one of the above modifiers used to identify who performed the medical checkup.*

Submit claims for THSteps medical services to TMHP in an approved electronic format or on a CMS-1500 claim form.

43.1.8.2 Immunizations Billed Within THSteps Medical Checkups, Exception to Periodicity, and Follow-Up Visit

Diagnosis code V202 is *required* to be used with the combination of the procedure code and the appropriate vaccine administration code from the table located in Section 43.1.8.3. Providers must use their THSteps provider identifier and TOS S.

43.1.8.3 Immunizations Billed Outside of THSteps Medical Checkups, Exception to Periodicity, or Follow-Up Visit

Diagnosis code V069 is required to be used with the procedure codes 1-90465, 1-90466, 1-90467, 1-90468, 1-90471, 1-90472, 1-90473, and 1-90474 in combination with the appropriate vaccine administration code in the following table. Providers must use their regular Medicaid provider identifier and TOS 1.

For all immunizations, if only one immunization is administered during a checkup or visit, providers should bill administration procedure code 1/S-90471 or 1/S-90473 with a quantity of 1 in addition to the appropriate national code that describes the immunization administered. If two or more immunizations are administered, providers should bill administration procedure codes 1/S-90465, 1/S-90467, 1/S-90471, or 1/S-90473 with a quantity of 1, procedure codes 1/S-90466, 1/S-90468, 1/S-90472, or 1/S-90474 with a quantity of 1 or more (depending on the number of vaccines administered), and the appropriate national procedure codes that describe each immunization administered. The procedure codes that identify each vaccine are considered informational but are required on the claim.

Vaccine Procedure Codes		
1/S-90632	1/S-90633	1/S-90645
1/S-90646	1/S-90647	1/S-90648
1/S-90655	1/S-90656	1/S-90657
1/S-90658	1/S-90669	1/S-90700
1/S-90701	1/S-90702	1/S-90707
1/S-90710	1/S-90712	1/S-90713
1-90715	1/S-90716	1/S-90718
1/S-90720	1/S-90723	1-90734

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Vaccine Procedure Codes		
1-90740	1-90743	1/S-90744
1/S-90746	1-90747	1/S-90748
1/S-90749		

Exception: *Medical contraindications and exclusions from immunizations for reasons of conscience (including a religious belief and parental/client refusal) are the only acceptable reasons for not administering immunizations.*

Refer to: "Immunizations Overview" on page H-2 for exclusions from immunizations.

43.1.8.4 Billing

Providers should bill the usual and customary fee. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee. THSteps providers do not have to bill private insurance; they can bill TMHP directly. A medical checkup has a maximum fee of $70, immunization administration (per injection) has a maximum fee of $5, and a medical checkup follow-up visit has a maximum fee of $6.

Important: *All procedures, including the informational-only procedures, must have a billed amount associated with each procedure listed on the claim.*

The procedure code on the claim form indicates whether referral for diagnosis and treatment is needed for eligible clients; consequently, all information *must* be accurate.

The following are instructions for completing the CMS-1500 form when billing a THSteps medical checkup:

- The diagnosis code in Block 21.1 of the CMS-1500 is always V202. Electronic billers also use V202.
- Type of service on the CMS-1500 (Block 24C) is always S.
- POS on the CMS-1500 (Block 24B) is 1, Alpha O, or 11 for electronic billers. For services provided in an RHC setting, providers must use national POS 72.
- Patient records must reflect that each of the required screening procedures was completed in accordance with the medical checkup periodicity schedules based on the child's age.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup:

- Appropriate THSteps medical checkup procedure code (all ages)
- TB skin test procedure code, if administered (1 through 20 years of age)
- Immunization administration and vaccine procedure code(s) if administered (all ages)
- Condition indicators
- Provider type modifiers
- EP modifier, if appropriate

Submit claims to the following address:

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

43.1.8.5 Claim Filing Resources

Refer to the following sections and/or forms for claims filing information:

Resource	Page Number
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
Diagnosis and Treatment (Referral from THSteps Checkup) Claim Form Example	D-11
THSteps Complete Medical Checkup (CMS-1500) Claim Form Examples	D-34
Acronym Dictionary	F-1

43.1.9 THSteps Medical Checkup Facilities

All THSteps medical checkup policies apply to examinations completed in a physician's office, a health department, clinic setting, or in a mobile/satellite unit. Enrollment of a mobile/satellite unit must be under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office and are not separate entities.

The physical setting must be appropriate so that all elements of the checkup can be completed. For specific information, review the periodicity schedules and narrative explaining the schedules.

43.1.9.1 Medical Home Concept

HHSC and DSHS encourages providers participating in the Texas Medicaid Program to practice the "medical home concept" for clients with Medicaid. To realize the maximum benefit of health care, each family and individual needs to be a participating member of a readily identifiable, community-based medical home.

The medical home provides primary medical care and preventive health services and is the individual's and family's initial contact point when accessing health care. It is a partnership among the individual and family, health care providers within the medical home, and extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship.

The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs.

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When referring for consultation, specialty/hospital services, and health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

43.1.9.2 Continuity of Care and the Medical Home

The individual providing the medical checkup must ask the parents whether the child has a private physician or a medical home where the child usually receives medical care.

If the child's medical home provides THSteps checkups, it is in the child's and family's best interest for providers to encourage that relationship. If the family has a medical home but prefers to have their checkup done by another provider, that provider should send a copy of the THSteps medical checkup records examinations to the primary care provider.

If the medical checkup provider is unable to offer a medical home to the child, that provider must enter into written agreements with providers who are willing to offer medical homes.

43.1.9.3 Mobile Units and the Medical Home

If a provider has mobile units functioning in different communities, the agreements with providers who are willing to offer the medical home must be signed in each community so that children are referred to local providers for medical homes.

Providers with mobile units must advise families that they have freedom of choice concerning who completes the medical checkups.

43.1.10 THSteps Dental Services

Access to THSteps dental services is mandated by Medicaid and provides reimbursement for the early detection and treatment of dental health problems for Medicaid-eligible clients younger than 21 years of age. THSteps dental service standards were designed to meet federal regulations and to incorporate the recommendations of representatives of dental professional groups in the state.

OBRA of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which federal financial participation (FFP) is available, regardless of the limitations of the Texas Medicaid Program. This expansion is referred to as the CCP.

Refer to: "THSteps-CCP Overview" on page 43-33 for more information.

43.1.11 How the THSteps Dental Program Works

THSteps-designated staff (HHSC, DSHS, or contractor), through outreach and information, encourages the parents or caregivers of eligible children to use THSteps dental checkups and prophylactic care when children first become eligible for Medicaid and each time children are periodically due for their next dental checkup.

Upon request THSteps-designated staff (HHSC, DSHS, or its contractor) assists the parents or caregivers of eligible children with scheduling of appointments and transportation. Medicaid clients have freedom of choice of providers and are given names of enrolled providers. Call the DSHS THSteps Hotline at 1-877-847-8377 for a list of THSteps dental providers in a specific area.

When a child is eligible for a THSteps dental checkup, a message is present on the Medicaid Identification (Form H3087 or H3087 STAR) under the child's name. If the child or caregiver believes the child is due for a dental checkup and a message is not present, the provider may contact TMHP through the TMHP website at www.tmhp.com or the Automated Inquiry System (AIS) at 1-800-925-9126 to verify that the child is due for a dental checkup.

Children may receive an initial THSteps dental checkup at 12 months of age and a periodic dental checkup every 6 months thereafter, through 20 years of age. Children younger than 12 months of age are not eligible for *routine* dental examinations; however, they may be referred when a medical checkup identifies the medical necessity for dental services. All THSteps clients younger than 21 years of age can be seen by the dentist at any time for emergency dental services for trauma, early childhood caries, or any other appropriate dental or therapeutic procedure.

Clients up to 21 years of age may self-refer for dental services.

Note: *Clients enrolled in Medicaid Managed Care are required to choose a provider in their health plan's network. The health plan does not reimburse for services rendered by nonparticipating providers. Please contact the specific health plan for enrollment information.*

43.1.12 Vision Services

Appropriate vision screening is a mandatory part of each medical checkup visit.

Additionally, vision exams and services include eye examinations with refraction and eyeglasses. Eyeglasses are available once every 24 months. Eye examinations are available once per state fiscal year (SFY) (September 1 through August 31). This limit does not apply if the examination is for aphakia, disease, injury of the eye, or if medically necessary (for eyeglasses, defined as a 0.5 diopter change in one eye). Replacement of lost or destroyed eyewear is a benefit for THSteps-eligible clients.

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Refer to: "Vision Screening" on page 43-21 for information about vision screening for children and adolescents.

"Vision Care (Optometrists, Opticians)" on page 45-1 for more information.

43.1.13 Hearing Services

Appropriate hearing screening is a mandatory part of each medical checkup.

Additionally, hearing exams and services, including hearing aids, are available when medically necessary. Payment for services to eligible clients received through approved Program for Amplification for Children of Texas (PACT) providers is made through PACT at DSHS.

Refer to: "Inpatient Hearing Screening" on page 43-21 for information about hearing screening for children and adolescents.

43.1.14 Referrals for Medicaid-Covered Services

When a provider performing a checkup determines that a referral for diagnosis or treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents. A referral should be made to a provider who is qualified to perform the necessary diagnosis or treatment services. Medicaid Managed Care clients must be referred to their designated primary care provider for further treatment or referral.

A provider needing assistance to find a specialist that accepts patients with Medicaid coverage can call the DSHS THSteps Hotline at 1-877-847-8377.

Effort should be made to maintain continuity of care including follow-up to determine that the appointment was kept and that the provider receiving the referral has provided diagnosis and recommendations for further care to the referring provider.

If the provider performing the medical checkup can provide treatment for the condition identified, a separate claim (CMS-1500 or HCFA-1450 [UB-92]) may be submitted for the same date of service as the checkup with an appropriate established patient office visit for the diagnosis and treatment of the identified problem.

For the acute care claim, an appropriate level CPT code for evaluation and management (E/M) of *established* patients should be selected with the diagnosis supporting this additional billing documented. Not all minor illnesses or conditions, such as follow-up of a mild upper respiratory infection, identified during the THSteps medical checkup warrant additional billing. The billing of an additional office visit is only appropriate if the additional evaluation and treatment is required and performed for the identified condition(s). This additional service, since it is billed as an acute care claim to Medicaid, is independent of the THSteps medical checkup and is viewed as a stand-alone service. Consequently, the medical record must contain documentation that supports the medical necessity and the level of service of the E/M code submitted for reimbursement.

In addition to referrals for conditions discovered during a checkup or for specialized care, the following referrals may be used:

- *Routine Dental Referrals.* Routine dental referrals are required for all children at 1 year of age and every six months thereafter through 20 years of age (see "THSteps Dental Services" on page 43-12). Children younger than 12 months of age are not eligible for *routine* dental examinations; however, they may be referred when a medical checkup identifies the medical necessity for dental services. Children younger than 12 months of age also can be seen for emergency dental services by the dentist at any time for trauma, baby bottle tooth decay, or other oral health problems, such as early childhood caries. *Clients up to 21 years of age may also self-refer for dental care.*
- *Emergency Dental Referrals.* If a medical checkup provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all THSteps clients eligible for Medicaid up to 21 years of age.

Note: *In cases of both emergency and nonemergency dental services, clients have freedom of choice in selecting a dental provider who is participating in the THSteps Dental Program.*

- *Family Planning and Genetic Services Referrals.* For people eligible for Medicaid needing genetic services or family planning services, a referral should be made. Information about Medicaid-covered genetic services is available in "Genetic Services" on page 22-1 and information about family planning services is available in "Family Planning Services" on page 20-1. If the THSteps medical provider also provides family planning, the provider may inform the client of the availability of these services.
- *THSteps-CCP Services Referrals.* CCP benefits are medically necessary services for which FFP is available and may not currently be covered by Texas Medicaid (e.g., orthotics, private duty nursing, and others), as well as expanded coverage of current services that have limitations.

Refer to: "Hearing Referrals" on page 43-22 for referrals following a hearing screening.

"Medicaid Managed Care" on page 7-4 for more information on referrals for providers in areas of the state covered by Medicaid Managed Care.

"THSteps-CCP Overview" on page 43-33 for more information.

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43.1.15 Texas Vaccines for Children Program

For Medicaid children younger than 19 years of age, the TVFC program provides free vaccines that are routinely recommended according to the *Recommended Childhood Immunization Schedule* (Advisory Committee on Immunization Practices [ACIP], AAP, and the American Academy of Family Physicians [AAFP]). To obtain free vaccines for children birth through 18 years of age, THSteps providers must enroll in TVFC at DSHS. There is no reimbursement to providers for vaccines available from TVFC.

Refer to: Appendix H, "Immunizations" on page H-1 and "TVFC Provider Enrollment (3 Pages)" on page C-97 for more information about enrolling as a TVFC provider.

43.1.16 Benefits and Limitations

Medical checkup services are covered for clients younger than 21 years of age when delivered in accordance with the THSteps Medical Checkups Periodicity Schedule, which specifies the screening procedures recommended at each stage of the client's life and identifies the time period based on the client's age when medical checkup services are reimbursable.

Important: *Providers should treat each THSteps visit as the only opportunity for a client's comprehensive assessment.*

In acknowledgment of the practical situations that occur in the office or clinic settings, the periodicity schedule published in this manual has stressed the philosophy that the components of the THSteps medical checkup should be completed according to the individual child's appropriate needs. If a component cannot be completed because of a medical contraindication of a child's condition, then a follow-up visit is necessary.

Client eligibility for a medical checkup is determined by the client's age on the first day of the month. If a client has a birthday on any day except the first day during the month, the new eligibility period begins on the first of the following month. If a client turns 21 years of age during a month, the client continues to be eligible for THSteps services through the end of that month.

If components of the THSteps checkup have been provided one month preceding the child's birthday month and the medical checkup occurs in the following month, providers should clearly refer to that previous documentation, including the date(s) of service in the current clinical notation, and add appropriate new documentation for the checkup currently being billed.

All components of the THSteps medical checkup are included in the reimbursement of the visit. The visit is a comprehensive medical checkup and must include all assessments, screenings, immunizations, and laboratory tests as indicated on the periodicity schedule. Specifically, when there is an available CPT code for a component, it is not reimbursed separately on the same day as a medical checkup.

Sports examinations are not a covered Medicaid service. If the child or adolescent is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed.

Providers should call TMHP THSteps Medical Inquiries at 1-800-757-5691 with questions about the THSteps medical checkups. The line is available from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

Clients that are eligible for Medicaid and have questions about the THSteps program should call the DSHS THSteps Hotline at 1-877-847-8377. Clients with questions about their Medicaid eligibility for the THSteps program should be directed to their caseworker at the local HHSC office or site.

43.1.17 Information and Assistance

43.1.17.1 Assistance with Program Concerns

Providers that have questions, concerns, or problems with program rules, policy, or procedure should contact DSHS regional program staff. THSteps staff contact numbers can be found in Appendix A, Section A.7 "DSHS Health Service Region Contacts" on page A-8, or on the THSteps website, www.dshs.state.tx.us/thsteps/default.shtm, or by calling THSteps at 1-512-458-7745.

THSteps regional staff make routine contact with providers to educate and assist providers with THSteps program policies and procedures.

43.1.17.2 Assistance with Claims Concerns

Providers with questions, concerns, or problems about claims should contact the TMHP Contact Center at 1-800-925-9126. For regional contact information, providers can refer to the TMHP website at www.tmhp.com/Providers/default.aspx then click on the *Regional Support* link.

43.2 Clinical Information

This section contains specific information about medical and dental services. For more specific administrative information, see "THSteps Medical and Dental Administrative Information" on page 43-5.

43.2.1 Documentation of Completed Checkups

To assure completion of comprehensive medical checkups and the quality of care provided, providers must document all components of the THSteps medical checkups as they are completed. Clinical charts are subject to quality review activities including random chart review and focused studies of well-child care.

In acknowledgment of the practical situations that occur in the office or clinic settings, the AAP has stressed the philosophy that the components of all medical checkups

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should be performed that are appropriate to the needs of the individual child. Consequently, completion of all recommended components of a THSteps medical checkup may require follow-up checkups.

The Centers for Medicare & Medicaid Services (CMS) has clarified, in its Medicaid Guide To State Entities, the following expectations for the content of comprehensive preventive health visits:

- Comprehensive health history, including developmental and nutritional assessment.
- Comprehensive unclothed physical examination, including graphic recording of head circumference.
- Appropriate immunizations as indicated in the Recommended Childhood and Adolescent Immunization Schedule - United States.
- Age-appropriate laboratory tests for anemia, lead poisoning, and newborn screening.
- Health education, including anticipatory guidance, is required.
- Age-appropriate vision and hearing screening.
- Direct referral to dental checkups beginning at 12 months of age.

43.2.2 THSteps Medical Checkups Periodicity Schedule

The client is periodically eligible for medical checkup services based on the THSteps medical checkups periodicity schedule. All the checkups listed on the periodicity schedule have been developed based on recommendations of the AAP. The AAP continues to emphasize the importance of separate counseling and anticipatory guidance for the child and the accompanying parent/guardian during the adolescent years. In Texas the THSteps program has modified the AAP periodicity schedule based on the scheduling of a test in federal EPSDT regulations, state statutes or other programs, or to meet the population's needs.

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43.2.2.1 THSteps Medical Checkups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The columns across the top of the schedule indicate the age a client is periodically eligible for a medical checkup. The first column on the left of the chart identifies each procedure that must be performed at each appropriate age. (See Key at bottom of page and Footnotes on the following page.)

	Weeks		Months							Years																
Age[1]	**Inpatient**	**2**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**2**	**3**	**4**	**5**	**6**	**8**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
History																										
Family	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neonatal	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔													
Physical, Mental Health, and Developmental	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral Risk[2]																●	●	●	●	●	●	●	●	●	●	●
Physical Examination[3]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements																										
Height, Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Body Mass Index (BMI)										●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Fronto-Occipital Circumference	●	●	●	●	●	●	●	●	●	●																
Blood Pressure											●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Nutrition	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental[4]		●	●	●	●	●	●	●	●	●	●	●	●	●												
Mental Health		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screening[5]																										
Vision Screening[5a]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening[5b]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tuberculosis Screening[6]							●	✔	✔	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Laboratory[7]																										
Newborn Hereditary/Metabolic Testing[8]	●	●	✔	✔	✔	✔	✔																			
Hgb or Hct[9]					●	✔	●	✔	✔	●	✔	✔	✔	●	✔	✔	✔	●	✔	✔	✔	●	✔	✔	✔	✔
Lead Screening[10]					✚	✚	●	✚	✚	●	✚	✚	✚	✚												
Hemoglobin Type[11]	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
STD Screening[14]																	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
HIV Screening[15]																	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Pap Smear[16]																	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Hyperlipidemia[12]										✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Glucose[13]																✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Immunizations[17]	●	✔	●	●	●	✔	●	✔	✔	✔	✔	●	✔	✔	✔	✔	✔	✔	●	●	✔	✔	✔	✔	✔	✔
Dental Referral[18]							●	✔	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory Guidance[19]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Key

● Required, unless medically contraindicated or because of parent's reasons of conscience including a religious belief.

✔ Required as above, unless already provided on a previous checkup at the required age and documented on the health record with the date of service.

✚ If answers on high risk assessment questionnaires or other screening show a risk factor, further screening is required. Refer to Footnotes for more information about marked items.

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43.2.2.2 THSteps Medical Checkups Periodicity Schedule for Infants and Children (Birth Through 20 Years of Age) (continued)

Footnotes

1. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up-to-date with required procedures as soon as possible.
2. Screening for adolescent lifestyle risk factors is to include eating disorders, sexual activity, alcohol (and other drug use), tobacco use, school performance, depression, and risk of suicide.
3. An age-appropriate complete unclothed physical exam is required at each checkup. Older children are to be appropriately draped. For adolescents who are sexually active, a pelvic exam should be part of the examination.
4. Developmental screening:
   a. Medical checkups completed by physicians, physician assistants, and advanced practice nurses (pediatric nurse practitioners and family nurse practitioners) conducting THSteps checkups for children birth up to and including the six-year medical check-up must include:
      - A standardized developmental screen (the provider's choice of observational or parent questionnaire) for a child between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter.
      - Standardized screening should also be conducted if a parent expresses concern about the child's developmental progress.
      - Developmental screening at all other visits to include a review of milestones (gross and fine motor skills; communication skills, speech-language development; self help/care skills; social, emotional, and cognitive development) and mental health.

   b. Registered nurses conducting THSteps medical checkups for children birth up to and including the six-year medical check-up are required to conduct:
      - A standardized observational screen for children in the following age groups: 9 through 12 months of age; 18 through 24 months of age; and if the child does not have a record of a standardized observational developmental screen, again between 24 months up to and including the six-year medical check-up.
      - A standardized parent questionnaire at all other periodic visits birth up to and including the six-year medical check-up or when a parent expresses concern about the child's developmental progress.
5. Sensory screening:
   a. Vision:
      - Birth through 2 years of age—Screening includes history of high-risk conditions, observation, and physical examination.
      - Ages 3 through 10, 12, 15, and 18 years of age—Screening includes administration of an age-appropriate vision chart. Documentation of test results from a school vision screening program may be used if conducted within 12 months of the checkup.

   b. Hearing:
      - Birth through 3 years of age—Screening includes history, observation, and screening by use of the Parent Hearing Questionnaire.
      - Ages 4 through 10, 12, 15, and 18 years of age—A puretone audiometer should be used to screen hearing at checkups. Subjective screening may be completed at all other checkups. Documentation of results from a school audiometric screening program may be used if conducted within 12 months of the checkup.
6. In areas of low prevalence, administer the Tuberculosis (TB) Questionnaire annually beginning at 1 year of age. In areas of high prevalence, administer the TB skin test at 1 year of age, once between 4 through 6 years of age, and once between 11 through 17 years of age. Administer the TB Questionnaire annually beginning at 2 years of age and thereafter at other checkups. All clients should return for the provider to read the skin test. The TB Questionnaire is available in the *Texas Medicaid Provider Procedures Manual* (TMPPM).
7. All blood specimens are to be submitted to the DSHS Laboratory for analysis.
8. Newborn screening (hereditary/metabolic testing [hypothyroidism, PKU, galactosemia, sickle Hgb, and CAH]) is required by Texas law before hospital discharge and again between 1 and 2 weeks of age. Date and results of the second newborn screening are to be documented.
9. Hemoglobin (Hgb) and hematocrit (Hct) testing conducted at a Women, Infants, and Children (WIC) clinic or in a provider's office is acceptable within one month if date and value are documented.
10. Mandatory blood lead screening at 12 and 24 months of age. The Lead Exposure Questionnaire (available in the TMPPM) is acceptable at other visits.
11. If Hgb type has been performed previously and results are documented in the client's chart, it does not need to be repeated. Hgb type also is part of the newborn screening.
12. Hyperlipidemia screening should be completed for those at risk of increased levels of cholesterol (THSteps does not provide a formal questionnaire).
13. Children should be screened for risk of Type II diabetes. Fasting glucose screening should be obtained for those at risk of Type II diabetes.
14. For sexually active or high-risk adolescents, screening is to include evaluation for genital warts, cultures for gonorrhea and chlamydia, and blood test for syphilis.
15. While all adolescents should be screened for the risk of human immunodeficiency virus (HIV) infection, actual testing is voluntary.
16. The first Pap smear should be obtained at 21 years of age, 3 years from the onset of sexual activity, or at another age based on provider discretion.
17. Clients are not to be referred to the local health department for immunizations. Vaccines must be obtained from the Texas Vaccines for Children Program at DSHS and administered at the time of the checkup, unless medically contraindicated or because of parent's reasons of conscience including a religious belief.
18. Dental referrals are required for all patients beginning at 1 year of age. Patients are eligible for preventive dental checkups every six months thereafter, as well as emergency dental treatment at any time.
19. Counseling/anticipatory guidance is a required integral part of each checkup and must be face-to-face with the child's parent/caretaker and face-to-face with adolescents.

Note: Additional information is available in the TMPPM. To quickly reference the subjects listed above, refer to the manual's Index or use the Search tool available in the electronic edition.

43.2.3 Medical Checkups for Infants, Children, and Adolescents (Birth Through 20 Years of Age)

The following information lists descriptions and standards for each pediatric assessment and test that must be performed during a THSteps medical checkup in accordance with the periodicity schedule. The checkup includes face-to-face contact with the child's or adolescent's parent or guardian.

Refer to: "THSteps Medical Checkups Periodicity Schedule for Infants, Children, and Adolescents (Birth Through 20 Years of Age)" on page 43-16.

43.2.3.1 History

The child's or adolescent's initial history must include the following:

- Family medical history
- Neonatal history
- Physical and mental health history
- Developmental history
- Immunization history
- History of feeding or nutrition problems
- A complete review of body systems

Subsequent histories may be specific for the child's or adolescent's age and health history.

The history must be obtained from an adult caregiver familiar with the child and the child's health history. Preferably, the adolescent and the parent should be interviewed separately.

Refer to: "Additional Adolescent Screening" on page 43-26 for more history/screening information for adolescents.

43.2.3.2 Physical

A complete physical examination is required at each visit, with infants totally unclothed and older children undressed and suitably draped. The physical examination must include assessment of the following systems:

- Skin
- Head, eyes, ears, nose, and throat (HEENT)
- Dental
- Heart
- Chest/lungs (includes breast exam for females past menarche)
- Abdomen (including hernia)
- Skeletal
- Neurological (includes evaluation of cerebral, cranial nerve, and cerebellar functions; motor and sensory systems; and reflexes)
- Genitalia (includes observation for appropriate sexual development and testicular exam for adolescent males)

The unclothed physical examination must be completed by one of the following:

- A physician
- An NP
- A CNS
- An RN or licensed PA as stated in "Additional Education Requirements for Registered Nurses (RNs)" on page 43-6

Note: *An RN may only perform under a physician's supervision. The physician ensures that the RN or PA has appropriate training and adequate skills to perform the procedures for which they are responsible.*

43.2.3.3 Measurements

The physical examination must include the following measurements:

- Length, for children approximately birth through 2 years of age
- Height, for children approximately 3 through 20 years of age
- Weight, for children birth through 20 years of age
- Body Mass Index (BMI) for children 2 through 20 years of age
- Head circumference, fronto-occipital circumference, for children younger than 2 years of age
- Blood pressure (for children 3 years of age and older, using the appropriate cuff size)

The requirements for measurements other than blood pressure are to be compared to the National Center for Health Statistics growth charts to identify significant deviations from norms. These charts are available by calling THSteps at 1-512-458-7745.

Refer to: The Women, Infants, and Children (WIC) website as a resource for information about measuring heights and weights at www.dshs.state.tx.us/wichd/secure%2Dpol/nutrassess.pdf.

The requirements for measurements of blood pressure should be compared to Appendix I in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, revised), located at www.brightfutures.org or *Guidelines for Health Supervision III* from the AAP Publication Department, located at www.aap.org.

Refer to: "Documentation of Completed Checkups" on page 43-14.

43.2.3.4 Nutritional Assessment

The nutritional assessment is to be accomplished during the basic examination using the following methods:

- Ask questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets that are deficient or excessive in one or more food groups.

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- Determine quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs like WIC and Texas Food Stamps).
- Conduct a complete physical examination, including an oral dental examination, paying special attention to general features, such as pallor, apathy, and irritability.
- Obtain accurate height and weight measurements and calculation of BMI as important indices of nutritional status.
- Perform laboratory screenings for anemia (hemoglobin and hematocrit), as indicated.

Copies of the Nutritional Assessment Forms are listed in Appendix C of this manual.

Refer to: Appendix C, "24-Hour Dietary Recall, Assessment for Infants (Birth–11 Months) (2 Pages)" on page C-18.

"24-Hour Dietary Recall and Assessment for Children (1–4 Years) (2 Pages)" on page C-20.

"24-Hour Dietary Recall and Assessment for Children (5–9 Years) (2 Pages)" on page C-22.

"24-Hour Dietary Recall and Assessment for Children (10–20 Years) (2 Pages)" on page C-24.

Risk Factors/Screening for Eating Disorders and Obesity

The risk factors/screening for eating disorders and obesity assessment is to be accomplished in the basic examination, using the following methods:

- Adolescents should be asked about body image and dieting patterns.
- Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found:
    - Weight loss greater than ten percent of previous weight
    - Recurrent dieting when not overweight
    - Use of self-induced emesis, laxatives, starvation, or diuretics to lose weight
    - Distorted body image
    - BMI below the fifth percentile
- Adolescents should have an in-depth dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease if they have a BMI equal to or greater than the 95th percentile for age and gender.
- Adolescents with a BMI between the 85th and 94th percentile are at risk for becoming overweight. A dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease should be performed on these youth if the following are true:
    - Their BMI has increased by two or more units during the previous 12 months.
    - There is a family history of premature heart disease, obesity, hypertension, or diabetes mellitus.
    - They express concern about their weight.
    - They have elevated serum cholesterol levels or blood pressure.

If this assessment is negative, these adolescents should be provided general dietary and exercise counseling and should continue to be monitored annually.

43.2.3.5 Developmental Assessment

Requirements for Developmental Screening by Physicians, Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists

Medical checkups completed by physicians, PAs, and NPs or CNSs (pediatric or family specialities) for children birth through 6 years of age must include:

- A standardized developmental screen (the provider's choice of observational or parent questionnaire) for a child between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter, or when a parent expresses concern about the child's developmental progress.
- A developmental screen at all other visits, including a review of milestones (gross and fine motor skills, communication skills and speech-language development, self help and care skills, social, emotional, and cognitive development) and mental health.

Requirements for Registered Nurses

RNs conducting THSteps medical checkups for a child birth through 6 years of age are required to conduct a standardized observational screen for a child 9 through 12 months of age and 18 through 24 months of age. If the child does not have a record of a standardized observational screen, the child should receive one between 24 months through 6 years of age. A standardized parent questionnaire is required at all other periodic visits through the 6th year of age or when a parent expresses concern about the child's developmental progress.

The combined use of a questionnaire and an observational screen reflects the child's developmental status more accurately than a single observational screen. If parents are unable to read or understand the questionnaire, the provider should use the parent questionnaire in an interview format. If the child fails the parent questionnaire, the provider should follow the instructions of the standardized screening tool concerning either observation testing or referral.

Children 7 years of age and older should be screened by observation, history of school progress, and neurological assessment.

Choice and Use of Tools

A standardized screening tool is one that has been extensively evaluated through screening thousands of children and comparing the screen outcome of each individual child with the outcome of an in-depth developmental evaluation on that child.

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If the screening tool specifies that training is required to use the tool, the screener must complete this training.

Referrals for Developmental Assessment

Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool. The screener should understand and follow them. Referral for in-depth evaluation of development should be provided when parents express concern about their child's development, regardless of scoring on a standardized development screening tool.

Referrals for in-depth evaluation of development must be made to an early childhood intervention (ECI) program (birth through 3 years of age) for suspected developmental delay, as required by state law. The provider also may refer to a pediatrician with skill in developmental assessment or the school district (3 years of age and older).

Refer to: "Texas Health Steps Statutory State Requirements" on page K-1 for more information.

43.2.3.6 Mental Health

Guidelines for Mental Health Screening

The mental health screen is part of every comprehensive medical checkup. The age-specific interview tools and parent questionnaires are provided as an option for performing this screen. They are intended for use as part of a comprehensive pediatric assessment. If these interview tools are used outside the context of a comprehensive examination, the interviewer must remember to collect information usually gathered in a pediatric history: household members, prenatal/newborn history, child's health history, and family illnesses.

The purpose of the mental health screen is to identify problems in any of six domains: feelings, behavior, social interactions, thinking, physical problems, and other problems that may include substance abuse. The provider choosing alternative screening tools or techniques should be certain to screen in these domains. Screening may reveal several minor problems or one or more significant problems that warrant referral for, or provision of, evaluation and, if indicated, treatment. In determining whether behaviors are serious enough to warrant referral, the screener must weigh the extent and intensity of the problems and explore the child's resiliency and positive behaviors. If the child has been or is under treatment for any mental health conditions, record that treatment in the child's medical record.

Referral options may include parenting education programs, ECI programs (birth to 3 years of age), mental health evaluation and counseling, substance abuse programs, acute psychiatric hospitalization, or child protective services. The screener's responsibility is to identify and establish a referral relationship with these resources in the community.

Screeners with special training and credentials allowing evaluation and treatment of childhood behavior problems, mental illness, or substance abuse may choose to provide these services rather than referring. Other screeners should refer to mental health specialists.

Confidentiality

The screener introduces the screen by explaining that the information provided will be held in strictest confidence unless the screener recognizes a situation that places the child or others in danger.

Children older than 4 years of age should not be present when the screener questions the parent about possible abuse or neglect.

Beginning when the child is about 10 years of age, questions about peer and family social interaction and substance abuse are explored with the child and parent separately. All parts of the screen are administered to the adolescent and their parent/caregiver separately.

If observations of the child, the parent, or parent-child interaction lead the screener to suspect possible abuse or neglect, the screener must make a report to Child Protective Services. The report is required even though the screener may refer a family for evaluation or treatment of abuse/neglect.

Behavior of Particular Concern

Behavior generally expressive of mental health problems include those listed below. If the screener finds any of the following significant behaviors, further screening is unnecessary because referral is indicated:

- Setting fires
- Suicidal behavior or ideation
- Self-destructive activities
- Torturing animals
- Hurting other people
- Destroying property
- Loss of touch with reality
- Inappropriate sexual behavior
- Substance abuse
- Parental concern about their ability to maintain the child in the home

Important: *At the conclusion of a screening that is judged by the provider to be within regular limits, the screener should refer the child for a comprehensive mental health evaluation if the parent of an older child remains concerned that the child has mental health or behavior problems.*

Interview Tools/Referral Forms

The interview tools found on pages C-28 through C-35 contain age-specific questions to guide the provider. Items of concern should be circled. Extensive notes may have to be made on a separate sheet. A copy of this form may be used as a referral form.

The parent questionnaire is similar to the interview tool. It is advisable in the first visit to explain and administer the interview face-to-face. At subsequent visits, the age-appro-

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priate form may be given to a literate parent or adolescent with the instruction, “Circle any of these items that you feel are a problem for your child/you and that you would like to discuss with your provider.”

43.2.3.7 Sensory Screening

Vision Screening

Newborns

During the initial test at birth, the provider should do the following:

- Check for red reflex.
- Note history for high-risk conditions, such as congenital infections (rubella, herpes, and others) or a family history of vision or eye problems.

Birth Through 2 Years of Age

The provider should do the following:

- Collect observations and a history from a caregiver.
- Check for red reflex.
- Determine whether pupils equally react to light.
- Screen for heterophoria with the corneal light reflex and cover test for children older than 6 months of age.
- Note history for high-risk conditions, such as congenital infections (rubella, herpes, and others) or a family history of vision or eye problems.

At 3 Through 4 Years of Age

The provider should do the following:

- Administer Tumbling E or HOTV test or equivalent at both the 3- and 4-year visit.
- Screen through the 20/20 line.
- Determine whether the child reads more than half of the 20/40 line or four out of six HOTV symbols; refer if unable to read the majority of 20/40 line (one more than half of the symbols) or four out of six HOTV symbols.
- Screen for heterophoria with the corneal light reflex and cover test or Random Dot E.
- Refer children with a two-line difference between the two eyes.
- Document and complete the test as described for birth to 2 years of age if a 3-year-old is unable to cooperate.

For Children 5 Years of Age and Older

The provider should do the following:

- Evaluate with a letter chart or Tumbling E chart at ages 5 through 10, 12, 15, and 18 years of age.
- Refer if unable to read the majority of 20/30 line (one more than half of the symbols) or four out of six HOTV symbols.
- Administer a cover test or Random Dot E.

Note: *Documentation of the results of a school vision screening program may be used in place of testing in the office if within 12 months of the checkup.*

Vision Screening Supplies

Vision screening supplies can be ordered from the following vendors:

Vendors
School Health 865 Muirfield Drive Hanover Park, IL 60103 1-800-323-1305
Good-Lite Company PO Box 387 Streamwood, IL 60107-0387 1-630-529-9720 1-800-362-3860
Prevent Blindness Texas 3211 West Dallas Houston, TX 77019 1-713-526-2559
Wilson Ophthalmic PO Box 496 Mustang, OK 73064 1-800-222-2020
Universal Ophthalmic Instruments, Inc. 8902 FM 2920 Spring, TX 77379 1-281-320-7550

Refer to: "Vision Care (Optometrists, Opticians)" on page 45-1 for more information.

Inpatient Hearing Screening

Newborn Hearing Screening

Health Safety Code, Chapter 47, *Vernon’s Texas Codes Annotated* mandates that a hearing screening occur at the birthing facility before hospital discharge. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program in accordance with DSHS standards, and notification to the provider, parents, and DSHS of screening results. There is no additional Medicaid reimbursement for the hearing screening, as the procedure is part of the newborn diagnosis related group (DRG). Hospitals should use the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) procedure code 09547 to report this newborn hearing screen on the HCFA-1450 (UB-92).

This facility-based screening also meets the physician’s required component for hearing screening in the inpatient newborn THSteps checkup. The physician must assure that the hearing screening is completed before discharging the newborn unless the birthing facility is exempt under the law from performing hearing screenings, in which case, the physician must assure there is an appropriate referral for a hearing screening to a birthing facility participating in the Newborn Hearing Screening Program.

The physician should discuss the screening results with the parents, especially if the hearing screening results are abnormal, and should order an appropriate referral for further diagnostic testing. If the results are abnormal, parent/legal guardian consent must be obtained to send information to DSHS for tracking and follow-up purposes.

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A physician with any concerns about this process should contact the hospital administrator or the DSHS Audiology Services Program at 1-800-252-8023.

Initial Test at Birth

The provider should do the following:

- Verify that the parents received the results of the hearing screen at the birthing facility.
- Check for obvious physical abnormalities.
- Supply a Hearing Checklist for Parents and instruct in its use. This checklist should be discussed at the first in-office THSteps medical checkup.
- Provide a referral for further diagnostic audiological testing for an infant with abnormal screening results or who is at high risk for hearing impairment.

Outpatient Hearing Screening and Diagnostic Testing for Children

As part of the THSteps medical checkups, physicians are required to complete the hearing screening component. Separate procedure codes should not be billed when hearing screenings are part of medical checkups or daycare/school requirements. Medicaid does not reimburse separately.

For children that are seen in the office setting, the THSteps program requires a puretone audiometric test at visits where objective screening is required. In other childcare settings (e.g., daycare, preschool, Head Start, and elementary, middle, and high school), the DSHS Vision and Hearing Screening Program requires that a puretone audiometer be used for hearing screening.

Birth Through 3 Years of Age

The provider should do the following:

- Observe and record history from a responsible adult familiar with the child, using the Hearing Checklist for Parents located on page C-26, English and Spanish.
- Refer high-risk children for further audiological diagnostic testing.

At 4 Years of Age and Older

The provider should do the following:

- Assess children with a puretone audiometric hearing screen (1000, 2000, 4000 Hz) at 4 through 10 years of age.
- Perform a subjective hearing evaluation, which includes client history and observation of the child for the ability to answer questions and follow directions, at all other medical checkups where an audiometric screen is not required.
- Refer the child if any one of the three frequencies are recorded as greater than 25 dB in either ear.

At 11 Years of Age and Older

- The child or adolescent must be assessed with a puretone audiometric hearing screen (1000, 2000, and 4000 Hz) at 12, 15, and 18 years of age.
- The child or adolescent should have a subjective hearing evaluation at 11, 13, 14, 16, 17, 19, and 20 years of age that includes patient history and observation for the ability to answer questions and follow directions.
- Adolescents who do not respond to a 25 dB tone at any frequency should be referred for a diagnostic hearing evaluation.

Note: *Documentation of the results of a school screening audiometric testing program may be used in place of testing in the office if within 12 months of the checkup.*

The CPT audiometric screening procedure codes 5/I-92551 and 5/I-92552 may not be billed on the same day by the same provider with THSteps medical check-up procedure codes S-99381, S-99382, S-99383, S-99384, S-99385, S-99391, S-99392, S-99393, S-99394, or S-99395.

It is recommended that pneumatic otoscopy be the primary method to visualize and assess the mobility of the tympanic membrane when distinguishing between otitis media with effusion and acute otitis media.

Tympanometry (impedance testing) may be considered for reimbursement as an objective diagnostic test of middle ear disease. Tympanometry (procedure code 5-92567) should never be used as the sole clinical means to establish the presence or absence of acute or chronic middle ear effusion or infection. Direct otoscopic examination by a suitably qualified provider, with or without pneumatic otoscopy, is the key element of the standard method used to establish a diagnosis of middle ear disease. Tympanometry must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment.

Tympanometry is limited to four services per year by the same provider and is based on medical necessity. Medical necessity must be documented in the client's medical record. Tympanometry does not meet the requirements for a sensory screening component of the THSteps medical checkup. Acoustic reflex testing does not meet the requirement for hearing screening and is diagnosis restricted.

Hearing Referrals

For all age groups, providers must refer children and adolescents identified during the THSteps medical checkup as needing a diagnostic hearing evaluation or other hearing services, including hearing aids, to a PACT provider. PACT provides services and hearing aids for children birth through 20 years of age that have permanent hearing loss and are Medicaid-eligible.

Hearing exams and services, including hearing aids (*prior authorization needed*), are available when medically necessary. Payment for services to eligible clients received through approved PACT providers is made through PACT at DSHS. An appropriate hearing screening is a mandatory part of each medical checkup.

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Separate procedure codes may be billed for children who require diagnostic hearing testing. The diagnostic audiometric testing codes 5/I-92567, 5/I-92585, 5-92586, 5/I/T-92587, and 5/I/T-92588 may be billed, as appropriate.

43.2.3.8 Tuberculosis Screening

The periodicity schedule for tuberculin tests is in accordance with federal Centers for Disease Control and Prevention (CDC) guidelines. THSteps requires a form of TB screening annually, as noted on the periodicity schedule, that is to be performed in the provider's office or clinic. This screening must be either the TB Questionnaire or a TB Mantoux skin test as described below. The TB Questionnaire was developed by the DSHS Infectious Disease Control Unit TB Program to determine if the child or adolescent is at high risk for contracting tuberculosis and needs Mantoux skin testing. Providers may photocopy the questionnaires from Appendix C of this manual or download the form at www.dshs.state.tx.us/idcu/disease/tb/forms/#clinic. Select EF12-11494 (English) or EF12-11494A (Spanish).

If any question on the questionnaire is answered with a "yes" or "I don't know," a TB Mantoux skin test is to be performed at the visit, unless medically contraindicated (e.g., has a history of a previous positive purified protein derivative [PPD] test). If all questions are answered with a "no," the child or adolescent does not need to have skin testing unless the provider believes it is needed for other medical reasons. Any newly-identified positive reactions should be evaluated by a screening provider or referred for evaluation. Report any suspected cases or diagnosed cases of TB to the child's local or regional health department.

Providers should contact their local or regional health department to determine whether their service area is a low- or high-prevalence area for TB. A listing of counties with a high prevalence for TB is available at www.dshs.state.tx.us/idcu/disease/tb/statistics/hiprev/default.asp.

In areas determined to be low-prevalence for TB, the TB Questionnaire should be administered annually beginning at 1 year of age. A TB skin test should be performed if the TB Questionnaire indicates a risk factor or if the provider determines that a TB skin test is appropriate.

In areas of high TB prevalence, the provider shall administer the TB skin test at 1 year of age and once between 4 through 6 years of age then again between 11 through 17 years of age. In those age ranges where a skin test is recommended, the provider should administer the skin test at one of these ages and the questionnaire at the other annual checkups. However, the questionnaire should be administered if the client refuses the skin test or the child is uncooperative.

The TB skin test also should be administered at any time a risk factor is indicated or the provider determines a skin test is appropriate. TB skin tests should be performed on children or adolescents who have been in contact with a case of active TB, have lived in a homeless shelter, have been incarcerated or live with someone who has been incarcerated, have lived or visit regularly in an area endemic for TB, currently work in a health care setting, recently immigrated from a country with a high prevalence of TB, or have associated with someone with human immunodeficiency virus (HIVs) infection.

Important: *"Live virus vaccines can interfere with response to a tuberculin test (TB). TB testing, if otherwise indicated, can be performed either on the same day that the live virus vaccines are administered or no sooner than 4 to 6 weeks later." Morbidity and Mortality Weekly Report (MMWR), Vol. 43 #RR 1, p. 15.*

Note: *Tracking the completed TB Questionnaire is no longer necessary. The provider must document the screening, any risk factors identified, and any appropriate follow-up in the client's medical record.*

The materials (PPD-Mantoux antigen and syringe) are available free of charge to the provider at the provider's local or regional health departments. Tine® testing materials are not supplied by DSHS and should not be used. The cost of administering the test is included in the medical checkup fee. A follow-up medical checkup visit is required to read all TB skin tests. The provider may bill the follow-up medical checkup fee of $6 for visit procedure code S-99211 with a THSteps provider identifier. Providers must indicate on the claim procedure code 5-86580 when a skin test is performed. It is not necessary to track the completion of the TB Questionnaire on the claim.

If further evaluation is required to diagnose either latent TB infection or active TB disease, the provider may bill the appropriate office visit code. Diagnosis and treatment are provided as a medical office visit.

THSteps providers may obtain PPD-Mantoux antigen and syringes from their local or regional DSHS office. They will be requested to sign a DSHS Infectious Disease Control Unit PPD Agreement.

Refer to: "Guidelines: Tuberculosis Skin Testing (2 Pages)" on page C-89 for guidance on the evaluation of a positive skin test.

"TB Questionnaire" on page C-92.

"Cuestionario Para la Detección de Tuberculosis" on page C-93.

"PPD Agreement for Texas Health Steps Providers" on page C-95.

43.2.3.9 Immunizations

All providers must assess the immunization status of the client at every encounter and administer any medically indicated immunizations according to the ACIP schedule, unless medically contraindicated or because of parent's reason of conscience, including a religious belief. The reason the indicated vaccination/toxoid was not administered must be documented in the client's medical record. (CFR and TAC). The checkup provider is responsible for the administration of immunizations and must not refer children to local health departments or other entities.

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Reminder: *A $5 administration fee per dose is paid for immunizations given during a THSteps medical checkup or as part of a follow-up visit. THSteps providers should bill for each vaccine separately. If administering a combined vaccine such as diphtheria, tetanus, and pertussis vaccines (DTaP), do not bill separately for each antigen. Combined antigens are reimbursed as one immunization.*

The TVFC Program provides free vaccines to children enrolled in Medicaid who are younger than 19 years of age. TVFC provides vaccines that are recommended according to the Recommended Childhood Immunization Schedule (ACIP, AAP, and the AAFP).

Refer to: "Immunizations" on page H-1 and "TVFC Provider Enrollment (3 Pages)" on page C-97 for more information on enrolling as a TVFC provider.
"Recommended Childhood and Adolescent Immunization Schedule, 2006" on page H-3.

Vaccine Information Statement (VIS)

A VIS is required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, but it is also important that providers use the most current forms available. For more information about immunizations, vaccine preventable diseases, or literature and forms, call the DSHS Immunization Branch at 1-800-252-9152.

43.2.3.10 Dental Assessment

Dental Assessment Guidelines for THSteps Medical Providers

The following information provides guidelines for THSteps medical providers in performing the initial dental screening as required within a comprehensive THSteps medical checkup.

The applicable periodicity schedule for THSteps dental assessment follows the standards as adopted by the American Academy of Pediatric Dentistry. The oral screening by the medical provider, as required within the comprehensive THSteps medical checkup, must occur at *all* THSteps medical checkups. The medical checkup provider must initiate the referral for a comprehensive THSteps dental checkup by a THSteps participating dentist, starting at 1 year of age and every six months thereafter (unless unusual circumstances dictate more frequent referrals).

Early Childhood Caries (ECC)

To reduce the risk of early childhood caries (ECC) the parent/guardian should always be counseled in proper feeding practices, including the following:

- Never put a child to bed with a bottle containing any liquid other than water.
- Recommendations for decreasing the frequency and duration of bottle feeding.
- Bottle contents (water is recommended in the bottle other than at regular feeding times). Feedings should be followed by gentle cleansing of the oral structures with a clean, damp cloth or soft brush.
- Establish a goal to have the child to begin drinking from a cup at 6 months of age.

Early signs of ECC often present as chalky white spots, particularly on the lingual surfaces of maxillary incisors. These signs, or any indication of more advanced caries, should prompt an immediate referral to appropriate dental care providers for evaluation.

Primary Teeth

The 20 primary teeth are also called deciduous teeth or baby teeth. Besides functioning in mastication, they also serve roles in speech development, jaw development, and eventually, in the position of the permanent dentition. Premature loss of the primary teeth can lead to permanent space loss within the dental arch and significant problems with alignment and function of the permanent teeth. If a primary tooth is lost prematurely, it is important that the client be evaluated within the next few weeks by a dentist, and that a determination is made for space supervision. Delayed exfoliation of the primary teeth may also have a harmful effect on the permanent dentition and calls for a dental evaluation.

Permanent Teeth

The first permanent tooth is the 6-year molar, which is the sixth tooth from the mid-line between the central incisors. There are four of them, that erupt when a child is between 5 and 6 years of age. The first permanent molar is often mistaken for a primary tooth because no tooth is lost. These teeth are termed the keystones of the dental arches because they help guide the subsequent teeth into proper alignment.

Caries (Cavities)

Children with developing primary or mixed (primary-permanent) dentition should be evaluated for caries (cavities).

Oral Soft Tissues

Oral soft tissues should be examined for any abnormalities. Consultation with a dental provider, where a differential diagnosis may apply, is highly recommended.

Sealants

Many studies have shown that dental sealants can protect teeth from decay when properly applied.

Patient Dental Education

This education should include the following:

- The need for thorough daily oral hygiene practices
- Education in potential gingival manifestations for clients with diabetes and clients under long-term medications therapy
- Utilization of the THSteps eligibility for dental services

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Smokeless Tobacco

The use of smokeless tobacco is expanding in many population groups and is strongly correlated with an increase in the prevalence of oral cancer. Early intervention and education can play a significant role in reducing risks. The following steps should be taken:

- Assess patterns of use.
- Offer assistance in cessation, if appropriate.
- Evaluate oral hard and soft tissues particularly the mucobuccal folds, cheeks, and sublingual areas.
- Refer all suspected lesions to appropriate providers for evaluation and follow-up.

Referral Assistance

Assistance in coordinating the referral can be obtained from the TMHP THSteps Dental Hotline at 1-800-568-2460 or the DSHS Regional THSteps Coordinator for the respective region (lists are provided in the “DSHS Health Service Region Contacts” on page A-8).

Dental Disease Prevention

Perhaps the two most important interventions are:

- Early and periodic dental examinations.
- Parent education that stresses to parents the important role they can play in preventing dental disease in their children.

Regularly-positioned teeth with normal occlusion add symmetry and harmony to the facial appearance and are an important aspect of the expression of emotion and personality.

THSteps Dental Services

Access to THSteps dental services are mandated by Medicaid and provide reimbursement for the early detection and treatment of dental health problems for Medicaid-eligible clients younger than 21 years of age. THSteps dental service standards were designed to meet federal regulations and incorporate the recommendations of representatives of dental professional groups in the state.

Follow-up Dental Care and Referrals

If a THSteps medical provider identifies the medical necessity for dental services, the provider must assist the client in planning follow-up care or in making a referral to a THSteps dental provider. OBRA of 1989 mandated the expansion of the federal EPSDT Program to include any service that is medically necessary and for which FFP is available, regardless of the limitations of the Texas Medicaid Program, and is referred to as the CCP.

Refer to: "THSteps Medical and Dental Administrative Information" on page 43-5 for more information.

43.2.3.11 Medical Checkup Laboratory Component

All components of the THSteps medical checkup are included in the reimbursement for the visit, including all laboratory tests as indicated on the periodicity schedule. All required laboratory work is to be performed by the DSHS laboratory. DSHS makes these services available free of charge to all enrolled THSteps medical checkup providers for THSteps-eligible children. THSteps services provided in a private laboratory are not reimbursed. See "Checkup Laboratory Procedures" on page 43-27 for more information.

43.2.3.12 Health Education/Anticipatory Guidance

Health education is a federally mandated component of the THSteps medical checkup and includes anticipatory guidance. *Face-to-face* health education and counseling with parents or guardians and children *are required* to assist parents in understanding what to expect in terms of the child’s development and to provide information about the benefits of healthy lifestyles and practices, and accident and disease prevention. Written material also may be given but will not replace face-to-face counseling.

Developmentally and age-appropriate health education, anticipatory guidance, and counseling include the following:

- Developmental expectations
- Dental health
- Sleep
- Feeding and nutrition
- Elimination
- Lead poisoning risks
- Healthy lifestyle/practices
- Accident and disease prevention

Adolescent Development

Providers must give adolescents the following health guidance:

- Promote a better understanding of their physical growth and their psychosocial and psychosexual development.
- Promote the importance of becoming involved in decisions about their health care.

Safety Practices

Providers must give adolescents health guidance on the following injury-prevention techniques:

- Avoid the use of alcohol or other substances while using motor or recreational vehicles or where impaired judgment may lead to injury.
- Use safety devices, including seat belts, motorcycle and bicycle helmets, and appropriate athletic protective devices.
- Resolve interpersonal conflicts without violence.
- Avoid the use of weapons and promote weapon safety.
- Obtain appropriate physical conditioning before exercise.

Diet and Fitness

Providers must give adolescents health guidance on the following diet and fitness guidelines:

- Benefits of a healthy diet
- Ways to achieve a healthy diet
- Safe weight management

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- Benefits of exercise
- Safe exercise on a regular basis
- Benefits of adequate rest

Healthy Lifestyles

Providers must give adolescents health guidance about healthy lifestyle guidelines including:

- Avoiding tobacco, alcohol, high noise exposure, other abusable substances, and anabolic steroids.
- Abstaining from vaginal, oral, and anal intercourse as the most effective way to prevent pregnancy and sexually transmitted diseases (STDs), including HIV infection.
- How the HIV infection is transmitted, the dangers of the disease, and the fact that latex condoms are effective in reducing the risk of some STDs, including HIV infection.
- Reinforcing of responsible sexual behavior for adolescents who are not currently sexually active and for those who are using birth control and condoms appropriately.
- Protecting themselves and their partners from pregnancy, sexual exploitation, and STDs, including HIV infection.

Refer to: *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition revised), at www.brightfutures.org.

Guidelines for Health Supervision III from the AAP Publication Department, PO Box 927, 141 Northwest Point Blvd., Elkgrove Village IL 60009-0927.

43.2.3.13 Additional Adolescent Screening

Alcohol and Drug Use

Providers must ask about the use of alcohol and other substances (marijuana, cocaine, paint/glue sniffing and others), and over-the-counter or prescription drugs (for nonmedical purposes), including anabolic steroids.

Adolescents that report any use of alcohol or other drugs or inappropriate use of medicines during the past year should be assessed further about family history, circumstances surrounding use, amount and frequency of use, attitudes and motivation about use, use of other drugs, and the adequacy of physical, psychosocial, and school functioning.

Adolescents whose substance use endangers their health should receive counseling and mental health treatment, as appropriate.

Adolescents that use anabolic steroids should be counseled to stop using steroids and informed about the danger of sharing needles.

The routine urine toxicology screening of adolescents is *not* recommended.

Adolescents that use alcohol or other drugs should also be asked about their sexual behavior and use of tobacco products.

Depression/Suicide Risk

Providers must ask about behavior or emotions that indicate recurrent or severe depression or suicide risk.

Providers must perform screening for depression or suicide risk on adolescents that exhibit cumulative risk as determined by declining school grades, chronic melancholy, family dysfunction, homelessness, anxiety about sexual orientation, physical or sexual abuse, alcohol or other drug use, previous suicide attempt, and suicidal inclination or plans.

If suicide risk is suspected, adolescents should be evaluated immediately and referred to a psychiatrist or other mental health professional, or they should be hospitalized for immediate evaluation.

Nonsuicidal adolescents with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

Learning Problems

Providers must ask about learning or school problems and noise exposure (music, motorcycles, cars, etc.).

Providers must assess adolescents for a history of truancy, repeated absences, or poor or declining performance that could interfere with school success. Conditions to assess include learning disabilities, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, and alcoholic or other drug abuse.

This assessment and the subsequent management plan should be coordinated with school personnel and the adolescent's parents or caregivers.

Tobacco Use

Providers must ask about use of cigarettes and smokeless tobacco. Adolescents who use tobacco products should be assessed further to determine their patterns of use. A cessation plan should be provided for adolescents who use tobacco products. A dental referral should be made for all adolescents with a history of tobacco use.

Physical, Sexual, or Emotional Abuse

Providers must ask about history of emotional, physical, and sexual abuse.

If abuse is suspected, adolescents should be assessed to determine the circumstances surrounding the abuse and the presence of physical, emotional, and psychosocial consequences, including involvement in health risk behaviors.

Health providers should be aware of local laws about the reporting of abuse to appropriate state officials, in addition to ethical and legal issues about how to protect the confidentiality of the adolescent client.

Adolescents who report emotional or psychosocial sequelae should be referred to a psychiatrist or other mental health professional for evaluation and treatment.

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Reporting Suspected Sexual Abuse

Reporting Abuse or Neglect, Rider 33 of Article II of the *General Appropriations Act*, House Bill 1, 78th Legislative Regular Session, 2003, requires DSHS to ensure all Medicaid providers comply with the provisions of state law as set forth in Chapter 261 of the *Texas Family Code* relating to investigations of child abuse and neglect reports, including suspected sexual abuse and HHSC reporting requirements.

Refer to: "Child Abuse Reporting Guidelines (2 Pages)" on page B-12 for more information. Providers must use the "Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring" on page B-14 to document referral of suspected abuse.

Sexual Behavior/Sexually Transmitted Diseases (STDs)

Providers must ask about involvement in sexual behaviors during a general screening.

- Adolescents that are sexually active should be asked about their use and motivation to use condoms or barrier methods and contraceptive methods, their sexual orientation, the number of sexual partners they have had, whether they have exchanged sex for money or drugs, and their history of prior pregnancy or STDs.
- Adolescents at risk for pregnancy, STDs (including HIV), or sexual exploitation should be counseled on how to reduce this risk.
- Adolescents that are sexually active should also be asked about their use of tobacco products, alcohol, and other drugs.

STD Screening Procedures for Sexually Active Adolescents

Sexually transmitted disease risk status includes the following:

- Having used injectable drugs
- Having had STD infections
- Having had vaginal, anal, or oral sex
- Having exchanged sex for drugs or money
- Having had a sexual partner who is at risk for HIV infection (e.g., injectable drug use or past or present STD infection)

Note: *HIV testing should be performed only after informed consent is obtained from the adolescent. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/AIDS testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations at 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired. The Texas HIV/STD Community Resource Directory is available at www.tdh.state.tx.us/hivstd/commsvcs/default.htm.*

HIV prevention counseling should be made available, which should include health guidance about responsible sexual behaviors, including abstinence.

HIV prevention counseling should include the following:

- Counseling that abstinence from vaginal, oral, and anal intercourse is the most effective way to prevent pregnancy, STDs, and HIV infection
- Counseling on how HIV infection is transmitted, the dangers of the disease, and the fact that using latex condoms reduces the risk of transmission of HIV and some STDs
- Reinforcement of responsible sexual behavior for adolescents who are not sexually active currently and for those who use birth control and condoms appropriately
- Counseling on the need to protect themselves and their partners from pregnancy, STDs, HIV infection, and sexual exploitation

43.3 Checkup Laboratory Procedures

These services and supplies are limited to THSteps medical checkup laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is a violation of federal regulations. The reimbursement for the complete medical checkup includes specimen collection supplies, mailing and shipping supplies, and receiving test results from the DSHS laboratory.

43.3.1 Laboratory Services

Laboratory services are available from the DSHS laboratory and may *not* be billed separately with an office visit or consultation on the same day as a THSteps medical checkup.

A THSteps laboratory test included in the periodicity schedule for a specific visit (or needed if not obtained at a previous visit) is a required component of the visit. These laboratory specimens *must* be submitted to the DSHS laboratory. Providers can refer to the table at the end of this section for a list of the tests available from the DSHS laboratory that are included in the periodicity schedule. It is permissible to complete hematocrit and hemoglobin testing on site; however, there is no reimbursement for these tests and results must be clearly documented in the medical record. Results from these two tests are also acceptable from a WIC clinic or other provider, if actual results are available and have been obtained within one month of the visit date.

Because all THSteps laboratory tests must be processed at the DSHS laboratory, they cannot be billed as separate claims on the same date of service as a medical checkup. These claims include those for tests that were processed at a provider's office or a commercial laboratory.

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The THSteps program requires that all laboratory tests noted on the periodicity schedule are to be obtained as part of the medical checkup, so all providers are reminded to use the date of the medical checkup as the date of laboratory service.

Separate claims for tests indicated by the periodicity schedule are *denied*. Claims for THSteps checkups and for laboratory services are subject to retrospective review to assure compliance with the policy.

If the medical checkup findings result in an evaluation and management visit for an acute problem, the provider should complete the test necessary to make a diagnosis. Tests obtained as part of the evaluation and management visit may be processed at the provider's laboratory of choice and may be billed *unless* the test is a required component of the THSteps visit on the same day of a THSteps medical checkup.

***Note:** Providers should make a request on the laboratory form if an extreme health problem exists and telephone results are needed quickly. With the exception of weekends and holidays, routine specimens are analyzed and reported within three days after receipt by the DSHS laboratory. Critical abnormal tests results (e.g., hemoglobin equal to or below 7g/dL or blood lead level greater than or equal to 40 ug/dL) are identified in the laboratory within 36 hours after receipt of specimens and are reported to the submitter by telephone within one hour of confirmation.*

THSteps laboratory specimens submitted to DSHS must include the client's name and Medicaid number as they appear on the Medicaid Identification (Form H3087) on a DSHS laboratory Request Form (Newborn Screening NBS-3, G-1B, G-2A, G-2B). Providers must write "pending" in the Medicaid number space, which is located in the payor source section of the laboratory requisition form, if a number is not currently available but is pending (i.e., a newborn or a newly-certified client verified by a Medicaid Eligibility Verification (Form H1027) as eligible for Medicaid).

Laboratory specimens received at DSHS that do not have a Medicaid number or the word *pending* written in the nine-character space for the Medicaid number will be analyzed, and the provider will be billed.

The $70 reimbursement for the complete medical checkup includes specimen collection, shipping, testing, and receiving test results from the DSHS laboratory.

The following services may not be billed separately with an office visit or consultation on the same day as a THSteps medical checkup either by a provider or laboratory. Claims for procedure codes listed below submitted by a provider or a commercial laboratory for the same date of service as a THSteps medical checkup are denied and are subject to retrospective review:

Laboratory Test Procedure Codes		
5-83020	5-83655	5-84203
5-85014	5-85018	5-86592
5-86689	5-86701	5-87490
5-87590	5-88142	5-88147
5-88150	5-88164	

Cytopathology procedure codes 5-88142, 5-88147, and 5-88164 are not reimbursed if billed on the same day by the same provider with THSteps medical checkup procedure codes S-99384, S-99385, S-99394, or S-99395.

43.3.2 Laboratory Supplies

Upon request DSHS provides the items listed below associated with blood specimen collection. All newly-enrolled THSteps medical providers automatically receive a startup package of forms, supplies, and containers, including air bills for the shipping of serum specimens. Requests for specimen requisition forms are routed to the laboratory reporting staff and mailed separately to the providers. Before startup packages are sent to providers, the DSHS laboratory verifies enrollment of THSteps medical providers. The startup package includes:

- 2 mL vacuum tube (with anticoagulant) for venipuncture
- Safety needle holders
- 250 - 500 uL finger stick blood collector (with anticoagulant)
- 6 mL vacuum tube (without anticoagulant) for venipuncture (required for Rapid Plasma Reagin [RPR])
- 22 gauge x 1 inch vacuum needle
- Safety lancets
- Laboratory Forms G-1A, G-1B, and G-2A
- *Get the Lead Out* handbook
- Mailing container with postage paid label (single- or multiple-tube)

A written request for a Newborn Screening Specimen Collection Form, NBS-3, and NBS supplies is required. To obtain an order form for written requests, providers should call 1-512-458-7661 or 1-888-963-7111, Ext. 7661.

All reorder requests for forms and supplies should be made using DSHS Form G-399, which should be submitted to the following address:

DSHS Laboratory Services
1100 West 49th Street
Austin, TX 78756-3199
1-512-458-7661 or 1-888-963-7111, Ext. 7661

Supply requests can be faxed to the DSHS laboratory at 1-512-458-7672. Providers should not order more than a three-month supply as most supplies have expiration dates and must be rotated frequently for efficient usage. To reduce waste in ordering, DSHS monitors supply requests according to the number of specimens submitted by the provider. Keep unused tubes with anticoagulant in the original airtight self-closing plastic bag to prevent moisture and dust from reaching the anticoagulant.

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Send Comments

Providers with complaints or comments about THSteps specimen collection supplies should contact the DSHS laboratory. Supplies are evaluated continually, and comments from supply users are solicited. Documented comments may support or change an item in a state contract. Send a brief letter or fax to the following address:

DSHS Laboratory Services
Quality Control Unit
1100 West 49th Street
Austin, TX 78756-3199
Fax: 1-512-458-7672

43.3.3 Required Tests

The following laboratory screening procedures are a required component of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule.

43.3.3.1 Glucose

Children should be screened for risk of type 2 diabetes. Fasting glucose screening should be obtained for those at risk of type 2 diabetes.

43.3.3.2 Hemoglobin or Hematocrit

Hemoglobin or hematocrit levels are required to indicate anemia resulting from poor diet or diseases. The required minimum frequency for hemoglobin or hematocrit testing is at 6 months, 12 months, 24 months, 6 years, 12 years, and 16 years of age. At 12 and 24 months of age, hemoglobin should be quantitated in conjunction with the lead screen. The laboratory request form must be marked for both hemoglobin and lead. Hemoglobin and hematocrit laboratory procedures performed at a WIC clinic or in a provider's office are acceptable if performed within one month and the date and value are documented.

The provider should note that the DSHS laboratory uses the sulfolyser (SLS-Hb) method to measure hemoglobin.

43.3.3.3 Hemoglobin Type

If the hemoglobin type has been done as a part of newborn screening and results are documented on the chart, the test does not need to be repeated. It also may be performed at the provider's discretion, as appropriate for age and population groups. For instance, certain children need this procedure to screen for sickle cell disease or trait, if not done previously.

The DSHS laboratory uses isoelectric focusing electrophoresis for hemoglobin type screening.

The laboratory reports the types of hemoglobin detected. Providers should compare reported test results to the expected ranges, which are noted on the patient report, to determine whether further testing, such as confirmation, is needed. If a hemoglobin variant is reported as "Other," a specimen can be submitted to a reference laboratory for further testing and confirmation.

43.3.3.4 Hyperlipidemia

Hyperlipidemia is based on risk assessment. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information.

The cholesterol screen consists of a blood cholesterol level. Clients do not need to fast before the screen. Specimens for lipid profiles should be from clients that have fasted at least 12 hours and are at-risk. A lipid profile includes the measurement of total blood cholesterol, triglycerides, and high-density lipoproteins (HDL), as well as a calculated value for low-density lipoproteins (LDL).

43.3.3.5 Lead Screening

In accordance with current federal regulations, THSteps requires that children be screened for lead poisoning through either blood tests and/or questionnaires at 6, 12, 15, 18, and 24 months of age and annually until 6 years of age.

Important: *The "Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure" on page C-61 may be used for children with a previously recorded normal blood lead level.*

Lead screening involves actual blood lead analysis or completion of a parent questionnaire (with appropriate action taken depending on the answers) per current federal regulations. *Blood lead analyses are mandatory at 12 and 24 months of age for THSteps clients.* At other THSteps medical checkups (6 months, 18 months, 3, 4, 5, and 6 years of age), the parent questionnaire must be administered. If (at any age) the parent answers "yes" or "I don't know" to any of the questions, a blood lead analysis is to be performed. Providers may download the Abbreviated Parent Questionnaire and the Detailed Parent Questionnaire (available in both English and Spanish), as well as guidelines for their use, at www.dshs.state.tx.us/lead/questionnaires.shtm.

If the provider chooses not to use the parent questionnaire, the provider must continue to have blood lead testing performed at 6, 12, 15, 18, and 24 months of age and annually until the 6 years of age.

Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248.

Specimen Collection and Handling

Submit a K2EDTA (purple top) specimen with the specified volume marked on the Vacutainer® to the DSHS laboratory for hemoglobin type, hemoglobin and lead testing. A separate tube (red top tube) must be submitted for syphilis (RPR) and/or hyperlipidemia testing, and a gray top tube (sodium fluoride/potassium oxalate) must

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be submitted for glucose testing regardless of any additional THSteps laboratory screening procedures being performed at the same time.

Due to changes in specimen collection, handling, and submission criteria recommended by Clinical Laboratory Improvement Amendments (CLIA) (Regulatory Agency), contact the DSHS laboratory for the most current specimen requirements at 1-888-963-7111, Ext. 7430.

Refer to: “Lead Screening” on page J-1 for more information on lead screening procedures and follow-up.

43.3.3.6 Newborn Screening

The second mandated newborn screen at 1 to 2 weeks of age is a required component of the THSteps medical checkup but is not required as an informational detail of the claim. Providers should document the date and the results of the second newborn screening in the client’s medical record. Clients should not be referred to the local health department or other providers for this service.

Health and Safety Code, Chapter 33, *Vernon’s Texas Codes Annotated*, requires testing for 27 disorders on all newborns. This testing is the responsibility of any provider attending the newborn. All newborns must be tested a second time at 1 to 2 weeks of age. If there is any doubt that a child younger than 12 months of age was properly tested, the provider should submit the blood sample on the appropriate DSHS Form NBS-3 to the DSHS Newborn Screening Laboratory.

The provider should note the following:

- Results are mailed to the provider’s address indicated on Form NBS-3.
- Laboratory recommendations for necessary follow-up procedures are included with the report.
- The DSHS NBS Case Management staff contacts the provider in cases of significant abnormality.

43.3.3.7 Urinalysis

Urinalysis (i.e., dipstick) is performed at the discretion of the provider. Providers must purchase their own supplies. The cost for performing this service is included in the fee for the medical checkup.

Refer to: "Checkup Laboratory Procedures" on page 43-27 for more information on laboratory collection techniques.

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43.3.4 Follow-Up Care Guidelines Summary Table

Laboratory Results							Interpretation	Refer for Follow-up Care	Genetics Counseling
RPR Card			Hb	Hb Type		Lead			
NR	R	Titer	g/dL	A:A	Other	ug/dL			
X							Serological signs of syphilis not present.	No	
	X						Possible indication of syphilis. Further testing necessary.	Yes	
	X	1:1 etc.					Indication of degree of reactivity of laboratory result. 1:1, 1:2, 1:4, etc. Confirmed by Treponema I Pallidum-Particle Agglutination (TP-PA) or Fluorescent Treponemal Antibody Absorbed (FTA-ABS).	Yes	
						<10	Normal.	No	
						10–14	Retest periodically.	Yes	
						15–19	Retest periodically.	Yes	
						20–69	Treatment needed.	Yes	
						≥70	Emergency care needed.	Yes	
				X			Normal adult hemoglobin present.	No	
					A, F		Probable normal on patients younger than 12 months of age. Should be retested after first birthday.	No	
					A, S		Probable sickle trait condition (carrier of sickle cell). Check patient history.	No	X
					F, A, S		Usually occurs in infants. Probably will result in sickle trait when F declines to normal adult levels.	No	X
					A, C		Probable C-trait condition.	No	X
				Probable A, D or A, G			Either D-trait or G-trait condition, but could be other hemoglobin having similar properties on electrophoresis.	No	X
				A, Other			Probable unknown trait condition. Contact DSHS THSteps Case Management for availability of complete structural analysis through reference laboratory.	No	X
				S, S			Indicative of sickle cell disease. Total hemoglobin usually low (7 - 8 g/dL).	Yes	X
				S, F			Probable sickle cell disease. Should be checked for hereditary persistence of fetal hemoglobin (HPFH). If F < 20%, possible S-beta thalassemia.	Yes	X
				S, C			Probable hemoglobin S-C disease.	Yes	X
				C, C			Probable homozygous C disease.	Yes	X
				S, A			Probable S-beta thalassemia.	Yes	X
			<11.0				Probably anemic. Evaluate according to severity.	Yes	

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43.3.5 Additional Required Laboratory Tests Related to Medical Checkups for Adolescents

The DSHS Clinical Chemistry Laboratory must perform laboratory screening tests for THSteps clients for cholesterol, HIV, gonorrhea/chlamydia, and syphilis. The DSHS Women's Health Laboratories, Cytopathology Department performs Pap smear screening for THSteps clients.

Laboratory specimen collection testing materials and necessary forms and supplies are available at no additional cost to all enrolled THSteps medical providers. The following information describes laboratory test procedures, interpretation of laboratory test results, guidelines, and criteria for follow-up, as well as helpful information on specimen collection and handling.

43.3.5.1 Communicable Disease Reporting

Diagnoses of STDs, including HIV, are reportable conditions under 25 TAC, Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC §97.132.

43.3.5.2 Cervical Cancer Screening

The first Pap smear should be obtained at 21 years of age, 3 years from the onset of sexual activity, or at any other age based on provider discretion. A Pap smear test is a microscopic examination of cells exfoliated or scraped from a mucosal surface. This test is most widely used in detecting malignant, premalignant, and infectious disease of the uterine cervix.

Laboratory Procedure

Specimens for the pap smear must be sent to the DSHS Women's Health Laboratory in San Antonio. Pap smears arrive by mail or courier service and are processed in the Cytopathology Laboratory. The slides are stained with the Pap stain technique and coverslipped. Staff cytotechnologists examine all Pap smears for cellular disease and render a diagnosis on those determined to be negative or abnormal.

A quality control cytotechnologist rescreens at least 10 percent of the cases considered negative by the staff cytotechnologists. All abnormal cases are referred to a pathologist for final interpretation and follow-up recommendation. A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A statistical report is mailed monthly to providers documenting their totals by diagnosis and adequacy.

Request Form

Follow these steps to submit a request form:

1) Submit a test request form (Form M-47).
2) Make sure the slide and request form (or liquid-based Pap vial) are labeled with the client's last name. Wrap the completed M-47 form around the cardboard mailer for conventional Pap smears and fasten with a rubber band. For liquid-based Pap smears, place the vial in a zip-lock biohazard transport bag, and place the M-47 in the corresponding pocket.
3) The completed M-47 form must include the following information:
   - Name as it appears on the Medicaid Identification (Form H3087)
   - Address
   - Date of birth
   - Social Security number (SSN)
   - Date of service
   - Examiner
   - ICD-9-CM diagnostic code for the visit or a descriptive narrative
   - Test(s) ordered
   - Specimen site (cervix, endocervix, and vaginal)
   - Submitting clinic code or name and address of clinic
4) The completed test request form must include the Medicaid number or "Medicaid pending" must be written on the form for billing purposes.

Mailing Specimens and Ordering Supplies

THSteps providers can call for information, mail specimens to, or order supplies for obtaining Pap smears for THSteps adolescent screening from the following laboratory:

Women's Health Laboratories
2303 SE Military Drive, Suite 1
San Antonio, TX 78223
Customer Service: 1-888-440-5002 or 1-210-531-4596
Fax: 1-210-531-4506

To order supplies, providers should do the following:

- Providers must use order Form AG-30, 1643, or letterhead stationery.
- Fax the supply order form or include in the specimen packaging.
- Request supplies by telephone or email.
- Include their THSteps provider identifier.

The following supplies are available for order:

Conventional Pap Smears	Surepath Liquid-Based Pap Smears
Frosted slides	Cervex brush
Cytocervial brush	Cytorich preservative vial
Cyto fixative	M-47 form
Cardboard slide mailers	Zip-lock biohazard transport bag
M-47 forms	
Cervical scrapers	Cardboard boxes
Cardboard boxes	Labels
Labels	AG-30 supply order form
AG-30 supply order form	

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Providers that are already on the automated system through the DSHS Pharmacy Division are encouraged to continue using this system. Larger numbers of supplies are sent through the DSHS Pharmacy. Providers with consistent monthly workload volumes can request to be set up with a *standard monthly order* that is shipped at the same time each month.

43.3.5.3 STD Testing

Syphilis Testing

Syphilis testing should be performed on adolescents that are at high risk for infection. These high-risk adolescents include sexually active individuals living in an area with a high prevalence of STD, endemic for syphilis, or individuals at risk (e.g., past family history or prior history of other STDs or for adolescents who have had vaginal, anal, or oral sex, or have had a sexual partner who is at risk for infection). RPR card test is no longer a required test but should be obtained based on risk assessment.

Laboratory Procedure

Specimens for syphilis screening must be sent to the DSHS laboratory. A RPR card test is the screening procedure. Due to changes in specimen collection, handling, and submission criteria, recommended by CLIA (Regulatory Agency), contact the DSHS laboratory for the most current specimen requirements at 1-888-963-7111, Ext. 7430. The provider should note the following:

- The RPR card test is a macroscopic nontreponemal testing procedure similar in sensitivity and reliability to the Venereal Disease Research Laboratory (VDRL).
- False-positive reactions occur with variable frequency as a result of reagin produced in diseases other than syphilis or provoked by immunization antigens.
- Specimens found reactive by RPR card test are confirmed for syphilis by TP-PA or FTA-ABS tests.
- The RPR Card Test cannot be performed if hemolysis of the specimen has occurred, the specimen volume is less than 0.5 mL, or the specimen is grossly contaminated with bacteria, lipemic, or otherwise extremely turbid.

Gonorrhea and Chlamydia Infection Testing

Gonorrhea and chlamydia infections are the most common reportable sexually transmitted diseases in the United States today. For this reason, sexually active adolescents are tested for both these diseases simultaneously. Untreated infections may result in severe complications, including sterility and pelvic inflammatory disease.

HIV Testing

It is critical to maintain confidentiality when caring for clients, as well as their specimens. Providers must not leave specimens identified for HIV testing in open view of unauthorized medical personnel. Discussions with clients about their risk factors should be confidential. *Testing should be performed only after informed consent is obtained from the adolescent. Providers must not mail the client consent to the laboratory; the consent must be retained with the client's records.*

HIV testing may be performed for adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening. If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in the medical record that notification of the HIV test and the right to refuse was given. Providers may call the HIV/STD InfoLine for referrals to HIV/acquired immune deficiency syndrome (AIDS) testing sites; prevention, case management, and treatment providers; STD clinics; and other related service organizations. The HIV/STD InfoLine is 1-800-299-2437. This toll-free HIV/AIDS and STD information and referral service is available for English- and Spanish-speaking callers and for those who are hearing-impaired.

Laboratory Procedure

Specimens for HIV screening must be sent to the DSHS laboratory. The presence of HIV-1 antibodies in client serum is a long-term marker of infection. Specimens are tested on an enzyme immunoassay (EIA) that identifies antibodies that are specific for the HIV-1 virus. Specimens that are initially reactive on the EIA screen are retested in duplicate on the EIA. If either of the duplicate retests are reactive, the EIA is considered repeatedly reactive and a confirmatory test, the Western blot, is performed.

The Western blot involves the separation of the virus proteins by size on a special strip of filter paper. This strip is soaked in a dilution of client serum. If antibodies specific for the different proteins are present, they will bind to that portion of the strip. The antibodies are then detected with enzyme-labeled antibodies that cause a darkening on the strip where client antibodies have bound. Western blot bands are named by a letter indicating the type of molecule (p=protein, gp=glycoprotein), and a number that indicates their relative size in kilodaltons (e.g., p17=a protein 17 kilodaltons in size).

43.4 THSteps-Comprehensive Care Program (CCP)

43.4.1 THSteps-CCP Overview

THSteps-CCP is an expansion of the EPSDT service as mandated by the OBRA of 1989, which requires all states to provide treatment for correction of physical or mental problems to THSteps-eligible clients for any medically necessary services and for which FFP is available even if the services are not covered under the state's Medicaid plan. This expansion of services is provided only for those clients who are younger than 21 years of age and eligible to receive THSteps services.

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In May 1991, the CMS issued a clarification of this legislation that expanded THSteps-CCP services to include treatment for problems identified by any health care professional, regardless of whether a formal EPSDT checkup has been performed.

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

- "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)" on page 43-37
- "Durable Medical Equipment Supplier (THSteps-CCP Only)" on page 43-39
- "Early Childhood Intervention (ECI) (THSteps-CCP Only)" on page 43-53
- "Licensed Dietitians (THSteps-CCP Only)" on page 43-54
- "Occupational Therapists (THSteps-CCP Only)" on page 43-55
- "Orthotic and Prosthetic Suppliers (THSteps-CCP Only)" on page 43-58
- "Pharmacies (THSteps-CCP Only)" on page 43-60
- "Private Duty Nursing (PDN) THSteps-CCP Only" on page 43-64
- "Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)" on page 43-71
- "Speech-Language Pathologists (THSteps-CCP Only)" on page 43-78

Refer to: "THSteps Medical and Dental Administrative Information" on page 43-5 for more information.

43.4.1.1 Enrollment

THSteps-CCP providers must meet Medicaid/HHSC participation standards to enroll in the program. All CCP providers must be enrolled in Medicaid to be reimbursed for services. Send provider enrollment inquiries and application requests to TMHP Provider Enrollment at the TMHP address in "Written Communication with TMHP" on page xi. Write “Provider Enrollment” on the first line of the address.

43.4.1.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care health plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plans for enrollment information. Refer to "Managed Care" on page 7-1 for more information on Medicaid Managed Care programs.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.1.3 Communication with THSteps-CCP

Providers can use the following telephone or fax numbers for prior authorization or information on CCP services:

Telephone and Fax Numbers for Prior Authorization or Information on CCP Services	
In-Home Care (Home Health Services)/CCP	1-800-846-7470
CCP Fax	1-512-514-4212
Comprehensive Care Inpatient Psychiatric (CCIP)	1-800-213-8877
CCIP Fax	1-512-514-4211

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Send requests for prior authorization and appeals of prior authorization requests to the following address:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program
PO Box 200735
Austin, TX 78720-0735

Address first-time claims and appeals of incomplete claims for CCP only to the following address:

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

Direct all other correspondence to a department (e.g., Provider Enrollment). Send all other claims, appeals, and resubmissions to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200285
Austin, TX 78720-0285

Clients should direct written communication to HHSC at the following address:

HHSC
Customer Service
1100 West 49th Street
Austin, TX 78756-3168

Medicaid clients and families may contact HHSC at 1-800-252-8263.

Documentation requirements for specific services and supplies are found in the provider-specific sections of this chapter.

43.4.1.4 Client Eligibility

The client must be younger than 21 years of age and eligible for THSteps at the time of the service request and service delivery. If the client’s Medicaid Identification (Form H3087) states “Emergency Care,” “PE,” or “QMB,” the client is not eligible for THSteps-CCP benefits.

Clients are ineligible for THSteps-CCP services beginning the day of their 21st birthday.

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43.4.1.5 Benefits

Payment is considered for any health care service that is medically necessary and for which FFP is available. CCP benefits are allowable services not currently covered under the Texas Medicaid Program (e.g., speech-language pathology [SLP] services for nonacute conditions, private duty nursing [PDN], prosthetics, orthotics, apnea monitors and some durable medical equipment [DME], some specific medical nutritional products, medical nutrition services, inpatient rehabilitation, travel strollers, and special needs car seats). CCP benefits also include expanded coverage of current Texas Medicaid Program services where services are subject to limitations (e.g., diagnosis restrictions for total parenteral nutrition [TPN]). Requests for services that require a prior authorization (prior authorization is a condition for reimbursement, not a guarantee of payment) must be submitted to the TMHP Medical Director. For information about dental, TPN, respiratory therapy, and vision care benefits, refer to provider-specific sections of this manual.

Medicaid Benefits for Children

The following are Medicaid benefits for children living with a family (including foster care):

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses)
- THSteps medical checkups (including immunizations) and dental exams and services
- Medications through the Texas Medicaid Vendor Drug Program (VDP) (unlimited prescriptions, some over-the-counter with prescription)
- THSteps-CCP (prosthetics, orthotics, and speech-language pathology services for nonacute conditions)
- Texas Medicaid Home Health Services that may be considered medically necessary (e.g., nursing visits, supplies, DME, and PT and OT for acute conditions provided in the home)

Medicaid benefits for children living in residential treatment centers include the following:

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses)
- THSteps medical checkups (including immunizations) and dental exams and services
- Medications through VDP (unlimited prescriptions, some over-the-counter with prescription)
- THSteps-CCP, excluding outpatient mental health services

Medicaid benefits for children living in nursing facilities include the following:

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses)
- THSteps medical checkups (including immunizations) and dental exams and services
- Medications through VDP (unlimited prescriptions)
- THSteps-CCP is limited to the following:
    - Adaptive strollers
    - Augmentative communication devices
    - Orthotics
    - Prosthetics
    - Texas Medicaid Home Health Services custom DME

Medicaid benefits for children in ICF-MR facilities (*not* state schools) include the following:

- Medical services (physician, hospital, hearing aids [PACT], and eyeglasses)
- THSteps medical checkups (including immunizations) and dental exams and services
- Medications through VDP (unlimited prescriptions)
- THSteps-CCP (limited to orthotics and prosthetics)
- DME (covered in the daily rate)

Pneumococcal 7-Valent Conjugate Vaccine

Pneumococcal 7-valent conjugate vaccine is covered under TVFC. If a child does not meet TVFC criteria, coverage may be considered through THSteps-CCP.

The pneumococcal 7-valent conjugate vaccine is reimbursed only when all of the following criteria are met:

- The child must be eligible for THSteps-CCP.
- The child must be 2 through 59 months of age.
- The physician must provide documentation of medical necessity supporting the administration of the vaccine to the specific child above and beyond the TVFC criteria.
- The provider has obtained prior authorization through THSteps-CCP. Prior authorization is a condition for reimbursement, not a guarantee of payment.

Providers must use procedure code 1-90669 when billing for the pneumococcal 7-valent conjugate vaccine approved through CCP and procedure codes 1-90471 or 1-90472 when billing for the administration.

Medicaid Procedure Codes

The following table identifies CCP-related Medicaid procedure codes. This list is not all-inclusive but represents the most commonly billed CCP procedures that are not listed in specific sections. These codes are not payable for all provider types. Other codes are listed in specific CCP sections of this manual, and additional codes can be found in "Texas Medicaid (Title XIX) Home Health Services" on page 24-1. Prices are subject to change.

If a provider uses additional codes not listed, the reimbursement may be obtained by requesting a fee schedule from TMHP.

Procedure Code	Maximum Fee
9-E1340	MP
J-E1639	$214.68
L-E1639	$21.47
J-E1800	MP
J-E1805	MP
MP = Manually priced	

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Procedure Code	Maximum Fee
J-E1810	MP
J-E1815	MP
9-L1500	$1,292.11
9-L1500 *with* modifier TF	$1,483.13
9-L1500 *with* modifier TG	$1,867.50
9-L1940	$316.47
9-L2270	$31.98
9-L3150	$65.77
9-L6628	$366.57
MP = Manually priced	

Limitations

Payment cannot be made for any service, supply, or equipment for which FFP is not available. The following are some examples:

- Vehicle modification, mechanical, and/or structural (such as wheelchair lifts)
- Structural changes to homes, domiciles, or other living arrangements
- Environmental equipment, supplies, or services, such as room dehumidifiers, air conditioners, filters, space heaters, fans, water purification systems, vacuum cleaners, and treatments for dust mites, rodents, and insects
- Ancillary power sources and other types of standby equipment (except for technology-dependent clients such as those who are ventilator-dependent for more than six hours per day)
- Educational programs, supplies, or equipment (such as a personal computer or software)
- Equine or hippotherapy
- Exercise equipment, home spas or gyms, toys, or therapeutic balls
- Tennis shoes
- Attendant care (any in-home care need that does not require a licensed nurse, such as grooming, bathing, lifting, turning, and house-cleaning or -keeping). Clients requiring this type of care should contact their local DSHS office for information about community-based programs for primary home care, day activities, or other related services
- Respite care (relief to caregivers)
- Aids for daily living (toothbrushes, spoons, and foot stools)
- Take-home drugs from hospitals. Eligible hospitals may enroll in and bill VDP. Pharmacies that want to enroll should call 1-512-338-6978
- Therapy involving any breed of animal

43.4.1.6 Prior Authorization and Documentation Requirements

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. A prior authorization number (PAN) is a TMHP-assigned number establishing that a service or supply has been determined to be medically necessary and for which FFP is available. It is *each provider's responsibility* to check the client's Medicaid Identification (Form H3087) at the time *each service is provided* to verify eligibility. Any service provided while the client is not eligible cannot be reimbursed by TMHP, and the responsibility for payment of services is determined by private arrangements made between the provider and client.

Prior authorization of THSteps-CCP services may be requested in writing by completing the appropriate request form, attaching any necessary supportive documentation, and mailing or faxing it to the TMHP-CCP department. All requested information on the form must be completed, or the request are returned to the provider. Incomplete forms are *not* accepted. If prior authorization is granted, the potential provider of service (such as the DME supplier, pharmacy, RN, or physical therapist) receives a letter that includes the PAN, the procedures authorized, and the length of the authorization. Providers are notified in writing whether additional information is needed to process the request for services.

Written requests for prior authorization are *mandatory* for the following services:

- Apnea monitors for clients older than 4 months of age or after an initial two months of rental
- Customized DME not authorized under Medicaid Home Health Services (such as power wheelchairs)
- Diapers, wipes, and underpads for children younger than 4 years of age
- DME not authorized under Medicaid Home Health Services
- Formula for a client younger than 21 years of age if the client does not have a gastrostomy tube (G-tube) or has a metabolic disorder
- Freestanding psychiatric services
- Freestanding rehabilitation services
- Gastrostomy buttons (G-buttons) not authorized under Medicaid Home Health Services
- High-power lenses
- Pediatric pneumograms, except for the first two pediatric pneumograms for infants younger than 12 months of age (refer to criteria in "Physician" on page 36-1)
- PDN
- Physical therapy (PT), occupational therapy (OT), SLP services
- TPN

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Submit a THSteps-CCP Prior Authorization Request Form and documentation to support medical necessity to the CCP department *before* providing services.

Important: *Documentation to support medical necessity of the service, equipment, or supply (such as prescription, letter, and therapy notes) must be current and signed by a physician (MD or DO) before services are performed. Providers must keep the information on file.*

Refer to: CCP provider-specific sections for prior authorization requirements of specific services.

Diagnosis Coding

All providers should obtain the client's medical diagnosis from the physician. This information must be reflected on each claim submitted to TMHP using ICD-9-CM coding.

Exception: *Pharmacy DME providers enrolled in Medicaid with a "VP" provider identifier are not required to provide diagnoses; however, electronic claims must have a diagnosis code of V7285 for the claim to be accepted.*

Purchase Versus Equipment Rental

When providing equipment not authorized under Medicaid Home Health Services for THSteps-CCP clients with long-term or chronic conditions, it is more cost-effective, in many cases, to purchase the equipment rather than rent it. The client's condition and length of time the equipment will be used should be carefully assessed before authorization for rental or purchase is requested.

THSteps-CCP does not pay for the purchase of certain types of equipment (e.g., apnea monitors); consequently, long-term rental may be considered. Most other equipment is rented for only four months initially. During this time, the provider should assess whether the equipment should be purchased *before* the rental lapses. Rentals must be prior authorized.

After prior authorization is obtained for purchase, the new equipment must be provided and rental discontinued. THSteps-CCP does not purchase used equipment.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Providers of customized or nonbasic medical equipment also must be enrolled as Medicare DME providers.

Drug Approval, Medical Device

Manufacturers may request drug or medical device products be added to THSteps-CCP by sending the information in writing to the following address:

HHSC
1100 West 49th Street
Austin, TX 78756-3179

HHSC reviews the information. Requests for consideration should *not* be sent to TMHP.

Refer to: "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-108.

43.4.1.7 Physician Signature

The signature of the physician (MD or DO) on a prescription or THSteps-CCP Authorization Request Form must be current to the service date(s) of the request, i.e., the signature must always be before the service start date and no older than three months before the current date(s) of service requested. Physician signatures dated after the service start date on initial requests cannot be accepted as documentation supporting medical necessity. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. If services begin as a result of a verbal order before the physician's signature date, submit proof of the verbal order with the request.

Stamped signatures are not accepted on THSteps-CCP Authorization Request Forms or prescriptions for THSteps CCP prior authorized services, supplies, or equipment. Verbal orders must be cosigned by a physician (MD or DO) within two weeks or per provider policy if less. Signatures of NPs, CNSs, PAs, or doctors of philosophy (PhDs) are *not* accepted.

Physician prescriptions must be specific to the type of service requested. For example, if the provider is requesting PT, the prescription must request physical therapy, not just therapy.

43.4.2 Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)

43.4.2.1 Enrollment

Comprehensive outpatient rehabilitation facilities (CORFs) and outpatient PT/speech pathology (OPT/SP) providers must be certified by Medicare, have a valid provider agreement with HHSC, and have documentation that the TMHP enrollment process has been completed.

For questions about enrollment or billing, call the TMHP Contact Center at 1-800-925-9126.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

43.4.2.2 Reimbursement

CORFs and ORFs for THSteps-CCP physical, occupational, and speech therapy is based on a prospective payment system (PPS) fee schedule in accordance with 1 TAC §355.8085.

Previously, the reimbursement methodology was based on reasonable costs with interim payment percentages applied to billed charges.

After the PPS fees were implemented effective January 1, 2006, and a CORF/ORF had its final cost settlement based on the provider's fiscal year covering dates of service through December 31, 2005, TMHP will discontinue the cost settlement process for CORFs/ORFs for all services regardless of the type (old and/or any newly

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added). CORFs/ORFs will no longer be subject to cost settlement once the provider's cost report covering dates of service through December 31, 2005, has been settled.

To update PPS fees for CORFs/ORFs for future periods, CORFs/ORFs may be required to submit cost reports or cost surveys.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.2.3 Benefits and Limitations

CORFs/ORFs may only bill for outpatient rehabilitation services to Medicaid-THSteps clients.

PT, OT, and/or speech therapy (ST) may be billed in POS 1, 2, or 5 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) as POS 9.

The client must be eligible for CCP for consideration of reimbursement and under a physician's treatment.

Children receiving therapy services reimbursed by CCP must have conditions that require ongoing medical supervision. To establish medical necessity, a physician prescription and revised therapy treatment plan are needed at least every six months. (Therapy services for acute conditions are reimbursed by the Texas Medicaid Program.)

PT, OT, and ST services require prior authorization. Providers must indicate the modifiers GP (PT) or GO (OT) to identify the type of therapy being requested and must file claims with these modifiers to identify the type of therapy performed. Claims received without the appropriate modifier(s) are denied with the message, "This procedure requires a modifier. Please appeal claim with the appropriate modifier."

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy request must include the following:

- A TP-1
- A copy of the current evaluation
- Documentation indicating the treatment goals
- Anticipated measurable progress toward goals
- Client gross or fine motor delays, or expressive or receptive delays, in years or months versus chronological age

Refer to: "Request for Initial Outpatient Therapy (Form TP-1)" on page B-78.

A Request for Extension of Outpatient Therapy (Form TP-2) must include a current physician signature, a summary statement of measurable progress made during the treatment period, and documentation indicating new treatment goals and anticipated measurable progress for the next treatment period.

Refer to: "Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)" on page B-79.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new evaluation is required. Prior authorization is mandatory and is not a guarantee of payment. Providers must adhere to filing guidelines for payment consideration.

PT, OT, and ST assessments should be billed using appropriate procedure codes. These codes should be billed with a quantity of 1 for each type of therapy performed (PT, OT, and SLP), regardless of time spent with the client.

OT, PT, and ST should be billed in increments of 15 minutes (i.e., a quantity of 1 equals 15 minutes, a quantity of 2 equals 30 minutes, etc.). Evaluations and re-evaluations are based on a per-evaluation/re-evaluation encounter with a quantity of 1. An evaluation and therapy of the same discipline/type are not reimbursable when performed on the same day (e.g., PT evaluation with PT services are not payable on the same day). OT, PT, and ST evaluations are still limited in payment to once per six months for any provider at the same facility. OT, PT, and ST re-evaluations are also limited in payment to once per month for any provider at the same facility. An evaluation or re-evaluation on a more frequent basis would be outside the current benefit limitations and would only be considered for payment with prior authorization or written documentation of medical necessity. CORFs and ORFs are still subject to a maximum of 8 units (2 hours) each of PT, OT, or ST services per date of service per modifier and per client.

The procedures below may be payable to CORFs/ORFs based on a PPS fee schedule.

Procedure Code	Type	Modifier	Reimbursement Amount and Billing Increment
1-92506	ST		$280.00 per evaluation
1-92507	ST		$45.00 per 15 min.
1-92508	ST		$22.50 per 15 min.
1-92610	ST		$280.00 per evaluation
1-92526	ST		$45.00 per 15 min.
1-97001	PT		$200.00 per evaluation
1-97002	PT		$200.00 per re-evaluation
1-97003	OT		$200.00 per evaluation
1-97004	OT		$200.00 per re-evaluation
1-97012	PT, OT	GO, GP	$45.00 per 15 min.
1-97014	PT, OT	GO, GP	$45.00 per 15 min.
1-97016	PT, OT	GO, GP	$45.00 per 15 min.
1-97018	PT, OT	GO, GP	$45.00 per 15 min.
1-97022	PT, OT	GO, GP	$45.00 per 15 min.
1-97024	PT, OT	GO, GP	$45.00 per 15 min.
1-97026	PT, OT	GO, GP	$45.00 per 15 min.

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Procedure Code	Type	Modifier	Reimbursement Amount and Billing Increment
1-97028	PT, OT	GO, GP	$45.00 per 15 min.
1-97032	PT, OT	GO, GP	$45.00 per 15 min.
1-97033	PT, OT	GO, GP	$45.00 per 15 min.
1-97034	PT, OT	GO, GP	$45.00 per 15 min.
1-97035	PT, OT	GO, GP	$45.00 per 15 min.
1-97036	PT, OT	GO, GP	$45.00 per 15 min.
1-97039	PT		$45.00 per 15 min.
1-97110	PT, OT	GO, GP	$45.00 per 15 min.
1-97112	PT, OT	GO, GP	$45.00 per 15 min.
1-97113	PT, OT	GO, GP	$45.00 per 15 min.
1-97116	PT, OT	GO, GP	$45.00 per 15 min.
1-97124	PT, OT	GO, GP	$45.00 per 15 min.
1-97139	PT, OT	GO, GP	$45.00 per 15 min.
1-97140	PT, OT	GO, GP	$45.00 per 15 min.
1-97150	PT, OT	GO, GP	$22.50 per 15 min.
1-97530	PT, OT	GO, GP	$45.00 per 15 min.
1-97535	PT, OT	GO, GP	$45.00 per 15 min.
1-97537	PT, OT	GO, GP	$45.00 per 15 min.
1-97542	PT, OT	GO, GP	$45.00 per 15 min.
1-97750	PT, OT	GO, GP	$45.00 per 15 min.
1-97799	PT, OT	GO, GP	$45.00 per 15 min.

43.4.2.4 Claims Information

CORFs must file their claims on the HCFA-1450 (UB-92) claim form. Providers may purchase these claim forms from the vendor of their choice. TMHP does not supply the forms. Submit electronic claims with a PAN. Failure to provide a PAN on an electronic claim results in claim denial.

Refer to: "Prior Authorization and Documentation Requirements" on page 43-36 for more information about PANs.

The procedure codes CORFs use are HCFA-1450 (UB-92) revenue or CPT codes. The acceptable POS is outpatient facility (POS 5).

The PAN must be identified in Block 63 of the HCFA-1450 (UB-92) claim form or the appropriate field of the electronic software. PT, OT, and SLP *evaluations* should be billed with procedure code B-424, B-434, or B-444. This code should be billed with a quantity of 1 for each type of therapy performed (PT, OT, and SLP), regardless of time spent with the client. The codes used for billing therapy are the CPT codes. The codes are in the 1-9000 series. The *Texas Medicaid Bulletin* provides updates to the CPT codes. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its equivalent.

Refer to: "Occupational Therapists (THSteps-CCP Only)" on page 43-55.

"Physical Therapists (THSteps-CCP Only)" on page 43-62.

"Speech-Language Pathologists (THSteps-CCP Only)" on page 43-78.

“Comprehensive Outpatient Rehabilitation Facility (CORF) (THSteps-CCP Only)” on page D-10 for a claim form example.

"HCFA-1450 (UB-92) Claim Filing Instructions" on page 5-32 for paper claims completion instructions.

43.4.3 Durable Medical Equipment Supplier (THSteps-CCP Only)

Medicaid beneficiaries younger than 21 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries younger than 21 years of age if medically necessary. Likewise, time periods for replacement of DME do not apply to Medicaid beneficiaries younger than 21 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

43.4.3.1 Enrollment

To be eligible to participate in THSteps-CCP, providers of DME must be enrolled in VDP (for payment of prescription drugs) or be enrolled in Medicare. Providers of customized or nonbasic medical equipment must also be enrolled as a Medicare DME provider. Orthotic and prosthetic providers are also enrolled as Medicare DME providers.

Home health agencies that provide DME should refer to "Texas Medicaid (Title XIX) Home Health Services" on page 24-1 to enroll as a DME–Home Health Services (DMEH) provider.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.3.2 Reimbursement

DME and expendable supplies are reimbursed according to a fee schedule, with fees calculated in accordance with 1 TAC §355.8441 (4)-(5). The current DME fee schedule is available on the TMHP website at www.tmhp.com. A provider reimbursed according to a fee schedule is reimbursed the lower of the provider’s billed charges or the published Medicaid fee.

TMHP manually prices purchases of DME and expendable supplies, other than nutritional products, that have no established fee, based on the manufacturer’s suggested retail price (MSRP) less 18 percent, with documentation

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of the MSRP submitted by the provider. Nutritional products that require manual pricing are priced at 89.5 percent of the average wholesale price (AWP). TMHP manually prices monthly rental of DME and expendable supplies other than nutritional products that have no established fee based on the MSRP less 18 percent divided by 13 months.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.3.3 Benefits and Limitations

THSteps-CCP benefits are for Medicaid THSteps-eligible clients younger than 21 years of age. CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits.

The majority of DME and expendable supplies are covered through the Medicaid Home Health Services Program.

If a service cannot be provided through Medicaid Home Health Services, these services may be covered through CCP if they are determined to be medically necessary for the child and have FFP available for them.

Providers must use the following TOS codes when providing CCP services:

TOS	Description
J	Purchase (new)
L	Rental (monthly)
1	Medical services (including some injectable drugs)
9	Medical supplies
9	Purchase of orthotic or prosthetic devices

To establish medical necessity of the equipment for the child, the provider must have on file in the client's records current documentation that is signed by a physician (e.g., signed and dated prescription) showing the following:

- A diagnosis relative to each item requested
- The specific type of supply needed
- The length of time needed

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Prior Authorization and Documentation Requirements

Prior authorization is required. Prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Providers requesting written authorization should complete the THSteps-CCP Prior Authorization Request Form and attach documentation to support the request. The documentation must include a current prescription signed and dated by a physician (MD or DO) and then be mailed or faxed to TMHP. For specific policy information not contained in this manual related to the purchase of DME, such as augmentative communication devices (ACDs), call the TMHP In-Home Care Contact Center (formerly CCP Customer Service) at 1-800-846-7470.

43.4.3.4 Physician Signature

The physician's signature, required on a prescription and the THSteps-CCP Prior Authorization Request Form, must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

Physician prescriptions must be specific to the TOS requested. For example, if the provider is requesting a customized wheelchair, the prescription must request a customized wheelchair, not just a wheelchair.

Documentation of Services for Supplies

Providers must retain delivery slips or invoices, documenting the date of delivery for all supplies provided to a client, which they must disclose to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

Documentation of delivery must include *one* of the following:

- Delivery slip or invoice signed and dated by the client/caregiver
- A dated carrier tracking document attached to the delivery slip or invoice

The DOS is the date supplies are delivered and/or shipped to the client as evidenced by the dated tracking document.

DME Certification and Receipt Form

Providers must complete and retain the "DME Certification and Receipt Form" on page B-35 for all Medicaid clients before submitting a claim for payment. The DME provider must retain this form and not submit it with the claim.

Specific THSteps-CCP Policies

Most DME and supplies are available under Texas Medicaid Home Health Services. If the service is not available under Home Health Services, CCP may cover the requested service, if the client is THSteps-CCP-eligible and the service is medically necessary, requested by a physician, and for which FFP is available.

Refer to: "DME Certification and Receipt Form" on page B-35.

"Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for specific policies.

43.4.3.5 Mobility Aids

Mobility aids and related supplies, including, but not limited to, strollers, special needs car seats, travel safety restraints, and thoracic-hip-knee-ankle orthoses (THKAO)/

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parapodiums are a benefit to assist clients to move about in their environment. Mobility aids equipment includes, but is not limited to, the items detailed below.

Mobility aids and related supplies may be considered for reimbursement through the THSteps-CCP for clients younger than 21 years of age that are THSteps-CCP eligible when the following criteria are met:

- The equipment requested must be medically necessary.
- FFP must be available.
- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.

Mobility aids may be considered through THSteps-CCP if the requested equipment is not available through Title XIX Home Health Services or the client does not meet criteria through Title XIX Home Health.

Mobility aid lifts for vehicles, and vehicle modifications are not reimbursed through Texas Medicaid according to Federal Regulations.

Note: *Permanent ramps, vehicle ramps and home modifications are not a benefit of Texas Medicaid.*

Authorization

Prior authorization is required for all mobility aids and related services except travel safety restraints for children with a medical condition requiring them to be transported in either a prone or supine position.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

A completed THSteps–CCP Prior Authorization Request Form prescribing the durable medical equipment and/or medical supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures are not accepted. The completed THSteps-CCP Prior Authorization Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of the medical necessity for the equipment/services requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the mobility aid. A determination is made by the THSteps-CCP nurses as to whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Mobility aid equipment that has been purchased is anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. The durable medical equipment may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

When prior authorization of a mobility aid replacement is requested before five years have passed, the following information must be submitted with the request:

- A statement from the prescribing physician or licensed occupational or physical therapist
- Documentation supporting why the equipment no longer meets the client's needs

HHSC or its designee determines whether the equipment is rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

Reimbursement

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

Items and/or services addressed in this policy are either reimbursed at a maximum fee determined by the HHSC or are manually priced. If an item is manually priced, MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount as determined by HHSC.

Mobility aid equipment that has been purchased is anticipated to last a minimum of 5 years and may be considered for replacement when 5 years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent recurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management unit will be made by the Home Health Services unit for clients less than 21 years of age. The provider is notified that the State is monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

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Strollers (a multi-positional client transfer system with integrated seat, operated by care giver)

A stroller for medical needs may be considered under any of the following conditions:

- The client does not own another seating system, including, but not limited to, a wheelchair.
- The client's condition does not require another type of seating system, including, but not limited to, a wheelchair.

If the client does not meet criteria for a stroller, a wheelchair may be considered through Title XIX Home Health Services.

A medical stroller does not have the capacity to accommodate the client's growth. Strollers for medical use may be considered for prior authorization when the following criteria are met:

- The client weighs 30 pounds or more.
- The client does not already own another seating system, including but not limited to, a standard or custom wheelchair.
- The stroller must have a firm back and seat, or insert.
- The client is expected to be ambulatory within one year of request date or is not expected to need a travel chair or wheelchair within two years of request date.

The following supporting documentation must be submitted:

- A completed Wheelchair/Stroller Seating Assessment Form that includes documentation supporting medical necessity. This documentation should address why the client is unable to ambulate a minimum of 10 feet due to his/her condition (including, but not limited to, AIDS, sickle cell anemia, fractures, a chronic diagnosis, or chemotherapy), or if able to ambulate further, why a stroller is required to meet the client's needs.
- If the client is over two years of age, documentation must support that the client's condition, stature, weight, and positioning needs to allow adequate support from a stroller.

Note: *A stroller may be considered on a case-by-case basis with documentation of medical necessity for a client who does not meet the criteria listed above.*

A seating assessment must be completed by a physician or licensed occupational or physical therapist who is not employed by the equipment supplier before requesting prior authorization. If the seating assessment is completed by a physician, reimbursement is considered part of the physician's office visit and is not prior authorized. Providers must use procedure codes 1-97001 and 1-97003 when billing for a seating evaluation.

The seating assessment must:

- Explain how the family will be trained in the use of the equipment.
- Anticipate changes in the client's needs and include anticipated modifications or accessory needs, as well as the anticipated width of the medical stroller to allow client growth with use of lateral/thigh supports.
- Include significant medical information pertinent to the client's mobility and how the requested equipment will accommodate these needs, including intellectual, postural, physical, sensory (visual and auditory), and physical status.
- Address trunk and head control, balance, arm and hand function, existence and severity of orthopedic deformities, any recent changes in the client's physical and/or functional status, and any expected or potential surgeries that will improve or further limit mobility.
- Include information on the client's current mobility/seating equipment, how long the client has been in the current equipment, and why it no longer meets the client's needs.
- Include the client's height, weight, and a description of where the equipment is to be used. Seating measurements are required.
- Include the accessibility of client's residence.
- Include manufacturer's information, including the description of the specific base, any attached seating system components, and any attached accessories.

To request prior authorization for procedure code J-E1035, the criteria must be met for the level of stroller requested:

- *Level One: Basic Stroller.* The client meets the criteria for a stroller. Providers must use procedure code J-E1035.
- *Level Two: Stroller with Tray for Oxygen and/or Ventilator.* The client meets the criteria for a level-one stroller and is oxygen- or ventilator-dependent. Providers must use procedure code J-E1035 with modifier TF.
- *Level Three: Stroller with Positioning Inserts.* The client meets the criteria for a level-one or level-two stroller and requires additional positioning support. Providers must use procedure code J-E1035 with modifier TG.

Stroller Ramps—Portable and Threshold

A portable ramp is defined as a ramp that is a unit able to be carried as needed to access a home and weighing no more than 90 pounds and/or measuring no more than ten feet in length. A threshold ramp is defined as a ramp that provides access over elevated thresholds.

Portable ramps exceeding the above criteria may be considered on a case-by-case basis with documentation of medical necessity and a statement that the requested equipment is safe for use.

Providers must use procedure code J-E1399 for stroller ramps–portable and threshold.

One portable and one threshold ramp for stroller access may be considered for prior authorization when documentation supports medical necessity to include the following documentation:

- The date of purchase and serial number of the client's medical stroller or documentation of a medical stroller request being reviewed for purchase.
- Diagnosis with duration of expected need.

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- Ramps may be considered for rental for short-term disabilities.
- Ramps may be considered for purchase for long-term disabilities.
- A diagram of the house showing the access point(s) with the ground-to-floor elevation and any obstacles.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Prior authorization is a condition for reimbursement, not a guarantee of payment.

Mobility aid lifts for vehicles, and vehicle modifications are not reimbursed through the Texas Medicaid Program according to federal regulations.

Note: *Permanent ramps, vehicle ramps, and home modifications are not a benefit of the Texas Medicaid Program.*

43.4.3.6 Thoracic-Hip-Knee-Ankle Orthoses (THKAO) (Vertical or Dynamic Standers, Standing Frames/ Braces, and Parapodiums)

Thoracic-hip-knee-ankle orthoses (THKAO) (vertical or dynamic standers, standing frames/braces, and parapodiums), including all accessories, require prior authorization. A THKAO may be considered if the client requires assistance to stand and remain standing. A THKAO is not considered for prior authorization if the client already owns a stander (other than a vertical stander or standing frame/brace) or gait trainer.

Prior authorization may be considered for the THKAOs with the following documentation:

- Diagnoses relevant to the requested equipment, including functioning level and ambulatory
- Anticipated benefits of the equipment
- Frequency and amount of time of a standing program
- Anticipated length of time the client will require this equipment
- Clients height/weight/age
- Anticipated changes in the client's needs, anticipated modifications, or accessory needs, as well as the growth potential of the stander

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Vertical or Dynamic Stander

A vertical stander is used to initiate standing for children who cannot maintain a good standing posture or may never be able to stand independently. A vertical stander is used to develop weight bearing through the legs in order to decrease demineralization and to promote better body awareness. Documentation for a dynamic stander must address medical necessity for the stander to be mobile.

Standing Frame/Brace

A standing frame/brace is used to help very young children, 12 months of age or older who have good head control in the upright position, and who have a neuromuscular disease/condition resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free.

Providers must use procedure code 9-L1510 for a vertical stander or standing frame/brace. Providers must use procedure code J-E0642 for a dynamic stander.

Parapodium

A parapodium is used to help children with neuromuscular diseases/conditions resulting in a lack of sufficient muscle power in the trunk and lower extremities to stand with their hands free. It helps develop a sense of balance and aids in learning functional movements such as standing with the hands free. A parapodium acts as an exoskeleton, providing side struts and chest, hip, knee, and foot bracing.

A parapodium may be considered for reimbursement for one of the following levels:

- *Level One: Small Parapodium.* The client has a maximum axillary height of 35 inches and a maximum weight of 55 pounds (normal age range is 1 through 10 years of age). Providers must use procedure code 9-L1500 or 9-L1520.
- *Level Two: Medium parapodium.* The client has a maximum axillary height of 41 inches and a maximum weight of 77 pounds (normal age range is 5 through 12 years of age). Providers must use procedure code 9-L1500-TF or 9-L1520-TF.
- *Level Three: Large parapodium.* The client has a maximum axillary height of 45 inches and a maximum weight of 115 pounds (normal age range is 10 through 16 years of age). Providers must use procedure code 9-L1500-TG or 9-L1520-TG. Labor for parapodium assembly may be prior authorized.

Feeder Seats, Floor Sitters, Corner Chairs, and Travel Chairs

Feeder seats, floor sitters, corner chairs, and travel chairs are not considered medically necessary and are not a benefit of THSteps-CCP. If a child requires seating support and meets the criteria for a seating system, a stroller may be considered for reimbursement with prior authorization through THSteps-CCP, or a wheelchair may be considered through Texas Medicaid Title XIX Home Health Services.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Scooters

Scooters may be considered for reimbursement through Texas Medicaid Title XIX Home Health Services.

Equipment Accessories

Consideration for prior authorization may be given under THSteps-CCP for equipment accessories, such as ventilator and oxygen trays and positioning inserts, when supporting documentation takes into account all the client's needs, capabilities, and physical/mental status.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

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Equipment Modifications

Modifications are replacement of components due to changes in the clients condition, not replacement due to the component no longer functioning as designed.

All modifications within the first six months after delivery are considered part of the purchase price.

Consideration for prior authorization may be given under THSteps-CCP for modifications to custom equipment if a change occurs in the client's needs, capabilities, or physical/mental status that cannot be anticipated. Documentation must include:

- All projected changes in the client's needs.
- The age of the current equipment, and the cost of purchasing new equipment versus modifying current equipment.

Equipment Adjustments

Adjustments do not require supplies.

Adjustments within the first six months after delivery are not prior authorized. Adjustments within the first six months after delivery are considered part of the purchase price.

Up to one hour of labor for adjustments may be considered for reimbursement with prior authorization through THSteps-CCP as needed after the first six months. Providers must use procedure code 9-E1340 for adjustments.

Equipment Repairs

Repairs require replacement of components that are no longer functional. Repairs to client-owned equipment may be considered for reimbursement with prior authorization through THSteps-CCP.

Technician fees are considered part of the cost of the repair. Providers must use procedure code 9-E1340.

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

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Rentals may be considered for reimbursement during the repair period of the client's owned equipment.

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

Mobility Aids – CCP HCPCS Procedure Codes and Limitations

Procedure Code	Maximum Limitation	Allowed Amount
1-97001	As needed	$140.00
1-97003	As needed	$140.00
J-E0700*	One per five years	$26.00
J-E1035*	One per five years	$1,161.94
J-E1035-TF*	One per five years	$2,296.00
J-E1035-TG*	One per five years	Manually priced
J-E1037	Not a benefit	Not a benefit
L-E1037	Not a benefit	Not a benefit
9-E1340*	As needed	Manually priced
J-E1399*	One per five years	Manually priced
9-L1500*	One per five years	$1,292.11
9-L1500-TF*	One per five years	$1,483.13
9-L1500-TG*	One per five years	$1,867.50
9-L1510*	One per five years	$743.76
9-L1520*	One per five years	$266.57
9-L1520-TF*	One per five years	$510.04
9-L1520-TG*	One per five years	Manually priced

*** Procedure codes that require prior authorization**

Providers must use modifiers TF and TG for equipment repairs.

43.4.3.7 Apnea Monitor

Apnea monitors to monitor chest movement and measure heart rate are a benefit of THSteps-CCP for infants.

Apnea monitors used in the home are paid for two months without prior authorization for infants with one of the following diagnoses:

Diagnosis Code	Description
53010	Esophagitis, unspecified
53011	Reflux esophagitis
53012	Acute esophagitis
53019	Other esophagitis
53020	Ulcer of esophagus without bleeding
53021	Ulcer of esophagus with bleeding
53081	Esophageal reflux
53085	Barrett's esophagus
7707	Chronic respiratory disease arising in the perinatal period
77081	Primary apnea of newborn
77082	Other apnea of newborn
77083	Cyanotic attacks of newborn
77084	Respiratory failure of newborn
77089	Other respiratory problems after birth

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Diagnosis Code	Description
78603	Apnea
V198	Family history of other condition, e.g., sudden infant death syndrome

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Procedure code L-E0619 is used when billing for apnea monitors.

All apnea monitors provided to THSteps-CCP clients must be capable of recording apneic episodes.

The place of service for apnea monitors is in the client's home.

Prior authorization is required for rental of an apnea monitor if the child is more than 4 months of age *or* the initial two-month rental period has expired.

Prior authorization must be obtained in writing and must include:

- A completed CCP Prior Authorization Request Form, signed and dated by the physician
- Documentation to support medical necessity and appropriateness of the apnea monitor
- A physician interpretation, signed and dated by the physician, of the most recent two-month's apnea monitor downloads

Apnea monitors are not authorized if the documentation does not support medical necessity.

Procedure code I-93272 may be used by the physician to bill for the interpretation of the apnea monitor recordings.

Electrodes and lead wires for the apnea monitor are a benefit only if the apnea monitor is owned by the client. If the apnea monitor is rented, the electrodes and lead wires are considered part of the rental fee. The electrodes and lead wires may be considered for purchase with procedure codes 9-A4556 and 9-A4557 and only with documentation of medical necessity and a statement from the physician that the client owns the monitor. The apnea monitor/pulse oximeter combination device is not a benefit of the Texas Medicaid Program.

43.4.3.8 Croup Tent/Pulse Oximeter

Croup Tent

The croup tent consists of a plastic tent and humidification system placed over a crib or bed to provide a high humidity environment.

A croup tent requires prior authorization.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Reimbursement for the croup tent is per month, regardless of whether the therapy is for only one day or one week.

Rental of the croup tent includes purchase of the croup tent canopy, rental of a compressor, set-up charge, and supplies.

Separate payment is not made for individual components.

Procedure code L-E1399 must be used for rental of the croup tent.

Pulse Oximeter

A pulse oximeter is used to monitor the client's body oxygen saturation level for those clients at risk for hypoxia.

A pulse oximeter is a benefit of the Texas Medicaid Program through CCP. A higher level pulse oximeter may be reimbursed based on documentation of medical necessity.

A pulse oximeter requires prior authorization.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

A pulse oximeter may be reimbursed for rental only once a month and is limited to a maximum of six months, at which time purchase may be considered for those clients requiring long-term monitoring.

The provider is responsible for retaining a current prescription.

A pulse oximeter rental, including the probes, may be authorized for clients who:

- Are younger than 21 years of age and are ventilator and/or oxygen dependent, *or*
- Are weaning from oxygen and/or a ventilator and have other documented medically necessary conditions requiring a pulse oximeter in the home

A pulse oximeter may be considered for reimbursement for clients younger than 21 years of age with one of the following levels:

- *Level One.* Basic level monitoring and/or spot checks. Applicable if the client meets at least one the of the following criteria:
  - Client is oxygen- and/or ventilator-dependent at least part of the day (Less than eight hours per day).
  - Client is clinically stable and able to wean from oxygen and/or ventilator.
  - Client has another medically necessary condition requiring monitoring of oxygen saturation.
  - There is a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.
- *Level Two.* Providers must use modifier TF when the oximeter device is for intermediate level of care and continuous monitoring. Applicable if the client meets all the following criteria:
  - Client is oxygen- and/or ventilator-dependent a significant portion of the day (e.g., 8 to 16 hours per day).
  - Client needs continuous monitoring of oxygen saturation during sleep and/or to maintain optimal levels.

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- There is a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.
- *Level Three.* Providers must use modifier TG if the oximeter device is for a serious condition and there is critical need for continuous monitoring. Applicable if the client meets all the following criteria:
  - Client has frequent need for changes in oxygen and ventilator settings.
  - Client is oxygen- and/or ventilator-dependent (e.g., 16 to 24 hours per day).
  - Client is in the weaning process from oxygen and/or ventilator and experiencing respiratory complications.
  - Client requires equipment that is motion-sensitive, has more complex readouts, or monitoring capabilities.
  - There is a caregiver identified and present who has been trained in use of the oximeter and how to respond to readings in a medically safe way.

A pulse oximeter rental is limited to once per month for a maximum of six months. For those clients not requiring long-term monitoring, a rental extension may be considered for up to six months for level two and three oximeters (TF and TG devices). Purchase may be considered for those clients requiring long term monitoring. Before purchase, the provider must supply a new oximeter to the client.

For all requests providers must:

- Submit the completed Pulse Oximeter Form in addition to the required THSteps-CCP Prior Authorization Request Form. (see "Pulse Oximeter Form" on page B-76 and the "THSteps-CCP Prior Authorization Request Form" on page B-106.)
- Clearly indicate medical necessity using the TF and TG modifiers on the Pulse Oximeter Form.
- Continue to use the current code for lease (J/L-E0445 with modifier RR) and purchase (J/L-E0445 with modifier NU).

When requesting prior authorization, providers must use the following procedure codes with the appropriate modifier:

Procedure Code	Limitation
J/L-E0445 *with* modifier RR	One per month
J/L-E0445 *with* modifier NU	One every three years
J/L-E0445 *with* modifiers RR *and* TF	One per month
J/L-E0445 *with* modifiers NU *and* TF	One every three years
J/L-E0445 *with* modifiers RR *and* TG	One per month
J/L-E0445 *with* modifiers NU *and* TG	One every five years

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Replacement sensor probes (reusable or disposable) for client-owned oximeters require prior authorization through CCP.

Sensor probes are limited to four per month using procedure code 9-A4606. Clients under 21 years of age may obtain additional probes with documentation of medical necessity.

Respiratory Care Equipment – CCP Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-A4556	15 per month/client-owned monitor
9-A4557	Two pair per year/client-owned monitor
L-E0445	One per month
J-E0445	One per five years
L-E0619	One per month
L-E1399	One per month

43.4.3.9 Electronic Blood Pressure Monitoring Device

An electronic blood pressure monitoring device is not a benefit of Texas Medicaid Home Health Services. It is a benefit of THSteps-CCP only in the home setting when:

- The client is younger than 12 months of age (coverage for clients 12 months of age or older may be considered upon review by HHSC or its designee with supporting documentation of medical necessity).
- The client is THSteps-CCP-eligible.
- The equipment is prescribed by a physician.
- Documentation is provided supporting medical necessity of the requested equipment.

Prior authorization is required for an electronic blood pressure monitoring device. A THSteps-CCP Prior Authorization Request Form, signed and dated by the physician, must be submitted with the documentation supporting medical necessity for the device. Supporting documentation of medical necessity must include the diagnosis.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

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An electronic blood pressure monitoring device is restricted to the following diagnosis codes. Other diagnoses can be considered upon review by HHSC or its designee.

Diagnosis Code	Description
4010	Malignant essential hypertension
4011	Benign essential hypertension
4019	Unspecified essential hypertension
40200	Malignant hypertensive heart disease without congestive heart failure
40201	Malignant hypertensive heart disease with congestive heart failure
40210	Benign hypertensive heart disease without congestive heart failure
40211	Benign hypertensive heart disease with congestive heart failure
40290	Unspecified hypertensive heart disease without congestive heart failure
40300	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified
40301	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
40310	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
40311	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
40390	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
40391	Hypertensive kidney disease, unspecified, with chronic kidney disease
40400	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40401	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40402	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
40403	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
40410	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40411	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40412	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
40413	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
40490	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40491	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
40492	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
40493	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
40501	Malignant renovascular hypertension
40509	Other malignant secondary hypertension
40511	Benign renovascular hypertension
40519	Other benign secondary hypertension
4150	Acute cor pulmonale
41511	Iatrogenic pulmonary embolism and infarction
41519	Other pulmonary embolism and infarction
4160	Primary pulmonary hypertension
4161	Kyphoscoliotic heart disease
4168	Other chronic pulmonary heart diseases

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Diagnosis Code	Description
4169	Chronic pulmonary heart disease, unspecified
4240	Mitral valve disorders
4241	Aortic valve disorders
4242	Tricuspid valve disorders, specified as nonrheumatic
4243	Pulmonary valve disorders
4251	Hypertrophic obstructive cardiomyopathy
4252	Obscure cardiomyopathy of Africa
4253	Endocardial fibroelastosis
4254	Other primary cardiomyopathies
4260	Atrioventricular block, complete
42610	Atrioventricular block, unspecified
42611	First degree atrioventricular block
42612	Mobitz (type) II atrioventricular block
42613	Other second degree atrioventricular block
4262	Left bundle branch hemiblock
4263	Other left bundle branch block
4264	Right bundle branch block
42650	Bundle branch block, unspecified
42651	Right bundle branch block and left posterior fascicular block
42653	Other bilateral bundle branch block
42654	Trifascicular block
4266	Other heart block
4267	Anomalous atrioventricular excitation
42681	Lown-Ganong-Levine syndrome
42682	Long QT syndrome
42689	Other specified conduction disorders
4269	Conduction disorder, unspecified
4270	Paroxysmal supraventricular tachycardia
4271	Paroxysmal ventricular tachycardia
4272	Paroxysmal tachycardia, unspecified
42731	Atrial fibrillation
42732	Atrial flutter
42781	Sinoatrial node dysfunction
4280	Congestive heart failure
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42822	Chronic systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure

Diagnosis Code	Description
42831	Acute diastolic heart failure
42832	Chronic diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspecified combined systolic and diastolic heart failure
42841	Acute combined systolic and diastolic heart failure
42842	Chronic combined systolic and diastolic heart failure
42843	Acute on chronic combined systolic and diastolic heart failure
4289	Heart failure, unspecified
5830	Nephritis and nephropathy, not specified as acute or chronic, with lesion of proliferative glomerulonephritis
5831	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranous glomerulonephritis
5832	Nephritis and nephropathy, not specified as acute or chronic, with lesion of membranoproliferative glomerulonephritis
5834	Nephritis and nephropathy, not specified as acute or chronic, with lesion of rapidly progressive glomerulonephritis
5836	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal cortical necrosis
5837	Nephritis and nephropathy, not specified as acute or chronic, with lesion of renal medullary necrosis
58381	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere
58389	Other nephritis and nephropathy, not specified as acute or chronic, with specified pathological lesion in kidney
5839	Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney
5845	Acute renal failure with lesion of tubular necrosis
5846	Acute renal failure with lesion of renal cortical necrosis
5847	Acute renal failure with lesion of renal medullary (papillary) necrosis
5848	Acute renal failure with other specified pathological lesion in kidney

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Diagnosis Code	Description
5849	Acute renal failure, unspecified
5880	Renal osteodystrophy
58889	Other specified disorders resulting from impaired renal function
591	Hydronephrosis
59371	Vesicoureteral reflux with reflux nephropathy, unilateral
59372	Vesicoureteral reflux with reflux nephropathy, bilateral
59373	Other vesicoureteral reflux with reflux nephropathy nos
7450	Common truncus
74510	Complete transposition of great vessels
74511	Double outlet right ventricle
74512	Corrected transposition of great vessels
74519	Other transposition of great vessels
7452	Tetralogy of Fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
74560	Endocardial cushion defect, unspecified type
74561	Ostium primum defect
74569	Other endocardial cushion defects
7457	Cor biloculare

Procedure code L-E1399 is used to bill for the monthly rental of an electronic blood pressure monitoring device.

43.4.3.10 Incontinence Supplies for Children Younger Than 4 Years of Age

Incontinence supplies, such as diapers/briefs/liners, wipes, and underpads, may be considered for reimbursement through THSteps-CCP for those children younger than 4 years of age with a medical condition resulting in an increased urine and/or stool output beyond the typical output for this age group, such as celiac disease, short bowel syndrome, Crohn's disease, thymic hypoplasia, AIDS, congenital adrenal hyperplasia, diabetes insipidus, Hirschsprung's disease, or radiation enteritis.

Lack of bladder and/or bowel control is considered normal development up to 4 years of age.

Prior authorization is required for incontinence supplies through THSteps-CCP. A completed THSteps-CCP Prior Authorization Request Form prescribing the supplies must be signed and dated by the prescribing physician familiar with the client before requesting prior authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed THSteps-CCP Prior Authorization Request Form must be maintained by the DME provider and the prescribing physician in the client's medical record.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation, of the medical necessity of the supplies requested.

To request prior authorization for incontinence supplies, the following documentation must be provided for the item(s) requested:

- Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status
- Diagnosis/condition causing increased urination/stooling
- Client height, weight, and waist size
- Number of times per day the physician has ordered the supply be used
- Quantity of disposable supplies requested per month

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

A determination is made by the State or its designee as to the number of incontinence supplies prior authorized based on the child's medical needs.

A combination of diapers, briefs, and liners may be considered for authorization for clients younger than 4 years of age and are limited to 300 per month.

Note: *Procedure codes identified with (*) in the table below indicate those considered in the combination of 300 per month. Requests for services exceeding the amounts listed must be submitted with documentation of medical necessity.*

Providers must use the following procedure codes when billing for incontinence supplies for children younger than 4 years of age:

Procedure Code	Maximum Limitation
9-A4335	2 per month
9-A4554	150 per month
9-A6250	2 per month*
9-T4521	300 per month*
9-T4522	300 per month*
9-T4523	300 per month*
9-T4524	300 per month*
9-T4525	300 per month*
9-T4526	300 per month*
9-T4527	300 per month*

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Procedure Code	Maximum Limitation
9-T4528	300 per month*
9-T4529	300 per month*
9-T4530	300 per month*
9-T4531	300 per month*
9-T4532	300 per month*
9-T4533	300 per month*
9-T4534	300 per month*
9-T4535	300 per month*

43.4.3.11 Pediatric Hospital Cribs/Enclosed Beds/ Reflux Wedges and Slings

Pediatric hospital cribs, enclosed beds, reflux wedges, and slings may be considered under the THSteps-CCP Program with prior authorization.

The safety enclosure frame/canopy/bubble top (E0316) may be a benefit when the protective crib top/bubble top is for safety use. It is not considered when it is to be used as a restraint or for the convenience of family or caregivers.

Enclosed bed systems which are not approved by the Federal Drug Administration are not a covered benefit.

Non-pediatric hospital cribs/enclosed beds can be considered through Title XIX Home Health Services.

Reflux slings or wedges may be considered for clients who are younger than 12 months of age. Reflux slings or wedges may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate.

The child's diagnosis, medical needs, developmental level, and functional skills. A diagnosis alone without documentation of medical necessity and functional skills is insufficient information to approve a pediatric hospital crib or enclosed bed.

Prior Authorization

Prior authorization is required for the durable medical equipment (DME) addressed in this policy and provided through THSteps-CCP. In order to facilitate a determination of medical necessity and avoid unnecessary denials, providers must include all necessary information at the time a request is made.

A completed THSteps-CCP Prior Authorization Form prescribing the durable medical equipment and/or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. The completed THSteps-CCP Prior Authorization Form must include the procedure codes for the services requested. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures are not accepted. The completed THSteps-CCP Prior Authorization Form must be maintained by the requesting provider and the prescribing physician The original signature copy must be kept in the physician's medical record for the client. To complete the prior authorization process the provider must fax or mail the completed THSteps-CCP Prior Authorization Form to the CCP prior authorization unit.

Documentation supporting medical necessity must include:

- The diagnosis, medical needs, treatments, developmental level, and functional skills of the child. A diagnosis alone is insufficient information to consider prior authorization of the requested equipment;
- The age, length, and weight of the child;
- A description of any other devices that have been used, the length of time used, and why they were ineffective;
- How the requested equipment will correct or ameliorate the client's condition beyond that of a standard child's crib, regular bed, or standard hospital bed; and
- The name of the manufacturer and the MSRP.

A determination will be made by the State or its designee whether the equipment will be rented, purchased, repaired, or modified based on the client's needs, duration of use, and age of equipment.

Reimbursement

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

The following procedure codes may be considered for pediatric hospital cribs, enclosed beds, and/or a reflux wedge or sling: J/L-E0300, J/L-E0316, 9-E1340, and J/L-E1399

Procedure code J/L-E1399 may be used for pediatric hospital cribs which are not enclosed, reflux wedges, or reflux slings.

Items and/or services addressed in this policy are either reimbursed at a maximum fee determined by the HHSC or through manual pricing. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases, repairs, and modifications are reimbursed at MSRP minus a discount as determined by HHSC.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver a referral to the DSHS THSteps Case Management unit will be made by the THSteps -CCP prior authorization unit for clients under 21 years of age. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Replacement

Pediatric hospital cribs, enclosed beds, and safety enclosure frame/canopies that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer functional and no

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longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

Repairs

Repairs to client-owned equipment may be considered with documentation of medical necessity.

Technician fees are considered part of the labor cost on the repair.

Providers are responsible for maintaining documentation in the client's medical record specifying repairs.

Rentals may be considered during the period of repair.

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

43.4.3.12 Medical Nutritional Products

Medical nutritional products for clients younger than 21 years of age are available only through THSteps-CCP.

Medical nutritional products may be approved for clients who are THSteps-CCP-eligible, are younger than 21 years of age, and have specialized nutritional requirements. Medical nutritional products must be prescribed by a physician and be medically necessary. FFP for the medical nutritional product must also be available.

Documentation that supports medical necessity must include one of the following:

- Identification of a metabolic disorder requiring a medically necessary nutritional product
- Indication that part or all nutritional intake is through a tube (e.g., nasogastric or gastrostomy/jejunostomy)
- Identification/explanation of the medical condition resulting in the requirement for a medical nutritional product

Prior authorization is not required for the following:

- Nutritional products developed for use in metabolic disorders for those clients with a documented metabolic disorder. (Claims must include the diagnosis indicating the metabolic disorder, and the nutritional product must be for use in metabolic disorders, or the claim is denied.)
- Nutritional products used for clients receiving part or all of their nutritional intake through a tube. Claims submitted for nutritional products not covered by CCP are denied. Claims submitted must indicate the client has a feeding tube, or the claim is denied.

Mandatory prior authorization is required for any request that does *not* meet the above criteria. To request prior authorization, submit the THSteps-CCP Prior Authorization Request Form and documentation to support medical necessity. Documentation may include the following:

- Height and weight
- Growth history
- Why the client cannot be maintained on an age-appropriate diet
- Other formulas tried and why they did not meet client's needs

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Authorization may be given for up to 12 months.

THSteps-CCP will *not* cover the following:

- Nutritional products for clients that could be sustained on an age-appropriate diet.
- Products traditionally used for infant feeding.
- Pudding products (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product).
- Nutritional products for the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth. Documentation should describe the medical condition that led to the conditions listed previously.
- Nutritional products for infants younger than 12 months of age unless medical necessity is documented and other criteria are met. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Generic medical nutritional products that have been approved by the United States Department of Agriculture (USDA) for use in the Special Supplemental Nutrition Program for WIC may be approved for use by THSteps-CCP clients. Reimbursement is determined using the *Drug Topics Red Book*, less 10.5 percent. Reimbursement for products not listed in the Red Book is based on the same methodology using the AWP supplied by the manufacturer of the product. The provider is responsible for obtaining and submitting necessary product information with the request for products.

Enteral Nutritional Products

All enteral nutritional products paid under the Texas Medicaid Program are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate "B" code (as documented by the Statistical Analysis Durable Medical Equipment Regional Carrier [SADMERC] Product Classification List for Enteral Nutrition in effect at the time) and with the appropriate modifier based on the product's AWP less 10.5 percent (as documented by the Red Book).

It is the provider's responsibility to know the correct "B" code, the correct units of 100 calories, and the modifier for requesting prior authorization and payment. Supporting documentation for these components must be maintained in the provider's records and be made available upon request by HHSC or TMHP. Payment is based on the lower of billed charges or the Medicaid allowed fee, with the Medicaid allowed fee based on the appropriate "B" code, modifier, and units of 100 calories.

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It is the provider's responsibility to know when products are discontinued by the manufacturer, when container sizes change, and when names change. Submit requests for prior authorization and payment accordingly.

A written request must be submitted when using procedure code 9-B9998 to request generic medical nutritional products that require prior authorization.

Note: *The Palmetto GBA SADMERC Product Classification List is located on the website www.palmettogba.com.*

The following modifiers should be used if indicated as necessary on the Palmetto GBA SADMERC Product Classification list for that medical nutritional product.

Modifier	Fee per Unit
U1	$0.30
U2	$0.50
U3	$0.70
U4	$0.85
U5	$1.05
U6	$1.70
U7	$2.00
U8	$2.50
U9	$3.00
UA	$4.00
UB	$5.00
UC	$6.00
UD	Manually priced

43.4.3.13 Donor Human Milk

Donor human milk is a benefit of THSteps-CCP for eligible THSteps clients 0 through 11 months of age meeting *all* of the following criteria:

- The requesting physician has documented medical necessity.
- The parent or guardian has signed and dated an informed consent form indicating that the risks and benefits of using banked donor human milk have been discussed with them.
- The donor human milk bank adheres to quality guidelines consistent with the Human Milk Bank Association of North America or such other standards as may be adopted by HHSC.

A Donor Human Milk Request Form must be completed every 180 days, and copies must be maintained in the client's records of both the ordering physician and the providing milk bank. The physician ordering the donor human milk must complete all fields in Part A of the original form, including the documentation of medical necessity. This information *must* be substantiated by written documentation in the clinical record. The physician must specify the quantity and time frame in the Quantity Requested field (e.g., cubic centimeters per day or ounces per month).

A copy of the Donor Human Milk Request Form must also be maintained in the client's records at the providing milk bank. The donor milk bank providing the donor human milk must complete all fields in Part B of the original form.

The milk bank must specify the quantity and time frame in the Quantity Provided field.

Refer to: "Donor Human Milk Request Form" on page B-36.

The physician's substantiating documentation of medical necessity and the signed and dated written informed consent form must be maintained in the child's clinical records. The clinical records are subject to retrospective review by HHSC or its designee.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The documentation must address all of the following criteria:

- Why the particular infant cannot survive and gain weight on any other formula (e.g., elemental, special, or routine formulas or food) or any enteral nutritional product other than donor human milk.
- Why donor human milk must be used.
- That a clinical feeding trial of an appropriate nutritional product has occurred every 180 days. If the infant is too fragile for a feeding trial, documentation *must* support the illness that makes the infant too fragile to test.
- That the informed consent details for the parent or guardian the risks and benefits of using banked donor human milk.

The physician *must* address the benefits and risks of using donor human milk, such as HIV, freshness, effects of pasteurization, nutrients, and growth factors to the parent. The physician also must address donor screening, pasteurization, milk storage, and transport of the donor milk. The physician may obtain this information from the donor milk bank.

Donor human milk is reimbursed only to a Texas Medicaid-enrolled donor milk bank and only for children in the home setting. Donor human milk may be reimbursed for a maximum of six months per request.

Providers must use procedure code 9-B9998 to bill for donor human milk, per ounce. Donor human milk is reimbursed at $2.50 per ounce. Reimbursement for donor human milk provided in the inpatient setting is included in the DRG.

43.4.3.14 Special Needs Car Seats and Travel Restraints

Special Needs Car Seats

A special needs car seat may be considered for reimbursement with prior authorization for a client who has outgrown an infant car seat and is unable to travel safely in a booster seat or seat belt. Consideration should

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be given to the manufacturer's weight and height limitations and must reflect allowances for at least 12 months of growth.

A special needs car seat must have a top tether installed. The top tether is essential for proper use of the car seat. The installer is reimbursed for the installation by the manufacturer.

The provider must maintain a statement that has been signed and dated by the client's parent or legal guardian in the client's medical record that states the following:

- A top tether has been installed in the vehicle in which the client will be transported, by a manufacturer-trained vendor.
- Training in the correct use of the car seat has been provided by a manufacturer-trained vendor.
- The client's parent or legal guardian has received instruction and has demonstrated the correct use of the car seat to a manufacturer-trained vendor.

Providers must use procedure code J-E1399 for a special needs car seat.

Car seat accessories available from the manufacturer may be considered for reimbursement with prior authorization when medically necessary for correct positioning.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

To request prior authorization for a special needs car seat or accessories, the following criteria must be met:

- The client's weight must be at least 40 pounds, *or t*he client's height must be at least 40 inches.
- Supporting documentation must include the following and must be submitted for prior authorization:
    - Accurate diagnostic information pertaining to the underlying diagnosis/condition as well as any other medical diagnoses/conditions, to include the client's overall health status
    - A description of the client's postural condition specifically including head and trunk control (or lack of control) and why a booster chair or seatbelt will not meet the client's needs (the car seat must be able to support the head if head control is poor)
    - The expected long-term need for the special needs car seat
    - A copy of the manufacturer's certification for the installer's training to insert the specified car seat, such as Columbia Medical Manufacturing Corporation for Columbia products

A request for a client who does not meet the criteria may be considered on a case-by-case basis on review by the State or its designee.

A stroller base for a special needs car seat is not a benefit of Texas Medicaid.

Travel Safety Restraints

A travel safety restraint and ankle or wrist belts may be considered for reimbursement through THSteps-CCP without prior authorization for children with a medical condition requiring them to be transported in either a prone or supine position. The DME provider and the prescribing physician familiar with the client must maintain documentation in the client's medical record supporting the medical necessity of the travel safety restraint.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Authorization is a condition for reimbursement, not a guarantee of payment.

Providers must use procedure code J-E0700 for travel safety restraints, ankle, and wrist belts.

43.4.4 Early Childhood Intervention (ECI) (THSteps-CCP Only)

43.4.4.1 Enrollment

To be a qualified provider, the provider must contact the Texas ECI Program at 1-512-424-6759. After meeting the criteria of the Texas ECI Program, providers should request a Medicaid application from TMHP Provider Enrollment. ECI providers are eligible to enroll as Texas Medicaid THSteps-CCP providers rendering service to children younger than 3 years of age with a disability and/or developmental delay as defined by ECI criteria.

To participate in the Texas Medicaid Program, an ECI provider must comply with all applicable federal, state, and local laws and regulations about the services provided.

Reimbursement is available for PT, OT, speech-language therapy, nutrition, audiology, and psychological services for children enrolled in ECI through THSteps-CCP. Regular CCP guidelines apply, including the requirement for evaluations.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for more information.

"Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.4.2 Reimbursement

Services are reimbursed according to the maximum allowable fee established by HHSC.

Refer to: "Reimbursement" on page 43-7 for more information about reimbursement.

43.4.4.3 ECI-CCP Services

ECI THSteps-CCP services end on the client's third birthday.

Because the ECI program requires local ECI providers to follow quality assurance procedures and develop individualized family service plans for each child, CCP does not

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require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. ECI providers must complete the entire "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-108. The form must include a physician signature current for all dates of service and the appropriate therapist signature for the requested service (e.g., a request for OT must be signed by an occupational therapist and not a physical therapist).

Prior authorization through CCP is necessary to expedite claims processing.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Physician Signature

The physician's signature, required on a prescription and the THSteps-CCP ECI Request for Initial Renewal Outpatient Therapy form, must be current to the service date of the request.

Speech therapy services provided to children enrolled in ECI are eligible for reimbursement through THSteps-CCP when provided by or under the direction (supervision) of a Texas-licensed speech-language pathologist with a master's degree or certified by the American Speech-Language Hearing Association (ASHA). Speech-language pathologists, with a Certificate of Clinical Competence in Speech-Language Pathology from ASHA or licensed by the Texas State Board of Examiners for Speech-Language Pathology and Audiology with a master's degree (ASHA equivalent qualified SLP), may provide supervision of ECI speech-language therapy services provided by individuals practicing with a Texas SLP intern license or individuals licensed as SLP assistants.

The supervision must meet the following provisions:

- The supervising speech-language pathologist provides sufficient supervision as set forth by the State Board of Examiners for Speech-Language Pathology and Audiology to ensure appropriate completion of the responsibilities assigned.
- Documentation exists of direct involvement of the supervising speech-language pathologist in overseeing the services provided.
- The speech-language pathologist providing the direction must ensure that the personnel carrying out the directives meet the minimum qualifications set forth in the rules of the State Board of Examiners for Speech-Language Pathology and Audiology relating to Licensed Assistant in Speech-Language Pathology.

SLP is a regulated profession in Texas. Speech therapy providers with ASHA certification must also be licensed by the State Board of Examiners for Speech-Language Pathology and Audiology.

ECI providers must complete the THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy Form for authorization for reimbursement of speech-language services. The form must include a physician signature current for all dates of service and a signature of an ASHA-certified or equivalent qualified speech-language pathologist enrolled in the Texas Medicaid Program.

Claims for services provided by licensed SLP interns or individuals licensed as SLP assistants must reflect the ASHA-certified or -equivalent supervising speech-language pathologist's provider identifier.

Refer to: "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-108.

"Physician Signature" on page 43-37 for complete information about this requirement.

43.4.4.4 Claims Information

Providers must submit services by an ECI provider to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its equivalent.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-24 for claims completion instructions.

"Early Childhood Intervention (THSteps-CCP Only)" on page D-12.

"Case Management for Early Childhood Intervention (ECI)" on page 13-1 for more information.

43.4.5 Licensed Dietitians (THSteps-CCP Only)

43.4.5.1 Enrollment

Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to THSteps-CCP clients. Providers of nutrition assessments and counseling must be currently licensed by the Texas State Board of Examiners of Dietitians in accordance with the *Licensed Dietitians Act*, Chapter 701, Texas Occupations Code.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.5.2 Reimbursement

Services provided by licensed dietitians are reimbursed based on the fees listed in Section 4.5.3 "Benefits and Limitations" below. Providers are reimbursed the lower of their billed charges or the published Medicaid fee calculated in accordance with 1 TAC §355.8085. Only providers enrolled as licensed dietitians are eligible for reimbursement for dietitian services.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.5.3 Benefits and Limitations

THSteps-CCP is for Medicaid THSteps-eligible children younger than 21 years of age. CCP eligibility ends on the client's 21st birthday. If the client's Medicaid ID states

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"Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits. THSteps-CCP may cover nutrition assessment and/or counseling to prevent, treat, or minimize the effects of illness, injury, or other impairments.

Nutrition services may be a benefit when:

- The client is THSteps-CCP eligible.
- Prescribed by a physician.
- Medically necessary.
- Completed by a Medicaid-enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians.
- Completed in the home or office.

Prior authorization is *not* required for two nutrition assessments per year or for four nutrition counseling visits per year. Providers are responsible for maintaining documentation to support medical necessity in the client's clinical record. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Prior authorization *is* required for more than two assessments or more than four nutrition counseling visits per year. Submit these requests with written documentation to support medical necessity. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

To request prior authorization or submit claims, providers must use the procedure code 1-S9470 with a maximum fee of $30.45 and procedure code 1-97802 or 1-97803 with a maximum fee of $10.15 per 15 minutes.

If 1-S9470 and either 1-97802 or 1-97803 are billed for the same date of service, 1-97802 or 1-97803 is paid and 1-S9470 is denied.

Physician Signature

The physician's signature, required on a prescription and the THSteps-CCP Prior Authorization Request Form, must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

43.4.5.4 Claims Information

Providers must submit services provided by licensed dietitians in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its equivalent.

Refer to: "Licensed Dietitians (THSteps-CCP Only)" on page D-20 for a claim form example.

"CMS-1500 Claim Filing Instructions" on page 5-24 for claims completion instructions.

43.4.6 Occupational Therapists (THSteps-CCP Only)

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary PDN services and/or home health skilled nursing services. Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the *Texas Nursing Practice Act* and its implementing regulations.
- The requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.
- There is no third-party resource financially responsible for the services.

Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the beneficiary's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.

Medically necessary nursing services are authorized either as PDN services or as home health skilled nursing services, depending on whether the beneficiary's nursing needs can be met on a per-visit basis.

43.4.6.1 Enrollment

HHSC allows Medicaid enrollment of independently practicing, currently licensed occupational therapists in THSteps-CCP. Some OT services are also available under Home Health Services.

The Texas Medicaid Program enrolls and reimburses occupational therapists only for CCP services and Medicare crossovers. The information in this section is applicable to CCP services only. This section does not apply to CORFs. CORF information is provided in "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/ Outpatient Rehabilitation Facilities (ORFs)" on page 43-37.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Occupational Therapy (OT) Services" on page 24-12.

43.4.6.2 Reimbursement

OT services provided by home health agencies are reimbursed according to a statewide visit rate calculated in accordance with 1 TAC §355.8021(a). The current statewide visit rate for OT services is $118.62 per visit. Procedural modifiers are required for home health agencies billing for OT visits. Providers must use procedural modifier GO for OT.

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OT services provided by outpatient hospitals are reimbursed based on a reasonable cost methodology in accordance with 1 TAC §355.8061, with an interim rate based on the provider's most recent Medicaid cost report settlement.

OT services provided by CORFs/ORFs are reimbursed based on a reasonable cost methodology in accordance with 1 TAC §355.8441, with an interim rate based on the provider's most recent Medicaid cost report settlement.

OT services provided by providers other than home health agencies and outpatient hospitals are reimbursed according to rates calculated in accordance to 1 TAC §355.8085. The current physician fee schedule is available on the TMHP website at www.tmhp.com.

The following CPT codes should be used for billing OT services under THSteps-CCP. Not all codes are payable to all provider types.

Procedure Codes			
1-97003	1-97004	1-97012	1-97014
1-97016	1-97018	1-97022	1-97024
1-97026	1-97028	1-97032	1-97033
1-97034	1-97035	1-97036	1-97039
1-97110	1-97112	1-97113	1-97116
1-97124	1-97139	1-97140	1-97150
1-97530	1-97535	1-97537	1-97542
1-97750	1-97760	1-97761	1-97762
1-97799			

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.6.3 Benefits and Limitations

THSteps-CCP is available for Medicaid THSteps-eligible children younger than 21 years of age. CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits.

OT may be billed as POS 1 or 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS as POS 9.

OT services are benefits under CCP when provided to clients who have disabilities or an ongoing health condition such as a musculoskeletal or neuromusculoskeletal condition, or other conditions requiring medically necessary OT. OT services are a benefit of Texas Medicaid Home Health Services when provided in the home for acute conditions. If the client is ineligible for these services through Texas Medicaid Home Health Services, these services may be provided under THSteps-CCP.

Procedure codes 1-97012, 1-97014, 1-97016, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one service per day. The procedure codes in the following table may be paid in multiple 15-minute quantities.

Procedure Codes			
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140	1-97530	1-97535	1-97537
1-97760	1-97761		

Procedure code 1-97760 is only payable for clients younger than 21 years of age. Procedure code 1-97010 is not a benefit.

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure codes 1-97750 and 1-97762 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit is denied as part of another procedure billed the same day. Procedure code 1-97762 is only payable for clients younger than 21 years of age.

Procedure code 1-97003 is payable once per six months for any provider at the same facility. Procedure code 1-97004 is payable once per month for any provider at the same facility. These codes are not payable on the same day as the procedure codes in the following table:

Procedure Codes			
1-97012	1-97014	1-97016	1-97018
1-97022	1-97024	1-97026	1-97028
1-97032	1-97033	1-97034	1-97035
1-97036	1-97039	1-97110	1-97112
1-97113	1-97116	1-97124	1-97139
1-97140	1-97150	1-97530	1-97750
1-97760	1-97761	1-97762	

Important: *OT prescribed primarily as an adjunct to psychotherapy is not a benefit.*

Providers must use the procedure codes 1-97003 with a maximum fee of $140.00, 1-97004 with a maximum fee of $140.00, or 1-97535 with a maximum fee of $35.00 for services provided by an independently practicing occupational therapist for developmental treatment. Procedure code 1-97003 may be billed without prior authorization. Procedure code 1-97535 may be billed only once per month per provider.

For procedure code 1-97003, a quantity of 1 is allowed for payment per six months per provider without prior authorization or written documentation of medical necessity. An evaluation is not paid on the same day as a treatment.

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A request for OT services may be prior authorized for no longer than six months duration. A new request must be submitted if therapy is required for a longer duration.

Typical sessions do not exceed one hour in length. Documentation supporting the need for longer sessions is required. No limits exist on the number of sessions that may be provided per week. The number of sessions per week must be supported by documentation showing that such sessions are medically necessary.

Refer to: "Occupational and Physical Therapy Services" on page 25-109 for acute conditions.

Prior Authorization, Documentation Requirements

Providers must use “Request for Initial Outpatient Therapy (Form TP-1)” on page B-78 for initial requests and “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” on page B-79 for extension requests. Home health agencies must include the GO modifier on the TP1 or TP2 form when requesting OT.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Prior authorization for OT services is required except for evaluation and re-evaluation. Submit appropriate documentation with the request for prior authorization or with each claim for consideration of reimbursement.

Children receiving therapy services reimbursed by CCP must have chronic conditions that require ongoing medical supervision. To establish medical necessity, a physician prescription and revised therapy treatment plan are needed at least every six months.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy request must include a TP-1 form and an initial therapy treatment plan. The initial therapy treatment plan must include the following:

- A physician prescription
- A copy of the current evaluation
- The documented age of the client at the time of the evaluation
- Documentation indicating the treatment goals, anticipated measurable progress toward goals, the prognosis, and the client’s fine motor skills in years/ months. Goals may include improving function, maintaining function, or slowing the deterioration of function

To request an extension of service, the following documentation must be submitted:

- A TP-2 form, including a *current* physician signature
- All documentation required in initial authorizations (except the TP-1 form)
- Documentation of all progress made from the beginning of the previous treatment period to the current service request date, including progress towards previous goals
- Information that supports the client’s capability of continued measurable progress
- A proposed treatment plan for the requested extension dates with specific goals related to client’s individual needs. Therapy goals may include improving function, maintaining function, or slowing of deterioration of function

Therapy may be extended *beyond two years*, but the following required documentation must be forwarded for authorization to be considered:

- A TP-2 form
- All documentation required in initial authorizations (except the TP-1 form)
- A comprehensive team evaluation summarizing all prior treatment as well as all progress that was made during that time
- A report from case managing physician indicating all progress that the client made toward all goals during all previous therapy sessions

If a provider discontinues therapy with a client and a new provider *begins* therapy during an existing authorization period, submission of a new treatment plan is required as well as documentation of the last therapy visit with the previous provider. A letter from the guardian stating the date therapy ended with the previous provider is sufficient.

Physician Signature

The physician’s signature, required on a prescription and the appropriate authorization request form, must be current to the service date(s) of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

ECI Program Provisions

Because the state ECI Program requires local ECI providers to follow quality assurance procedures and develop individualized family service plans for each child, CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. ECI providers should complete the ECI Request for Initial/Renewal Outpatient Therapy form, which must include a physician signature current for all dates of service. Prior authorization through CCP is encouraged to expedite claims processing, or the form may be submitted with the claim.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

43.4.6.4 Claims Information

Providers must submit claims for services provided by an independently practicing occupational therapist in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Important: *Attach the invoice to the claim for any specialized equipment.*

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Therapy is only reimbursed when provided in POS 1 (office) or 2 (home). Procedure code 1-97003 may only be billed with a quantity of 1. Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its electronic equivalent.

Refer to: "Occupational Therapists (THSteps-CCP Only)" on page D-24.

"CMS-1500 Claim Filing Instructions" on page 5-24 for claims completion instructions. Attach the invoice to the claim for any specialized equipment.

43.4.7 Orthotic and Prosthetic Suppliers (THSteps-CCP Only)

Medicaid beneficiaries younger than 21 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries younger than 21 years of age if medically necessary. Likewise, time periods for replacement of DME do not apply to Medicaid beneficiaries younger than 21 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item of quantity is medically necessary.

43.4.7.1 Enrollment

To be eligible to participate in THSteps-CCP, providers of orthotics and prosthetics services must be enrolled in Medicare.

The Texas Medicaid Program enrolls and reimburses orthotic and prosthetic suppliers only for CCP services and Medicare crossovers. The information in this section is applicable to CCP services only.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.7.2 Reimbursement

Orthotic and prosthetic services are reimbursed in the same manner as DME and expendable supplies, i.e., in accordance with 1 TAC §355.8441. Outpatient hospitals are reimbursed for THSteps DME and expendable supplies in accordance with 1 TAC §355.8061.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.7.3 Benefits and Limitations

Orthotics and prosthetics are a covered benefit of CCP for clients requiring orthotics or prosthetics that are medically necessary and prescribed by a physician (MD or DO). Orthotic devices, provided to ICF-MR clients and clients who reside in a nursing facility, are a benefit of THSteps-CCP. Payment is made directly to the vendor. The equipment belongs to the client or family. Non-orthotic devices, such as a knee immobilizer, are not a benefit to nursing facility residents and ICF-MR clients.

Orthoses must be dispensed, fabricated, and modified by an approved orthotist or orthotist/prosthetist. Prostheses must be dispensed, fabricated, and modified by an approved prosthetist or orthotist/prosthetist.

Prior Authorization, Documentation Requirements

All requests for prior authorization or claim reimbursement must:

- Be for orthotic or prosthetic devices prescribed by a physician (MD or DO) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot. The prescription is placed on file for a time period not to exceed 12 months. At the end of the prescription period, an authorization is required for any repairs, replacement parts, devices, or supplies.
- Contain a prescription dated before the date of service. The date of service must be within three months of the prescription date. The service is considered "provided" on the date the supplier has placed an order for the equipment and has incurred liability for the equipment.
- Include accurate diagnostic information pertaining to the orthotic/prosthetic device requested.
- Explain the medical necessity of the orthotic or prosthetic requested. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Be for orthotic devices provided by a currently licensed orthotist or prosthetist enrolled with Medicare and THSteps-CCP. *Exception*: upper extremity splints made with low temperature materials and inhibitive casting may be provided by occupational or physical therapists.
- Be for prosthetic devices provided by a currently licensed prosthetist or orthotist/prosthetist.

Requests for prior authorization must be filed using a THSteps-CCP Prior Authorization Request Form completed by the treating physician.

Telephone authorization is allowed for most orthotic devices. When authorization has not been requested, the documentation supporting medical necessity must be maintained in the client's medical record.

Requests for authorization and reimbursement of single items exceeding $1,500.00 allowable dollar amount must be supported by written documentation demonstrating medical necessity. All other items may be authorized during a telephone request.

The DOS for a custom-made or fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. For a recipient who has lost eligibility, custom-made orthotic devices may be reimbursed when the DOS occurred during a month the client was eligible for Medicaid.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

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43.4.7.4 Cranial Molding Devices

Cranial orthotic devices are molding helmets or bands that are used for the purpose of shaping the skull or to protect the skull and has proven to be most effective in children between the ages of 3 and 18 months of age.

Cranial orthosis (cranial molding devices) when used as a treatment of plagiocephaly without synostosis is considered cosmetic, not medically necessary, and not a benefit of the Texas Medicaid Program.

Cranial orthosis for nonsynostotic plagiocephaly may be considered for authorization with documentation supporting associated functional impairment and use of the cranial orthosis will modify or prevent the development of functional impairment including orofacial musculo-skeletal or neurocognitive disorders.

Cranial orthotic devices may be authorized for clients between the ages of 3 and 18 months of age.

Cranial orthotic devices must be prior authorized for reimbursement through THSteps-CCP with documentation supporting medical necessity/appropriateness. Written documentation must include:

- Client's diagnosis and age
- The recommendations of the craniofacial team (the team must include a pediatric neurosurgeon or cranio-facial surgeon) or pediatric neurosurgeon
- The determining factors used in recommendation of treatment
- Any alternative treatment courses that have been tried
- Plan of treatment and/or follow up schedule

Cranial orthotic devices may be reimbursed using procedure codes 9-L0100, 9-L0110, and 9-S1040.

Craniostenosis Helmets

Procedure codes 9-L0100 and 9-L0110 require prior authorization and may be considered for reimbursement for neoplasm of the brain, subarachnoid hemorrhage, epilepsy, or cerebral palsy.

All requests for diagnoses other than those listed above or for clients younger than 4 months of age or older than 18 months of age require submission of documentation of medical necessity. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

43.4.7.5 Corrective Shoe, Wedge, and Lift

THSteps-CCP may authorize and reimburse prescription shoes (corrective/orthopedic), wedges, and lifts. The authorization request and reimbursement must meet the following requirements:

Corrective Shoes

For consideration of coverage, corrective shoes must be prescribed by a licensed physician (MD or DO) or a podia-trist *and* meet one of the following requirements:

- Permanently attached to a brace
- Custom modified by an orthotist or orthotist/prosthetist at the direction of the prescribing physician
- Necessary to hold a surgical correction, postoperative casting, or serial/clubfoot casting. The corrective shoe may be authorized up to one year post procedure

Note: *Corrective shoes that are not attached to a brace require authorization.*

Requests for corrective shoes that do not meet the criteria listed above may be submitted with the appropriate documentation to medical review for consideration.

A corrective shoe does *not* include tennis shoes (even if prescribed by a physician and worn with a removable brace).

A corrective shoe does *not* include a shoe insert when it is not part of a modified shoe or when the shoe in which it is inserted is not attached to a brace (other than procedure code 9-L3000).

Only one pair of corrective shoes can be authorized every three months. Two pairs of shoes may be purchased at the same time; however, in such situations additional requests for shoes are not considered for another six months.

Requests for corrective shoes that do not meet the criteria listed above may be submitted with the appropriate documentation to medical review for consideration.

Authorization requests for corrective shoes *must* be submitted in writing.

Wedge and Lift

This must be for unequal leg length greater than one-half inch. Reimbursement may include the cost of the prescription shoe.

Dynamic Splint

Dynamic splints, such as Dynasplint® , may be authorized by the Medical Director when submitted with the following documentation supporting medical necessity:

- Client's condition
- Client's current course of therapy
- Rationale for the use of the dynamic splint
- Likelihood that the family and client will comply with the prescribed use of the dynamic splint

Removable Shoe Insert, UCB (University of California at Berkeley) Type

Shoe inserts are not a benefit when they are not part of a modified shoe or when the shoe in which they are inserted is not attached to a brace, with the exception of the UCB removable shoe insert.

A UCB removable shoe insert may be prior authorized and reimbursed when the service meets the following:

- Client is at least 5 years of age
- Client has a valgus deformity and significant congenital pes planus (75461) with pain, *or*
- Client has a structural problem which results in signif-icant pes planus, such as Down's syndrome, *or*
- Client has acute plantar fasciitis

Procedure code 9-L3000 may be payable when billing for a removable foot insert.

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Reciprocating Gait Orthoses (RGO)

RGO may be covered for children with spina bifida or similar functional disabilities. Prior authorization is required. The prior authorization request must include a statement from the prescribing physician indicating the medical necessity, PT plan, and information that the family is expected to comply with the treatment plan.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Repairs, Modifications, and Fittings of Orthosis/ Prostheses

Repairs due to regular wear and modifications due to growth or change in medical status are a benefit when proven more cost-effective than replacing the device. Additional information from the provider may be requested to determine cost-effectiveness.

Authorization is required for repairs, modifications, and fittings. Documentation supporting medical necessity must be provided when requesting authorization.

Reimbursement of fittings is considered included in the regular reimbursement fee except in situations such as parapodiums, where time spent at fitting may be extensive. Fitting for parapodiums must be authorized.

For repairs, modifications, and fittings to an orthosis, providers must bill using procedure codes 9-E1340, 9-L4205, and 9-L4210.

Replacement of Orthoses/Prostheses

Replacement of an orthotic/prosthetic device is considered when loss or irreparable damage has occurred. A copy of the police or fire report is required when appropriate, along with the measures to be taken to prevent recurrence of similar loss. Supporting medical documentation is required for the replacement of an orthotic or prosthetic device if less than six months from the actual date the client received the device. If less than one year since initial purchase, request for replacement is referred to the medical director for review.

Training in Using the Orthotic or Prosthetic Device

Training in the use of an orthotic or prosthetic device for a client who has not worn one previously, has not worn one for a prolonged period, or is receiving a different type may be reimbursed when the training is provided by a physical or occupational therapist.

If prior authorization is not requested, submit documentation to support medical necessity with each claim and include a prescription signed by a physician (MD or DO).

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Prior authorization is a condition for reimbursement, not a guarantee of payment.

Physician Signature

The physician's signature is required on a prescription and the THSteps-CCP Prior Authorization Request Form must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

43.4.7.6 Claims Information

Submit services provided by orthotic and prosthetic suppliers in an approved electronic format or on a CMS-1500 claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: "CMS-1500 Instruction Table" on page 5-27 for claims completion instructions and information on electronic billing.

Important: *Attach the invoice to the claim for any specialized equipment.*

Include the name of the referring physician in Block 17 of CMS-1500 claim form or its electronic equivalent. Orthotics or prosthetics may be billed in POS 1 (office), 2 (home), or 5 (outpatient). Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its electronic equivalent.

Refer to: "Orthotic and Prosthetic Suppliers (THSteps-CCP Only)" on page D-25 for a claim form example.

43.4.8 Pharmacies (THSteps-CCP Only)

43.4.8.1 Enrollment

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

Pharmacy providers currently enrolled with VDP are also enrolled in THSteps-CCP with TMHP. This enrollment allows pharmacy providers to bill for those medications and supplies payable by Medicaid for clients younger than 21 years of age but *not* covered by VDP (e.g., some over-the-counter drugs, diapers, and disposable or expendable medical supplies). Pharmacy providers must continue to bill HHSC for drugs covered under VDP.

Direct questions about VDP to 1-800-435-4165.

Pharmacies that wish to supply disposable or expendable medical supplies or DME must be enrolled as DMEH providers and should obtain these items through the Home Health Services Unit.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Texas Medicaid (Title XIX) Home Health Services" on page 24-1 for details about coverage through Home Health Services.

43.4.8.2 Reimbursement

Providers of DME and expendable supplies are reimbursed for THSteps services in accordance with 1 TAC §355.8441. Outpatient hospitals are reimbursed for THSteps DME and expendable supplies in accordance with 1 TAC §355.8061.

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Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.8.3 Eligibility

Providers must issue one month's supply of the required items at a time because client eligibility is determined monthly.

43.4.8.4 Benefits and Limitations

Expendable medical supplies and basic medical equipment are available under Texas Medicaid Home Health Services. Some services may be provided under THSteps-CCP. Clients must be younger than 21 years of age and eligible for THSteps-CCP; the services must be medically necessary and have FFP available for them. CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits.

Physician Signature

The physician's signature, required on a prescription and the appropriate request form, must be current to the service date of the request.

Physician prescriptions must be specific to the type of service requested.

Example: *If requesting incontinent supplies, the prescription must request incontinent supplies, not just supplies.*

Examples of expendable supplies include incontinent supplies and medical nutritional products for clients younger than 21 years of age.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

Incontinence Supplies for Children Younger Than 4 Years of Age

Incontinence supplies for children younger than 4 years of age are only available through THSteps-CCP.

Written prior authorization is required for diapers and all other related incontinence supplies (such as diaper wipes and underpads) for children younger than 4 years of age. Providers must use the appropriate national procedure codes when billing for incontinent supplies for children younger than 4 years of age.

Supplies that any guardian or caretaker would usually provide during the routine care of the child are *not* covered under CCP. Examples are:

- Nutritional products traditionally used for infant feeding
- Incontinence supplies, such as diapers (Diapers are considered usual for children younger than 4 years of age. An exception may be made by written request for prior authorization based on specific medical criteria.)
- Lotions, soaps, powder, or aids for daily living

Claims may be reduced because the *customary* limits have been exceeded. Providers may submit a prior authorization request for amounts over the *customary* limits if there is documentation that supports the medical necessity of such a request. If prior authorization is not given, the provider may appeal the claim.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Medications, Vitamins, and Minerals

VDP reimburses for a large number of prescription and over-the-counter medications. See "Vendor Drug Program" on page E-1 for more information about VDP. Some prescription medications that are not payable through VDP may be paid to enrolled pharmacy providers through CCP if the medications are determined to be medically necessary.

Not all medications covered by CCP require prior authorization. For those medications that require prior authorization, submit complete documentation with each prior authorization request, including:

- A prescription by the physician, including the name of the medication, dosage, frequency, duration, and route of administration
- Documentation and diagnosis that supports the medical necessity of the requested medications

Providers must use the appropriate national procedure code when billing for medications and vitamins through CCP.

43.4.8.5 Claims Information

Pharmacy providers are not required to provide a diagnosis on the claim form.

Providers must submit claims for billing for supplies and equipment supplied to the client by the pharmacy on a CMS-1500 claim form (obtained from a vendor of their choice or billed electronically).

Claims for services that have been prior authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its equivalent.

Pharmacies using their VDP provider identifier should obtain prior authorization for prescription medications not paid through VDP. If a claim is submitted without a diagnosis, then a provider must attach documentation establishing medical necessity and a signed prescription from a physician (MD or DO). Electronic claims must have diagnosis code V7285 for the claim to be accepted.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Triplicate Prescription Form

The State Pharmacy Board requires the use of the triplicate prescription form for Schedule II controlled substances. The pharmacy filling the prescription sends a

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copy of the form to the Texas Department of Public Safety. Completion of the form is not substantially different from writing a prescription.

Incidental Services

Medicaid payments to providers for covered services include incidental services such as completion of required forms. Because completion of the triplicate prescription form as required by the State Pharmacy Board is a requirement of doing business, it is not acceptable to charge Medicaid clients a fee for completing the form. Providers that charge Medicaid clients this fee are violating provisions of Medicaid regulations and are subject to administrative sanctions or actions.

Refer to: “Pharmacy (THSteps-CCP Only)” on page D-25 for a claim form example.

"CMS-1500 Instruction Table" on page 5-27 for claims completion instructions. Attach the invoice for any specialized equipment to the claim.

43.4.9 Physical Therapists (THSteps-CCP Only)

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary PDN services and/or home health skilled nursing services. Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the *Texas Nursing Practice Act* and its implementing regulations.
- The requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.
- There is no third-party resource financially responsible for the services.

Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the beneficiary's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.

Medically necessary nursing services are authorized either as PDN services or as home health skilled nursing services, depending on whether the beneficiary's nursing needs can be met on a per-visit basis.

43.4.9.1 Enrollment

HHSC allows enrollment of independently-practicing licensed physical therapists under THSteps-CCP.

The information in this section applies to CCP services only. This section does not apply to CORFs. CORF information may be found in "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)" on page 43-37.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Physical Therapists/Independent Practitioners" on page 35-1 for acute services.

43.4.9.2 Reimbursement

PT services provided by home health agencies are reimbursed according to a statewide visit rate calculated in accordance with 1 TAC §355.8021(a). The current statewide visit rate for PT services is $116.36 per visit. Procedural modifiers are required for home health agencies billing for PT visits. Providers must use procedural modifier GP for PT.

PT services provided by outpatient hospitals are reimbursed based on a reasonable cost methodology in accordance with 1 TAC §355.8061, with an interim rate based on the provider’s most recent Medicaid cost report settlement.

PT services provided by CORFs/ORFs are reimbursed based on a reasonable cost methodology in accordance with 1 TAC §355.8441, with an interim rate based on the provider’s most recent Medicaid cost report settlement.

PT services provided by providers other than home health agencies and outpatient hospitals are reimbursed according to rates published in a fee schedule. The current physician fee schedule is available on the TMHP website at www.tmhp.com.

The following CPT codes should be used for billing PT services under THSteps-CCP. Not all codes are payable to all provider types.

CPT Procedure Codes			
1-97001	1-97002	1-97012	1-97014
1-97016	1-97018	1-97022	1-97024
1-97026	1-97028	1-97032	1-97033
1-97034	1-97035	1-97036	1-97039
1-97110	1-97112	1-97113	1-97116
1-97139	1-97150	1-97530	1-97535
1-97537	1-97542	1-97750	1-97760
1-97761	1-97762	1-97799	

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.9.3 Benefits and Limitations

CCP is for Medicaid/THSteps-eligible clients younger than 21 years of age. CCP eligibility ends on the day of the client’s 21st birthday. If the client’s Medicaid ID states “Emergency Care,” “PE,” or “QMB,” the client is not

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eligible for THSteps or CCP benefits. If the client is ineligible for Texas Medicaid Home Health Services, these services may be provided under THSteps-CCP.

PT may be billed as POS 1 or 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS as POS 9.

A request for PT services may be prior authorized for no longer than six months duration. A new request must be submitted if therapy is required for a longer duration.

Typical sessions do not exceed one hour in length. Documentation supporting the need for longer sessions is required. No limitations exist to the number of sessions that may be provided per week; however, documentation supporting the medical necessity for the requested services is required.

Providers must use the procedure codes 1-97001 with a maximum fee of $140.00, 1-97002 with a maximum fee of $140.00, and 1-97535 with a maximum fee of $35.00 for services provided by an independently practicing physical therapist for developmental therapies. Procedure code 1-97001 may be billed without prior authorization. Only a quantity of 1 is allowed for payment per six months per provider without prior authorization or written documentation of medical necessity. An evaluation should not be billed on the same day as a treatment. Procedure code 1-97002 may only be billed once per month per provider.

Prior Authorization, Documentation Requirements

Providers must use the “Request for Initial Outpatient Therapy (Form TP-1)” on page B-78 for an initial request and the “Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)” on page B-79 for an extension request. Home health agencies must include the GP modifier on the TP1 or TP2 form when requesting PT.

Prior authorization is a condition for reimbursement; it is *not* a guarantee of payment.

Prior authorization for PT services is required except for evaluation and re-evaluation. Submit appropriate documentation with the request for prior authorization or with each claim for consideration of reimbursement.

Children receiving therapy services reimbursed by CCP have chronic conditions that require ongoing medical supervision. To establish medical necessity, a physician prescription and revised therapy treatment plan are needed at least every six months.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy treatment plan must include a TP-1 and the following:

- A physician prescription.
- A copy of the current evaluation.
- The documented age of the client at the time of the evaluation.
- Documentation indicating the treatment goals, anticipated measurable progress toward goals, the prognosis, and the client’s gross motor skills in years/months. Goals may include improving function, maintaining function, or slowing the deterioration of function.
- Description of specific therapy being prescribed.

To request an *extension of services*, the following documentation must be submitted:

- A TP-2 form, including a *current* physician signature.
- All documentation required in initial authorizations (except the TP-1 form).
- Documentation of all progress made from the beginning of the previous treatment period to the current service request date, including progress towards previous goals.
- Information that supports the client’s capability of continued measurable progress.
- A proposed treatment plan for the requested extension dates with specific goals related to the client’s individual needs. Therapy goals may include improving function, maintaining function, or slowing the deterioration of function.

Therapy may be extended beyond two years, but the following required documentation must be forwarded for review for authorization to be considered:

- All documentation required in initial authorizations (except the TP-1 form).
- A comprehensive team evaluation summarizing all prior treatment as well as all progress that was made during that time.
- A report from the case-managing physician indicating all progress that the client made toward all goals during all previous therapy sessions.

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new treatment plan is required, as well as documentation of the last therapy visit with the previous provider. A letter stating when therapy ended with the previous provider is sufficient.

Physician Signature

The physician’s signature, required on a prescription and the “THSteps-CCP Prior Authorization Request Form” on page B-106, must be current to the service date of the request.

Physician prescriptions must be specific to the TOS requested.

Example: *If requesting PT, the prescription must request physical therapy, not just therapy.*

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ECI Program Provisions

Because the state ECI program requires local ECI providers to follow quality assurance procedures and develop individualized family service plans for each child, CCP does not require copies of therapy evaluations or periodic progress notes to be submitted with therapy claims. ECI providers should complete the "THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy" on page B-108, which must include a physician signature current for all dates of service. Physician prescriptions requirements as stated on the form must be followed by ECI providers. (Refer to CCP-PT, OT, and SLP sections.) Prior authorization through the CCP is encouraged to expedite claims processing or the form may be submitted with the claim.

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

All providers should obtain the client's medical diagnosis supporting the need for therapy from the physician. Reflect this information on each claim submitted to TMHP using ICD-9-CM coding.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

"Request for Initial Outpatient Therapy (Form TP-1)" on page B-78.

43.4.9.4 Claims Information

Providers must submit claims for services provided by independently practicing licensed physical therapists in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Refer to: "CMS-1500 Instruction Table" on page 5-27 for claims completion instructions.

Important: *Attach the invoice to the claim for any specialized equipment.*

Therapy is only payable when provided in POS 1 (office) or 2 (home). Procedure codes 1-97001, 1-97110, 1-97150, and 1-97535 may only be billed with a quantity of 1. Claims for services that have been authorized must reflect the PAN in Block 23 of the CMS-1500 Claim Form or its electronic equivalent.

Refer to: "Physical Therapists (THSteps-CCP Only)" on page D-26.

43.4.10 Private Duty Nursing (PDN) THSteps-CCP Only

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary PDN services and/or home health skilled nursing services. Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the *Texas Nursing Practice Act* and its implementing regulations.
- The requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition when the services improve, maintain, or slow the deterioration of the beneficiary's heath status.
- There is no third-party resource financially responsible for the services.

Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the beneficiary's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.

Medically necessary nursing services are authorized either as PDN services or as home health skilled nursing services, depending on whether the beneficiary's nursing needs can be met on a per-visit basis.

"Parent/guardian" means the person or persons lawfully charged with the duty of taking care of the beneficiary, and includes biological parents, adoptive parents, foster parents, guardians, and individuals court-appointed as managing conservators. A parent/guardian provides daily, uncompensated care for the beneficiary and participates in the development of the beneficiary's plan of care (POC). A parent/guardian or any person living with the beneficiary is not eligible for Medicaid reimbursement for providing PDN services to the beneficiary.

43.4.10.1 Enrollment

Licensed and certified home health services agencies may enroll to provide PDN under THSteps-CCP.

RNs and licensed vocational nurses (LVN) may also enroll independently to provide PDN under THSteps-CCP.

Home health agencies *must do all of the following*:

- Comply with provider participation requirements for home health agencies that participate in the Texas Medicaid Program
- Comply with mandatory reporting of suspected abuse and neglect of children or adults
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent/guardian
- Comply with all requirements in this manual and the *Texas Medicaid Bulletin*

Independently-enrolled RNs and LVNs must be enrolled as providers in THSteps-CCP and comply with all of the following:

- The terms of the Texas Medicaid Provider Agreement

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- All state and federal regulations and rules relating to the Texas Medicaid Program
- The requirements of this manual, including all updates and revisions published in the *Texas Medicaid Bulletin*, all handbooks, standards, and guidelines published by HHSC.

Independently-enrolled RNs and LVNs must also:

- Provide at least 30-days written notice to clients of their intent voluntarily to terminate services except in situations of potential threat to the nurse's personal safety.
- Comply with mandatory reporting of suspected abuse and neglect of children.
- Maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the parent/guardian.

Independently enrolled RNs must:

- Hold a current license from the Board of Nurse Examiners for the State of Texas to practice as an RN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the *Texas Nursing Practice Act.*
- Comply with accepted professional standards and principles of nursing practice.

Independently enrolled LVNs must:

- Hold a current license from the Board of Nurse Examiners of the State of Texas to practice as an LVN.
- Agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including the *Texas Nursing Practice Act.*
- Comply with accepted standards and principles of vocational nursing practice.
- Be supervised by an RN monthly. The supervision must occur when the LVN is present and be documented in the client's medical record.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.10.2 Reimbursement

PDN services are reimbursed according to a maximum allowable fee schedule in accordance with 1 TAC §355.8441. Home health agencies must submit claims on the HCFA-1450 (UB-92) claim form. Independently-enrolled nurses must submit claims on the CMS-1500 claim form.

PDN services must be billed in 15-minute increments. To be reimbursed for PDN services, providers must use the following procedure codes:

Procedure Code	Maximum Fee
1-T1000 *with* modifier TD	$6.25 per 15 minutes
1-T1000 *with* modifier TE	$5.00 per 15 minutes
C-T1002 *or* C-T1003	$8.25 per 15 minutes

Note: *Independently enrolled LVNs should use the TE modifier, and independently enrolled RNs should use the TD modifier.*

Important: *Currently, electronic HCFA-1450 (UB-92) does not accommodate billing for partial PDN hours. Paper claims must be used to bill partial PDN hours.*

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day should be billed together, on one detail, even if they involve two shifts. For example, if Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m., services should be billed for eight hours (32 15-minute units) on one detail for that date of service.
- An individually-enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.
- A single nurse may be reimbursed for services to more than one client in a single setting when the following conditions are met:
  - Hours for PDN services for each client have been authorized through CCP.
  - Only the actual "hands-on" time spent with each client is billed for that client.
  - The hours billed for each client does not exceed the total hours approved for that client and does not exceed the actual number of hours for which services were provided.

Example: *If the authorized PDN hours for Client A is four hours and Client B is six hours and the actual time spent with both clients is eight hours, the provider must bill for the actual "one-on-one" time spent with each client, not to exceed the client's authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the nurse actually spent ten hours onsite providing authorized PDN services split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the nurse worked only eight hours.*

Refer to: "Reimbursement" on page 43-7 for more information about reimbursement.

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Benefits and Limitations

PDN is skilled nursing reimbursed hourly for clients who meet the THSteps-CCP medical necessity criteria and who require individualized, continuous skilled care beyond the level of skilled nursing visits authorized under the Texas Medicaid Home Health Services.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The purpose of PDN is to provide direct, skilled nursing care and caregiver training and education intended to optimize client health status and outcomes, and to promote family-centered, community-based care.

PDN is one of an array of services intended to support the care of the client living at home; and the parent/guardian remains responsible for a portion of a client's daily care. PDN shall neither replace parents or guardians as primary caregivers nor provide all the care that a client requires to live at home.

PDN cannot be authorized for the primary purpose of providing respite care, childcare, activities of daily living for the client, housekeeping services, or comprehensive case management beyond the service coordination required by the *Texas Nursing Practice Act*.

43.4.10.3 Criteria

Client Eligibility Criteria

To be eligible for PDN services, a client must meet *all* the following criteria:

- Be younger than 21 years of age and eligible for Medicaid and THSteps

Note: *THSteps-CCP is available for Medicaid THSteps-eligible children younger than 21 years of age. CCP eligibility ends on the day of the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits.*

- Meet medical necessity criteria for PDN
- Have a primary physician who:
  - Provides a prescription for PDN.
  - Establishes a plan of care (POC).
  - Provides a statement that PDN services are medically necessary.
  - Provides continuing medical care and supervision of the client including, but not limited to, examination or treatment within 30 days (*initial requests of PDN services*) or examination or treatment that complies with the THSteps periodicity schedule or is within 6 months of the PDN extension start-of-care date, whichever is more frequent (*for extensions of PDN services*). This requirement may be waived based on review of the client's specific circumstances.
  - Provides specific written, dated orders for the client.
- Require care beyond the level of services provided under Texas Medicaid Home Health Services.
- Have an identified parent/guardian residing in the client's residence and an identified alternate caregiver who is or can be trained to provide part of the client's care; or if no alternate caregiver is identified, have a plan to enable the client to receive care in an alternate setting or situation if the parent/guardian is unable to fulfill their role.

Retroactive Client Eligibility

Retroactive eligibility occurs when an individual has applied for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of service delivery.

To be reimbursed for any current services after the client's eligibility is on TMHP's eligibility file, a provider must obtain authorization from TMHP-CCP within three business days of the date eligibility is added to the TMHP system. This date is called the "add date." The request must be received by TMHP-CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days.

The provider is responsible for verifying eligibility. The provider is strongly recommended to access AIS or TMHP EDI frequently while providing services to the client. If services were discontinued before the client was added to TMHP's eligibility file, the agency must still obtain authorization within three business days and submit all claims within 95 days from the add date.

Medical Necessity Criteria

PDN is considered medically necessary if a person requires continuous, skillful observation and judgment to maintain or improve health status, *and* the individual:

- Is dependent on technology to sustain life, and/or
- Requires ongoing and frequent skilled interventions to maintain or improve health status, and delayed skilled intervention is expected to result in any of the following conditions:
  - Deterioration of a chronic condition
  - Loss of function
  - Imminent risk to health status
  - Risk of death

The determination of medical necessity for PDN services is based on submitted documentation that describes the complexity and intensity of the client's care, stability and predictability of the client's condition, and frequency of the client's need for skilled nursing interventions.

Place of Service (POS)

PDN authorizations are based on the need for skilled care in the client's home; however, these services may follow the child and may be provided in any of the following settings:

- The home of the primary or alternate caregiver
- The home of the nurse provider
- The client's school

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- A daycare facility

The POS must be able to support the client's health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

Amount and Duration of PDN Services

The amount and duration of PDN services are determined based on review of submitted documentation for the following:

- Frequency of skilled nursing interventions
- Complexity and intensity of the client's care
- Stability and predictability of the client's condition
- Identified problems, goals, and progress toward goals

The amount and duration of PDN should decrease when:

- One or more of the client's problems documented in the POC are resolved.
- One or more identified client goals are met.
- A reduction in the frequency of skilled nursing interventions occurs.
- A decrease in the complexity and intensity of the client's care occurs.
- Alternate resources for comparable care become available.

For some clients who continue to meet the criteria for medical necessity, PDN services may decrease to and remain at a plateau. PDN may continue to be authorized after the parent/guardian is trained and capable of meeting the client's need.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The amount of PDN services may increase when the client's condition warrants more nursing intervention due to the identification of new problems or goals, an increase in frequency of skilled nursing interventions, or an increase in the complexity and intensity of the client's care.

A full 24-hours-per-day PDN is authorized for limited periods of time with defined end dates only when one of the following conditions exist:

- When medically necessary based on the client's needs
- When related to the medical needs of the parent/guardian, only when an alternate caregiver is not available
- In the absence of both the primary and alternate caregiver, when another person is designated who can legally make decisions on the client's behalf, and who will reside in the client's home during the time that 24-hours-a-day PDN will be provided

43.4.10.4 Authorization

Authorization Requirements

When a provider receives a referral for PDN services, the provider must assess the client before seeking authorization. The assessment must be completed by an RN. An assessment includes, but is not limited to, the following:

- Nursing assessment
- Assessment of medical necessity for PDN (a request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply)
- Client safety
- Medical necessity of care in the POS
- Training and ability of the parent/guardian
- All criteria for the authorization of PDN services

Note: *TMHP will not review or authorize PDN services based on partial or incomplete documentation.*

The following criteria *must* be met before seeking authorization for PDN services. The provider and the parent/guardian establish that the client has:

- A designated parent/guardian who will provide a portion of the client's daily care
- An identified alternate caregiver, or a plan to be used if the parent/guardian is unable to care for the client
- A primary care physician who provides ongoing health care and medical supervision
- Verification that the client has been seen by the primary physician within 30 days of the start of care date for initial requests or according to THSteps guidelines or within six months (extension requests)
- A place where PDN services will be delivered that supports the client's health and safety
- Appropriate emergency plans in place
- Necessary backup utilities, communication, fire, and safety systems available

Following the assessment/evaluation of the client for PDN services, the provider must seek prior authorization from TMHP. Prior authorization is required for payment of PDN services. Nursing services are prior authorized when the requested services correct or ameliorate the client's disability or physical or mental illness or condition. PDN services are prior authorized when the client requires more individual and continuous care than is available on a per-visit basis through home-health skilled nursing visits. Prior authorization is a condition for reimbursement, not a guarantee of payment.

Only those services that TMHP determines to meet the medical criteria for PDN are reimbursed. Before a TMHP reviewer determines that the requested nursing services do not meet the criteria, the TMHP medical director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN services. If the TMHP medical director is not successful in contacting the treating physician or cannot

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obtain additional information or clarification, the TMHP medical director makes a decision based on the available information.

Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client's physician, and the provider, and as listed on the POC and the THSteps-CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN services, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client's family on receipt of an authorization, a denial, or a change in PDN services.

Providers must submit complete documentation no later than three business days from an SOC date to obtain initial coverage for the SOC date.

Note: *The Texas Medicaid Home Health Services does not authorize a SOC date earlier than three business days before contact with TMHP.*

For PDN extensions, TMHP-CCP must receive complete documentation 3 business days prior to the start of care date. It is recommended that extension requests be submitted up to 30 days before the current authorization ends.

During the authorization process for initial and extension requests, providers are required to deliver the requested services from the SOC date.

Authorization of Initial Requests

Completed initial requests must be received and dated by TMHP-CCP within three business days of the SOC. The request must be received by TMHP-CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Example: *A provider begins PDN services on Monday, June 1. The completed request is received by TMHP-CCP on Friday, June 5. The authorization will start on Tuesday, June 2 (three business days before June 5). If the complete request had been received on Thursday, June 4, the authorization would have started on June 1, as requested.*

Authorization for Revision of Current Services

Completed requests for revision of PDN hours during the current authorization period must be received by TMHP-CCP within three business days of the revised SOC. The request must be received by TMHP-CCP no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to TMHP.

Example: *A provider begins PDN services on Monday, June 1. The client becomes ill on Friday, June 5, and requires increased skilled nursing intervention of a short duration. The completed revision request is received by TMHP-CCP on Thursday, June 11. The authorization will start on Monday, June 8 (three business days before June 11). If the complete request had been received on Wednesday, June 10, the revision authorization would have started on June 5, as requested.*

Authorization of Extension Requests

Completed extension requests must be received and dated by TMHP-CCP at least 7 calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by TMHP-CCP no later than 5 p.m., Central Time, on the seventh day, to be considered received within 7 calendar days. If a request is received less than 7 calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than 7 calendar days after the receipt of the completed request by TMHP-CCP.

Example: *A provider has a current authorization that expires on June 10. The completed request is received by TMHP-CCP on June 2, eight calendar days before the current authorization period ends. The authorization for extension will begin on June 11, as requested. If the completed request had been received on June 15, the authorization could not begin until June 12, instead of June 11, as requested.*

Initial and revision requests for PDN generally are considered for up to 60 days of services. Extensions may be considered for longer periods based on submitted documentation and the stability of the client's condition.

Extended Authorizations Available

TMHP-CCP accepts requests for extended authorizations for PDN. Extensions may be authorized for four or six months. The following criteria are required for extended authorization:

- The client must have received PDN services for at least a year.
- The client's condition has been medically stable for at least six months.
- PDN requests *and* authorizations for the previous six months have been at the same level.
- No significant changes in the client's condition are anticipated.
- The client's parent/guardian, physician, and provider agree that an extended authorization is appropriate.

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The authorization process involves the following:

- All required documentation for PDN services (including the Physician POC, the Nursing Care Addendum, and the THSteps-CCP Prior Authorization Request Form) is submitted.
- Dates of service on the THSteps-CCP Prior Authorization Request Form covers four or six months as appropriate.
- Attach the new THSteps-CCP Prior Authorization Form, Private Duty Nursing 4 or 6 Month Authorization Form (refer to "THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization" on page B-107). This form must be complete and include all required information and signatures.
- The nursing care provider is responsible for ensuring that a new Physician POC is obtained every 60 days and maintained in the client's record. Providers should *not* submit interim POCs to TMHP unless requesting a revision.
- The nursing care provider should notify TMHP at any time during the authorization period if the client's condition and need for skilled nursing care significantly changes.
- The nursing care provider may request a revision from TMHP at any time during the authorization period if the client's condition requires it.
- All authorization timelines apply to extended authorizations also.

Termination of Authorization

Authorization may be terminated when the:

- Client is no longer eligible for THSteps-CCP.
- Client no longer meets the criteria for PDN.
- Place of service can no longer accommodate the client's health and safety.
- Client or caregiver refuses to comply with the primary physician's POC.

Client/Provider Notification

When PDN services are approved as requested, the provider receives written notification. The provider is responsible for notifying the client/family and the physician of the authorized services.

TMHP notifies the client and provider in writing when the following instances occur:

- PDN services are denied.
- PDN hours authorized are less than the hours requested on the POC.
- PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
- TMHP-CCP receives incomplete information from the provider.
- Dates of service authorized are different from those requested.

The provider is responsible for notification and coordination with the physician and family.

Authorization Appeals

Providers may appeal denials/modifications of requested PDN services with documentation to support the medical necessity of the requested PDN services. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply. Appeals must be submitted to TMHP-CCP with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, TMHP-CCP goes back no more than three business days for initial or revision requests and no more than seven calendar days for extension requests when additional documentation is submitted. Clients/families are notified of any denial or modification of requested services and are given information about how to appeal TMHP's decision.

43.4.10.5 Documentation

Documentation Details

Documentation forms have been designed to improve communication between providers and TMHP. The forms are available in English.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at TMHP-CCP by 3 p.m., Central Time, a response is returned to the provider within one business day. Complete documentation for initial, revision, and extension requests for PDN authorizations include all the following:

- The new "THSteps-CCP Prior Authorization Request Form" on page B-106
- The physician's POC
- The "Nursing Addendum to Plan of Care (THSteps-CCP) (3 Pages)" on page B-59

THSteps-CCP Prior Authorization Request Form

The Prior Authorization Request Form must be completed, signed, and dated by the physician. The physician must mark the Private Duty Nursing box documenting the stability of the client for PDN services. All requested dates of service must be included.

Plan of Care (POC)

The POC must be recommended, signed, and dated by the client's primary care provider. A POC must meet the standards outlined in the 42 CFR 484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the parent/guardian, for each authorization, or more frequently as the physician deems necessary or the client's situation changes.

Pursuant to 42 CFR 484.18, the POC must include the following elements:

- All pertinent diagnoses
- Client's mental status
- Types of services requested including amount, duration, and frequency

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- Medical equipment needed
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medications
- Treatments, including amount and frequency
- Safety measures needed
- Instructions for a timely discharge from service, if appropriate
- Date the client was last seen by the physician
- Other medical orders
- Start and end-of-care dates

Note: *Coverage periods do not coincide necessarily with calendar weeks or months but, instead, cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period. A week covers from the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week.*

Nursing Addendum to POC–CCP Private Duty Nursing Form

The Nursing Addendum addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN services requested.

The following is a description of the nursing care plan summary:

- The nursing care summary is not a complete nursing care plan.
- Information must be client-focused and detailed.
- The *Problem List* must reflect the reasons that skilled nursing services are needed. The problem list is not the nursing care plan. Providers should identify two to four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed should focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents are not accepted in lieu of this section.
- The *Goals* should relate directly to the problems listed and be client-specific, and measurable. Goals may be short- or long-term; however, for many clients who receive PDN services, the goals generally are long-term.
- The *Outcomes* are the effects of the provider's nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.
- The *Progress* should be viewed as a "yardstick" or continuum on which progress toward goals is marked. Initial requests should state expected progress for the authorization period. Extension requests should list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.
- The addendum must summarize the client's health problems that relate to the medical necessity for PDN services.
- The addendum must clearly communicate a picture of the client's overall condition and skilled care needs.
- The summary of recent health history is imperative in determining whether the client's condition is stable or if new skilled care needs have been identified. This section gives the PDN provider an opportunity to describe the client's recent health problems, including acute episodes of illness, hospitalizations, injuries, etc. The summary should create a complete picture of the client's condition and skilled care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client's recent health problems and current health priorities. This section should not be merely a list of events.

  This section is the place to indicate the frequency of nursing interventions if they are different from the physician's order on the POC, such as, the order may be for a procedure to be PRN (when necessary), but it is actually being performed every two hours.
- The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN services and must relate to the client's health problems and goals.
- The addendum must include the provider's plan to decrease hours or discharge from service (if appropriate).

The Client's 24-hour Daily Schedule

All direct care services must be identified. It is understood that the schedule may change, as the client's needs change. TMHP does not have to be notified of changes in the schedule except as they occur when a PDN extension is requested.

Requirement That an Alternate Caregiver be Identified

This requirement is necessary for the client's safety and well-being. If a single parent/caregiver who is the sole person with legal responsibility for the client becomes unable to care for the child, no one would be legally capable of making decisions about the child's care. A nurse provider is not an alternate caregiver with legal authority for a child.

In situations where no alternate caregiver can be identified, the client's parent/caregiver should establish an emergency plan with the nurse provider that indicates the parent/caregivers wishes if they become ill or disabled. Checking the box on the Nursing Care

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Addendum indicates that this plan has been discussed between the family and the provider and that a written plan is in place.

The parent/guardian's signature must be on the form acknowledging that:

- Information about THSteps-CCP PDN services has been discussed and received.
- PDN services may change or end based on a client's need for skilled care.
- PDN services are not authorized for the primary purpose of providing respite, childcare, activities of daily living, or housekeeping.
- All requirements have been met before seeking authorization for PDN services.
- The parent/guardian has participated in the development of the POC and the nursing care plan for the child.
- Emergency plans have been made and are part of the client's care plan.
- The parent/guardian agrees to follow the physician's POC.
- The parent/guardian has learned or agrees to learn the skills necessary to provide care to their child.

Retrospective Review/Documentation of Services Provided

Documentation elements that will be routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted above, as well as the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All nurses' arrival/departure times are documented with signature and time in the narrative section of the nurses' notes.
- Entries are dated and timed every one to two hours.
- The name of the medication, dose, route, time given, client response, and other pertinent information must be provided when medication is administered.
- The name of treatment, time given, route or method used, client response, and other pertinent information must be provided when treatments are administered.
- The amount, type, times given, route or method used, client response, and other pertinent information must be provided when feedings are administered.
- The POC and documentation of services should correlate with and reflect medical necessity for the services provided on any given day. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Client's arrival or departure from the home setting must be documented with the time of arrival, departure, mode of transportation, and who accompanied the client.
- Documentation of teaching the client or the client's parent/guardian should include the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.
- Supervisory visits must include specifics of the visit.
- If a client is receiving skilled nursing services through another program/service in addition to THSteps-CCP, such as the Medically Dependent Children's Program, each provider's shift notes must designate specifically which type of service they are providing during that shift.

43.4.11 Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)

43.4.11.1 Enrollment

To be eligible to participate in THSteps-CCP, a psychiatric hospital/facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet the Joint Commission on Accreditation of Health Care Organizations accreditation requirements.

Freestanding psychiatric hospitals enrolled in Medicare may also receive payment for Medicare deductible and coinsurance amounts with the exception of clients 21 through 64 years of age. The information in this section is applicable to CCP services only.

All providers of laboratory services must comply with CLIA rules and regulations. Providers not complying with CLIA are not reimbursed for laboratory services.

Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS, Department of Health and Human Services, a change in ownership of a hospital does not terminate Medicare eligibility. Medicaid participation may be continued subject to the following requirements:

- Recertification as a Title XVIII (Medicare) hospital is obtained if applicable.
- A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership is obtained.

Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

"Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2 for information about CLIA requirements.

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43.4.11.2 Reimbursement

Inpatient

Reimbursement for acute care inpatient psychiatric care provided by mental health facilities is made according to the *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA) interim reimbursement principles (reasonable cost basis). A new provider is reimbursed initially at an 80-percent interim rate. At the time of a tentative or final cost settlement, the interim rate is adjusted to reflect the hospital's cost-to-charge ratio.

For more information on cost reports for their facility, providers should call Medicaid Audit at 1-512-506-6117.

Refer to: "Reimbursement" on page 43-7 for more information.

43.4.11.3 LoneSTAR Select 015 – Managed Care

LoneSTAR Select affects how hospitals are reimbursed for inpatient services provided to Medicaid clients not enrolled in one of the programs operated by HHSC.

Acute care hospitals providing inpatient services to Medicaid clients enrolled in a Medicaid Managed Care organization such as an HMO, a prepaid health plan, or PCCM model operated by HHSC, are reimbursed according to the agreement each hospital has with each Medicaid Managed Care health plan.

Inpatient services provided to Medicaid clients before their enrollment in a Medicaid Managed Care health plan are reimbursed according to one of the following:

- Agreement each contracted hospital has with LoneSTAR Select
- Standard reimbursement methodologies usually in effect for the hospital, for noncontracted and exempt hospitals

Inpatient services provided to Medicaid clients after the effective date of their enrollment in one of the Medicaid Managed Care health plans are reimbursed according to the agreement each hospital has with the Medicaid Managed Care health plan.

If a Medicaid client disenrolls from one of the Medicaid Managed Care health plans, the inpatient services provided after the disenrollment date are again reimbursed according to the agreement that the hospital has in effect with LoneSTAR Select or according to standard reimbursement methodologies in effect for noncontracted and exempt hospitals.

Outpatient Services

Day treatment or outpatient services are not a benefit for freestanding psychiatric hospitals under traditional Medicaid.

Provider Cost Reporting, Review

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient costs in the cost reports submitted annually. One copy of the applicable CMS cost report form is to be prepared by the provider.

If a change of ownership or provider termination occurs, the cost report is due within 45 days after the date of the termination or change in ownership. Any request for an extension should be made on or before the cost report due date and sent to Medicaid Audit at the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers must file annual cost reports as follows:

- Provider submits one copy of the cost report to Medicaid Audit within five months of the end of the hospital's fiscal year (FY) along with any amount due to the Texas Medicaid Program.
- Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary:
  - Audited or settled without audit Medicare Cost Report
  - Medicare Notice of Amount of Program Reimbursement
  - Medicare Audit Adjustment Report, if applicable
- Field audits are conducted when necessary.

Call Medicaid Audit at 1-512-514-3686 for more information.

Medicaid hospitals may request copies of their claim summaries for their cost reporting FY. The summaries for tentative settlements include three additional months of claim payments for the FY. The summaries for final settlements include ten additional months of claim payments for the FY. This is the same data used by Medicaid Audit to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data is only generated once a month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs should be submitted within 30 days after the fiscal year-end. Final settlement log requests should be submitted within nine months after the fiscal year-end.

These Medicaid logs can be requested in paper copies by mailing a "Medicaid Audit Request for Claims Summary" on page B-54 to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

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43.4.11.4 Benefits and Limitations

Inpatient Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid psychiatric hospital or by an approved out-of-state hospital under the direction of a psychiatrist for the care and treatment of inpatient clients. The client must be Medicaid THSteps-eligible and under 21 years of age at the time of the service request and service delivery. The following conditions must apply:

- The client has a psychiatric condition that requires inpatient treatment.
- The inpatient treatment is directed by a psychiatrist.
- The inpatient treatment is provided in a nationally accredited freestanding psychiatric facility or state psychiatric hospital.
- The provider is enrolled in the Texas Medicaid Program.

If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits.

Client services must be provided in the most appropriate setting and in a timely manner to meet the mental health needs of the client.

Supporting documentation (certification of need) must be documented in the individual client's record. This documentation must be maintained by each facility for a minimum of five years and be readily available for review whenever requested by HHSC or its designee.

When a client requires admission, or once the client becomes Medicaid-eligible while in the facility, a certification of need must be completed in the client's record within 14 days.

Prior authorization is required for inpatient psychiatric care.

A completed Psychiatric Inpatient Admission Form or Psychiatric Inpatient (Extended) Request Form prescribing the inpatient psychiatric services must be signed and dated by the admitting physician familiar with the client prior to requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures are not accepted. The completed Psychiatric Inpatient Admission Form or Psychiatric Inpatient Admission (Extended) Request Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the hospital's medical record for the client.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period.

For initial inpatient admissions, the completed Psychiatric Inpatient Admission Form must be faxed no later than the date of the client's admission unless the admission is after 5 p.m. or on a holiday or a weekend. When the admission occurs after 5 p.m. or on a holiday or a weekend, the Comprehensive Care Inpatient Psychiatric (CCIP) unit must receive the faxed request on the next business day following admission. If the admission occurs after 2 p.m., the provider should contact the CCIP unit by telephone and fax the Psychiatric Inpatient Admission Form to the CCIP unit on the following business day. To complete the prior authorization process, the provider must fax the completed Psychiatric Inpatient Admission Form to the CCIP prior authorization unit. To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate documentation of medical necessity for the services requested.

Initial admissions may be prior authorized for a maximum of five days based on Medicaid eligibility and documentation of medical necessity. All psychiatric admission requests for clients under 12 years of age are reviewed by a psychiatrist. Psychiatric admission requests for clients ages 12 through 20 are reviewed by a mental health professional. Any requests for psychiatric admissions that do not meet criteria for admission are referred to a psychiatrist for final determination.

Providers must submit a Psychiatric Inpatient (Extended) Request Form to the CCIP unit requesting prior authorization for a continuation of stay. Requests for a continuation of stay must be received on or before the last day authorized or denied. The provider is notified of the decision in writing via fax by the CCIP unit. If the date of the CCIP unit determination letter is on or after the last day authorized or denied, the request for continuation of stay is due by 5:00 p.m. of the next business day.

The Psychiatric Inpatient (Extended) Request Form must reflect the need for continued stay in relation to the original need for admission. Any change in the client's diagnosis must be noted on the request. Additional documentation or information supporting the need for continued stay may be attached to the form. Up to seven days may be authorized for an extension request.

Court-ordered services are not subject to the five-day admission limitation or the seven-day continued stay limitation. Court-ordered services include:

- Mental health commitments
- Condition of probation (COP)

Medicaid Clinical Criteria for Inpatient Psychiatric Care For Children and Adolescent

The client must have a valid Axis II, DSM-IV-TR diagnosis as the principle admitting diagnosis, and outpatient therapy or partial hospitalization must have been attempted and failed, or a psychiatrist must have documented reasons why an inpatient level of care is required. The client's Axis II diagnosis must also be included on the request for inpatient psychiatric treatment.

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The client must meet at least one of the following criteria:

- The client is presently a danger to self, demonstrated by at least one of the following:
  - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide
  - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self)
  - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self
  - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the client. A medical diagnosis of Axis III which must be treatable in a psychiatric setting
- The client is a danger to others. This behavior should be attributable to the client's specific Axis I, DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
  - Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat
  - Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior
  - Active hallucinations or delusions directing or likely to lead to serious harm of others
- The client exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis rendering the client unmanageable and unable to cooperate in treatment, and the client is in need of assessment and treatment in a safe and therapeutic setting.
- The client has a severe eating or substance abuse disorder, which requires 24-hours-a-day medical observation, supervision, and intervention.
- The proposed treatment/therapy requires 24-hours-a-day medical observation, supervision, and intervention.
- The client exhibits severe disorientation to person, place, or time.
- The client’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, and other behaviors which may include physical, psychological, or sexual abuse.
- The client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.
- The client is involved in the legal system, manifests psychiatric symptoms, and is ordered by court to undergo a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs.

The proposed treatment/therapy plan must include all of the following:

- Active supervision by a psychiatrist with the appropriate credentials as determined by the Texas Medical Board and with documented specialized training, supervised experience, and demonstrated competence in the care and treatment of children and adolescents. Treatment/therapy plans should be guided by the standards of treatment specified by the Texas Society of Child and Adolescent Psychiatry.
- Implementation of individualized treatment plan.
- Provision of services that can reasonably be expected to improve the client's condition or prevent further regression so a lesser level of care can be implemented.
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available. Ambulatory care resources available in the community do not meet the client's needs.

Continued Stays

Continued stays are considered when the client meets at least one of the criteria from above and a treatment/therapy regimen must include all of the following:

- Active supervision by a psychiatrist is provided.
- The treatment/therapy requires an inpatient level of care.
- Initial discharge plans have been formulated and actions have been taken toward implementation including documented contact with a local mental health provider.

Continued stays are considered for children and adolescents whose discharge plan does not include returning to their natural home if the party responsible for placement has provided the provider with three documented placement options for which the child meets admission criteria, but cannot accept the child. Up to five days may be authorized per request to allow alternative placement to be located. Up to three extensions may be authorized.

Authorization is a condition for reimbursement; it is not a guarantee of payment.

A toll-free telephone and fax line are available to complete the authorization process. Contact the TMHP CCIP Unit at 1-800-213-8877, or fax to 1-512-514-4211.

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In Medicaid Managed Care projects, eligible children must receive all medically necessary services. Authorization procedures and approved providers may differ for managed care clients. Contact the client's specific health care plan for details.

Reimbursement

All prior authorization requests not submitted or received by the TMHP THSteps-CCIP unit in accordance with established policies are denied through the submission date, and claim payment is not made for the dates of service denied.

All denials may be appealed. The TMHP THSteps-CCIP unit must receive these appeals within 15 days of the TMHP THSteps-CCIP unit denial notice. Appeals of a denial for an initial admission and/or a continued stay, must be accompanied by the documentation supporting medical necessity that the provider believes warrants reconsideration. Appeals of a denial for late submission of information, must be accompanied by documentation which the provider believes supports the compliance with HHSC claims submission guidelines. Appeals are reviewed first by an experienced psychiatric Licensed Clinical Social Worker (LCSW) or an RN to determine whether the required criteria is documented and then forwarded to a psychiatrist for final determination. The provider is notified of all denial determinations in writing via fax by the TMHP THSteps-CCIP unit.

Utilization Review

All decisions on requests and/or appeals for admission or continuation of stay are responded to in writing and faxed to the provider by TMHP.

Utilization review activities of all Medicaid services provided by hospitals reimbursed under either the DRG prospective payment system or TEFRA are required by Title XIX of the *Social Security Act*, Sections 1902 and 1903. The review activities are performed through a series of monitoring systems developed to ensure that services are appropriate to need and in the optimum quality and quantity. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and the quality of care reflected by the choice of services provided, type of provider involved, and settings in which care was delivered. This monitoring ensures cost-effective administration of the Texas Medicaid Program.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Utilization review may also occur by an examination of particular claims or services not within the regular screening review when a specific utilization review is requested by HHSC or the Texas Attorney General's Office.

Retrospective Utilization Review

All admissions are subject to retrospective utilization review. The complete medical record is used to evaluate the medical necessity of admission, each day of continued inpatient care, and the quality of care provided.

Reminder: *Admissions and continued stays must be certified in accordance with 42-CFR.441.150 through 441.182. Certification of need must be established and maintained as documentation for each Medicaid client. Each facility must maintain this documentation and make it readily available for review whenever requested by HHSC or its designee.*

For admissions of Medicaid-eligible clients or admission of clients who gain Medicaid eligibility while in the facility, the certification of need must be completed by the interdisciplinary team responsible for the POC within 14 days of admission.

Documentation of medical necessity for inpatient psychiatric care must specifically address the following issues:

- Why the ambulatory care resources in the community cannot meet the treatment needs of the client.
- Why inpatient psychiatric treatment under the care of a psychiatrist is required to treat the acute episode of the client.
- How the services can reasonably be expected to improve the condition or prevent further regression of the client's condition in a proximate time period.

A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

43.4.11.5 Claims Information

Submit inpatient psychiatric hospital services to TMHP in an approved electronic claims format or on a HCFA-1450 (UB92) claim form. The PAN must be identified in Block 63 of the HCFA-1450 (UB-92) or the appropriate field of the electronic form. Prior authorization is a condition for reimbursement; it is *not* a guarantee of payment.

Important: *Attach the invoice to the claim for any specialized equipment.*

Providers must purchase the HCFA-1450 (UB-92) claim forms from the vendor of their choice. TMHP does not supply the forms.

Use of revenue code 124 is restricted to freestanding psychiatric and rehabilitation hospitals. Acute care hospital claims billing charges using revenue code 124 are manually changed to reflect the same charges using revenue code 120. TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims.

Refer to: "Psychiatric Hospital/Facility (THSteps-CCP Only)" on page D-27 for a claim form example.

"HCFA-1450 (UB-92) Instruction Table" on page 5-34 for claims completion instructions.

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43.4.12 Rehabilitation Hospital (Freestanding) (THSteps-CCP Only)

Note: *Rehabilitation provided at an acute care facility is covered through traditional Medicaid.*

43.4.12.1 Enrollment

To be eligible to participate in THSteps-CCP, a freestanding rehabilitation hospital must be certified by Medicare, have a valid Provider Agreement with HHSC, and have completed the TMHP enrollment process. The Texas Medicaid Program enrolls and reimburses freestanding rehabilitation hospitals for CCP services and Medicare deductible/coinsurance. The information in this section is applicable to CCP services only.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

43.4.12.2 Continuity of Hospital Eligibility Through Change of Ownership

Under procedures set forth by the CMS and Department of Health and Human Services, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued subject to the following requirements:

- Recertification as a Title XVIII (Medicare) hospital is obtained.
- A new Title XIX (Medicaid) agreement between the hospital and HHSC under new ownership is obtained.

Providers can obtain the Medicaid hospital participation agreement by contacting TMHP Provider Enrollment.

43.4.12.3 Reimbursement

Inpatient

Reimbursement for care provided in the freestanding rehabilitation hospital is made under the Texas DRG Payment System.

A new provider is given a reimbursement interim rate of 50 percent until a cost audit has been performed. Payment is calculated by multiplying the standard dollar amount (SDA) for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Important: *Outpatient services are not reimbursed.*

The DRG payment may be enhanced by an adjusted day or cost outlier payment, if applicable. For example, the limit per spell of illness under Texas Medicaid guidelines is waived for clients younger than 21 years of age. An outlier payment may be made to compensate for unusual resource utilization or lengthy stay.

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

To establish a cost outlier, TMHP determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital's SDA multiplied by 11.14.

The calculation that yields the greater amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is paid.

The Remittance and Status (R&S) report reflects the outlier reimbursement payment and defines the type of outlier paid, day or cost.

Providers should call the TMHP provider relations representative for their area with questions about the outlier payment.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Client Transfers

When more than one hospital provides care for the same case, the hospital furnishing the most significant amount of care receives consideration for a full DRG payment.

The other hospital(s) is paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. The DRG modifier PT on the R&S report indicates per diem pricing related to a client transfer.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The facility must bill only one claim.

After all hospital claims have been submitted, TMHP performs a post-payment review to determine whether the hospital furnishing the most significant amount of care received the full DRG. If the review reveals that the hospital furnishing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

Provider Cost Reporting, Review

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient costs in the cost reports submitted annually. One copy of the applicable CMS cost report form is to be prepared by the provider.

If a change of ownership or provider termination occurs, the cost report is due within 45 days after the date of the termination or change in ownership. Any request for extension of time to file should be made on or before the cost report due date and sent to Medicaid Audit at the address indicated below.

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Providers must file annual cost reports as follows:

- Provider submits one copy of the cost report to Medicaid Audit within three months of the end of the hospital's FY, along with any amount due to the Texas Medicaid Program.
- The Medicaid Audit Department performs a desk review of the cost report and makes tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time, based on the cost report.
- Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary: audited or settled without audit Medicare Cost Report, Medicare Notice of Amount of Program Reimbursement, and Medicare Audit Adjustment Report, if applicable.
- Field audits are conducted when necessary.

Providers can call Medicaid Audit at 1-512-514-3686 for more information.

Medicaid hospitals may request copies of their claim summaries for their cost reporting FY. The summaries for tentative settlements include two additional months of claim payments for the FY. The summaries for final settlements include ten additional months of claim payments for the FY. Medicaid Audit uses the same data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data is only generated once a month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs should be submitted within 30 days after the fiscal year-end. Final settlement log requests should be submitted within one month after the fiscal year-end.

These Medicaid logs may be requested in paper copies by mailing a Medicaid Audit Request for Claims Summary to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Providers should allow 45 days for receipt of these logs.

43.4.12.4 Benefits and Limitations

Inpatient Rehabilitation Hospital Services

Inpatient rehabilitation hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Conditions requiring rehabilitation may be acute, an exacerbation of a chronic condition, or chronic. A condition is considered to be acute or an exacerbation only during the six months from the onset date of the acute condition or the exacerbation of the chronic condition. Requests for services beyond this time period may be considered on a case-by-case basis.

Prior authorization is mandatory. After receiving the documentation establishing the medical necessity and plan of medical care by the treating physician, prior authorization is considered by CCP for both the initial service and an extension of service. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

Requests for prior authorization of subsequent services are not to exceed 60 days. Requests for prior authorization of subsequent services must be received before the end-date of the preceding prior authorization.

The request for inpatient rehabilitation and the treatment plan must be signed and dated by the physician. All signatures must be original and handwritten. Computerized or stamped signatures are not accepted.

Send CCP prior authorization requests and any other CCP correspondence to the following address:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program (CCP)
PO Box 200735
Austin, TX 78720-0735

All prior authorization documentation must be made a permanent part of the medical record.

Electronic billers also must submit the PAN on the claim. Electronic billers should consult their software vendor for the location of this field in their software.

Client

Prior authorization is considered for clients that meet the following criteria:

- Are younger than 21 years of age
- Are THSteps-eligible at the time of service
- Have an acute problem and/or acute deterioration of a chronic problem that would benefit from comprehensive treatment
- Are expected to improve within a 60-day period and be restored to a more functional lifestyle for an acute condition or the previous level of function for an exacerbation of a chronic condition

Note: *Prior authorization is a condition for reimbursement, not a guarantee of payment.*

Comprehensive Treatment

The intensity of necessary rehabilitative service cannot be provided in the outpatient setting.

Comprehensive treatment must be under the leadership of a physician.

Comprehensive treatment must be an active interdisciplinary team, defined as at least two types of therapies.

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Comprehensive treatment must consist of at least two appropriate physical modalities designed to resolve or improve the client's condition (PT, OT, and speech language), and must be provided for a minimum of three hours per day for five days per week.

Goal

The goal is to return the client to a functional or more functional lifestyle in a reasonable period of time.

Length of Treatment

Initial authorization may be for up to two months. Additional increments may be given per recertification.

Termination of Treatment Authorization

The minimum requirements for termination of treatment authorization are as follows:

- Active progressive treatment plan is not aggressively pursued under the direction of a physician.
- Progress cannot be documented in a reasonable amount of time by the interdisciplinary team.
- A plateau is reached and additional progress cannot be documented or expected. Plateauing is defined as the point at which maximal improvement has been documented and continued improvement ceases.

Attending Physician Documentation

The minimum requirements provided by the medical request are as follows:

- The date of onset of the illness or injury requiring the rehabilitation admission
- A brief synopsis of previous medical treatment, including outcomes of the treatment relative to the debilitating condition
- The treatment plan to be followed in the inpatient rehabilitation hospital
- The expected outcome to be achieved by the active treatment plan, and the time interval at which such an outcome should be obtained
- Why outpatient PT, speech language, and/or OT does not meet client needs
- That alternative treatment sites have been evaluated, and why they are inappropriate for the client needs
- Whether the client has a reasonable expectation for meaningful improvement from the treatment plan that will restore the client to maximum expected function and/or achieve independent living capabilities in a reasonable period of time

For an extension of prior authorization, discussion of why the initial two months of inpatient rehabilitation has not met the client's needs and why the client cannot be treated in an outpatient setting is required.

43.4.12.5 Claims Information

Submit inpatient rehabilitation hospital services to TMHP in an approved electronic claims format or on a HCFA-1450 (UB-92) claim form. Providers must purchase the HCFA-1450 (UB-92) claim forms from the vendor of their choice. TMHP does not supply the forms. Use of revenue code 124 is restricted to freestanding psychiatric and rehabilitation hospitals. Acute care hospital claims billing charges using revenue code 124 are manually changed to reflect the same charges using revenue code 120. TMHP must receive claims for payment consideration according to filing deadlines for inpatient claims. Claims for services that have been authorized must reflect the PAN in Block 23 of the CMS-1500 claim form or its electronic equivalent.

Refer to: "Rehabilitation Hospital (THSteps-CCP Only)" on page D-29 for a claim form example.

"HCFA-1450 (UB-92) Claim Filing Instructions" on page 5-32 for claims completion instructions.

43.4.13 Speech-Language Pathologists (THSteps-CCP Only)

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary PDN services and/or home health skilled nursing services. Nursing services are medically necessary under the following conditions:

- The requested services are nursing services as defined by the *Texas Nursing Practice Act* and its implementing regulations.
- The requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.
- There is no third-party resource financially responsible for the services.

Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the beneficiary's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition.

Medically necessary nursing services are authorized either as PDN services or as home health skilled nursing services, depending on whether the beneficiary's nursing needs can be met on a per-visit basis.

43.4.13.1 Enrollment

HHSC allows enrollment of independently-practicing licensed speech-language pathologists under THSteps-CCP. The Texas Medicaid Program enrolls and reimburses speech-language pathologists for CCP services only. This section does not apply to CORFs.

Refer to: "Provider Enrollment" on page 43-5 for more information about enrollment procedures.

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43.4.13.2 Reimbursement

Speech-language services provided by home health agencies are reimbursed according to a statewide visit rate calculated in accordance with 1 TAC §355.8021(a). The current statewide visit rate for SLP services is $119.61 per visit.

Speech-language services provided by outpatient hospitals are reimbursed based on PPS fee schedule in accordance with 1 TAC §355.8085.

Speech-language services provided by CORFs are reimbursed based on a reasonable cost methodology, in accordance with 1 TAC §355.8441 (15), with an interim rate based on the provider's most recent Medicaid cost report settlement.

Speech-language services provided by providers other than home health agencies and outpatient hospitals are reimbursed according to rates published in a fee schedule calculated in accordance with 1 TAC §355.8441. The current physician fee schedule is available on the TMHP website at www.tmhp.com.

The following procedure codes should be used for billing speech-language services under THSteps-CCP, but not all codes are payable to all provider types: 1-92507, 1-92506, and 1-92508.

Refer to: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

43.4.13.3 Benefits and Limitations

CCP is for Medicaid/THSteps-eligible clients younger than 21 years of age. CCP eligibility ends on the client's 21st birthday. If the client's Medicaid ID states "Emergency Care," "PE," or "QMB," the client is not eligible for THSteps or CCP benefits.

Speech therapy may be billed as POS 1 or 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's daycare facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as SHARS as POS 9.

A request for speech therapy services may be prior authorized for no longer than six months duration. A new request must be submitted if therapy is required for a longer duration.

Typical sessions do not exceed one hour in length. Documentation supporting the need for longer sessions is required. No limitations exist to the number of sessions that may be provided per week; however, documentation supporting the medical necessity for the requested services is required.

Speech-language services are benefits under CCP when provided to clients experiencing speech-language difficulty because of a disability, ongoing health condition, or communication disorder such as a disease or trauma, developmental delay, oral motor problem, or congenital anomaly or other conditions requiring medically necessary speech-language services.

Providers must use the following procedure codes for services provided by an independently-practicing speech-language pathologist for developmental therapies:

Procedure Code	Maximum Fee
1-92506	$210.00
1-92506 *with* modifier U4	$210.00
1-92507	$70.00
1-92508	$35.00
1-97535	$35.00

Procedure code 1-92506 may be billed without prior authorization. Only one is allowed for payment per six months per provider without prior authorization or written documentation of medical necessity. An evaluation should not be billed on the same day as treatment.

Procedure code 1-92506 with modifier U4 may only be billed once per month per provider.

Refer to: "Speech-Language Therapy" on page 36-327.

43.4.13.4 Prior Authorization, Documentation Requirements

Providers must use the "Request for Initial Outpatient Therapy (Form TP-1)" on page B-78 for initial requests and the "Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)" on page B-79 for extension requests.

Prior authorization is a condition for reimbursement; it is *not* a guarantee of payment.

Prior authorization is required for speech-language therapy services except for evaluation and re-evaluation. Submit documentation with the request for prior authorization or with each claim for consideration of reimbursement.

Children receiving therapy services reimbursed by CCP must have chronic conditions that require ongoing medical supervision. To establish medical necessity, a physician prescription and revised therapy treatment plan are required at least every six months. A request for authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.

The initial therapy treatment plan must include a TP-1 and an initial therapy treatment plan. The initial therapy treatment plan must include the following:

- A physician prescription
- A copy of the current evaluation
- The documented age of the client at the time of the evaluation

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- Documentation indicating the treatment goals, anticipated measurable progress toward goals, the prognosis, and the client's gross motor skills in years/months. Goals may include improving, maintaining, or slowing the deterioration of function

To request an extension of services, the following documentation must be submitted:

- A TP-2 form, including a current physician signature
- All documentation required in initial authorizations (except the TP-1 form)
- Documentation of all progress made from the beginning of the previous treatment period to the current service request date, including progress towards previous goals
- Information that supports the client's capability of continued measurable progress
- A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs. Therapy goals may include improving, maintaining, or slowing the deterioration of function

Therapy may be extended beyond two years, but the following required documentation must be forwarded for review for authorization to be considered:

- A TP-2 form
- All documentation required in initial authorizations (except the TP-1 form)
- A comprehensive team evaluation summarizing all prior treatment as well as progress that was made during that time
- A report from the case-managing physician indicating all progress that the client made toward all goals during all previous therapy sessions

If a provider discontinues therapy with a client and a new provider begins therapy during an existing authorization period, submission of a new treatment plan is required, along with documentation of the last therapy visit with the previous provider. A letter from the guardian stating the date therapy ended with the previous provider is sufficient.

Physician Signature

The physician's signature, required on a prescription and the appropriate authorization request form, must be current to the service date of the request.

Refer to: "Physician Signature" on page 43-37 for complete information about this requirement.

43.4.13.5 Claims Information

Providers must submit claims for services provided by speech-language pathologists in an approved electronic claims format or on a CMS-1500 claim form from the vendor of their choice. TMHP does not supply the forms.

Therapy is only payable when provided in POS 1 (office) or 2 (home). Procedure codes 1-92506, 1-92507, 1-92508, and 1-97535 may only be billed with a quantity of 1. Claims for services that have been authorized must reflect the PAN in Block 23 for the CMS-1500 claim form or its electronic equivalent.

Refer to: "Speech-Language Pathologists (THSteps-CCP Only)" on page D-33 for an example.

"CMS-1500 Claim Filing Instructions" on page 5-24 for claims completion instructions.

43.4.13.6 THSteps-CCP Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
HCFA-1450 Claim Filing Instructions	5-32
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Donor Human Milk Form Example	B-36
Medicaid Audit Request for Claims Summary	B-54
Psychiatric Hospital Inpatient Admission Form	B-74
Psychiatric Inpatient (Extended) Request Form	B-75
THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy	B-108
THSteps-CCP Prior Authorization Request (2 pages)	B-106
Wheelchair/Seating Evaluation Form (THSteps-CCP) (6 pages)	B-118
CORF (THSteps-CCP Only) Claim Form Example	D-10
Durable Medical Equipment (THSteps-CCP Only) Claim Form Example	D-12
Early Childhood Intervention (THSteps-CCP Only) Claim Form Example	D-12
Licensed Dietitian (THSteps-CCP Only) Claim Form Example	D-20
Occupational Therapists (THSteps-CCP Only) Claim Form Example	D-24
Orthotic and Prosthetic Suppliers (THSteps-CCP Only) Claim Form Example	D-25
Pharmacy (THSteps-CCP Only) Claim Form Example	D-25
Physical Therapist (THSteps-CCP Only) Claim Form Example	D-26
Private Duty Nurses (THSteps-CCP Only) Claim Form Example	D-27

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Resource	Page Number
Psychiatric Hospital/Facility (THSteps-CCP Only) Claim Form Example	D-27
Rehabilitation Hospital (THSteps-CCP Only) Claim Form Example	D-29
Speech-Language Pathologists (THSteps-CCP Only) Claim Form Example	D-33
Acronym Dictionary	F-1

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Section

44

Tuberculosis (TB) Clinics

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44.1 Enrollment

To enroll in the Texas Medicaid Program, a tuberculosis (TB) clinic must be:

- A public entity operating under a HHSC tax identification number (TIN) (TB regional clinic); *or*
- A public entity operating under a non-HHSC TIN (city/county/local clinic); *or*
- A nonhospital-based entity for private providers.

Providers of TB-related clinic services must apply to the Department of State Health Services (DSHS) Infectious Disease Control Unit Tuberculosis Program (IDCU/TB). The following enrollment process must be followed:

- Providers must complete a provider application from IDCU/TB. Providers must have the facilities and resources available to provide all services required under the Texas Medicaid Program. Upon written notice of approval by IDCU/TB, Medicaid enrollment applications from the TMHP Provider Enrollment are sent to HHSC-approved providers of TB-related clinic services.
- Providers must complete a provider agreement from TMHP for enrollment into the Texas Medicaid Program. TMHP is responsible for issuing a group or individual nine-digit provider identifier. Providers that list additional (satellite) clinics in the IDCU/TB provider application will receive nine-digit performing provider identifiers for each off-site clinic. TB off-site clinics operating under the jurisdiction of the applying provider must use the assigned group provider identifier and their nine-digit performing provider identifier. Enrollment as a Medicaid provider is not complete until the TMHP enrollment packet has been finalized and a nine-digit provider identifier number is issued to the provider.

Important: *The effective date for participation is the date an approved provider application with* IDCU/TB *is established.*

To receive a provider application form or provider supplement, send a request to the following address:

Infectious Disease Control Unit
Tuberculosis Program
Mail Code 1939
1100 West 49th Street
Austin, TX 78756-3199

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures related to the TMHP Medicaid enrollment applications.

44.1.1 Managed Care Program Enrollment

TB clinics do not need to enroll with the Medicaid Managed Care health plans. All services provided by TB clinics are submitted to TMHP for all Medicaid clients, including Medicaid Managed Care clients.

44.2 Provider Responsibilities

If approved to bill as a TB clinic under the Texas Medicaid Program, the provider must adhere to the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital, but is organized and operated to provide medical care to outpatients.
- Comply with all applicable federal, state, and local laws and regulations.
- Employ or have a contract or formal arrangement with a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]) who is responsible for providing medical direction and supervision over all services provided to the clinic's clients. To meet this requirement, a physician must see the client at least once, prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
- Adhere to the guidelines issued by HHSC, under the authority of the *Texas Health and Safety Code*, and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention (CDC). For more information, visit the website at www.cdc.gov/nchstp/tb/pubs/mmwrhtml/maj_guide.htm.
- Ensure that services provided to each client are commensurate with the client's medical needs based on the client's assessment/evaluation, diagnostic studies, plan of care, and physician direction. These services must be documented in the client's medical records.
- Be enrolled and approved for participation in the Texas Medicaid Program.
- Sign a written provider agreement with HHSC or its designee. By signing the agreement, the provider of TB-related clinic services agrees to comply with the terms of the agreement and all requirements of the Texas Medicaid Program including regulations, rules, handbooks, standards, and guidelines published by HHSC or its designee.
- Bill for services covered by the Texas Medicaid Program in the manner and format prescribed by HHSC or its designee.
- Be organized and operated to provide TB-related services, which include, but are not limited to, the covered services as indicated in "Benefits and Limitations" on page 44-3.
- Not provide services within a skilled nursing facility (SNF), intermediate care facility (ICF), or ICF for the mentally retarded (ICF-MR).

Refer to: "Provider Enrollment" on page 1-2 for more information.

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44.3 Reimbursement

The Medicaid rates for TB clinics are calculated in accordance with Title 1 *Texas Administrative Code* (TAC) §355.8341.

Chest X-rays are payable in addition to the encounter rate for TB clinic services because of the large variations in client needs and frequency of X-rays. The Medicaid rate for X-rays are calculated in accordance with 1 TAC §§355.8341 and 355.8085 and are listed in the current physician fee schedule, which is available at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Private providers of TB-related clinic services will receive the maximum allowable fee. Public providers of TB-related clinic services will only receive the federal matching rate of the maximum allowable fee in effect at the time of service. The federal matching rate is adjusted on October 1 of each year, or as otherwise directed by the Centers for Medicare & Medicaid Services (CMS).

Public providers of TB-related clinic services receive only the federal share of Medicaid payments. The nonfederal share of the Medicaid payments to public provider TB clinics are funded through certification of public expenditures (CPE). DSHS will certify for those public provider TB clinics that have a contract with IDCU/TB.

Refer to: “Reimbursement” on page 2-2 for more information.

44.4 Certification of Funds

As public providers of TB-related clinic services receiving only the federal share of Medicaid payments, public provider TB clinics fund the state/local (e.g., nonfederal) share through CPE.

The Certification of Funds letter is mailed by TMHP Provider Enrollment to DSHS at the end of each quarter of the federal fiscal year (FFY), which is October 1 through September 30. The letter requires certification of 100 percent of the Medicaid-allowable costs for the dates of services covered by payments received within the previous federal fiscal quarter (including the federal share, the total state/local share, and the total computable expenditure).

To assist in certifying the funds documented in the letter, the Certification of Funds Claims Information Report will be available for review upon receipt of the letter. The report will contain Texas Medicaid fee-for-service (FFS) (Program 100) and Texas Medicaid Primary Care Case Management (PCCM) (Program 200) claims on the same page sorted by paid date.

Refer to: “TMHP Provider Relations” on page -xiii for more information about provider relations representatives.

The Certification of Funds letter must be:

- Signed by a DSHS business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider’s payments until the signed Certification of Funds letter is received by TMHP. If the Certification of Funds letter was not received, contact TMHP Contact Center at 1-800-925-9126.

44.5 Benefits and Limitations

The level of service provided varies depending on whether the services are delivered by a nonphysician or physician and if medications are prescribed.

44.5.1 TB-Related Clinic Services and Procedure Codes

Providers may be required to demonstrate the ability to provide the full scope of services and documentation of service delivery methodology. The following services are covered for reimbursement:

44.5.1.1 Chest X-Rays Procedure Codes

Procedure Code	Maximum Fee
4-71010	$21.55
4-71020	$27.55
4-71021	$33.00
4-71022	$34.64
4-71035	$22.91

44.5.1.2 Classification System for TB

The current clinical classification system for TB is based on the pathogenesis of the disease. TB disease should be ruled in or out, within the standard 90 day period. Therefore, a client should not be a class 5 for more than 90 days (three months). Health care providers should comply with state and local laws and regulations requiring the reporting of TB. All persons with class 3 or class 5 TB should be reported within one business day to the regional or local health department.

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The following table lists the TB classifications:

TB Class	Description
Class 0—No TB exposure: not infected	No history of exposure; negative reaction to tuberculin skin test.
Class 1—TB exposure: no evidence of infection	History of exposure; negative reaction to tuberculin skin test.
Class 2—Latent TB infection (LTBI): no disease	Positive reaction to tuberculin skin test. Negative bacteriologic studies (if done). No clinical, bacteriological, or radiographic evidence of active TB.
Class 3—TB clinically active	M. tuberculosis cultured (if done). Clinical, bacteriological, or radiographic evidence of current disease.
Class 4—TB not clinically active	History of episode(s) of TB. *or* Abnormal but stable radiographic findings. Positive reaction to the tuberculin skin test. Negative bacteriologic studies (if done). *and* No clinical or radiographic evidence of current disease.
Class 5—TB suspected	Diagnosis is pending.

44.5.1.3 Initial Examination and Procedure Codes

An initial examination should be performed by providers when any class of client is evaluated for the first time. A client can receive another initial examination six months (180 rolling days) from the previous one if there has been an interruption in therapy (such as reinitiation of treatment for clients lost to follow-up). Services may include, but are not limited to:

- Record initiation
- Clinical assessment/diagnostic procedures
- Counseling and education/preventive services
- Physician consultation and evaluation
- Prescribed medications/instruction

The following table describes the procedure codes and modifiers to be billed for initial examinations:

Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Initial Exam Level 01: Nonphysician services only	1 or 2	D-99204 *with* modifier TF	$26.53
	3 or 5	D-99204 *with* modifier TG	$43.27
Initial Exam Level 06: Nonphysician and Physician services	1 or 2	D-99204 *with* modifiers TF *and* AM	$52.90
	3 or 5	D-99204 *with* modifiers TG *and* AM	$73.51

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Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Initial Exam Level 08: Nonphysician and Physician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99205 *with* modifier TF	$54.10
	3 or 5	D-99205 *with* modifier TG	$253.99

Physician examination procedure codes may be used only when any class of client was initially evaluated without the consultation and evaluation of a physician. This examination cannot be billed if the provider billed for Level 06, 07, or 08 for the initial examination. Services may include, but are not limited to, the following:

- Record maintenance
- Nonphysician assistance with evaluation
- Physician consultation and evaluation
- Prescribed medications/instruction

Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Physician Exam Level 06: Nonphysician and Physician services	1 or 2	D-99201 *with* modifier TF	$37.48
	3 or 5	D-99201 *with* modifier TG	$38.51
Physician Exam Level 07: Nonphysician and Physician services Prescribed Medications (Initial Treatment)	3 or 5	D-99202 *with* modifier TG	$218.99
Physician Exam Level 08: Nonphysician and Physician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99202 *with* modifier TF	$38.68

44.5.1.4 Follow-Up Examination

Use the follow-up examination only when any class of client is being evaluated during the course of treatment. This examination cannot be billed on the same day as any other examination (except directly observed therapy [DOT] or directly observed preventive therapy [DOPT]). Services may include, but are not limited to, record maintenance, clinical assessment and diagnostic procedures, nonphysician assistance with evaluation, and physician consultation and evaluation.

The following procedure codes and modifiers may be billed for follow-up examinations:

Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Follow-Up Exam Level 01: Nonphysician services only	1 or 2	D-99214 *with* modifier TF	$22.12
	3 or 5	D-99214 *with* modifier TG	$27.12

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Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Follow-Up Exam Level 06: Nonphysician and Physician services	1 or 2	D-99214 *with* modifiers TF *and* AM	$46.37
	3 or 5	D-99214 *with* modifiers TG *and* AM	$51.59

44.5.1.5 Monthly Examination

Use the monthly examination only when any class of client is being evaluated for a routine monthly diagnostic examination. This examination may be reimbursed every 25 rolling days. This examination always includes a 30-day supply of medications regardless of level. Services may include, but are not limited to, record maintenance, clinical assessment and diagnostic procedures, nonphysician assistance with evaluation, physician consultation and evaluation, and prescribed medications/instructions.

The following procedure codes and modifiers may be billed for monthly examinations:

Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Monthly Exam Level 02: Nonphysician services Prescribed Medications (Initial Treatment)	3 or 5	D-99212 *with* modifier TG	$202.38
Monthly Exam Level 03: Nonphysician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99212 *with* modifier TF	$13.54
Monthly Exam Level 04: Nonphysician services Prescribed Medications (Maintenance Treatment)	3 or 5	D-99213 *with* modifier TG	$45.30
Monthly Exam Level 05: Nonphysician services Prescribed Medications (Advanced Treatment)	3 or 5	D-99215 *with* modifier TG	$809.94
Monthly Exam Level 07: Nonphysician and Physician services Prescribed Medications (Initial Treatment)	3 or 5	D-99212 *with* modifier TG *and* AM	$212.27
Monthly Exam Level 08: Nonphysician and Physician services Prescribed Medications (Preventive Treatment)	1 or 2	D-99212 *with* modifiers TF *and* AM	$47.57

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Service	Client Class	Procedure Code/ Modifier	Maximum Fee
Monthly Exam Level 09: Nonphysician and Physician services Prescribed Medications (Maintenance Treatment)	3 or 5	D-99213 *with* modifiers TG *and* AM	$55.19
Monthly Exam Level 10: Nonphysician and Physician services Prescribed Medications (Advanced Treatment)	3 or 5	D-99215 *with* modifiers TG *and* AM	$819.83

44.5.1.6 DOT/DOPT Examination

Use the DOT/DOPT examination only when any class of client is DOT or DOPT in the clinic and other settings. This examination is the only type of examination that can be billed more than once per day. Services may include, but are not limited to, the following:

- Monitoring and maintenance—Record documentation of each and every DOT/DOPT dose observed and swallowed
- Monitoring the reporting of the completion of drug therapy
- Toxicity assessment for each DOT/DOPT dose observed

The following procedure codes and modifiers may be billed for DOT/DOPT examinations:

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Service	Client Class	Procedure Code/ Modifier	Maximum Fee
DOT/DOPT Exam Level 01: Nonphysician services only	1 or 2	D-99211 *with* modifier TF	$9.69
	3 or 5	D-99211 *with* modifier TG	$15.77

44.5.1.7 Medication Levels

The medication levels vary according to length of regimen and number of medications per regimen. The following medication levels apply to specific examination types:

Level	Description
Initial	4-drug treatment for first two months (Level 02 and 07 only)
Preventive	2-drug treatment for preventive therapy (Level 03 and 08 only)
Maintenance	2-drug treatment for the remaining 4 months (Level 04 and 09 only)
Advanced	Multiple drug treatment for drug resistance clients (Level 05 and 10 only)

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44.5.1.8 Diagnosis Codes

Diagnoses are used in conjunction with the corresponding TB400B classifications.

The following table lists the available diagnosis codes:

Client Classification	Modifier Code	ICD-9-CM Code
1 or 2	TF	7955 or V011
3 or 5	TG	01010, 01011, 01012, 01013, 01014, 01015, 01016, 01080, 01081, 01082, 01083, 01084, 01085, 01086, 01090, 01091, 01092, 01093, 01094, 01095, 01096, 01100, 01101, 01102, 01103, 01104, 01105, 01106, 01110, 01111, 01112, 01113, 01114, 01115, 01116, 01120, 01121, 01122, 01123, 01124, 01125, 01126, 01130, 01131, 01132, 01133, 01134, 01135, 01136, 01140, 01141, 01142, 01143, 01144, 01145, 01146, 01150, 01151, 01152, 01153, 01154, 01155, 01156, 01160, 01161, 01162, 01163, 01164, 01165, 01166, 01170, 01171, 01172, 01173, 01174, 01175, 01176, 01180, 01181, 01182, 01183, 01184, 01185, 01186, 01190, 01191, 01192, 01193, 01194, 01195, 01196, 01200, 01201, 01202, 01203, 01204, 01205, 01206, 01210, 01211, 01212, 01213, 01214, 01215, 01216, 01220, 01221, 01222, 01223, 01224, 01225, 01226, 01230, 01231, 01232, 01233, 01234, 01235, 01236, 01280, 01281, 01282, 01283, 01284, 01285, 01286, 01300, 01301, 01302, 01303, 01304, 01305, 01306, 01310, 01311, 01312, 01313, 01314, 01315, 01316, 01320, 01321, 01322, 01323, 01324, 01325, 01326, 01330, 01331, 01332, 01333, 01334, 01335, 01336, 01340, 01341, 01342, 01343, 01344, 01345, 01346, 01350, 01351, 01352, 01353, 01354, 01355, 01356, 01360, 01361, 01362, 01363, 01364, 01365, 01366, 01380, 01381, 01382, 01383, 01384, 01385, 01386, 01390, 01391, 01392, 01393, 01394, 01395, 01396, 01400, 01401, 01402, 01403, 01404, 01405, 01406, 01480, 01481, 01482, 01483, 01484, 01485, 01486, 01500, 01501, 01502, 01503, 01504, 01505, 01506, 01510, 01511, 01512, 01513, 01514, 01515, 01516, 01520, 01521, 01522, 01523, 01524, 01525, 01526, 01550, 01551, 01552, 01553, 01554, 01555, 01556, 01560, 01561, 01562, 01563, 01564, 01565, 01566, 01570, 01571, 01572, 01573, 01574, 01575, 01576, 01580, 01581, 01582, 01583, 01584, 01585, 01586, 01590, 01591, 01592, 01593, 01594, 01595, 01596, 01600, 01601, 01602, 01603, 01604, 01605, 01606, 01610, 01611, 01612, 01613, 01614, 01615, 01616, 01620, 01621, 01622, 01623, 01624, 01625, 01626, 01630, 01631, 01632, 01633, 01634, 01635, 01636, 01640, 01641, 01642, 01643, 01644, 01645, 01646, 01650, 01651, 01652, 01653, 01654, 01655, 01656, 01660, 01661, 01662, 01663, 01664, 01665, 01666, 01670, 01671, 01672, 01673, 01674, 01675, 01676, 01690, 01691, 01692, 01693, 01694, 01695, 01696, 01700, 01701, 01702, 01703, 01704, 01705, 01706, 01710, 01711, 01712, 01713, 01714, 01715, 01716, 01720, 01721, 01722, 01723, 01724, 01725, 01726, 01730, 01731, 01732, 01733, 01734, 01735, 01736, 01740, 01741, 01742, 01743, 01744, 01745, 01746, 01750, 01751, 01752, 01753, 01754, 01755, 01756, 01760, 01761, 01762, 01763, 01764, 01765, 01766, 01770, 01771, 01772, 01773, 01774, 01775, 01776, 01780, 01781, 01782, 01783, 01784, 01785, 01786, 01790, 01791, 01792, 01793, 01794, 01795, 01796, 01800, 01801, 01802, 01803, 01804, 01805, 01806, 01880, 01881, 01882, 01883, 01884, 01885, 01886, 01890, or V712

44.5.1.9 Place of Service (POS)

The POS identifies where services are performed. Providers of TB-related clinic services should only use POS 1 (office).

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44.6 Claims Information

All TB-related clinic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form from the vendor of their choice. TMHP does not supply them.

Refer to: "Coding" on page 5-12 for more information on coding for claims submission.

44.6.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Tuberculosis (TB) Screening and Education Tool	C-91
Tuberculosis (TB) Claim Form Example	D-36
Acronym Dictionary	F-1

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Section

45

Vision Care (Optometrists, Opticians)

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45.1 Enrollment

To enroll in the Texas Medicaid Program, doctors of optometry must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

Ophthalmologists must refer to "Ophthalmology" on page 36-206.

Refer to: "Provider Enrollment" on page 1-2 for more information about enrollment procedures.

45.1.1 Medicaid Managed Care Enrollment

Vision aid providers must enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients.

45.2 Reimbursement

Professional services by a doctor of optometry for contact lenses and prosthetic eyewear are reimbursed in accordance with Title 1 *Texas Administrative Code* (TAC), 355.8085 and listed in the current physician fee schedule, which is available on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Federally qualified health centers (FQHCs) are paid an all-inclusive rate per visit for payable services. Specific procedure codes that meet the definition of a payable visit are marked with a "†."

Suppliers of nonprosthetic lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee.

Optometrist services provided in a skilled nursing facility (SNF) or intermediate care facility for the mentally retarded (ICF-MR) may be reimbursed by Medicaid if the client's attending physician has ordered the service and the order is included in the client's medical records at the facility.

Refer to: "Reimbursement" on page 2-2 for more information about reimbursement.

Vision Claim Form Example on page D-36

"Nonprosthetic Eyeglasses and Contacts" on page 45-20

45.3 Provider Responsibilities

Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Obtain the required eligibility information from the client's Medicaid Identification Form (Form H3087).
- Refer to the Eyeglasses column of the Medicaid Identification Form (Form H3087) to determine whether eyeglasses have been dispensed at Medicaid's expense within the last 24 months. Providers are advised to ask clients if they have recently received vision care services that may not appear on the Medicaid Identification Form (Form H3087) because of the monthly lag in updating form information.
- Update the Eyeglasses column of the Medicaid Identification Form (Form H3087) to indicate that eyewear was dispensed. Initial, date, and mark the form to indicate that the service was performed.

Important: *Temporary cataract lenses or glasses are payable during the four-month convalescent period even if the Medicaid Identification Form (Form H3087) does not have a check mark (✓) under the Eyeglasses column. However, the Medicaid Identification Form (Form H3087) must not have a check mark under the Eyeglasses column if nonprosthetic eyeglasses are to be obtained for use in conjunction with cataract contact lenses.*

- Have the client sign and date the Vision Care Eyeglass Patient Certification Form and retain it in the providers' records if the client selects eyewear that is not covered or eyewear is lost or destroyed.
- Have the client, parents, or guardian sign and date the Vision Care Eyeglass Patient Certification Form and retain in their records.
- Do not charge a Medicaid client more than a non-Medicaid patient for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyewear was dispensed.

45.4 Benefits and Limitations

45.4.1 Eye Examinations

Medicaid reimburses doctors of optometry for eye examinations with refractions for diagnoses of refractive error, aphakia, and disease or injury of the eye.

45.4.1.1 Refractive Errors

Procedure codes 1-S0620 and 1-S0621 are payable to optometrists when the diagnosis is refractive error.

Procedure code 1-S0620 or 1-S0621 is to be used by optometrists when billing for a Medicaid-only client and consists of preliminary diagnosis; analysis and complete diagnosis; and prescription and treatment.

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Claims for eye examination services require a diagnosis. If eyeglasses are not prescribed, diagnosis code V720, Eye examination, may be used. V720 must not be used on claims for eyewear. If the diagnosis is not known by the supplier of the eyewear, diagnosis code 3689, Unspecified visual disturbance, is acceptable. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

Procedure codes 1-S0620† and 1-S0621 are limited to the following diagnosis codes:

Diagnosis Code	Description
3670	Hypermetropia
3671	Myopia
36720	Astigmatism, unspecified
36721	Regular astigmatism
36722	Irregular astigmatism
36731	Anisometropia
36732	Aniseikonia
3674	Presbyopia
36751	Paresis of accommodation
36752	Total or complete internal ophthalmoplegia
36753	Spasm of accommodation
36781	Transient refractive change
36789	Other disorders of refraction and accommodation
3679	Unspecified disorder of refraction and accommodation
37182	Corneal disorder due to contact lens
V720	Examination of eyes and vision
† = Services payable to an FQHC based on an all-inclusive rate per visit.	

45.4.2 Eye Examinations for the Purpose of Prescribing Eyewear

Refer to the Eye Exam column of the client's current Medicaid Identification Form (Form H3087) to determine if the client is eligible for an eye examination. Any client younger than 21 years of age is eligible for new eyewear whenever there is a diopter change of 0.5 or more (old and new prescription must appear on the claim).

Clients aged birth to 20 years of age are eligible for one examination with refraction for the purpose of obtaining eyewear during each state fiscal year (SFY) (September 1 to August 31, vision care annual periodicity schedule).

The eye exam limitation can be exceeded for clients younger than 21 years of age, but only in the following situations:

- A school nurse, teacher, or parent requests the eye examination (identify this information in Block 9 of the CMS-1500 claim form) if medically necessary.
- Medically necessary (identify this information in Block 19 of the CMS-1500 claim form).

Clients 21 years of age and older are eligible for one examination with refraction for the purpose of obtaining eyewear every 24 months.

A new patient eye examination will be limited to one every 24 months, per client, per provider. A new patient eye examination in any place of service (POS) will be changed to an established patient eye exam, if the history shows that the same provider has furnished a medical service (type of service [TOS] 1), a surgical service (TOS 2), or a consult (TOS 3) within two years. Services billed as new patient eye exams, procedure codes 1-92002 or 1-92004, in excess of this limitation will be changed to 1-92012 and 1-92014 and reimbursed as an established patient exam.

Important: *Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above and are payable even if the Medicaid Identification Form (Form H3087) does not have a check mark (✓) under the Eye Exam column.*

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Vision care services performed in SNF or ICF-MR must be ordered by the attending physician. Providers must document the physician's name and address or nine-digit provider identifier in Block 17 of the CMS-1500 claim form. Claims submitted without this information are listed on the R&S as incomplete and must be corrected and resubmitted for consideration of payment. Electronic claims of this nature will be rejected. Attending physician information for electronic claims must be noted in the appropriate field of an approved electronic claims format.

If an office evaluation and management service or consultation is billed in addition to the eye exam, the evaluation and management service or consultation will be denied as part of the eye exam.

The following services are considered part of the office visit/eye examination reimbursement when performed on the same day:

Procedure Codes		
1-92015†	1-92020†	1-92060†
1-92100†		
† = Services payable to an FQHC based on an all-inclusive rate per visit.		

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The following services may be billed in addition to an office visit/eye examination:

Procedure Codes		
1-92018	1-92019	1-92081*†
1-92082*†	1-92083*†	1-92120†
1-92135	1-92140†	

*** Procedure codes that are considered bilateral.**
† = Services payable to an FQHC based on an all-inclusive rate per visit.

Orthoptic and/or pleoptics training is considered part of the office visit, and is not separately payable.

Office visits/eye examinations will be denied if billed with any of the following ophthalmology services on the same day:

Procedure Codes		
1-92225†	1-92226†	1-92230*†
1-92235*†	1-92240†	1-92250*†
1-92260*†	1-92265*†	1-92270*†
1-92275*†	1-92285*†	1-92286*†
1-92287*†	5/I/T-95930†	

*** Procedure codes that are considered bilateral.**
† = Services payable to an FQHC based on an all-inclusive rate per visit.

In accordance with the *Omnibus Budget Reconciliation Act (OBRA) of 1986,* Section 9336, a doctor of optometry is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation. Services by an optometrist are not limited to procedure codes 1-S0620 and 1-S0621.

The following procedure codes are payable to optometrists when accompanied by an appropriate diagnosis:

Procedure Codes			
1-65205	1-65210	1-65220	1-65222
1-65286	1-65430	1-67820	1-67938
1-68530	1-68761	1-68801	1-68810
1-68840	1-92002	1-92004	1-92012
1-92014	1-92015	1-92020	1-92060
1-92065	1-92081	1-92082	1-92083
1-92100	1-92120	1-92135	1-92140
1-92225	1-92226	1-92230	1-92235
1-92240	1-92250	1-92260	1-92265
1-92270	1-92275	1-92285	1-92286
1-92287	1-92326	1-95060†	1-95933†
1-99000	1-99050	1-99052	1-99054
1-99056	1-99058	1-S0620	1-S0621
1-S0820			

† = Services payable to an FQHC based on an all-inclusive rate per visit.

Client evaluation and management services and consultation codes are payable, when indicated, for the following diagnoses:

Diagnosis Code	Description
05320	Herpes zoster dermatitis of eyelid
05321	Herpes zoster keratoconjunctivitis
05322	Herpes zoster iridocyclitis
05329	Herpes zoster with other ophthalmic complications
05440	Herpes simplex with unspecified ophthalmic complication
05441	Herpes simplex dermatitis of eyelid
05442	Dendritic keratitis
05443	Herpes simplex disciform keratitis
05444	Herpes simplex iridocyclitis
05449	Herpes simplex with other ophthalmic complications
0760	Trachoma, initial stage
0761	Trachoma, active stage
0769	Trachoma, unspecified
077	Other diseases of conjunctiva due to viruses and chlamydiae
0770	Inclusion conjunctivitis
0771	Epidemic keratoconjunctivitis
0772	Pharyngoconjunctival fever
0773	Other adenoviral conjunctivitis
0774	Epidemic hemorrhagic conjunctivitis
0778	Other viral conjunctivitis
0779	Unspecified diseases of conjunctiva due to viruses and chlamydiae
07798	Unspecified diseases of conjunctiva due to chlamydiae
07799	Unspecified diseases of conjunctiva due to viruses
0903	Syphilitic interstitial keratitis
09150	Syphilitic uveitis, unspecified
09151	Syphilitic chorioretinitis (secondary)
09152	Syphilitic iridocyclitis (secondary)
09840	Gonococcal conjunctivitis (neonatorum)
09841	Gonococcal iridocyclitis
09842	Gonococcal endophthalmia
09843	Gonococcal keratitis

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Diagnosis Code	Description
09849	Other gonococcal infection of eye
11502	Histoplasma capsulatum retinitis
11512	Histoplasma duboisii retinitis
11592	Histoplasmosis retinitis, unspecified
1301	Conjunctivitis due to toxoplasmosis
1302	Chorioretinitis due to toxoplasmosis
1900	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
1901	Malignant neoplasm of orbit
1902	Malignant neoplasm of lacrimal gland
1903	Malignant neoplasm of conjunctiva
1904	Malignant neoplasm of cornea
1905	Malignant neoplasm of retina
1906	Malignant neoplasm of choroid
1907	Malignant neoplasm of lacrimal duct
1908	Malignant neoplasm of other specified sites of eye
2240	Benign neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
2241	Benign neoplasm of orbit
2242	Benign neoplasm of lacrimal gland
2243	Benign neoplasm of conjunctiva
2244	Benign neoplasm of cornea
2245	Benign neoplasm of retina
2246	Benign neoplasm of choroid
2247	Benign neoplasm of lacrimal duct
2248	Benign neoplasm of other specified parts of eye
2249	Benign neoplasm of eye, part unspecified
2340	Carcinoma in situ of eye
36642	Tetanic cataract
36643	Myotonic cataract
36644	Cataract associated with other syndromes
36645	Toxic cataract
36646	Cataract associated with radiation and other physical influences
3665	After-cataract
36650	After-cataract, unspecified
36651	Soemmering’s ring
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision

Diagnosis Code	Description
3668	Other cataract
3669	Unspecified cataract
36752	Total or complete internal ophthalmoplegia
36753	Spasm of accommodation
36789	Other disorders of refraction and accommodation
36800	Amblyopia, unspecified
36801	Strabismic amblyopia
36802	Deprivation amblyopia
36803	Refractive amblyopia
3681	Subjective visual disturbances
36810	Subjective visual disturbance, unspecified
36811	Sudden visual loss
36812	Transient visual loss
36813	Visual discomfort
36814	Visual distortions of shape and size
36815	Other visual distortions and entoptic phenomena
36816	Psychophysical visual disturbances
3682	Diplopia
3683	Other disorders of binocular vision
36830	Binocular vision disorder, unspecified
36831	Suppression of binocular vision
36832	Simultaneous visual perception without fusion
36833	Fusion with defective stereopsis
36834	Abnormal retinal correspondence
3684	Visual field defects
36840	Visual field defect, unspecified
36841	Scotoma involving central area
36842	Scotoma of blind spot area
36843	Sector or arcuate visual field defects
36844	Other localized visual field defect
36845	Generalized visual field contraction or constriction
36846	Homonymous bilateral field defects
36847	Heteronymous bilateral field defects
3685	Color vision deficiencies
36851	Protan defect
36852	Deutan defect
36853	Tritan defect
36854	Achromatopsia
36855	Acquired color vision deficiencies

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Diagnosis Code	Description
36859	Other color vision deficiencies
3686	Night blindness
36860	Night blindness, unspecified
36861	Congenital night blindness
36862	Acquired night blindness
36863	Abnormal dark adaptation curve
36869	Other night blindness
3688	Other specified visual disturbances
3689	Unspecified visual disturbance
369	Blindness and low vision
3690	Profound vision impairment, both eyes
36900	Blindness of both eyes, impairment level not further specified
36901	Better eye: total vision impairment; lesser eye: total vision impairment
36902	Better eye: near-total vision impairment; lesser eye: not further specified
36903	Better eye: near-total vision impairment; lesser eye: total vision impairment
36904	Better eye: near-total vision impairment; lesser eye: near-total vision impairment
36905	Better eye: profound vision impairment; lesser eye: not further specified
36906	Better eye: profound vision impairment; lesser eye: total vision impairment
36907	Better eye: profound vision impairment; lesser eye: near-total vision impairment
36908	Better eye: profound vision impairment; lesser eye: profound vision impairment
3691	Moderate or severe vision impairment, better eye; profound vision impairment of lesser eye
36910	Blindness, one eye; low vision other eye
36911	Better eye: severe vision impairment; lesser eye: blind, not further specified
36912	Better eye: severe vision impairment; lesser eye: total vision impairment
36913	Better eye: severe vision impairment; lesser eye: near-total vision impairment

Diagnosis Code	Description
36914	Better eye: severe vision impairment; lesser eye: profound vision impairment
36915	Better eye: moderate vision impairment; lesser eye: blind, not further specified
36916	Better eye: moderate vision impairment; lesser eye: total vision impairment
36917	Better eye: moderate vision impairment; lesser eye: near-total vision impairment
36918	Better eye: moderate vision impairment; lesser eye: profound vision impairment
3692	Moderate or severe vision impairment, both eyes
36920	Low vision, both eyes, not otherwise specified
36921	Better eye: severe vision impairment; lesser eye; impairment not further specified
36922	Better eye: severe vision impairment; lesser eye: severe vision impairment
36923	Better eye: moderate vision impairment; lesser eye: impairment not further specified
36924	Better eye: moderate vision impairment; lesser eye: severe vision impairment
36925	Better eye: moderate vision impairment; lesser eye: moderate vision impairment
3693	Unqualified visual loss, both eyes
3694	Legal blindness, as defined in USA
3696	Profound vision impairment, one eye
36960	Blindness, one eye, not otherwise specified
36961	One eye: total vision impairment; other eye: not specified
36962	One eye: total vision impairment; other eye: near-normal vision
36963	One eye: total vision impairment; other eye: normal vision
36964	One eye: near-total vision impairment; other eye: vision not specified
36965	One eye: near-total vision impairment; other eye: near-normal vision

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Diagnosis Code	Description
36966	One eye: near-total vision impairment; other eye: normal vision
36967	One eye: profound vision impairment; other eye: vision not specified
36968	One eye: profound vision impairment; other eye: near-normal vision
36969	One eye: profound vision impairment; other eye: normal vision
3697	Moderate or severe vision impairment, one eye
36970	Low vision, one eye, not otherwise specified
36971	One eye: severe vision impairment; other eye: vision not specified
36972	One eye: severe vision impairment; other eye: near-normal vision
36973	One eye: severe vision impairment; other eye: normal vision
36974	One eye: moderate vision impairment; other eye: vision not specified
36975	One eye: moderate vision impairment; other eye: near-normal vision
36976	One eye: moderate vision impairment; other eye: normal vision
3698	Unqualified visual loss, one eye
3699	Unspecified visual loss
370	Keratitis
3700	Corneal ulcer
37000	Corneal ulcer, unspecified
37001	Marginal corneal ulcer
37002	Ring corneal ulcer
37003	Central corneal ulcer
37004	Hypopyon ulcer
37005	Mycotic corneal ulcer
37006	Perforated corneal ulcer
37007	Mooren’s ulcer
3702	Superficial keratitis without conjunctivitis
37020	Superficial keratitis, unspecified
37021	Punctate keratitis
37022	Macular keratitis
37023	Filamentary keratitis
37024	Photokeratitis
3703	Certain types of keratoconjunctivitis
37031	Phlyctenular keratoconjunctivitis

Diagnosis Code	Description
37032	Limbar and corneal involvement in vernal conjunctivitis
37033	Keratoconjunctivitis sicca, not specified as Sjogren’s
37034	Exposure keratoconjunctivitis
37035	Neurotrophic keratoconjunctivitis
3704	Other and unspecified keratoconjunctivitis
37040	Keratoconjunctivitis, unspecified
37044	Keratitis or keratoconjunctivitis in exanthema
37049	Other keratoconjunctivitis, unspecified
3705	Interstitial and deep keratitis
37050	Interstitial keratitis, unspecified
37052	Diffuse interstitial keratitis
37054	Sclerosing keratitis
37055	Corneal abscess
37059	Other interstitial and deep keratitis
3706	Corneal neovascularization
37060	Corneal neovascularization, unspecified
37061	Localized vascularization of cornea
37062	Pannus (corneal)
37063	Deep vascularization of cornea
37064	Ghost vessels (corneal)
3708	Other forms of keratitis
3709	Unspecified keratitis
371	Corneal opacity and other disorders of cornea
3710	Corneal scars and opacities
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37105	Phthisical cornea
3711	Corneal pigmentations and deposits
37110	Corneal deposit, unspecified
37111	Anterior corneal pigmentations
37112	Stromal corneal pigmentations
37113	Posterior corneal pigmentations
37114	Kayser-Fleischer ring
37115	Other corneal deposits associated with metabolic disorders
37116	Argentous corneal deposits

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Diagnosis Code	Description
3712	Corneal edema
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37124	Corneal edema due to wearing of contact lenses
3713	Changes of corneal membranes
37130	Corneal membrane change, unspecified
37131	Folds and rupture of Bowman's membrane
37132	Folds in Descemet's membrane
37133	Rupture in Descemet's membrane
3714	Corneal degenerations
37140	Corneal degeneration, unspecified
37141	Senile corneal changes
37142	Recurrent erosion of cornea
37143	Band-shaped keratopathy
37144	Other calcerous degenerations of cornea
37145	Keratomalacia NOS
37146	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Other corneal degenerations
3715	Hereditary corneal dystrophies
37150	Hereditary corneal dystrophy, unspecified
37151	Juvenile epithelial corneal dystrophy
37152	Other anterior corneal dystrophies
37153	Granular corneal dystrophy
37154	Lattice corneal dystrophy
37155	Macular corneal dystrophy
37156	Other stromal corneal dystrophies
37157	Endothelial corneal dystrophy
37158	Other posterior corneal dystrophies
3716	Keratoconus
37160	Keratoconus, unspecified
37161	Keratoconus, stable condition
37162	Keratoconus, acute hydrops
3717	Other corneal deformities
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal staphyloma

Diagnosis Code	Description
3718	Other corneal disorders
37181	Corneal anesthesia and hypoesthesia
37182	Corneal disorder due to contact lens
37189	Other corneal disorders
3719	Unspecified corneal disorder
372	Disorders of conjunctiva
3720	Acute conjunctivitis
37200	Acute conjunctivitis, unspecified
37201	Serous conjunctivitis, except viral
37202	Acute follicular conjunctivitis
37203	Other mucopurulent conjunctivitis
37204	Pseudomembranous conjunctivitis
37205	Acute atopic conjunctivitis
3721	Chronic conjunctivitis
37210	Chronic conjunctivitis, unspecified
37211	Simple chronic conjunctivitis
37212	Chronic follicular conjunctivitis
37213	Vernal conjunctivitis
37214	Other chronic allergic conjunctivitis
37215	Parasitic conjunctivitis
3722	Blepharoconjunctivitis
37220	Blepharoconjunctivitis, unspecified
37221	Angular blepharoconjunctivitis
37222	Contact blepharoconjunctivitis
3723	Other and unspecified conjunctivitis
37230	Conjunctivitis, unspecified
37231	Rosacea conjunctivitis
37233	Conjunctivitis in mucocutaneous disease
37239	Other conjunctivitis
3724	Pterygium
37240	Pterygium, unspecified
37241	Peripheral pterygium, stationary
37242	Peripheral pterygium, progressive
37243	Central pterygium
37244	Double pterygium
37245	Recurrent pterygium
3725	Conjunctival degenerations and deposits
37250	Conjunctival degeneration, unspecified
37251	Pinguecula
37252	Pseudopterygium
37253	Conjunctival xerosis

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Diagnosis Code	Description
37254	Conjunctival concretions
37255	Conjunctival pigmentations
37256	Conjunctival deposits
3726	Conjunctival scars
37261	Granuloma of conjunctiva
37262	Localized adhesions and strands of conjunctiva
37263	Symblepharon
37264	Scarring of conjunctiva
3727	Conjunctival vascular disorders and cysts
37271	Hyperemia of conjunctiva
37272	Conjunctival hemorrhage
37273	Conjunctival edema
37274	Vascular abnormalities of conjunctiva
37275	Conjunctival cysts
3728	Other disorders of conjunctiva
37281	Conjunctivochalasis
37289	Other disorders of conjunctiva
3729	Unspecified disorder of conjunctiva
373	Inflammation of eyelids
3730	Blepharitis
37300	Blepharitis, unspecified
37301	Ulcerative blepharitis
37302	Squamous blepharitis
3731	Hordeolum and other deep inflammation of eyelid
37311	Hordeolum externum
37312	Hordeolum internum
37313	Abscess of eyelid
3732	Chalazion
3733	Noninfectious dermatoses of eyelid
37331	Eczematous dermatitis of eyelid
37332	Contact and allergic dermatitis of eyelid
37333	Xeroderma of eyelid
37334	Discoid lupus erythematosus of eyelid
3734	Infective dermatitis of eyelid of types resulting in deformity
3735	Other infective dermatitis of eyelid
3736	Parasitic infestation of eyelid
3738	Other inflammations of eyelids
3739	Unspecified inflammation of eyelid
374	Other disorders of eyelids

Diagnosis Code	Description
3740	Entropion and trichiasis of eyelid
37400	Entropion, unspecified
37401	Senile entropion
37402	Mechanical entropion
37403	Spastic entropion
37404	Cicatricial entropion
37405	Trichiasis of eyelid without entropion
3741	Ectropion
37410	Ectropion, unspecified
37411	Senile ectropion
37412	Mechanical ectropion
37413	Spastic ectropion
37414	Cicatricial ectropion
3742	Lagophthalmos
37420	Lagophthalmos, unspecified
37421	Paralytic lagophthalmos
37422	Mechanical lagophthalmos
37423	Cicatricial lagophthalmos
3743	Ptosis of eyelid
37430	Ptosis of eyelid, unspecified
37431	Paralytic ptosis
37432	Myogenic ptosis
37433	Mechanical ptosis
37434	Blepharochalasis
3744	Other disorders affecting eyelid function
37441	Lid retraction or lag
37443	Abnormal innervation syndrome of eyelid
37444	Sensory disorders of eyelid
37445	Other sensorimotor disorders of eyelid
37446	Blepharophimosis
3745	Degenerative disorders of eyelid and periocular area
37450	Degenerative disorder of eyelid, unspecified
37451	Xanthelasma of eyelid
37452	Hyperpigmentation of eyelid
37453	Hypopigmentation of eyelid
37454	Hypertrichosis of eyelid
37455	Hypotrichosis of eyelid
37456	Other degenerative disorders of skin affecting eyelid
3748	Other disorders of eyelid
37481	Hemorrhage of eyelid

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Diagnosis Code	Description
37482	Edema of eyelid
37483	Elephantiasis of eyelid
37484	Cysts of eyelids
37485	Vascular anomalies of eyelid
37486	Retained foreign body of eyelid
37487	Dermatochalasis
37489	Other disorders of eyelid
3749	Unspecified disorder of eyelid
375	Disorders of lacrimal system
3750	Dacryoadenitis
37500	Dacryoadenitis, unspecified
37501	Acute dacryoadenitis
37502	Chronic dacryoadenitis
37503	Chronic enlargement of lacrimal gland
3751	Other disorders of lacrimal gland
37511	Dacryops
37512	Other lacrimal cysts and cystic degeneration
37513	Primary lacrimal atrophy
37514	Secondary lacrimal atrophy
37515	Tear film insufficiency, unspecified
37516	Dislocation of lacrimal gland
3752	Epiphora
37520	Epiphora, unspecified as to cause
37521	Epiphora due to excess lacrimation
37522	Epiphora due to insufficient drainage
3753	Acute and unspecified inflammation of lacrimal passages
37530	Dacryocystitis, unspecified
37531	Acute canaliculitis, lacrimal
37532	Acute dacryocystitis
37533	Phlegmonous dacryocystitis
3754	Chronic inflammation of lacrimal passages
37541	Chronic canaliculitis
37542	Chronic dacryocystitis
37543	Lacrimal mucocele
3755	Stenosis and insufficiency of lacrimal passages
37551	Eversion of lacrimal punctum
37552	Stenosis of lacrimal punctum
37553	Stenosis of lacrimal canaliculi
37554	Stenosis of lacrimal sac
37555	Obstruction of nasolacrimal duct, neonatal

Diagnosis Code	Description
37556	Stenosis of nasolacrimal duct, acquired
37557	Dacryolith
3756	Other changes of lacrimal passages
37561	Lacrimal fistula
37569	Other changes of lacrimal passages
3758	Other disorders of lacrimal system
37581	Granuloma of lacrimal passages
37589	Other disorders of lacrimal system
3759	Unspecified disorder of lacrimal system
376	Disorders of the orbit
3760	Acute inflammation of orbit
37600	Acute inflammation of orbit, unspecified
37601	Orbital cellulitis
37602	Orbital periostitis
37603	Orbital osteomyelitis
37604	Orbital tenonitis
3761	Chronic inflammatory disorders of orbit
37610	Chronic inflammation of orbit, unspecified
37611	Orbital granuloma
37612	Orbital myositis
37613	Parasitic infestation of orbit
3762	Endocrine exophthalmos
37621	Thyrotoxic exophthalmos
37622	Exophthalmic ophthalmoplegia
3763	Other exophthalmic conditions
37630	Exophthalmos, unspecified
37631	Constant exophthalmos
37632	Orbital hemorrhage
37633	Orbital edema or congestion
37634	Intermittent exophthalmos
37635	Pulsating exophthalmos
37636	Lateral displacement of globe
3764	Deformity of orbit
37640	Deformity of orbit, unspecified
37641	Hypertelorism of orbit
37642	Exostosis of orbit
37643	Local deformities of orbit due to bone disease
37644	Orbital deformities associated with craniofacial deformities
37645	Atrophy of orbit

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Diagnosis Code	Description
37646	Enlargement of orbit
37647	Deformity of orbit due to trauma or surgery
3765	Enophthalmos
37650	Enophthalmos, unspecified as to cause
37651	Enophthalmos due to atrophy of orbital tissue
37652	Enophthalmos due to trauma or surgery
3766	Retained (old) foreign body following penetrating wound of orbit
3768	Other orbital disorders
37681	Orbital cysts
37682	Myopathy of extraocular muscles
37689	Other orbital disorders
3769	Unspecified disorder of orbit
377	Disorders of optic nerve and visual pathways
3770	Papilledema
37700	Papilledema, unspecified
37701	Papilledema associated with increased intracranial pressure
37702	Papilledema associated with decreased ocular pressure
37703	Papilledema associated with retinal disorder
37704	Foster-kennedy syndrome
3771	Optic atrophy
37710	Optic atrophy, unspecified
37711	Primary optic atrophy
37712	Postinflammatory optic atrophy
37713	Optic atrophy associated with retinal dystrophies
37714	Glaucomatous atrophy (cupping) of optic disc
37715	Partial optic atrophy
37716	Hereditary optic atrophy
3772	Other disorders of optic disc
37721	Drusen of optic disc
37722	Crater-like holes of optic disc
37723	Coloboma of optic disc
37724	Pseudopapilledema
3773	Optic neuritis
37730	Optic neuritis, unspecified
37731	Optic papillitis
37732	Retrobulbar neuritis (acute)

Diagnosis Code	Description
37733	Nutritional optic neuropathy
37734	Toxic optic neuropathy
37739	Other optic neuritis
3774	Other disorders of optic nerve
37741	Ischemic optic neuropathy
37742	Hemorrhage in optic nerve sheaths
37749	Other disorders of optic nerve
3775	Disorders of optic chiasm
37751	Disorders of optic chiasm associated with pituitary neoplasms and disorders
37752	Disorders of optic chiasm associated with other neoplasms
37753	Disorders of optic chiasm associated with vascular disorders
37754	Disorders of optic chiasm associated with inflammatory disorders
3776	Disorders of other visual pathways
37761	Disorders of other visual pathways associated with neoplasms
37762	Disorders of other visual pathways associated with vascular disorders
37763	Disorders of other visual pathways associated with inflammatory disorders
3777	Disorders of visual cortex
37771	Disorders of visual cortex associated with neoplasms
37772	Disorders of visual cortex associated with vascular disorders
37773	Disorders of visual cortex associated with inflammatory disorders
37775	Cortical blindness
3779	Unspecified disorder of optic nerve and visual pathways
378	Strabismus and other disorders of binocular eye movements
3780	Esotropia
37800	Esotropia, unspecified
37801	Monocular esotropia
37802	Monocular esotropia with a pattern
37803	Monocular esotropia with v pattern
37804	Monocular esotropia with other noncomitancies
37805	Alternating esotropia
37806	Alternating esotropia with a pattern
37807	Alternating esotropia with v pattern

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Diagnosis Code	Description
37808	Alternating esotropia with other noncomitancies
3781	Exotropia
37810	Exotropia, unspecified
37811	Monocular exotropia
37812	Monocular exotropia with a pattern
37813	Monocular exotropia with v pattern
37814	Monocular exotropia with other noncomitancies
37815	Alternating exotropia
37816	Alternating exotropia with a pattern
37817	Alternating exotropia with v pattern
37818	Alternating exotropia with other noncomitancies
3782	Intermittent heterotropia
37820	Intermittent heterotropia, unspecified
37821	Intermittent esotropia, monocular
37822	Intermittent esotropia, alternating
37823	Intermittent exotropia, monocular
37824	Intermittent exotropia, alternating
3783	Other and unspecified heterotropia
37830	Heterotropia, unspecified
37831	Hypertropia
37832	Hypotropia
37833	Cyclotropia
37834	Monofixation syndrome
37835	Accommodative component in esotropia
3784	Heterophoria
37840	Heterophoria, unspecified
37841	Esophoria
37842	Exophoria
37843	Vertical heterophoria
37844	Cyclophoria
37845	Alternating hyperphoria
3785	Paralytic strabismus
37850	Paralytic strabismus, unspecified
37851	Third or oculomotor nerve palsy, partial
37852	Third or oculomotor nerve palsy, total
37853	Fourth or trochlear nerve palsy
37854	Sixth or abducens nerve palsy
37855	External ophthalmoplegia
37856	Total ophthalmoplegia
3786	Mechanical strabismus

Diagnosis Code	Description
37860	Mechanical strabismus, unspecified
37861	Brown’s (tendon) sheath syndrome
37862	Mechanical strabismus from other musculofascial disorders
37863	Limited duction associated with other conditions
3787	Other specified strabismus
37871	Duane’s syndrome
37872	Progressive external ophthalmoplegia
37873	Strabismus in other neuromuscular disorders
3788	Other disorders of binocular eye movements
37881	Palsy of conjugate gaze
37882	Spasm of conjugate gaze
37883	Convergence insufficiency or palsy
37884	Convergence excess or spasm
37885	Anomalies of divergence
37886	Internuclear ophthalmoplegia
37887	Other dissociated deviation of eye movements
3789	Unspecified disorder of eye movements
379	Other disorders of eye
3790	Scleritis and episcleritis
37900	Scleritis, unspecified
37901	Episcleritis periodica fugax
37902	Nodular episcleritis
37903	Anterior scleritis
37904	Scleromalacia perforans
37905	Scleritis with corneal involvement
37906	Brawny scleritis
37907	Posterior scleritis
37909	Other scleritis
3791	Other disorders of sclera
37911	Scleral ectasia
37912	Staphyloma posticum
37913	Equatorial staphyloma
37914	Anterior staphyloma, localized
37915	Ring staphyloma
37916	Other degenerative disorders of sclera
37919	Other scleral disorders
3792	Disorders of vitreous body
37921	Vitreous degeneration

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Diagnosis Code	Description
37922	Crystalline deposits in vitreous
37923	Vitreous hemorrhage
37924	Other vitreous opacities
37925	Vitreous membranes and strands
37926	Vitreous prolapse
37929	Other disorders of vitreous
3793	Aphakia and other disorders of lens
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
37939	Other disorders of lens
3794	Anomalies of pupillary function
37940	Abnormal pupillary function, unspecified
37941	Anisocoria
37942	Miosis (persistent), not due to miotics
37943	Mydriasis (persistent), not due to mydriatics
37945	Argyll robertson pupil, atypical
37946	Tonic pupillary reaction
37949	Other anomalies of pupillary function
3795	Nystagmus and other irregular eye movements
37950	Nystagmus, unspecified
37951	Congenital nystagmus
37952	Latent nystagmus
37953	Visual deprivation nystagmus
37954	Nystagmus associated with disorders of the vestibular system
37955	Dissociated nystagmus
37956	Other forms of nystagmus
37957	Deficiencies of saccadic eye movements
37958	Deficiencies of smooth pursuit movements
37959	Other irregularities of eye movements
3798	Other specified disorders of eye and adnexa
3799	Unspecified disorder of eye and adnexa
37990	Disorder of eye, unspecified
37991	Pain in or around eye
37992	Swelling or mass of eye
37993	Redness or discharge of eye
37999	Other ill-defined disorders of eye
74300	Clinical anophthalmos, unspecified
74303	Cystic eyeball, congenital
74306	Cryptophthalmos
7431	Microphthalmos
74310	Microphthalmos, unspecified
74311	Simple microphthalmos
74312	Microphthalmos associated with other anomalies of eye and adnexa
7432	Buphthalmos
74320	Buphthalmos, unspecified
74321	Simple buphthalmos
74322	Buphthalmos associated with other ocular anomalies
7433	Congenital cataract and lens anomalies
74330	Congenital cataract, unspecified
74331	Congenital capsular and subcapsular cataract
74332	Congenital cortical and zonular cataract
74333	Congenital nuclear cataract
74334	Congenital total and subtotal cataract
74335	Congenital aphakia
74336	Congenital anomalies of lens shape
74337	Congenital ectopic lens
74339	Other congenital cataract and lens anomalies
7434	Coloboma and other anomalies of anterior segment
74341	Congenital anomalies of corneal size and shape
74342	Congenital corneal opacities, interfering with vision
74343	Other congenital corneal opacities
74344	Specified congenital anomalies of anterior chamber, chamber angle, and related structures
74345	Aniridia
74346	Other specified congenital anomalies of iris and ciliary body
74347	Specified congenital anomalies of sclera
74348	Multiple and combined congenital anomalies of anterior segment
74349	Other congenital anomalies of anterior segment

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Diagnosis Code	Description
7435	Congenital anomalies of posterior segment
74351	Vitreous anomalies, congenital
74352	Fundus coloboma
74353	Chorioretinal degeneration, congenital
74354	Congenital folds and cysts of posterior segment
74355	Congenital macular changes
74356	Other retinal changes, congenital
74357	Specified congenital anomalies of optic disc
74358	Vascular anomalies, congenital
74359	Other congenital anomalies of posterior segment
7436	Congenital anomalies of eyelids, lacrimal system, and orbit
74361	Congenital ptosis of eyelid
74362	Congenital deformities of eyelids
74363	Other specified congenital anomalies of eyelid
74364	Specified congenital anomalies of lacrimal gland
74365	Specified congenital anomalies of lacrimal passages
74366	Specified congenital anomalies of orbit
74369	Other congenital anomalies of eyelids, lacrimal system, and orbit
7438	Other specified anomalies of eye, congenital
7439	Unspecified anomaly of eye, congenital
8700	Laceration of skin of eyelid and periocular area
8701	Laceration of eyelid, full-thickness, not involving lacrimal passages
8702	Laceration of eyelid involving lacrimal passages
8703	Penetrating wound of orbit, without mention of foreign body
8704	Penetrating wound of orbit with foreign body
8708	Other specified open wounds of ocular adnexa
8709	Unspecified open wound of ocular adnexa
871	Open wound of eyeball
8710	Ocular laceration without prolapse of intraocular tissue
8711	Ocular laceration with prolapse or exposure of intraocular tissue
8712	Rupture of eye with partial loss of intraocular tissue
8713	Avulsion of eye
8714	Unspecified laceration of eye
8715	Penetration of eyeball with magnetic foreign body
8716	Penetration of eyeball with (nonmagnetic) foreign body
8717	Unspecified ocular penetration
8719	Unspecified open wound of eyeball
9180	Superficial injury of eyelids and periocular area
9181	Superficial injury of cornea
9182	Superficial injury of conjunctiva
9189	Other and unspecified superficial injuries of eye
9210	Black eye, not otherwise specified
9211	Contusion of eyelids and periocular area
9212	Contusion of orbital tissues
9213	Contusion of eyeball
9219	Unspecified contusion of eye
92300	Contusion of shoulder region
92301	Contusion of scapular region
92302	Contusion of axillary region
92303	Contusion of upper arm
92309	Contusion of multiple sites of shoulder and upper arm
9400	Chemical burn of eyelids and periocular area
9401	Other burns of eyelids and periocular area
9402	Alkaline chemical burn of cornea and conjunctival sac
9403	Acid chemical burn of cornea and conjunctival sac
9404	Other burn of cornea and conjunctival sac
9405	Burn with resulting rupture and destruction of eyeball
9409	Unspecified burn of eye and adnexa

Procedure code 1-S0620 or 1-S0621 is payable with a diagnosis of refractive error only. Procedure code 92015 is not payable with a diagnosis of refractive error.

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The following sonography procedures are payable to an optometrist when accompanied by an appropriate diagnosis:

Procedure Codes		
4/I/T-76511	4/I/T-76512	4/I/T-76513
4/I/T-76516	4/I/T-76519	4/I/T-76529

If an office evaluation and management service is billed in addition to the eye examination, the evaluation and management service will be denied as part of the eye exam.

If a consultation is billed in addition to the eye exam, it will be denied as part of the eye exam.

Procedure code 1-99173 will deny as part of another procedure/service billed on the same day (e.g., Texas Health Steps [THSteps] visit or evaluation and management service).

45.4.2.1 Disease or Injury to the Eye

The following codes are payable to optometrists for the diagnosis of aphakia, disease of the eye, or injury of the eye:

Procedure Codes	
1-92002†	1-92004†
1-92012†	1-92014†
† = Services payable to an FQHC based on an all-inclusive rate per visit.	

Important: *Providers may not withhold from a client a prescription for eyeglasses pending Medicaid payment for the eye examination. Prescriptions for eyeglasses must be given to the client on request.*

45.4.2.2 Echography

Procedure codes 4-76511, 4-76512, 4-76513, and 4-76999 are payable for the following diagnoses or conditions:

Diagnosis Code	Description
1900–1901, 1984, 2240–2241, 2340, 2388, 2398, 37992	Intraocular or retrobulbar tumors
25050–25053, 36201–36202, or 36641	Diabetic retinopathy
36100–3612, 36181–3619	Retinal detachment
36130–36133, 36210–36289	Retinal defect without detachment
36340–36343	Choroidal degenerations
36361–36363, 36370–36372	Choroidal hemorrhage or rupture; detachment
36441	Hyphema
37921–37926	Disorders of the vitreous

Procedure codes 4-76511, 4-76512, 4-76516, 4-76519 are payable for the following diagnoses:

Diagnosis Code	Description
3660	Infantile, juvenile, and presenile cataract
36600	Nonsenile cataract, unspecified
36601	Anterior subcapsular polar nonsenile cataract
36602	Posterior subcapsular polar nonsenile cataract
36603	Cortical, lamellar, or zonular nonsenile cataract
36604	Nuclear nonsenile cataract
36609	Other and combined forms of nonsenile cataract
3661	Senile cataract
36610	Senile cataract, unspecified
36611	Pseudoexfoliation of lens capsule
36612	Incipient senile cataract
36613	Anterior subcapsular polar senile cataract
36614	Posterior subcapsular polar senile cataract
36615	Cortical senile cataract
36616	Senile nuclear sclerosis
36617	Total or mature cataract
36618	Hypermature cataract
36619	Other and combined forms of senile cataract
3662	Traumatic cataract
36620	Traumatic cataract, unspecified
36621	Localized traumatic opacities
36622	Total traumatic cataract
36623	Partially resolved traumatic cataract
3663	Cataract secondary to ocular disorders
36630	Cataracta complicata, unspecified
36631	Cataract secondary to glaucomatous flecks (subcapsular)
36632	Cataract in inflammatory ocular disorders
36633	Cataract with ocular neovascularization
36634	Cataract in degenerative ocular disorders

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Diagnosis Code	Description
3664	Cataract associated with other disorders
36641	Diabetic cataract
36642	Tetanic cataract
36643	Myotonic cataract
36644	Cataract associated with other syndromes
36645	Toxic cataract
36646	Cataract associated with radiation and other physical influences
3665	After-cataract
36650	After-cataract, unspecified
36651	Soemmering's ring
36652	Other after-cataract, not obscuring vision
36653	After-cataract, obscuring vision
3668	Other cataract
3669	Unspecified cataract
37100	Corneal opacity, unspecified
37101	Minor opacity of cornea
37102	Peripheral opacity of cornea
37103	Central opacity of cornea
37104	Adherent leucoma
37105	Phthisical cornea
3711	Corneal pigmentations and deposits
37110	Corneal deposit, unspecified
37111	Anterior corneal pigmentations
37112	Stromal corneal pigmentations
37113	Posterior corneal pigmentations
37114	Kayser-Fleischer ring
37115	Other corneal deposits associated with metabolic disorders
37116	Argentous corneal deposits
3712	Corneal edema
37120	Corneal edema, unspecified
37121	Idiopathic corneal edema
37122	Secondary corneal edema
37123	Bullous keratopathy
37124	Corneal edema due to wearing of contact lenses
3713	Changes of corneal membranes
37130	Corneal membrane change, unspecified
37131	Folds and rupture of Bowman's membrane
37132	Folds in Descemet's membrane

Diagnosis Code	Description
37133	Rupture in Descemet's membrane
3714	Corneal degenerations
37140	Corneal degeneration, unspecified
37141	Senile corneal changes
37142	Recurrent erosion of cornea
37143	Band-shaped keratopathy
37144	Other calcerous degenerations of cornea
37145	Keratomalacia nos
37146	Nodular degeneration of cornea
37148	Peripheral degenerations of cornea
37149	Other corneal degenerations
3715	Hereditary corneal dystrophies
37150	Hereditary corneal dystrophy, unspecified
37151	Juvenile epithelial corneal dystrophy
37152	Other anterior corneal dystrophies
37153	Granular corneal dystrophy
37154	Lattice corneal dystrophy
37155	Macular corneal dystrophy
37156	Other stromal corneal dystrophies
37157	Endothelial corneal dystrophy
37158	Other posterior corneal dystrophies
3716	Keratoconus
37160	Keratoconus, unspecified
37161	Keratoconus, stable condition
37162	Keratoconus, acute hydrops
3717	Other corneal deformities
37170	Corneal deformity, unspecified
37171	Corneal ectasia
37172	Descemetocele
37173	Corneal staphyloma
3718	Other corneal disorders
37181	Corneal anesthesia and hypoesthesia
37182	Corneal disorder due to contact lens
37189	Other corneal disorders
3719	Unspecified corneal disorder
37931	Aphakia
37932	Subluxation of lens
37933	Anterior dislocation of lens
37934	Posterior dislocation of lens
37939	Other disorders of lens
74330	Congenital cataract, unspecified
74331	Congenital capsular and subcapsular cataract

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Diagnosis Code	Description
74332	Congenital cortical and zonular cataract
74333	Congenital nuclear cataract
74334	Congenital total and subtotal cataract
74335	Congenital aphakia
74336	Congenital anomalies of lens shape
74337	Congenital ectopic lens
74339	Other congenital cataract and lens anomalies

Procedure code 4-76529 is payable for the following diagnoses: 36050 through 36069, 3766, 8704, 8715, 8716, and 9300 through 9309, Diagnosis of foreign bodies of the eye or orbit.

Procedure code 4-76511, 4-76516, or 4-76519 will not be reimbursed if procedure code 4-76512 is billed on the same day, by any provider.

45.4.2.3 Corneal Topography

Procedure code 1-S0820 is a covered benefit.

An initial or established visit/consultation is payable on the same day as the topography. These visits remain subject to the global surgery fee guidelines.

If topography is performed within the global surgical pre- and post-care days of the following ophthalmic procedures, the topography is denied as *part of*.

Procedure Codes			
2/F-65270	2/F-65272	2/F-65273	2/F-65275
2/F-65280	2/F-65285	2/F-65286	2/F-65400
2/F-65420	2/F-65426	2/F-65430	2/F-65435
2/F-65436	2-65450	2-65600	2/F-65710
2/F-65730	2/F-65750	2/F-65755	2/F-65880
2/F-66600	2/F-66605	2/F-66625	2/F-66630
2/F-66635	2/F-66820	2/F-66821	2/F-66830
2/F-66840	2/F-66850	2/F-66852	2/F-66920
2/F-66930	2/F-66940	2/F-66983	2/F-66984
2/F-66985	2/F-66986		

Interpretations are payable in the office and outpatient and inpatient settings. The technical component is only reimbursed in the office setting, not the inpatient or outpatient settings. Depending on the POS billed, a maximum of two interpretations (one for each eye) and one technical component *or* one total component and one additional interpretation (if topography was performed on both eyes) may be reimbursed per client, per day.

Procedure Codes	
1-S0820†	I-S0820
T-S0820	
† = Services payable to an FQHC based on an all-inclusive rate per visit.	

Procedure code 1-S0820 is payable when used for the fitting of contact lenses for diagnoses 36720, 36722, 37281, 37289, and 74341. Prior authorization criteria must be met for contact lenses.

Services are payable to an FQHC based on an all-inclusive rate per visit.

Refer to: “Contact Lenses” on page 45-19 for contact lens information.

Diagnosis Code	Description
36720	Astigmatism, unspecified
36722	Irregular astigmatism
37281	Conjunctivachalasis
37289	Conjunctiva disorder NEC
74341	Anomalies of corneal size and shape

45.4.2.4 Therapeutic Optometrists

The following procedure codes are payable to therapeutic optometrists:

Procedure Codes		
2-65205	2-65210	2-65220
2-65222	2-65286	2-65430
2-67820	2-67938	2-68530
2-68761	2-68801	2-68810
2-68840		

45.4.3 Medicare/Medicaid

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses/contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Medicaid when performed for a Medicare/Medicaid client. Medicare coverage is limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for a Medicare/Medicaid client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 1-92015 must be used to bill Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.
- The medical portion of the eye examination (1-92002, 1-92004, 1-92012, 1-92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for payment of coinsurance and/or deductible.

Important: *Providers performing eye exams for refractive errors on STAR+PLUS Medicaid Eligibility Verification (MQMB)s* must *bill TMHP, not the STAR+PLUS health plan.*

Do not send the refraction (1-92015) to Medicare first.

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Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Medicaid for payment.

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an intraocular lens (IOL) (Medicare considers the IOL the prosthetic device). Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the *Y* codes in the "Nonprosthetic Eyeglasses and Contacts" tables beginning on page 45-20.

45.4.4 Nonprosthetic Eyewear

Eligible clients may receive nonprosthetic frames and/or lenses once every 24 months. This benefit period begins with the month the glasses are first dispensed. Refer to the Eyeglasses column of the client's Medicaid Identification Form (Form H3087) for determination of eligibility for this service. When there is a change in visual acuity (equal to or greater than 0.5 diopter in one eye), clients are eligible for new nonprosthetic eyeglasses, regardless of when they received their last pair of nonprosthetic eyeglasses or if their Medicaid Identification Form (Form H3087) does not have a check mark (✓) in the Eyeglasses column.

Medicaid provides for serviceable eyeglasses, contact lenses that are medically necessary and prior authorized, necessary major repairs to eyeglasses for clients younger than 21 years of age, and replacement of lost/destroyed eyeglasses and contact lenses for clients younger than 21 years of age.

Exception: *Diagnosis of aphakia does not require prior authorization.*

Important: *For clients younger than 21 years of age, there are no limitations on replacements for lost or destroyed eyewear. Eyewear will be reimbursed even if the client's Medicaid Identification Form (Form H3087) does not have a check mark (✓) in the services already rendered.*

Clients in Medicaid Managed Care health plans may be eligible for additional eyeglass benefits under their plan. Check with the client's health plan for details.

Eyewear must be medically necessary and:

- Prescribed by a Doctor of Medicine (MD), Doctor of Optometry (OD), or Doctor of osteopathy (DO)
- Prescribed to significantly improve vision or correct a medical condition
- Must meet the following eyeglass program specifications for frames and lenses:

Frames

- Frames composed of all zynolite components. The frame is the entire piece of eyewear without the lenses.
- Frames composed of a combination of zynolite and metal components are reimbursed to the maximum allowable amount for a zynolite frame. The client may be billed the difference between the reimbursed amount and the billed amount, as the metal portion is not a benefit of the program.
- All metal frames are *not* a benefit of Medicaid. Clients may be billed for frames that are beyond Medicaid benefits, as specified in "Noncovered Services/ Supplies" on page 45-19.
- American-made unless foreign-made frames are comparable in quality and are less expensive.
- Serviceable and able to meet statutory quality standards.
- Composed of new materials.

Eyeglass Lenses

- Clear glass or plastic.
- Heat or chemically-treated dress eyewear able to meet standards of the American Standard Prescription Requirements for first quality glass and plastic lenses.
- Composed of new materials.
- A minimum kryptoc or 22 mm flat top lens or equivalent if bifocal.
- A minimum flat top 7/25 lens or equivalent if trifocal.

45.4.4.1 Dispensing Requirements

Providers must be able to dispense standard size frames at no cost to the eligible client. Providers must also show each eligible client a minimum of three styles of zylonite frames for male or female, child or adult, in a choice of three colors. The provider may also show combination frames of zylonite and metal. Medicaid can reimburse the zylonite maximum allowable amount for a combination frame. If the cost of frames exceeds the Medicaid maximum allowable fee, the client may be billed the difference of the billed amount. If there is no Medicaid coverage for the eyewear, the client is responsible for the entire amount.

Clients must acknowledge their choice of eyewear beyond program limitations by signing the "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" on page B-116.

45.4.4.2 Replacements

Clients younger than 21 years of age may obtain replacements of nonprosthetic eyewear because of loss or destruction. Clients 21 years of age and older are not eligible for replacements because of loss or destruction of nonprosthetic eyewear. There is no limitation on the number of replacements a client younger than 21 years of age may receive. If eyewear is lost or destroyed, the provider must have the client sign the "Vision Care Eyeglass Patient (Medicaid Client) Certification Form" on page B-116. Replacement codes must be used to ensure accurate processing.

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45.4.4.3 Repairs

Clients younger than 21 years of age may obtain repairs of nonprosthetic eyewear when the actual cost of materials exceeds $2. An invoice for the repair materials is not required to be submitted with the claim. Providers are required to maintain this information in the client's medical file and make it available for review by TMHP, HHSC, or the Attorney General's office when requested. The cost of repair supplies cannot exceed the amount that would have been payable, if the damaged eyewear had been a new purchase. All repair materials billed to the Texas Medicaid Program must be new and at least equivalent to the original item.

Repairs costing $2 or less are considered minor repairs. The eyeglass supplier is required to perform minor repairs on request (without charge) on eyewear that they have dispensed. Therefore, the Texas Medicaid Program or the client may not be billed for any minor repairs.

No benefits are allowed for repair of eyeglasses that do not meet the minimum program specifications or for clients who are eligible for Medicaid and are 21 years of age and older.

45.4.4.4 Contact Lenses

The Texas Medicaid Program allows reimbursement for contact lenses when no other option is available to correct a visual defect. Prior authorization is mandatory and must be received before dispensing the lens(es), unless the diagnosis is aphakia. Additionally, the client must be eligible for Medicaid at the time the lens(es) are dispensed. Providers must include the following information in each prior authorization request for contact lens(es):

- The client's name and Medicaid number, as they appear on the Medicaid card
- The diagnosis causing the refractive error (for example, keratoconus)
- The current prescription (also include the previous prescription, if the request is because of a significant change in vision)
- The indication of the eye to be treated (right, left, or bilateral)
- The specific procedure code for contact lens(es) requested
- A brief statement addressing the medical need for contact lens(es) (specify why eyeglasses are inappropriate or contraindicated for this client)
- The provider identifer
- The signature of the physician or optometrist requesting prior authorization

Requests lacking this information will be denied. Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Soft bandage plano lenses may be dispensed and billed to Medicaid in an emergency situation without prior authorization. The claim must document the medical emergency.

Replacement contact lenses are a benefit for lost or destroyed contact lenses for clients younger than 21 years of age when prior authorized by TMHP. Clients eligible for Medicaid may receive new nonprosthetic contact lenses when there is a significant change in visual acuity (equal to or greater than 0.5 diopter in one eye) and when prior authorized by TMHP.

When billing for bilateral lenses, providers are to use the appropriate code for unilateral lens and specify a quantity of 2 in Block 24E of the claim form.

Refer to: "Nonprosthetic Eyeglasses and Contacts" on page 45-20.

The Vision Claim Form Example on page D-36

"Prosthetic Eyeglasses and Contacts" on page 45-23.

45.4.4.5 Noncovered Services/Supplies

Medicaid does not cover the following services/supplies:

- All metal frames (for example, frames with all metal structural components; plastic nose pieces or sheathing over ear pieces do *not* constitute a combination frame)
- Repairs and replacements of lost or destroyed eyewear for clients 21 years of age and older
- Artificial eyes
- Plano sunglasses
- Eyeglasses that do not significantly improve visual acuity or impede progression of visual problems
- Eyewear prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client's medical records
- Eyeglasses for residents of institutions where the reimbursement formula and vendor payment include this service
- Optional eyeglass features requested by the client that do not increase visual acuity (e.g., lens tint, industrial hardening, decorative accessories, or lettering)
- Prisms that are ground into the lenses

Clients may be billed for noncovered frames and other items beyond Medicaid benefits.

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Providers must have the client sign and date the Vision Care Eyeglass Patient Certification Form and retain it in the provider's records.

The client payment amount is *not* considered other insurance and must not be entered as a credit amount in the electronic field.

Example: *The client wants oversized frames and tinted lenses for a total of $140 ($100 for frames, $30 for lenses, $10 for tinting). Medicaid pays $33.15 for the eyeglasses ($14.45 for the frames and $9.35 per lens, or $18.70 for both lenses). With the Medicaid payment of $33.15, the client may be billed for the balance, which includes the difference between the Medicaid payment for the frames and lenses, plus the $10 charge for the tinted lenses.*

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames must be refunded to Medicaid. If a client requests eyewear that is beyond program benefits (for example, combination zylonite and metal frames or high-powered lenses), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid Program specifications, but is not included in the selection of Medicaid-covered eyewear.
- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Vision Care Eyeglass Patient Certification Form and retain it in the provider's records.

Important: *Providers who advertise "two-for-one" eyeglass special promotions without restrictions may not refuse the offer to clients with Medicaid coverage.*

For the purpose of Texas Medicaid, high-powered lenses are defined as those with a sphere greater than 7.00d or a cylinder greater than 4.00d. High-powered lenses are a benefit for clients younger than 21 years of age through THSteps-Comprehensive Care Program (CCP).

Procedure Codes for High-Powered Lenses

Procedure Codes		
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 invoice is no longer required to be submitted with the claim but must be maintained in the provider's files. To facilitate claim processing, prior authorization is highly recommended. When submitting for prior authorization, providers are to include a copy of the prescription and manufacturer's suggested retail price. If prior authorization is not obtained, providers are to use the invoice cost as the billed amount and list the prescription on the claim form, indicating the power is greater than plus or minus 7 diopters or the cylinder is greater than plus or minus 4 diopters.

A client who experiences difficulty with daily living activities or employment related to vision may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS). DARS can evaluate the client and may provide resources for assistance, as appropriate.

Modifier RP must be used when billing for replacement lenses. When billing for an adult with diagnosis code 37931, modifier VP must also be billed.

Refer to: The list of offices for the "Department of Assistive and Rehabilitative Services (DARS), Blind Services" on page A-18.

The claim form example, "Vision" on page D-36.
Nonprosthetic Eyeglasses and Contacts

45.4.5 Nonprosthetic Eyeglasses and Contacts

45.4.5.1 Frames

Procedure Code	Maximum Fee	Special Instructions
V2020	$14.45	Single vision eyeglasses (not high powered), procedure code V2020, should be billed with the lens codes on this table.
V2025	$14.45	Single vision eyeglasses (not high powered), with deluxe frames, procedure code V2025, should be billed with the lens codes on the following tables. V2025 must be used for nonprosthetic eyewear that is beyond program benefits.

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45.4.5.2 Lenses

Providers must use the following codes when dispensing new lenses only (e.g., a client has 0.5 or greater diopter change requiring new lenses only). Providers are to bill a quantity of 2 for a pair of lenses.

Procedure Code	Maximum Fee
V2100	$9.35
V2101	$9.35
V2103	$9.35
V2104	$9.35
V2107	$9.35
V2108	$9.35
V2200	$12.75
V2201	$12.75
V2203	$12.75
V2204	$12.75
V2207	$12.75
V2208	$12.75
V2300	$17.00
V2301	$17.00
V2303	$17.00
V2304	$17.00
V2307	$17.00
V2308	$17.00

45.4.5.3 Replacements

Providers must use the following codes when billing for lost or destroyed eyewear (only available for clients younger than 21 years of age):

Procedure Code	Modifier	Special Instructions
V2020	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2025	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2100	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2101	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2103	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2104	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2107	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2108	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2121	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2200	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2201	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2203	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2204	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2207	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2208	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2221	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2300	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2301	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2303	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2304	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2307	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2308	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.
V2321	RP	Use modifier RP to indicate replacement. Bill appropriate quantity of lenses.

Refer to: “Contact Lenses” on page 45-19 for prior authorization information.

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45.4.5.4 Contact Lenses (Must be Prior Authorized)

Procedure Code	Modifier	Special Instructions
1-92070	NA	NA
9-92326	NA	NA
9-V2500	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2501	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2502	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2510	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2511	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2512	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2513	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2520	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2521	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2522	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2523	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2530	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2531	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.
9-V2599	VP (aphakic patient)	Does not require prior authorization with a diagnosis of aphakia. Use modifier VP.

45.4.5.5 Contact Lens Services Not Covered

Procedure codes 9-V2503 and 1-92310 are not covered.

45.4.5.6 Major Eyeglass Repairs

Providers billing for major eyeglass repairs should use procedure code V2799. This procedure will be manually priced.

45.4.6 Prosthetic Eyewear

Postsurgical prosthetic lenses are those lenses that replace the function of the eye's organic lens. Replacement may be necessary because of a congenital defect or trauma. However, the most frequent cause is surgical cataract extraction. The lenses can be contact lenses, eyeglasses, or both. The date of cataract surgery is not required on claims for permanent postsurgical prosthetic eyewear. The date of surgery is required to determine the convalescence period for temporary prosthetic eyewear. Contact lenses required as a postsurgical prosthetic may be supplied *without* prior authorization. Claims for temporary lenses are not payable, if dispensed after the four-month convalescence period. Claims for temporary eyewear that do not include the date of surgery are listed on the R&S as a claim in process and must be resubmitted for consideration of payment. Electronic claims of this type will be rejected. A letter with the rejection reason and instructions for resubmission will be mailed to the provider the following business day. Surgery dates on electronic claims must be identified in the appropriate fields of an approved electronic claims format.

The name of the surgeon who performed the cataract surgery is not required on claims for postsurgical prosthetic eyewear.

Medicaid provides as many temporary prosthetic lenses (contacts or eyeglasses) as necessary during the postsurgical convalescence period (up to four months after surgery) and one pair of permanent prosthetic contact lenses, eyeglasses, or both, in a lifetime (exceptions include replacements and new prosthetic eyewear when there is a significant change in visual acuity).

Important: *Contact lenses required as a postsurgical prosthetic may be supplied without prior authorization. Procedure codes for temporary postsurgical prosthetic lenses must be used only during the four-month convalescence period. After the convalescence period, procedure codes for permanent prosthetic eyewear must be used.*

45.4.6.1 Medicare Coverage

Postsurgical prosthetic cataract lenses are also a benefit of Medicare. If the client is eligible for Medicare coverage, the provider must bill Medicare first. Medicaid pays any deductible and/or coinsurance due. The provider must not require the client to pay the deductible and/or coinsurance.

45.4.6.2 Replacements

Regardless of age, coverage is provided for the replacement of lost or destroyed prosthetic eyewear. Providers must use procedure code 9-92326 when billing

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for contact lenses replacement. For replacement of cataract eyewear frames or lenses, providers must use the permanent cataract eyewear codes.

The client must sign and date the Vision Care Eyeglass Patient Certification Form, and the provider must retain it in the provider's records.

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an intraocular lens (IOL). Medicare considers the IOL the prosthetic device. Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the *Y* codes from the "Nonprosthetic Eyeglasses and Contacts" tables beginning on page 45-20.

45.4.6.3 Significant Diopter Change

Clients are eligible for new prosthetic eyewear when there is a significant change in visual acuity (equal to or greater than 0.5 diopter in one eye). The new prescription must be indicated in Block 24D, line 5, and the old prescription directly below it in Block 24D, line 6 of the CMS-1500 claim form. Prescription information for electronic claims must be in the electronic claims format. Providers must consult their vendor for the location of this field in the providers' electronic format. The procedure codes listed for new eyewear must be used. Reimbursement is $61.37 per lens. Prior authorization is not required.

45.4.7 Prosthetic Eyeglasses and Contacts

Services for prosthetic eyewear must be billed with a diagnosis of aphakia (37391 or 74335) to be considered for reimbursement. Contact lenses require prior authorization unless billed with a diagnosis of aphakia.

Diagnosis Code	Description
37931	Aphakia
74335	Congenital aphakia

45.4.7.1 Contact Lenses

Providers must use the following codes when billing for cataract contact lenses:

Procedure Code	Maximum Fee	Special Instructions
1-92070	$167.81	NA
9-92326	$46.64	NA
9-V2500	$50.67	Does not require prior authorization with a diagnosis of aphakia.
9-V2501	$88.58	Does not require prior authorization with a diagnosis of aphakia.
9-V2502	$120.00	Does not require prior authorization with a diagnosis of aphakia.
9-V2510	$61.50	Does not require prior authorization with a diagnosis of aphakia.
9-V2511	$108.17	Does not require prior authorization with a diagnosis of aphakia.
9-V2512	$152.25	Does not require prior authorization with a diagnosis of aphakia.
9-V2513	$61.50	Does not require prior authorization with a diagnosis of aphakia.
9-V2520	$41.92	Does not require prior authorization with a diagnosis of aphakia.
9-V2521	$77.17	Does not require prior authorization with a diagnosis of aphakia.
9-V2522	$51.92	NA
9-V2523	$145.98	NA

45.4.7.2 Eyeglasses

Providers must use the following procedure codes when billing for cataract eyeglass frames and lenses (whether the lenses are glass or plastic):

Procedure Codes				
V2020	V2025	V2100	V2101	V2102
V2103	V2104	V2105	V2106	V2107
V2108	V2109	V2110	V2111	V2112
V2113	V2114	V2200	V2201	V2202
V2203	V2204	V2205	V2206	V2207
V2208	V2209	V2210	V2211	V2212
V2213	V2214	V2300	V2301	V2302
V2303	V2304	V2305	V2306	V2307
V2308	V2309	V2310	V2311	V2312
V2313	V2314	V2410	V2430	V2700
V2755				

When prescribing bilateral lenses, providers are to use the appropriate code for a unilateral lens and specify a quantity of 2 in Block 24E of the claim form.

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45.5 Claims Information

Submit vision care services to TMHP in an approved electronic claims format for eyewear or on a CMS-1500 claim form.

45.5.1 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Filing Instructions	5-24
TMHP Electronic Claims Submission	5-10
Communication Guide	A-1
Vision Care Eyeglass Patient (Medicaid Client) Certification Form	B-116
Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish) claim form example	B-117
Vision claim form example	D-36
Acronym Dictionary	F-1

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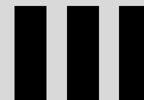
Part



Appendices

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

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Appendix

A

State and Federal Offices Communication Guide

A.1 Texas Health and Human Services Commission (HHSC) Central Office Addresses A-2
A.2 HHSC Regional Offices and Administrators A-3
A.2.1 Telephone Communication with HHSC and the Department of State Health Services (DSHS) A-4
A.3 Client Telephone Communication with HHSC A-4
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A.8 DSHS Public Health Nutrition Program A-12
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A.11 Department of Assistive and Rehabilitative Services (DARS), Blind Services A-18

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A.1 Texas Health and Human Services Commission (HHSC) Central Office Addresses

Use the following address for the Deputy Director for Medicaid Children's Health Insurance Program (CHIP) and for any group that is not listed in the table below:

HHSC
Medicaid CHIP–H200
1100 West 49th Street
Austin, TX 78756-3167

Note: *Remember to use the four-digit addition to the ZIP code.*

Use the following address for the HHSC Inspector General:

Texas Health and Human Services Commission
Office of Inspector General
PO Box 85200
Austin, TX 78708-5200

Note: *Remember to use the four-digit addition to the ZIP code.*

For the following groups, use the corresponding address and include the group name on the second line of the address.

Address	Group Name
DSHS (Group Name) (Mail Stop) Management Support Services 1100 West 49th Street Austin, TX 78756-3169	Children's Health Services Family Planning Genetic Services Indigent Health Care Medical Transportation Texas Health Steps (THSteps)
HHSC Medicaid CHIP–H200 PO Box 85200 Austin, TX 78708	
HHSC Quality Review/Limited Program—1323 PO Box 85200 Austin, TX 78708	
HHSC Third Party Resources (TPR) PO Box 85200 Mail Code 1354 Austin, TX 78708-5200	
HHSC Medical and UR Appeals H-230 PO Box 85200 Austin, TX 78708	
HHSC Vendor Drug H-630 PO Box 85200 Austin, TX 78708	

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A.2 HHSC Regional Offices and Administrators

Region	Administrator/Address	Telephone/Fax	RA Secretary
01	Arlene Rhodes, Interim 5806 34th Street PO Box 10528 Lubbock, TX 79408	1-806-791-7502 Fax: 1-806-791-7507	Lucy Pena
02/09	Barbara Evans 4380 Spindle Top PO Box 6635 Abilene, TX 79608	1-915-695-5750 Fax: 1-915-695-3324	Laverne Laird
03	Alvin Johnson 631-106th Street PO Box 5128 Arlington, TX 76011	1-817-640-5090 Fax: 1-817-695-5860	Rosie Ramirez
04	Sammie Bedford 302 East Rieck Road Tyler, TX 75703	1-903-561-5359 Fax: 1-903-509-5133	Cindi Hurst
05	Melanie Muse 285 Liberty PO Box 4906 Beaumont, TX 77701	1-409-835-3751 Fax: 1-409-880-3209	Carol Rice
06	Mamie Ewing 5425 Polk Avenue PO Box 16017 Houston, TX 77222-6017	1-713-767-2401 Fax: 1-713-767-2419	Eunice Sanchez
07	Barry Fredrickson 7901 Cameron Road Building 2 PO Box 15995 Austin, TX 78761	1-512-832-7656 Fax: 1-512-834-3459	Sherry Kothe
08	David C. Trejo 11307 Roszell PO Box 23990 San Antonio, TX 78223-0990	1-210-337-3271 Fax: 1-210-337-3405	Irma Sleighter
10	Tony Franco 1200 Golden Key Circle PO Box 10276 El Paso, TX 79994	1-915-599-3742 Fax: 1-915-599-3709	Peggy Wright
11	Frotze Kormeier 2520 South I Road PO Box 960 Edinburg, TX 78539	1-956-316-8203 Fax: 1-956-316-8338	Irma Reyes

For additional office information, visit the HHSC website at www.hhsc.state.tx.us.

Refer to: "DSHS Health Service Regions Map" on page A-7 to identify the regional boundaries.

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A.2.1 Telephone Communication with HHSC and the Department of State Health Services (DSHS)

Contact	Telephone Number
Assessment Utilization Services (limited program) (Option 4)	1-800-436-6184
DSHS Program for Amplification for Children of Texas (PACT) (hearing aid, evaluations)	1-512-458-7724
DSHS Emergency Medical Services Division	1-512-834-6700
DSHS Family Health Services Informational and Referral Line	1-800-422-2956
DSHS IMMTRAC Help Desk	1-800-348-9158
DSHS Immunization Branch	1-800-252-9152
DSHS Medical Transportation Program (MTP) Hotline	1-877-633-8747
DSHS THSteps/EPSDT Hotline	1-877-847-8377
Vendor Drug Program Provider Hotline	1-800-435-4165

A.3 Client Telephone Communication with HHSC

Clients should call the client toll-free number at 1-800-252-8263.

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A.4 Federal and State Telephone Numbers

Telephone Number	Department/Program
1-800-342-AIDS	AIDS Hotline (Nationwide, distributed by Centers for Disease Control and Prevention [CDC], Atlanta, Georgia)
1-800-299-2437	HIV/STD InfoLine
1-800-255-1090	Texas HIV Medication Program
1-800-252-5400	Child/Elder Abuse Intake (Department of Family and Protective Services [DFPS])
1-512-458-7420	Vision and Hearing Screening Program (DSHS)
1-512-834-6650, Ext. 2601	CLIA Certification Line
1-800-458-9858	Client Abuse Hotline for Long Term Care—Nursing Facilities (HHSC)
1-800-252-8263	Client Inquiry Hotline (HHSC) (Medicaid questions from clients with Medicaid only)
1-512-458-7745	THSteps Program (DSHS)
1-512-458-7661 Fax: 1-512-458-7672	Laboratory Supply Orders (DSHS)
1-512-458-7680 1-512-458-7578	Interpretation of Lab Results (DSHS) Report of Lab Results (DSHS)
1-210-534-8857 Ext. 2357	Adolescent Preventive Visit Pap Smear Supplies/Forms Texas Center for Infectious Disease (Women's Health Laboratories)
1-512-458-7796	Family Planning Program
1-512-424-6500	Fraud or Abuse of Provider Services (HHSC Office of Inspector General)
1-512-424-6500	Fraud or Abuse/Long Term Care—Nursing Facilities/HHSC
1-800-252-8011	Fraud or Abuse/Client/HHSC
1-800-792-1109	Goal-Directed Therapy
1-512-438-3169 or 1-800-252-8010	Hospice Program (HHSC Policy Development division)
1-800-252-9152	Immunization Branch (DSHS)
1-800-252-8263	Managed Care (LoneSTAR Health Initiative or STAR Program)—HHSC
1-800-925-9126	Medically Needy Spend Down Unit
1-800-MEDICARE or 1-800-633-4227	Medicare/Social Security Administration
1-800-252-8023	Newborn Screening (DSHS)
1-800-252-8023	Program for Amplification of Children of Texas (PACT) (DSHS)
1-800-436-6184	Recipient Utilization Control Unit (HHSC) (For Limited status review and for referrals from providers for potential client overutilization, etc.)
1-713-526-2559	Snellen Letter (Tumbling E Wall Chart)
1-800-435-4165 or 1-512-338-6962	Vendor Drug Program (HHSC) (Specifically for pharmacy use)

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A.5 DSHS Contract Manager Staff for Medicaid Eligibility Outstation Workers

Region	Contact	Telephone Number
1	Annie Gober	1-806-472-2508
2/9	Mary Evans	1-817-720-8434
3	Suzie Peterson	1-214-630-4411 Ext. 277
4	Kathy Knight	1-903-581-9243
5	Lynne Haynes	1-409-880-3490
6	Bob Nix	1-713-696-7171
7	Mike Blackard	1-512-834-3312
8	Daniel Lopez	1-210-619-8041
10	Judy Walker	1-915-599-3627
11	Joe T. Alvarez	1-956-316-8272

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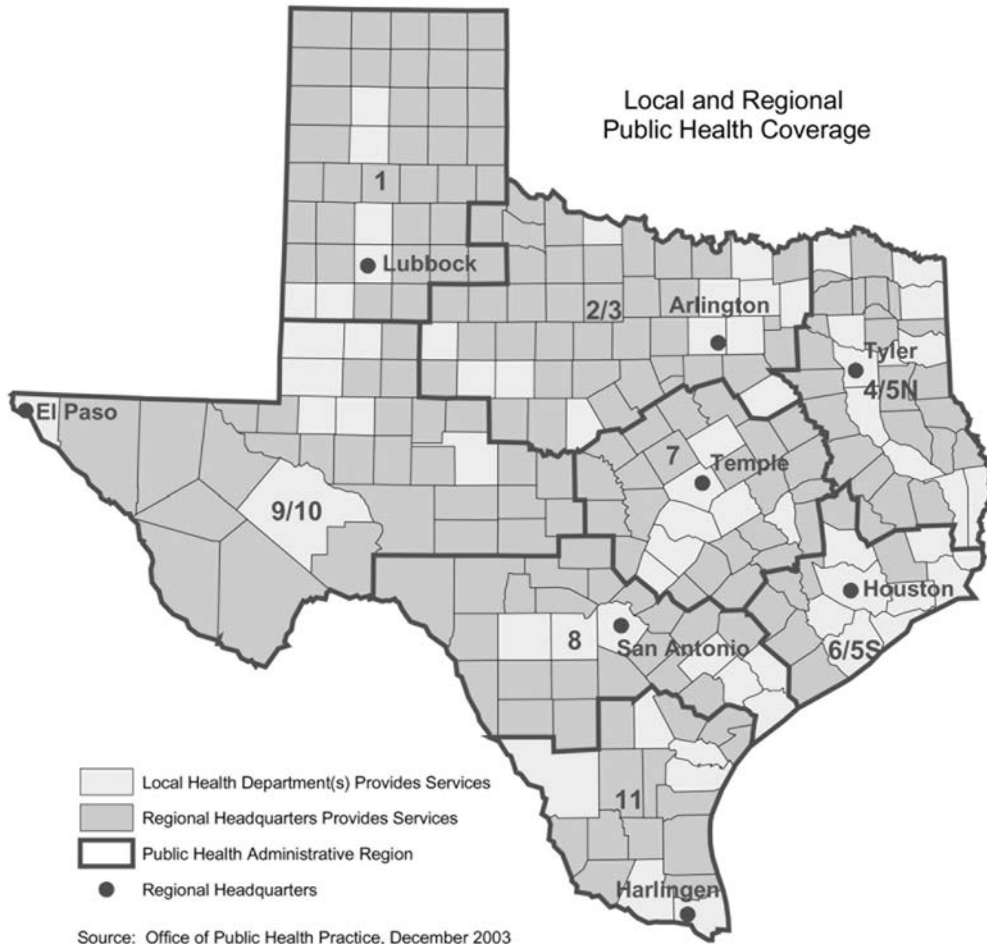
A.6 DSHS Health Service Regions Map



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A.7 DSHS Health Service Region Contacts

Health Service Region 1 Regional Office (Lubbock)	Health Service Regions 2 & 3 Regional Office (Arlington)
DSHS/PHR 1 1109 Kemper Lubbock, TX 79403 1-806-744-3577 Fax: 1-806-741-1366	DSHS/PHR 2 & 3 1301 S. Bowen, Suite 200 Arlington, TX 76013 1-817-264-4500 Fax: 1-817-264-4506
Public Health Director Nicolas (Nick) Curry, MD, MDH	Public Health Director James A. Zoretic, MD
Deputy Regional Director (acting) Barry Wilson	Deputy Regional Director (acting) Earlene Quinn
Director of Social Work Services Pat Greenwood, MSSW, LCSW	Director of Social Work Services Crystal Womack, LCSW
Regional HIV/STD Manager Vacant	Director of Clinic Operations Dorothy Kuhlmann, RN
Immunization Program Manager Keila Johnson	Immunization Program Manager Sonna Sander
Tuberculosis Team Leader Deborah Isaacks, RN, BSN	Communicable Disease Program Manager Gary Willett
THSteps Operations Lead Tricia Vowels 1109 Kemper Lubbock, TX 79403 1-806-767-0414	Tuberculosis Team Leader Jeff Ralston Emergency Preparedness Bryan Flow, DVM
DSHS Regional Family Planning Specialist Patricia Rennie 1101 Camino La Costa Austin, TX 78752 1-512-467-9875 Fax: 1-512-451-1468	THSteps Operations Lead Vacant 4601 South First, Suite L, Mail Code 5676 Abilene, TX 79605 1-940-795-5856
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 1-817-264-4743 Fax: 1-817-264-4912	HIV/STD Program Manager Scott Carson
	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Cindy Don 1301 S. Bowen Road, Suite 200 Arlington, TX 76013 1-817-264-4743 Fax: 1-817-264-4912

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Health Service Regions 4 & 5 (North) Regional Office (Tyler)	**Health Service Regions 6 & 5 (South) Regional Office (Houston)**
DSHS/PHR 4 & 5 North 1517 West Front Street Tyler, TX 75702 1-903-595-3585 Fax: 1-903-593-4187	DSHS 6 & 5 South 5425 Polk Avenue, Suite J Houston, TX 77023 1-713-767-3000 Fax: 1-713-767-3049
Public Health Director Dr. Paul K. McGaha, DO, MPH	Public Health Director (acting) James Morgan, MD, MPH
Deputy Regional Director (acting) James Wright, DVM	Deputy Regional Director Greta Etnyre, MS, RD
Director of Social Work Services Peggy Wooten, LCSW	Director of Social Work Services Raymond Turner, LCSW, MA
Director of Nursing Sharon Flournoy, RN, MSN	Director of Nursing Carol Patawri, MSRN
Immunization Program Manager Toni Wright, RN	Immunization Program Manager Alkarim Kanji, BS, RN, RRA
HIV/STD Program Manager Toni Wright	HIV/STD Program Manager Robert Castanada
Tuberculosis Program Manager Teresa Santiago, RN	Tuberculosis Program Manager Syed Haidry, MD, MPH
THSteps Operations Lead David Leary 1517 W. Front Tyler, TX 75702 1-903-595-3585	THSteps Operations Lead Sharon Hill 5425 Polk Avenue, Suite J Houston, TX 77023-1497 1-713-767-3105
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 1-903-232-3292 Fax: 1-903-232-3278	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Sharon Flournoy 1750 N. Eastman Road, Room 118 Longview, TX 75601 1-903-232-3292 Fax: 1-903-232-3278

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Health Service Region 7 Regional Office (Temple)	Health Service Region 8 Regional Office (San Antonio)
DSHS/PHR 7 2408 S 37th Street Temple, TX 76504-7168 1-254-778-6744 Fax: 1-254-778-4066	DSHS/PHR 8 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2000 Fax: 1-210-949-2010
Public Health Director James Morgan, MD, MPH	Public Health Director William S. Riggins, MD, MPH
Deputy Regional Director (acting) Anita Martinez	Deputy Regional Director Anita Martinez
Director of Social Work Services Leslie Anderson, LCSW, ACSW	Director of Social Work Services Vicky Contreras, LCSW
Director of Nursing Pat Collins, RN	Director of Nursing Sandra Jones, RN
Immunization Program Manager Mike Czepiel	Immunization Program Manager Laurie Henefey
HIV/STD Program Manager Al Gonzales	Communicable Disease Program Manager Vacant
Tuberculosis Program Manager/Nurse Consultant Dana Schoepf, RN	HIV/STD Program Manager Deborah Mayhew
THSteps Operations Lead Eileen Walker 2408 S. 36th Street Temple, TX 76504 1-254-778-6744	THSteps Operations Lead Vicky Contreras 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2112
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 1-254-778-6744 Ext. 2851 Fax: 1-254-773-2722	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Marlene McLeod, RN 1331 E. Court, Suite 101 Seguin, TX 78155 1-830-372-0841 Fax: 1-830-372-1784

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Health Service Regions 9 & 10 Regional Office (El Paso)	**Health Service Region 11 Regional Office (Harlingen)**
DSHS/PHR 9 & 10 401 E. Franklin, 2nd Floor PO Box 9428 El Paso, TX 79995-9428 1-915-834-7675 Fax: 1-915-834-7799	DSHS/PHR 11 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-412-3915
Public Health Director Miguel Escobedo, MD, MPH	Public Health Director Brian Smith, MD, MPH
Deputy Regional Director (acting) Charles Gaiser, DVM	Assistant Regional Director Sylvia Garces-Hobbs
Director of Social Work Services Lois Flynn, ACSW, LMS-ACP	Director of Social Work Services R. Scott Horney, LCSW
Director of Nursing Mary Urguidez, RN	Director of Nursing Marthalicia Leal, RN
Immunization Program Manager Jose Padilla	Immunization Program Manager Ivette Nunez
HIV/STD Program Manager Sarana Savage	HIV/STD Program Manager Richard Anguiano
Tuberculosis Program Specialist Gale Morrow	Tuberculosis Medical Consultant Richard Wing, MD
THSteps Operations Lead Arturo Diaz 401 E. Franklin, Suite 200 El Paso, TX 79901 1-915-834-7760	THSteps Operations Lead Vacant 601 W. Sesame Drive Harlingen, TX 78550 1-956-444-3257
DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Carolyn Wachel 2408 South 37th Street Temple, TX 76504 1-254-778-6744 Ext. 2852 Fax: 1-254-773-2722	DSHS Regional Contract Coordinator (Titles V, X, and XX Family Planning) Berta Cavazos 601 W. Sesame Drive Harlingen, TX 78550 1-956-423-0130 Fax: 1-956-444-3299

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A.8 DSHS Public Health Nutrition Program

Central Office	
Leslie Biediger, MPH, RD Chronic Disease Nutrition Consultant	Public Health Nutrition Coordinator Kim Sasser, MPH, RD, LD
Barbara Keir, MA, RD, LD Director, Division of Public Health Nutrition and Education	CSHCN Nutrition Consultant Mimi Kaufman, MPH, RD, LD
Roxanne Robinson, RD, CS, LD CSHCN Nutrition Consultant	

Health Service Region	Regional Nutritionist	Chronic Disease Nutritionist
1	Unhae Pak, RD, LD DSHS 1109 Kemper Lubbock, TX 79403 1-806-767-0463 Fax: 1-806-741-1366	
2/3	Cheryl Brien-Warren, RD, LD DSHS 1301 S. Bowen, Suite 200 Arlington, TX 76096-1869 1-817-264-4500	
4/5 North	Gretchen Stryker, RD, LD DSHS 1517 West Front Street Tyler, TX 75702 1-903-533-5315 Fax: 1-903-593-4187	Edee Crosman, MEd, RD, LD DSHS 1517 West Front Street Tyler, TX 75702 1-903-533-5376 Fax: 1-903-593-4187 **MCH Nutritionist:** Susan Bennett, RD, LD and Drue M. Evans, RD, LD DSHS 1517 West Front Street Tyler, TX 75702 1-903-533-5315 Fax: 1-903-593-4187
5/6	Dianne Gertson, RD, LD, MBA DSHS 5425 Polk Avenue, Suite J Houston, TX 77023-1497 1-713-767-3483 Fax: 1-713-767-3483	Lois Grant DSHS 5425 Polk Avenue, Suite J Houston, TX 77023-1497 1-713-767-3230 Fax: 1-713-767-3889
7	Linda Garriott, MS, RD, LD DSHS 1200 Avenue K, Suite 200 Marble Falls, TX 78654 1-210-693-8328 Fax: 1-210-693-8031	
8	Rosario Hamilton, RD, LD, MPH DSHS 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2043 Fax: 1-210-949-2084	Janice Brister, LD DSHS 7430 Louis Pasteur Drive San Antonio, TX 78229 1-210-949-2044 Fax: 1-210-949-2084

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Health Service Region	Regional Nutritionist	Chronic Disease Nutritionist
9/10	Chester Bryant DSHS PO Box 9428 El Paso, TX 79984-0428 1-915-774-6224 Fax: 1-915-774-6280	
11	Diana Garcia, MS, RD, LD DSHS 604 West Sesame Drive Harlingen, TX 78550 1-956-423-0130 ext 660 Fax: 1-956-423-0130	

A.9 State Participating Local Health Departments and Public Health Districts

State Participating Local Health Departments and Public Health Districts	
Abilene Public Health Department Region 2/3 Larry Johnson, Administrator PO Box 6489 (79608-6489) 2241 South 19th Street Abilene, TX 79605 1-915-692-5600 Fax: 1-915-690-6707	Hidalgo County Health Department Region 11 Mike Keenan, Administrator Omar Garza, MD, Director 1304 South 25th Street Edinburg, TX 78539-7205 1-956-383-6221 Fax: 1-956-383-8864
Amarillo Bi-City-County Health District Department of Health J. Rush Pierce, Jr., MD, Health Authority 1411 Amarillo Blvd. Amarillo, TX 79105 1-806-351-7220 Fax: 1-806-351-7275	Houston Health & Human Services Department Region 6/5 S Mary des Vignes-Kendrick, MD, MPH, Director 8000 North Stadium Drive Houston, TX 77054 1-713-794-9311 Fax: 1-713-798-0862
Andrews City-County Health Department Region 9/10 Robert Garcia, MD, Director 211 North West 1st Street Andrews, TX 79714 1-915-524-1434 Fax: 1-915-524-1461	Jackson County Health Department Region 8 Lanie Benson, MD, Director 411 North Wells, Room 102 Edna, TX 77957 1-512-782-5221 Fax: 1-512-782-7312
Angelina County & Cities Health District Region 4/5N Kevin Collins, Administrator Royce Read, MD, Director Lufkin, TX 75901 1-409-632-1372 Fax: 1-409-632-2640	Jasper-Newton County Public Health District Region 4/5 N Melvin K. Bottorff, MD, FACOG, Director 139 West Lamar Street Jasper, TX 75951 1-409-384-6829 Fax: 1-409-384-7861
Atascosa County Health Department Region 8 Gerald B. Phillips, MD, Director 1102 Campbell Avenue Jourdanton, TX 78026 1-210-769-3451 Fax: 1-210-769-2349	Jefferson County Health Authority Cecil A. Walkes, MD 1295 Pearl Street Beaumont, TX 77701 1-409-835-8530 Fax: 1-409-839-2353

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State Participating Local Health Departments and Public Health Districts	
Austin Department of Health & Human Services Region 7 Health District David Lurie, Director 2100 E. St. Elmo, Building E Austin, TX 78744 1-512-707-3220 Fax: 1-512-707-5404	Liberty County Health Authority Steven C. Ellerbe, DO 720 Travis Liberty, TX 77575 1-936-336-6439 Fax: 1-936-336-6517
Beaumont City Health Department Region 5/6 S William Novelli, Jr., MD PO Box 3827 950 Washington Blvd Beaumont, TX 77704 1-409-832-4000 Fax: 1-409-832-4270	Live Oak County Health Department Region 11 Roel Chapa, MD, Director Drawer 670 (78022) Live Oak County Courthouse George West, TX 78022 1-361-449-2733 Fax: 1-361-449-3035
Bell County Public Health District Region 7 Wayne Farrell, Director PO Box 3745 (76505) South 9th Street Temple, TX 76501 1-254-778-4766 Fax: 1-254-778-8251	Lubbock City Health Department Region 1 Tommy Camden, Director PO Box 2548 (79408) 1902 Texas Avenue Lubbock, TX 79405 1-806-762-6411 Fax: 1-806-775-3209
Brazoria County Health Department Region 6/5 S Leo D. O'Gorman, MD, MPH, Director 432 East Mulberry Angleton, TX 77515 1-979-864-1484 Fax: 1-979-756-1456	Maverick County Health Department Region 8 Arturo Batres, MD, Director 490 S. Bibb Eagle Pass, TX 78852 1-830-773-9438 Fax: 1-830-773-6450
Brazos County Health Department Region 7 Ken Bost, Executive Director 201 North Texas Avenue Bryan, TX 77803-5317 1-409-361-4440 Fax: 1-409-823-6993	Marshall-Harrison County Health District Region 4/5 N Andrew Gwynne, MD, Director PO Box 1627 (75670) 98 East Houston Street Marshall, TX 75670 1-903-938-8338 Fax: 1-903-938-8330
Brownwood-Brown County Health Department Region 2/3 Gary Butts, City Manager PO Box 1389 Brownwood, TX 76804 1-915-646-0554 Fax: 1-409-823-6223	Medina County Health Department Region 8 John W. Meyer, MD, Director 3103 Avenue G Hondo, TX 78861 1-830-741-6191 Fax: 1-830-741-6149
Calhoun County Health Department Region 8 Laine Benson, MD, Director 117 West Ash Port Lavaca, TX 77979 1-512-552-9721 Fax: 1-512-552-9722	Midland County Health Department Region 9/10 Albert J. Esparsen II, Administrator James M. Humphreys, Jr., MD, Director PO Box 4905 (79704) 501 Andrews Highway Midland, TX 79701 1-915-685-7370 Fax: 1-915-683-4751

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State Participating Local Health Departments and Public Health Districts	
Cameron County Health Department Region 11 Ivette Salinas, Administrator 1122 Morgan Blvd. Harlingen, TX 78550 1-956-427-8037 Fax: 1-956-427-8107	Milam County Health Department Region 7 Sonia Turnbo, Director E. Douglas Perrin, MD, Director PO Box 469 (76520) 209 South Houston Street Cameron, TX 76520 1-817-697-3411 Fax: 1-817-697-4809
Cass County Health Department Region 4/5 N R. Bruce LeGrow, MD, Director PO Box 310 (75563) South Kaufman and Rush Linden, TX 75563 1-903-756-7051 Fax: 1-214-796-3976	Montgomery County Health Department Region 6/5 S Debbie McCarthy, CNM, MSN, Director 508 Medical Center Blvd Conroe, TX 77304-2808 1-936-525-2800 Fax: 1-936-539-4668
Chambers County Health Department Region 6/5 S Leonidas S. Andres, MD, Director PO Box 670 (77514) 1222 Main Street Anahuac, TX 77514 1-409-267-8356 Fax: 1-409-267-4276 landres@ih2000.net	Orange County Health Department Region 6/5 Howard C. Williams, MD 1301 W. Park Ave Orange, TX 77630 1-409-886-1312 Fax: 1-409-886-0450 Williams@pnx.com
Cherokee County Health Department Region 4/5 N Austin A. Weaver, MD, Director 1209 N. Main Street Rusk, TX 75785 1-903-683-4688 Fax: 1-903-683-2393	Paris-Lamar County Health Department Region 4/5 N Bill E. Woodruff, MD, Director PO Box 938 (75460) 740 South West 6th Street Paris, TX 75460 1-903-785-4561 Fax: 1-903-737-9924
City of Dallas Department of Environmental & Health Services/Region 2/3 Beverly J. Weaver, Director 1500 Marilla Street, Suite 7AN Dallas, TX 75201 1-214-670-5216 Fax: 1-214-920-7976	Plainview-Hale County Health District Region 1 John Castro, Director 1001 Ash Street Plainview, TX 79072 1-806-293-1359 Fax: 1-806-296-1125
City of Laredo Health Department Region 11 Hector Gonzalez, Director PO Box 2337 (78044) 2600 Cedar Street Laredo, TX 78040 1-956-723-2051 Fax: 1-956-726-2632	Port Arthur City Health Department Region 6/5 S Ernestine Wade, RN, Director 603 5th Street Port Arthur, TX 77640 1-409-983-8800 Fax: 1-409-983-8870
Collin County Health Care Services Region 2/3 Bob Lindberg, Director 825 North McDonald Street McKinney, TX 75069 1-972-548-5500 Fax: 1-972-548-7221	San Angelo-Tom Green County Health Department Region 9/10 Mike Loving, Director PO Box 1751 (76902) 2 City Hall Plaza San Angelo, TX 76903 1-915-657-4214 Fax: 1-915-655-4874

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State Participating Local Health Departments and Public Health Districts	
Colorado County Health Authority Raymond R. Thomas, MD 610 S. Austin Road Eagle Lake, TX 77434 1-979-234-2551 Fax: 1-979-234-5994	San Antonio Metropolitan Health District Region 8 Fernando Guerra, MD, MPH, Director 332 West Commerce San Antonio, TX 78285 1-210-207-8780 Fax: 1-210-299-8999
Corpus Christi-Nueces County Public Health District/Region W Nina M. Sisley, MD, Director PO Box 9727 (78469) 1702 Horne Road Corpus Christi, TX 78416 1-512-851-7200 Fax: 1-512-851-7295	San Patricio County Health Department Region 11 Roger Barker, Director James Mobley, MD, Director 313 North Rachal Sinton, TX 78387 1-361-364-6208 Fax: 1-361-364-4518
Corsicana-Navarro County Public Health District Region 2/3 J.H. Barnebee, MD, Director PO Box 518 (75110) 508 North Main Corsicana, TX 75110 1-903-874-6731 Fax: 1-903-872-7215	Scurry County Health Department Region 2/3 Robert B. Pierce, MD, Director 911 26th Street Snyder, TX 79549 1-915-573-3508 Fax: 1-915-573-1266
Cuero-DeWitt County Health Department Region 8 Lanie Benson, MD, Director 106 North Gonzales Street Cuero, TX 77954 1-512-275-3461	Smith County Public Health District Region 4/5 N D.E. Sciarrini, FAAMA, Director PO Box 2039 Tyler, TX 75710 1-903-535-0034 Fax: 1-903-531-1166
Dallas County Health Department Region 2/3 James R. Farris, MD, Director 2377 Stemmons Freeway Dallas, TX 75207-2710 1-214-819-2103 Fax: 1-214-819-2107	South Plains Public Health District Region 1 Morris S. Knox, MD, Director PO Box 112 (79316) 919 East Main Street Brownfield, TX 79316 1-806-637-2164 Fax: 1-806-637-4295
Del Rio-Val Verde County Health Department Lawrence O'Brien, MD, Director 200 Bridge Del Rio, TX 78840 1-210-774-8701 Fax: 1-210-774-8795	Sweetwater-Nolan County Health Department Region 2/3 Don Ware, RS, Director PO Box 458 (79556) 301 East 12th Street Sweetwater, TX 7z9556 1-915-235-5463 Fax: 1-915-236-6856
Denton County Health Department Region 2/3 Bing Burton, Administrator 306 N. Loop 288, Suite 183 Denton, TX 76201 1-940-565-8569 Fax: 1-940-565-8621	Texarkana-Bowie County Family Health Center Region 4/5 N Kathy Moore, Administrator PO Box 749 (75504) 902 West 12th Texarkana, TX 75501 1-903-793-3255 Fax: 1-903-792-2289

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Ector County Health Department Region 9/10 Clyde S. Patterson, MD, Director 221 North Texas Odessa, TX 79761 1-915-335-3141 Fax: 1-915-335-3112	Uvalde City-County Health Department Region 8 Honorable William Mitchell Sterling H. Fly, Jr., MD, Director 119 East South Street Uvalde, TX 78801 1-830-278-2922 Fax: 1-830-278-7682
El Paso City-County Health and Environmental District/Region 9/10 Jorge Magaña, MD, Director 1148 Airway Blvd El Paso, TX 79925-3692 1-915-771-5701 Fax: 1-915-543-3541	Victoria County Health Department Region 8 Lanie Benson, MD, Director PO Box 2350 (77902) 107 West River Victoria, TX 77902 1-512-578-6281 Fax: 1-512-578-7046
Fort Bend County Health Department Region 6/5 S J. Johnson-Minter, MD, Interim Director PO Box 668 (77471) 3409 Avenue F Rosenberg, TX 77471 1-281-342-6414 Fax: 1-281-342-7371	Waco-McLennan County Public Health District Region 7 Janet Emerson, Director 225 West Waco Drive Waco, TX 76707 1-254-750-5450 Fax: 1-254-750-5663
Forth Worth-Tarrant County Department of Public Health Region 2/3 Bob Galvan, Director Nick Curry, MD, Director 1800 University Drive Fort Worth, TX 76107 1-817-871-7237 Fax: 1-817-871-7335	Walker County Health Authority Region 6/5 S M. Gebre-Selassie, MD 2804 Lake Road, #4 Huntsville, TX 77340 1-936-291-9600 Fax: 1-936-291-1625
Galveston County Health District Region 6/5 S Ralph D. Morris, MD, MPH, Director PO Box 939 (77568) 1207 Oak Street La Marque, TX 77568 1-409-938-2401 Fax: 1-409-938-2243 rmorris@gchd.org	Wichita Falls-Wichita County Public Health District Region 2/3 Barbara Clements, RNC, Director Tom Edmonson, Administrator 1700 Third Street Wichita Falls, TX 76301 1-940-761-7800 Fax: 1-940-767-5242
Grayson County Health Department Region 2/3 Carolyn Fruthaler, MD 515 North Walnut Sherman, TX 75090 1-903-893-0131 Fax: 1-903-892-3776	Williamson County and Cities Public Health District Region 7 Karen Wilson, RN, MN, MPH, Director PO Box 570 (78627) 303 Main Street Georgetown, TX 78626 1-512-930-4387 Fax: 1-512-930-3110
Greenville-Hunt County Health Department Region 2/3 Robert F. Deuell, MD, Director Henry Underwood, DO, Director 2500 Lee Street, Rm. 402 Greenville, TX 75401 1-903-455-1761 Fax: 1-903-454-1316	Wilson County Health Department Region 8 Harry L. Chavez, MD, Director PO Box 276 (78114) Wilson County Courthouse Floresville, TX 78114 1-830-393-7350

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Hardin County Health Department Region 6/5 S H.A. Hooks, MD, Director PO Box 820 (77625) Highway 326 West Kountze, TX 77625 1-409-246-5188 Fax: 1-409-246-4373	Wood County Health Department Region 4/5 N David C. Murley, MD, Director Wood County Courthouse PO Box 596 (75783 Quitman, TX 75783 1-903-763-5406 Fax: 1-903-763-2902
Harris County Health Department Region 6/5 S 2223 W. Loop South Houston, TX 77027 1-713-439-6016 Fax: 1-713-439-6080 thyslop@hc.co.harris.tx.us	Zavala County Health Department Region 8 Antonio Rivera, MD, Director 600 North John F. Kennedy Drive Crystal City, TX 78839 1-210-374-3010 Fax: 1-210-374-3007
Hays County Health Department Region N Larry Birdwell, DO, Director 401-A Broadway Drive San Marcos, TX 78666 1-512-353-4353 Fax: 1-512-396-4656	

A.10 Program for Amplification for Children of Texas (PACT) Participants

A current list of PACT providers can be found on the DSHS Audiology website at www.dshs.state.tx.us/audio/pactpro.shtm.

A.11 Department of Assistive and Rehabilitative Services (DARS), Blind Services

DARS, Blind Services	
Central Office Administrative Building 4800 North Lamar Administrative Building #100 Austin, TX 78756 1-512-377-0500 1-800-252-5204 (voice or TDD) Fax: 1-512-377-0461	Laredo 313 West Village Blvd., Suite 112 Laredo, TX 78041 1-956-723-2954 1-800-687-7030 Fax: 1-956-791-8142
Abilene 1250-B Petroleum Drive Abilene, TX 79602-7957 1-915-672-1385 1-800-687-7009 Fax: 1-915-673-1817	Lubbock Corporate Center 5121 69th Street, Suite A-5 Lubbock, TX 79424 1-806-798-8181 1-800-687-7032 Fax: 1-806-798-8689
Amarillo 7120 I-40 West, Suite 100 Amarillo, TX 79106-2500 1-806-353-9568 1-800-687-7010 Fax: 1-806-354-0982	Lufkin 3201 South Medford, #5 Lufkin, TX 75901 1-936-634-7733 1-800-687-7033 Fax: 1-936-634-7731

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DARS, Blind Services	
Austin (North) 7517 Cameron Road #120 Austin, TX 78752 1-512-459-8575 1-800-687-7008 Fax: 1-512-453-0200	McAllen 801 Nolana, Suite 115 McAllen, TX 78504 1-956-971-9419 1-800-687-7037 Fax: 1-956-971-9423
Austin (South) The Austin (South) DARS office has closed. Please use the contact information for the Austin (North) DARS office listed above.	Odessa 3016 Kermit Hwy. Odessa, TX 79764 1-915-332-3181 1-800-687-7034 Fax: 1-915-332-3183
Beaumont 6432 Concord Road Beaumont, TX 77708 1-409-898-4188 1-800-687-7013 Fax: 1-409-898-4225	San Angelo State of Texas Services Center 622 South Oakes, Suite D San Angelo, TX 76903-7013 1-915-659-7920 1-800-687-7038 Fax: 1-915-659-7929
Bryan-College Station 1115-A Welsh College Station, TX 77840 1-409-696-9610 1-800-687-7014 Fax: 1-409-693-4291	San Antonio Trinity Building 4204 Woodcock Drive, #274 San Antonio, TX 78228 1-210-732-9751 1-800-687-7039 Fax: 1-210-735-7508
Corpus Christi 410 S. Padre Island Drive, #103 Corpus Christi, TX 78405 1-361-289-1128 1-800-687-7015 Fax: 1-361-289-0754	Southeast 10060 Fuqua Houston, TX 77089 1-713-944-9924 1-800-687-7036 Fax: 1-713-944-0851
Dallas (East) 5510 Abrams, #115 Dallas, TX 75214-2090 1-214-360-9696 1-800-687-7019 Fax: 1-214-691-4281	Texarkana 410 Baylor, Suite C Texarkana, TX 75501 1-903-831-3846 1-800-687-7040 Fax: 1-903-831-3765
Dallas (West) 1555 West Mockingbird Lane, Suite 219 Dallas, TX 75235 1-214-688-7007 1-800-687-7017 Fax: 1-214-638-7550	Tyler Woodgate Office Park, Building 1 1121 ESE Loop 323, #106 Tyler, TX 75701 1-903-581-9945 1-800-687-7042 Fax: 1-903-581-9944
El Paso 1314 Lomaland Drive El Paso, TX 79935 1-915-590-7388 1-800-687-7020 Fax: 1-915-590-7098	Victoria Town Plaza Mall 1502 East Airline, #13 Victoria, TX 77901 1-361-575-2352 1-800-687-7043 Fax: 1-361-576-5712

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DARS, Blind Services	
Fort Worth 4200 South Freeway, #307 Fort Worth, TX 76115-1404 1-817-926-4646 1-800-687-7023 Fax: 1-817-926-0049	Waco 801 Austin Street, Suite 710 Waco, TX 76701 1-254-753-1552 1-800-687-7044 Fax: 1-254-753-1343
Harlingen 1812 West Jefferson Harlingen, TX 78550 1-956-423-9411 1-800-687-7025 Fax: 1-956-423-7145	Wichita Falls 3123 Lawrence Road, Suite D Wichita Falls, TX 76308 1-940-691-8675 1-800-687-7045 Fax: 1-940-691-5610
Houston 427 West 20th, #407 Heights Medical Tower Houston, TX 77008 1-713-880-0721 1-800-687-7028 Fax: 1-713-880-9209	

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B

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B.1 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed."

Signature ____

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities."

Signature ____

"I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities."

Signature ____

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B.2 Affidavit

THE STATE OF TEXAS

COUNTY OF ___________________

AFFIDAVIT

Before me, the undersigned authority, personally appeared, who being by me duly sworn, deposed as follows:

My name is ____

I am of sound mind, capable of making the affidavit, and personally acquainted with the facts herein stated:

I am the custodian of the records of ____
(Facility Name and Address)

____

Attached here are ________ pages from the medical record of:
(# of Pages)

____
(Patient Name)

Hospital Stay period: ____
(Admission and Discharge Date)

These pages of records are kept by said Hospital in the regular course of business and it was in the regular course of hospital business for an employee or representative of said Hospital, with knowledge of the act, event, condition, opinion or diagnosis recorded, to make the record or to transmit information thereof to be included in such record and the record was made at or near the time or reasonably soon thereafter.

The record attached hereto is the **original or an exact duplicate of the original** and **no other** documents exist on the files for the above named person, which pertain to the admission and discharge, noted above.

____
(Signature)

SWORN TO AND SUBSCRIBED before me on this ___________ day of __________________. 200_____

____
(Notary Public in and for the STATE OF TEXAS)

SEAL

____
(Printed Name)

My commission expires: _______________________________

B

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B.3 Ambulance Fax Cover Sheet

Texas Medicaid & Healthcare Partnership
12357-B RIATA TRACE PKWY, STE 150
Austin, TX 78727

DATE: ______________________________ TIME: ____________(AM) (PM)

FROM: ______________________________ TO: AMBULANCE UNIT

THIS FORM HAS BEEN UPDATED.

PHONE: ______________________________ PHONE: [illegible]

FAX: ______________________________ FAX: 1-512-514-4205

Click on the button above to access the new form.

*For clients who meet the definition of severely disabled: The client's physical condition limits his/her mobility, which requires the client to be bed-confined at all times or life support systems to be monitored.

If Hospital to Hospital or Hospital Discharge, supply:

ORIGIN: ______________________________ DESTINATION: ______________________________

All providers supply the following information:

*The requestor's name and title ______________________________

*The client's full name ______________________________

*The client's Medicaid number ______________________________

*The initial transport date ______________________________

*Full name of the transporting Ambulance Company ______________________________

*The Medicaid Provider Number of the transporting Ambulance Company ______________________________

*The type of Prior Authorization being requested: _____Annual (12 months) _____Short Term (1–60 days)

Please supply one or more of the following documentation:

*Admit and discharge records for dates of service

*A history and physical that has been done within 6 months

*The Care Plan with Daily Activity Sheet from the Nursing Home within 6 months

*Home Health Care Plan within 6 months

NUMBER OF PAGES INCLUDING COVER SHEET:____________________

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B.4 Authorization to Release Confidential Information (2 Pages)

PATIENT'S NAME ____

I authorize ________________________ and/or ________________________, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

____

Provider/Agency/Group Address City State ZIP

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

____

Provider/Agency/Group Address City State ZIP

Information to be released or exchanged include (check all that apply):

________ History and physical

________ Discharge and Summary

________ Behavioral Health Treatment Records

________ Laboratory Reports

________ Physical Health Treatment Records

________ Medication Records

________ Information on HIV or communicable disease treatment

________ Other (specify) ____

The authorized purpose(s) for this release are:

________ Diagnosis and Treatment

________ Coordination of Care

________ Insurance Payment Purposes

________ Other (specify) ____

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I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The ______________day of ________________, 20____.

_____________________________________ ____

Signature of Client Signature of Witness

____

Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT'S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this _______________day of _______________________, 20____.

_____________________________________ ____

Signature of Client Signature of Witness

____

Signature of Parent, Guardian, or Authorized Representative, if required

The person signing this authorization is entitled to a copy.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION: **PROHIBITION OF REDISCLOSURE**

Federal and state law protects the confidentiality of the information disclosed to you related to the individual's alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client's records.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.

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B.5 Authorization to Release Confidential Information (2 Pages) (Spanish)

NOMBRE DEL PACIENTE ____

Autorizo a ____________________, a ____________________ y a la siguiente persona, agencia o grupo:
(Nombre de la HMO) (Nombre de la BHO)

____
Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP

para que divulgue información y expedientes relacionados con mi tratamiento y estado de salud física, mental o de abuso de sustancias a las siguientes personas, agencias, doctores y centros profesionales:

____
Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP

La información que se divulgará o intercambiará es, entre otra (marque toda la que sea pertinente):

_____ Historia clínica y física

_____ Documentos de alta y resumen

_____ Documentos del tratamiento de la salud mental y abuso de sustancias

_____ Informes de laboratorio

_____ Documentos del tratamiento de la salud física

_____ Documentos de medicamentos

_____ Información del tratamiento del VIH o de las enfermedades transmisibles

_____ Otra (especifique) ________________________________

Esta divulgación se ha autorizado con el siguiente propósito (marque todos los que sean pertinentes):

_____ Diagnóstico y tratamiento

_____ Coordinación de la atención médica

_____ Pagos del seguro

_____ Otro (especifique) ________________________________

B

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Entiendo que mis expedientes de salud mental y abuso de sustancias están protegidos contra la divulgación bajo la ley federal o estatal. Puedo revocar esta autorización. Esta autorización tiene vigencia hasta que yo la revoque o sesenta (60) días después de que yo haya terminado el tratamiento, lo que suceda primero. Una vez que revoque esta autorización, no se podrá divulgar ninguna información, excepto como lo autorice o lo permita la ley. La copia de archivo se considera equivalente al original.

Se me explicó esta autorización y la firmé por mi propia voluntad:

El día ____________ del mes de ___________________ de 20____.

____ ____

Firma del cliente **Firma del testigo**

____

Firma del padre, tutor o representante autorizado, si es necesario

AVISO SOBRE LA DECISIÓN DEL CLIENTE DE NO AUTORIZAR LA DIVULGACIÓN DE INFORMACIÓN:

He revisado el formulario anterior para la divulgación de información y me he negado a autorizar la divulgación de información de salud mental y abuso de sustancias a los proveedores de salud física o de tratamiento de salud mental o contra el abuso de alcohol o drogas.

Firmado este día ____________ del mes de ___________________ de 20____.

____ ____

Firma del cliente **Firma del testigo**

____

Firma del padre, tutor o representante autorizado, si es necesario

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN

Las leyes federales y estatales protegen la confidencialidad de la información que usted recibió sobre el tratamiento del abuso de alcohol y drogas de la persona. Las normas federales (42 CFR Parte 2) le prohiben a usted dar esta información a otra persona a menos que se haya permitido expresamente en un consentimiento escrito de la persona de quien se trata, o de otra manera permitida por dichas normas. La divulgación se limita al propósito y a la persona anotados en el formulario de autorización. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente que tiene problemas de abuso de alcohol o drogas. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:

Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con NorthSTAR. Puede comunicarse con NorthSTAR escribiendo a 1199 S. Beltline Rd., Coppell, Texas 75019 ó llamando a la Línea de Ayuda de NorthSTAR al 1-972-906-2500.

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B.6 Birthing Center Report (Newborn Child or Children) Form 7484

MAIL FORM TO:

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin, TX 78714-9030

Date Rec'd in Data Integrity

PURPOSE: This form is to be used by BIRTHING CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid client No.
Mother's Mailing Address–Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . ❑Yes ❑No

If "Yes," give date of relinquishment . . . . _____________

Certified Midwife
Birthing Center Name
Birthing Center Address – Street
City, State, ZIP

Certification No C N M 0 0	TPI
Completed By (please type or print)	
Birthing Center Telephone No. ( )	Date Form Mailed

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B.7 Child Abuse Reporting Guidelines (2 Pages)

HHSC Child Abuse Screening, Documenting, and Reporting Policy for Medicaid Providers

Each contractor/provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of report of child abuse and neglect and the provisions of this HHSC policy. HHSC shall distribute funds only to a contractor/provider who has demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and this HHSC policy. Contractor/provider staff shall respond to disclosures or suspicions of abuse/neglect of minors [by reporting] to appropriate agencies as required by law.

PROCEDURES

I Each contractor/provider shall adopt this policy as its own.

II Each contractor/provider shall report suspected sexual abuse of a child as described in this policy and as required by law.

III. Each contractor/provider shall develop an internal policy and procedures that describe how it will determine, document, and report instances of abuse, sexual or nonsexual, in accordance with the Texas Family Code, Chapter 261.

REPORTING GENERALLY

I Professionals as defined in the law are required to report not later than the 48th hour after the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

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

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

IV Reports of abuse or indecency with a child shall be made to:

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

V The law requires that the following be reported:

- A Name and address of the minor, if known;
- B Name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known; and
- C Any other pertinent information concerning the alleged or suspected abuse, if known.

VI Reports can be made anonymously.

VII A contractor/provider may not reveal whether or not the child has been tested or diagnosed with HIV or AIDS.

VIII If the identity of the minor is unknown (e.g., the minor is at the provider's office to anonymously receive testing for HIV or an STD), no report is required.

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REPORTING SUSPECTED SEXUAL ABUSE

I Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of abuse who is an unmarried minor under 14 years of age and is pregnant or has a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission.

II The Texas Family Code, Chapter 261, requires other reporting of other instances of sexual abuse. Other types of reportable abuse may include, but are not limited to, the actions described in:

- A Penal Code, §21.11(a) relating to indecency with a child;
- B Penal Code, §21.01(2) defining “sexual contact”;
- C Penal Code, §43.01(1) or (3)-(5) defining various sexual activities; or
- D Penal Code, §22.011(a)(2) relating to sexual assault of a child;
- E Penal Code, §22.021(a)(2) relating to aggravated sexual assault of a child.

III Each contractor/provider may utilize the attached Checklist for HHSC Monitoring for all clients under 14 years of age. The checklist, if used, shall be retained by each contractor/provider and made available during any monitoring conducted by HHSC.

TRAINING

I Each contractor/provider shall develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff shall receive this training as part of their initial training/orientation. Training shall be documented.

II As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

B

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B.8 Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring

Date: ____

Client's name: ____

Client's age (use this checklist only if the client is under 14): ____

Staff person conducting screening: ____

Each contractor/provider shall ensure that its employees, volunteers, or other staff report a victim of child abuse who is a minor under 14 years of age who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has confirmed diagnosis of a sexually transmitted disease acquired in a manner other than through perinatal transmission.

Using the criteria above, did you determine that a report of child abuse is required? ______ Yes ______ No

If "yes," please report and complete the information below.

Report was made: ______ Yes ______ No

Staff person who submitted the report (optional): ____

Date reported: ____

Name of agency to which report was made: ____

DFPS call ID# or law enforcement assigned # (optional): ____

Name of person who received report (optional): ____

Phone number of contact (when applicable): ____

Use of the checklist for HHSC monitoring of reporting of abuse of children younger than 14 years of age who are pregnant or have STDs does not relieve contractors or subcontractors of the requirements in Chapter 261, Texas Family Code, to report any other instance of suspected child abuse.

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B.9 Claim Status Inquiry (CSI) Authorization Form

This form is for ACUTE CARE providers only.

If you are a Long Term Care provider, contact TMHP's EDI Help Desk at 888-863-3638 to request the correct form.

The following information MUST be completed before you can be granted Claim Status Inquiry (CSI) access.

1. Enter your Production User ID: ______________________________

2. Enter your Production User ID Password: ______________________________

*The TMHP **Production User ID** (Submitter ID) is the electronic mailbox ID used for downloading your Claim Status Inquiry reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.*

THIS FORM HAS BEEN UPDATED.

3. Select Action:
A. ☐ Add Claim Status Inquiry Privileges
R. ☐ Revoke Claim Status Inquiry Privileges

4. Enter organization information:

List the billing Texas Provider Identifier (TPI) number(s) you choose to access using the Production User ID given above. Submit additional copies of this form if you need to add more TPI numbers.

Click on the button above to access the new form.

Provider Name *Must be the name associated with the TPI Base number listed at right.*	**7–Digit BILLING TPI Base Number** *The first 7 digits of the 9 digit TPI number.**

***Note:** *Performing TPI numbers do not have Claim Status Inquiry access. Enter only **BILLING** TPI numbers.*

5. Enter Requestor Information:

Name: ______________________________

Title: ______________________________

Signature: ______________________________

Telephone Number: ______________________________ ext.

Fax Number: ______________________________ ext.

6. Return this form to:

Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk, MC–B14
PO Box 204270
Austin, TX 78720-4270

Or Fax to
512-514-4228 or 512-514-4230

DO NOT WRITE IN THIS AREA — For Office Use

Input By: ____________ Input Date: ____________ Mailbox ID: ____________

B

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B.10 Client Medicaid Identification (Form H3087) (18 Pages)

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

Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	**GOOD THROUGH:** VÁLIDA HASTA:
07/24/2006	610098	40	30	02	123456789	AUGUST 31, 2006

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

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JOHN DOE	08-27-1997	M	07-09-2006			✔	✔	✔		✔	✔

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

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

Form H3087-G1/January 2006

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FOR THE CLIENT: About your Medicaid ID Form

This is your MEDICAID IDENTIFICATION form. When you get any health care services, you must have this form with you if you want Medicaid to pay for your serivces.

WHAT IF YOU GET A BILL? If you get a bill from a doctor, hospital, or other health care provider, ask the provider why they are billing you. If you still get a bill, call 1-800-335-8957 for help.

WHAT IF THE SERVICES REQUESTED FOR YOU ARE DENIED? You will receive a letter telling you the request was denied and that you have the right to ask for a fair hearing. You may ask for a hearing in writing or by calling. The address and telephone number will be listed on the letter that you get.

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

FOR QUESTIONS REGARDING MEDICAID ELIGIBILITY, ID FORMS, AND ADDRESS CHANGES: Please contact the Texas Health and Human Services Commission (HHSC) office in your area. The telephone numbers and addresses are listed in your local telephone book.

For Questions About Other Medicaid Programs, You May Call the Following Toll-Free Numbers:

1-800-252-8263 **BENEFITS/POLICY—To find out what Medicaid pays for, or to find a provider.**

1-800-335-8957 **MEDICAID BILLING PROBLEMS—Any medical bills you may receive.**

1-877-847-8377 **TEXAS HEALTH STEPS—Care for clients up to age 21 including medical and dental checkups.**

1-877-633-8747 **MEDICAL TRANSPORTATION—For help with rides when you have no other way to get to and from the doctor, dentist, or drug store at no cost to you.**

1-866-566-8989 **STARLINK—Problems with the Managed Care STAR Program.**

1-800-335-8957 **MEDICALLY NEEDY PROGRAM (MNP)—About your spend down case.**

1-800-458-9858 **LONG TERM CARE (LTC)—Nursing Home Care.**

1-877-511-8858 **THIRD PARTY RESOURCES (TPR)—If you have other insurance.**

1-800-436-6184 **FRAUD – Medicaid, Food Stamps, and TANF.**

1-800-440-0493 **HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPP)—For help with private health insurance premiums.**

1-800-772-1213 **SOCIAL SECURITY ADMINISTRATION (SSA)—To report an address change if you are an SSI client.**

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

Ésta es su forma de IDENTIFICACIÓN DE MEDICAID. Cuando obtenga cualquier servicio de atención médica, tiene que presentar esta forma si quiere Medicaid pague los servicios que reciba.

¿QUÉ PASA SI RECIBE UNA CUENTA? Si recibe una cuenta de un doctor, un hospital u otro proveedor de atención médica, pregúntele al proveedor por qué le está cobrando. Si de todos modos recibe una cuenta, llame al 1-800-335-8957 para pedir ayuda.

¿QUÉ PASA SI LOS SERVICIOS SOLICITADOS PARA USTED SE NIEGAN? Usted recibirá una carta en la que se le informa que la solicitud fue negada y que tiene el derecho de pedir una audiencia imparcial. Puede pedir una audiencia por escrito o por teléfono. La dirección y el número de teléfono aparecerán el la carta que reciba.

AVERTENCIA. Si usted acepta los beneficios (servicios o artículos), de Medicaid, el estado de Texas tiene el derecho de recibir el pago de esos servicios o artículos de parte de otras compañías de seguro y otras fuentes responsables, hasta la suma necesaria para cubrir la cantidad que gastó Medicaid.

SI TIENE PREGUNTAS SOBRE LA ELEGIBILDAD PARA MEDICAID, LA FORMA DE IDENTIFICACIÓN O CAMBIOS DE DIRECCIÓN: Por favor, comuníquese con la ofician de la Comisión de Salud y Servicios Humanos de Texas (HHSC) de su región. El número de teléfono y la dirección se encuentran en el directorio telefónico de su comunidad.

Si tiene preguntas sobre otros programas de Medicaid, puede llamar gratis a los siguientes números de teléfono:

1-800-252-8263 BENEFICIOS Y NORMAS: para saber qué paga Medicaid o para encontrar a un proveedor.

1-800-335-8957 PROBLEMAS DE CUENTAS DE MEDICAID: para tratar cualquier cuenta médica que reciba.

1-877-847-8377 PASOS SANOS DE TEXAS: para saber sobre los servicios para clientes menores de 21 años, incluso los chequeos médicos y dentales.

1-877-633-8747 PROGRAMA DE TRANSPORTACIÓN MÉDICA: para conseguir ayuda de transporte gratis cuando no tiene ninguna otra manera de ir y venir al doctor, dentista o farmacia.

1-866-566-8989 STARLINK: para tratar problemas relactionados con el Program STAR de atención médica administrada.

1-800-335-8957 PROGRAMA DE SERVICIOS POR NECESIDAD MÉDICA (MNP): para hablar de su caso de cuota prescrita.

1-800-458-9858 ATENCIÓN A LARGO PLAZO (LTC): para hablar de los servicios de una casa para convalecientes.

1-877-511-8858 RECURSOS DE UN TERCERO (TPR): si tiene otro seguro.

1-800-436-6184 FRAUDE: para tratar casos de Medicaid, estampillas para comida, y TANF.

1-800-440-0493 SISTEMA DEL PAGO DE LA PRIMA DEL SEGURO MÉDICO (HIPP): para conseguir ayuda con las primas del seguro médico comercial.

1-800-772-1213 ADMINISTRACIÓN DE SEGURO SOCIAL (SSA): para informar de un cambio de dirección si es cliente de SSI.

HHSC **Form 3087**, Page 2/11-2004

B

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

1 ATFF 01-00001
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/05/2006	610098		40	02	123456789	JULY 31, 2006

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

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	12-09-1997	F	06-01-2006			✔	✔	✔		✔	✔
THSTEPS MEDICAL AND DENTAL CHECK-UP DUE / NECESITA SU EXAMEN MEDICO Y DENTAL DE THSTEPS												

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

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

Form H3087-G2/January 2006

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

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

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2006	610098		37	02	123456789	JULY 31, 2006

LIMITED

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

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1997	F	06-01-2006				✓	✓		✓	✓

LIMITED

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

TO PHARMACY:
HAPPY PHARMACY
11223 WEST 27th

AUSTIN TX 78759

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

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

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

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

Form H3087-GL/January 2006

B

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

15 ATFF 01-00015
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/24/2006	610098	13	13	04	123456789	JULY 31, 2006

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

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-14-1944	F	09-01-2006		123456789HIC	✔				✔	✔

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

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

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

Form H3087-GM/January 2006

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

8 ATFF 01-00008
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN PARA MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/24/2006	610098	13	14	04	123456789	JULY 14, 2006

QMB

952-X 123456789 13 14 04 030714
JOHN DOE
743 GOLF IRONS
LAREDO TX 78046

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JOHN DOE	11-30-1960	M	07-01-2006	M	123456789HIC

QMB

QUALIFIED MEDICARE BENEFICIARIES

NO MEDICARE PRESCRIPTION DRUGS AUTHORIZED. YOU ARE ELIGIBLE FOR MEDICARE RX.

NO SE AUTORIZÓ NINGUNA RECETA MÉDICA DE MEDICARE. USTED LLENA LOS REQUISITOS PARA RECIBIR MEDICARE RX.

Notice to Providers :

THIS CLIENT IS ELIGIBLE FOR QMB BENEFITS ONLY.

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

Form H3087-C1/January 2006

B

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

RETURN SERVICE REQUESTED
DO NOT SEND CLAIMS TO THE ABOVE ADDRESS

1 ATFF 01-00001
TEXAS DEPARTMENT OF HUMAN SERVICES
MEDICAID IDENTIFICATION
IDENTIFICACIÓN PARA MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/24/2003	610098		30	02	123456789	NOVEMBER 16, 2003

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EMERGENCY

952-X 123456789 30 02 021116
JANE DOE
743 GOLF IRONS
TEMPLE TX 76501

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	05-19-1981	F	11-14-2002							✔	✔

Form **3087EM**/8-2000

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1 ATFG 01-00001
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/24/2006	610098	13	13	04	123456789	AUGUST 31, 2006

HOSPICE

952-X 123456789 13 13 04 030831
JANE DOE
743 GOLF IRONS
CARROLTON TX 75006

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

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

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

READ THE BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	10-28-1944	F	07-01-1997			✔	✔	✔		✔	✔

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

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

Form H3087-GH/January 2006

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Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098	13	13	04	123456789	JULY 31, 2006

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77228

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's new plan for Medicaid in Harris County. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el nuevo plan del estado para Medicaid en el condado de Harris. Tiene un Proveedor de Cuidado Primario (PCP). Bajo su nombre aparecen el nombre de su plan de salud y de su PCP. Si usted recibe Medicare, el nombre del PCP no aparecerá.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-05-1983	F	10-01-1995			✔	✔	✔		✔	✔
	/ /WELBY MARCUS L MD											

LIMITED
PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY

Call the Limited Program at 1-800-436-6184

PARA MÁS INFORMACIÓN SOBRE EL USO DE UNA SOLA FARMACIA

Llame al Programa Limitado a 1-800-436-6184

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

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

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31 ATFF 01-00031
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/24/2006	610098		42	02	123456789	JULY 31, 2006

952-X 123456789 42 02 030731
JANE DOE
743 GOLF IRONS
RIO BRAVO TX 78046

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	11-08-1993	F	07-14-2006			✔	✔	✔		✔	✔

PRESUMPTIVE ELIGIBILITY

Notice to Providers : This client has been approved for Presumptive Medicaid Eligibility for Pregnant Women until the regular Medicaid determination is made.

Medicaid covered services during the presumptive eligibility period are limited to medically necessary outpatient services and family planning services. Labor, delivery, inpatient services and THSteps medical and dental services are not covered.

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

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

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MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098	13	13	04	123456789	JULY 31, 2006

LIMITED PHARMACY

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77220

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's new plan for Medicaid in Harris County. You have a Primary Care Provider (PCP). Your health plan and PCP are listed under your name. If you have Medicare you will not have a PCP listed.

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el nuevo plan del estado para Medicaid en el condado de Harris. Tiene un Proveedor de Cuidado Primario (PCP). Bajo su nombre aparecen el nombre de su plan de salud y de su PCP. Si usted recibe Medicare, el nombre del PCP no aparecerá.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1982	F	03-01-1994		

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

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

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

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

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

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IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	**GOOD THROUGH:** VÁLIDA HASTA:
07/15/2006	610098	13	13	04	123456789	JULY 31, 2006

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
LUCAS TX 75002

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años o más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	04-02-1963	F	11-01-2004			✔	✔	✔		✔	✔
	/	/WELBY		MARCUS		L MD						

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

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

Form H3087-S1/January 2006

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Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		01	02	123456789	JULY 31, 2006

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-04-1982	F	06-01-2005			✔	✔	✔		✔	✔
	/	/WELBY MARCUS L MD										

LIMITED
PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

FOR ADDITIONAL INFORMATION REGARDING LIMITATION TO ONE PHARMACY
Call the Limited Program at
1-800-436-6184

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

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

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

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Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		01	02	123456789	JULY 31, 2006

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77056

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.

NOTA: Puede que los beneficios de recetas para los clientes de Medicare mayores de 21 años se limiten a tres (3) por mes.

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in Harris County. Your health plan's name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en el condado de Harris. Bajo su nombre aparecen el nombre y el teléfono de su plan de salud. Llame al plan de salud para saber el nombre de su Proveedor de Cuidado Primario (PCP) o vea la tarjeta de identificación del plan. Si usted recibe Medicare, no tendrá un PCP de STAR+PLUS.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	01-04-1982	F	06-01-2005			✔	✔	✔		✔	✔
	/	/WELBY	MARCUS	L MD								

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

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

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MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		01	02	123456789	JULY 31, 2006

Primary Care Case Management (PCCM)

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

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

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

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

READ BACK OF THIS FORM!

TODA PERSONA NOMBRADA A CONTINUACIÓN PUEDE RECIBIR SERVICIOS DE MEDICAID

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

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

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.	EYE EXAM	EYE GLASSES	HEARING AID	ICF-MR DENTAL	PRESCRIPTIONS	MEDICAL SERVICES
765432198	JANE DOE	02-04-1983	F	07-01-2005			✔	✔	✔		✔	✔
PCCM /1-800-123-4567 / Dr. Jeremy Irons												

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

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

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Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		01	02	123456789	JULY 31, 2006

LIMITED PHARMACY

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77093

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?
Please call 1-800-964-2777 for help.
READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?
Por favor, llame al **1-800-964-2777** para conseguir ayuda.
¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1982	F	04-01-2006		

BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION

LIMITED PHARMACY

** TO PHARMACY:
** HAPPY PHARMACY
** 11223 WEST 27th
** AUSTIN TX 78759

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

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

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

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

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Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: / VÁLIDA HASTA:
07/15/2006	610098	13	13	04	123456789	JULY 31, 2006

952-X 123456789 13 13 04 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77231

NOTE: Prescription benefits for Medicare clients age 21 and over may be limited to three (3) per month.

NOTA: Puede que los beneficios de recetas para los clientes de Medicare mayores de 21 años se limiten a tres (3) por mes.

ANYONE LISTED BELOW CAN GET MEDICAID SERVICES

You are enrolled in STAR+PLUS, the state's plan for Medicaid in Harris County. Your health plan's name and telephone number are listed under your name. Call your health plan for your Primary Care Provider (PCP) name or refer to your health plan identification card. If you have Medicare you will not have a STAR+PLUS PCP.

If you have any concerns or questions about STAR+PLUS, please call 1-800-964-2777 for help.

READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en STAR+PLUS, el plan del estado para Medicaid en el condado de Harris. Bajo su nombre aparecen el nombre y el teléfono de su plan de salud. Llame al plan de salud para saber el nombre de su Proveedor de Cuidado Primario (PCP) o vea la tarjeta de identificación del plan. Si usted recibe Medicare, no tendrá un PCP de STAR+PLUS.

Si tiene alguna inquietud o pregunta con respecto a **STAR+PLUS,** por favor, llame al **1-800-964-2777** para conseguir ayuda.

¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1949	F	06-01-2002		
BEST HEALTH PLAN /1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION						

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

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

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186 ATFF 01-00186
Texas Health and Human Services Commission
MEDICAID IDENTIFICATION
IDENTIFICACIÓN DE MEDICAID

Date Run	BIN	BP	TP	Cat.	Case No.	GOOD THROUGH: VÁLIDA HASTA:
07/15/2006	610098		01	02	123456789	JULY 31, 2006

952-X 123456789 01 02 030731
JANE DOE
743 GOLF IRONS
HOUSTON TX 77096

ANYONE LISTED BELOW
CAN GET MEDICAID SERVICES

You are enrolled in the STAR Program. Your health plan's name and telephone number are listed under your name. You have a Primary Care Provider (PCP). Call your health plan for your PCP's name.

If you see a reminder under your name, please call your PCP or dentist to schedule a checkup. If you do not see a reminder and are 21 or older, you can get a medical checkup from your PCP once a year. You can also use the STAR Program to get the health care that you need.

Questions about the STAR Program?

Please call 1-800-964-2777 for help. READ BACK OF THIS FORM!

CADA PERSONA NOMBRADA ABAJO
PUEDE RECIBIR SERVICIOS DE MEDICAID

Usted está inscrito en el Programa STAR. El nombre y el teléfono de su plan de salud aparecen debajo de su nombre. Usted tiene un Proveedor de Cuidado Primario (PCP). Llame al plan de salud para averiguar el nombre de su PCP.

Si bajo su nombre hay una notificación, llame a su PCP o dentista para hacer una cita para un chequeo. Si no hay una notificación y usted tiene 21 años or más, puede hacerse un chequeo médico con su PCP una vez por año. También puede usar el Programa STAR para recibir los servicios médicos que necesita.

¿Tiene preguntas sobre el **Programa STAR**?

Por favor, llame al **1-800-964-2777** para conseguir ayuda. ¡LEA EL DORSO DE LA FORMA!

ID NO.	NAME	DATE OF BIRTH	SEX	ELIGIBILITY DATE	TPR	MEDICARE NO.
765432198	JANE DOE	07-25-1979	F	01-01-2005		
BEST HEALTH PLAN	**/1-800-123-4567 / CALL HEALTH PLAN FOR PCP NAME OR OTHER INFORMATION**					

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

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

Form H3087-ST/January 2006

B

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B.11 Credit Balance Refund Worksheet

Provider Name: ____

TPI: ____

ICN/PCN	Patient Name	Insurance Company Name/Address	Policy Number	Group Number	Insurance Paid Amount	Refund Amount

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Mail refund checks, made payable to TMHP, along with the "Credit Balance Refund Worksheet" to the following address:

Texas Medicaid & Healthcare Partnership
CBA Worksheets & Refunds
PO Box 202948
Austin TX 78720-9981

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B.12 DME Certification and Receipt Form

This certification is required by section 32.024 of the *Human Resources Code* and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client. This is to certify that on (month, day, year)..:

- The client received the ....(name of item/equipment) as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client's needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client, has received training and instruction regarding the equipment's proper use and maintenance.

....

Signature of DME Supplier

Signature of Client/Parent/Guardian/ Primary Caregiver

Certificación y recibo de equipo médico duradero (DME)

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder reembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid. Esto certifica que el: (mes, día, año)...

- El cliente recibió [el] [la] [los] [las] ....(nombre del artículo o equipo) que el doctor recetó.
- El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.
- El cliente, su padre o tutor, o el cuidador principal del cliente, ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.

....

Firma del Proveedor del Equipo Médico Duradero

Firma del Cliente, Padre, Tutor o Cuidador principal

B

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B.13 Donor Human Milk Request Form

Donor Human Milk Request Form
(Must be Reordered Every 180 Days)

Client Name: | Client Medicaid Number:

Date of birth: | Client's weight:

Parts A and B must be completed and copies retained in both the physician's and the milk bank's records. These forms and clinical records are subject to retrospective review.

THIS FORM HAS BEEN UPDATED.

Part A

The physician must keep up-to-date documentation of medical necessity *and* the signed written consent form in the child's clinical record to be considered for Medicaid reimbursement.

Click on the button above to access the new form.

The medical necessity for breast milk* is:

Child's diagnosis:

Date of last feeding trial:

Reason donor milk is the only appropriate source of human milk for this client:

(* This information *must* be substantiated by written documentation in the clinical record of why the particular infant cannot survive and gain weight on any appropriate formula, such as an elemental formula or enteral nutritional product, other than donor human breast milk, and that a clinical feeding trial has occurred every 180 days.)

The parent/guardian has signed and dated an informed consent that the risks and benefits of using banked donor human milk have been discussed with them.

Dates of service requested: From: | To: | Quantity Requested:

Physician's Signature ____________ Date ____________

Physician Name ____________ Physician License Number ____________

Physician's Fax Number ____________ Physician's TPI ____________

Part B

The particular donor human milk bank adheres to quality guidelines consistent with the Human Milk Banking Association of North America, or other standards established by HHSC. Yes ❑No ❑

Dates of service provided: From: | To: | Quantity Provided:

Milk Bank Name ____________ Milk Bank TPI ____________

Milk Bank Representative Signature ____________ Date ____________

Milk Bank Representative's Name ____________ Milk Bank Fax Number ____________

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B.14 Electronic Funds Transfer (EFT) Information

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

The following items are specific to EFT:

Pre–notification to your bank takes place on the cycle following the application processing.

Future deposits are received electronically after pre–notification.

The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.

Specific deposits and associated R&S reports are cross–referenced by both Texas Provider Identifier (TPI) and R&S number.

EFT funds are released by TMHP to depository financial institutions each Friday.

The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Please contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer's needs.

In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. ***You must return a voided check or deposit slip with the agreement to the TMHP address indicated on the form.***

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

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B.15 Electronic Funds Transfer (EFT) Authorization Agreement

*Enter **ONE** Texas Provider Identifier (TPI) per Form*

NOTE: *Complete all sections below and **attach a voided check or a photocopy of your deposit slip**.*

Type of Authorization: ☐ **NEW** ☐ **CHANGE**

Provider Name	**Nine–Character Billing TPI**
Provider Accounting Address	**Provider Phone Number** **( ) ext.**
Bank Name	**ABA/Transit Number**
Bank Phone Number	**Account Number**
Bank Address	**Type Account (check one)** ☐ Checking ☐ Savings

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its health insuring contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature **Date**

Title **Email Address (if applicable)**

Contact Name **Phone**

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

DO NOT WRITE IN THIS AREA — For Office Use

Input By: **Input Date:**

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B.16 External Insulin Pump

External Insulin Pump

Client Name: ______________________ Medicaid Number: ______________________

Date of Birth: ______________________ Physician: ______________________

Physician Specialty: ______________________ Physician's Phone Number: ______________________

TPI: ______________________ Provider's Fax Number: ______________________

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

[illegible] must be submitted with a completed and signed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form:

1. [illegible] date of lab draws.

2. Client history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reactions, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements.

3. Client history of any wide fluctuations in blood glucose level before mealtimes.

4. Client history of any dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL.

5. Day-to-day variations in client's work/school schedule, mealtimes and/or activity level, which require multiple insulin injections.

6. For purchase after the initial trial period a statement of client's compliance and effectiveness of the pump is required.

______________________________ ______________

Physician Signature Date

____

Print Physician's Name

B

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B.17 Federally Qualified Health Center Report (Newborn Child or Children) Form 7484

Texas Health and Human Services Commission
Data Integrity 952-X
PO Box 149030
Austin, TX 78714-9030

Date Rec'd in Data Integrity

PURPOSE: This form is to be used by FEDERALLY QUALIFIED HEALTH CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to the HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
Mother's Mailing Address–Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . ❑Yes ❑No

If "Yes," give date of relinquishment . . . . ____________

Child's Attending Physician
Certified Midwife
Health Center Name
Health Center Address – Street
City, State, ZIP

Physician's Medical Lic. No. T X B	TPI
Certification No C N M 0 0	TPI

Completed By (please type or print)	
FQHC Telephone No. ( )	Date Form Mailed

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B.18 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

Name (Last, First, Middle Initial)	Client No.	Age	Birth Date
Address (Street, City, State, ZIP Code)			
Date of Examination	Place of Examination	Puretone Audiometry: ANSI 1969 ❑ Yes ❑ No	
Date of Calibration	Ambient Noise** ______dBa______dBc	**Ambient noise level measurements MUST be made at the time of EACH evaluation not conducted in a commercially sound treated facility	

Indicate with an asterisk (*) by Recorded Threshold when masking is used

AIR CONDUCTION SOUND FIELD TEST RESULT IN DECIBELS
(Completed by physicians and audiologist only)

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

BONE CONDUCTION

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

SPEECH AUDIOMETRY

	SRT	PB Quiet	PB Level	Thres. Disc.
LE				
RE				
Masking Level LE				
Masking Level RE				

FITTING AND DISPENSING RESULTS

	UNAIDED	AIDED AID 1 ❑ LE ❑ RE	AIDED AID 2 ❑ LE ❑ RE	OPTIONAL ❑ LE ❑ RE
Make				
Model				
Gain/Volume				
SAT				
SRT				
PB Quiet				
PB Level				
PB Noise**				
PB Level				
Noise Level				
MCL				
Discomfort				
Dynamic Range				

**Specify type of noise used ____

Ear Fitted ❑ R ❑ L Acquisition Cost________________________________

Manufacturer____

Model____

Comments:

Is report of Physician's Examination attached? ❑ Yes ❑ No

FITTER AND DISPENSER: The fitter and dispenser must sign below.

____

Name of Fitter and Dispenser (please type or print)

____

Signature – Fitter and Dispenser Date

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, ________________________________ do hereby certify that I am ________________________________ and that
(Signature of Physician or Audiologist) (Title of Person Certifying)

I am duly authorized to make this certification for and on behalf of ________________________________
(Name of Payee Company Claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

____

(Signature of Physician or Audiologist) Date

____

B

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B.19 HHSC Physician Attestation Statement

<table>
<tr><td colspan="3">Provider Name</td></tr>
<tr><td colspan="3">Texas Provider Identifier (TPI):</td></tr>
<tr><td colspan="3">Client Name:</td></tr>
<tr><td>DOB:</td><td>Sex:</td><td>Medicaid #:</td></tr>
<tr><td colspan="2">Date of Admission:</td><td>Date of Discharge:</td></tr>
<tr><td colspan="3">Discharge Status:</td></tr>
<tr><td colspan="3">Secondary Diagnoses:</td></tr>
<tr><td colspan="3">Principal Procedure:</td></tr>
<tr><td colspan="3">Other (Secondary) Procedures:</td></tr>
<tr><td colspan="3">I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.</td></tr>
<tr><td colspan="2">Attending Physician Signature</td><td>Date of Signature</td></tr>
</table>

Texas Medicaid Program
March 29, 2001

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B.20 HHSC Physician Attestation Statement Requirements

The following information must be included on the attestation statement for a hospital's request for an oral appeal to be considered:

- Provider name and Texas Provider Identifier (TPI)
- Client's name, date of birth, sex, and Medicaid number
- Date of admission and discharge
- Discharge status
- Principal diagnosis[1], secondary diagnoses[2], and the principal procedures (with proper sequencing and diagnostic and procedure codes)[3]
- Statement: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."
- Attending physician's dated signature (immediately below the statement). In lieu of the attending physician, the statement may be signed by another physician involved in the patient's care.

Note: *The attending physician's signature, along with the other information required above, may be provided by electronic means through a hospital data system provided that HHSC is given sufficient evidence that this system meets appropriate legal requirements.*

---

1. The *principal diagnosis* is the diagnosis (condition) established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
2. The secondary diagnoses are conditions that affect the patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care, or monitoring, or, in the case of a newborn, clinically significant implications for future health care needs as deemed by a physician.
3. Normal newborn conditions or routine procedures are not considered.

B

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B.21 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B. **This form cannot be accepted beyond 90 days from the date of the prescribing physician's signature.**

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician's TPI is **only** required if the Physician is a Texas Medicaid provider.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

Requested Durable Medical Equipment and Supplies

Item No.	HCPCS Code	Quantity	Price
1	J-E1399	1	$50.00
2	J-E1220	1	$2500.00
3			
4			
5			

Examples of Supplies

Item No.	HCPCS Code	Quantity	Price
1	9-A4253	2 boxes	N/A
2	9-A4259	1 box	N/A
3	9-A4245	1 box	N/A
4			
5			

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Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician. The prescribing physician must indicate the ICD-9 code with a brief description, corresponding to the item number requested from Section A and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility. **The date last seen must be within the past 12 months.** The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Medicaid provider) and license number must be indicated. **Signatures from Nurse Practioner's, Physician Assistants, and Chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.**

Diagnosis and Medical Need Information

ICD-9	Requested Section A No.[2]	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies[1,2]
438	1,2	Unable to get in and out of the tub or shower
27801	2	Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.
3		
4		
5		

1. Refer to Footnote 1 of the *Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.*
2. Refer to Footnote 2 of the *Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.*

Examples of Supplies

ICD-9	Requested Section A No.[2]	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies[1,2]
25001	3,4,5	Test TID

1. Refer to Footnote 1 of the *Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.*
2. Refer to Footnote 2 of the *Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.*

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid P0 TPIs, ZO group TPIs, and UPIN numbers are not acceptable as licensure.

The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must be used when prescribing more than 5 items. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must accompany the H*ome Health Services (Title XIX) DME/Medical Supplies Physician Order Form*. **Addendums received without this form will not be accepted.**

Reminder: Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.

Note for DME: The DME company must also complete the DME Certification & Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer's instructions and warning.

B

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B.22 Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond **90 days** from the date of the physician's signature. Fax completed form to 1-512-514-4209.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ❒ Requesting Physician ❒ Supplier

Client name: ______________________ Client Medicaid number: ______________________

Client date of birth: ______/______/______ Is client under 21 years of age? YES ❒ NO ❒

Supplier name: ______________________ Supplier Medicaid TPI number: ______________________

Supplier Address: ______________________ City ____________ State ________ Zip ________

Supplier telephone number: ______________________ Supplier Fax number: ______________________

Prescribing physician name: ______________________ Physician telephone number: ______________________

Physician Fax number: ______________________

THIS FORM HAS BEEN UPDATED.

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature: ______________________ Date: _____/_____/______

DME/medical supplies provider representative name (Typed or Printed): ______________________

Click on the button above to access the new form.

Item number	HCPCS code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?		Beyond quantity limit?		Custom item?[1]	
1					❒ Y	❒ N	❒ Y	❒ N	❒ Y	❒ N
2					❒ Y	❒ N	❒ Y	❒ N	❒ Y	❒ N
3					❒ Y	❒ N	❒ Y	❒ N	❒ Y	❒ N
4					❒ Y	❒ N	❒ Y	❒ N	❒ Y	❒ N
5					❒ Y	❒ N	❒ Y	❒ N	❒ Y	❒ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

❒ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES ❒ NO ❒ If yes, indicate Medicare number: ______________________

Section B: Diagnosis and Medical Need Information

This is a *prescription* for DME/supplies and *must* be filled out by the prescribing physician.

ICD-9	Brief Diagnosis Descriptor	Requested Item Number from Section A[2]	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
___ ___ ___ . ___ ___			
___ ___ ___ . ___ ___			
___ ___ ___ . ___ ___ ___ ___ ___ . ___ ___			

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification. Enter all Item numbers from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

Note: *The "Date last seen" and "Duration of need" items below* ***must*** *be filled in!*

Date last seen by physician: ____/____/____

Duration of need for DME: ____________ month (s) Duration of need for supplies: ____________ month (s)

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician: ______________________ Date: _____/_____/________

Signature stamps and date stamps are not acceptable

Prescribing Physician's TPI number: ______________________ Prescribing physician's license number: ______________________

❒ Check if all of the information in Section A was complete at the time of the prescribing provider signature.

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B.23 Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section A --- Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ Requesting Physician ☐ Supplier

Client Name: ____ Client Medicaid number: ___________________________________

Supplier Name: ______________________________________ Supplier Medicaid TPI number: ______________________________

Prescribing Physician Name: ____________________________

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature: ____ Date: ____/____/_____

DME/medical supplies provider representative name (Typed or Printed): ____________________________________

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Item #	HCPCS Code	Description of DME/Medical Supplies	Quantity	Price	Prior Auth Required?	Beyond Quantity Limits?[1]	Custom Item?
6					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
12					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
13					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
14					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
15					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
16					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
17					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
18					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
19					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
20					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
21					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
22					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
23					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
24					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
25					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
26					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
27					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
28					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
29					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes", additional documentation must be provided to support determination of medical necessity.

☐ Check if additional documentation is attached as outlined in the TMPPM.

Section B --- Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician: ____________________________________ Date: _____/_____/_______

Signature stamps and date stamps are not acceptable

Prescribing Physician's **TPI** number: _________________________ Prescribing Physician's **LICENSE** number: ________________________

☐ Check if all of the information in Section "A" was complete at the time of prescribing provider signature.

B

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B.24 Home Health Services Plan of Care (POC) Instructions

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Client Name:	Last, First, MI
Medicaid No:	Nine-digit number from client's current Medicaid identification card.
DOB:	Date of Birth-month, day and year.
Date Last Seen By Doctor:	Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment.
Provider Name:	Name of home health agency.
TPI	Nine-character Texas Provider Identifier of agency whose suffix is for DMEH services.
Agency Phone No:	Area code and telephone number of agency.
Physician's Name/ Phone No/License No:	Name, area code/telephone number, and license # of client's physician who is ordering home health services.
Status:	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an [illegible]
Original SOC date:	First date of service in this 365 day benefit period.
Revised Request Effective Date:	Date revised services, supplies or DME became effective.
Services Client Receives From Other Agencies:	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnosis:	Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered. (Include ICD-9 code if PT ordered)
Functional Limitations/ Permitted Activities:	Include on revised request only if pertinent
Prescribed Meds:	List medications, dosages, routes, and frequencies (Include on revised request if applicable)
Diet Ordered:	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
Mental Status:	Examples: Alert and oriented, confused, slow to learn etc. (Include on revised request if applicable)
Prognosis:	Examples: Good, fair, poor, etc. (Include on revised request if applicable)
Rehab Potential:	Potential for progress – Examples: Good, fair, poor etc. (Include on revised request if applicable)
Safety Precautions:	Examples: O2 safety, seizure precautions, etc. (Include on revised request if applicable)
Medical Necessity, Clinical Condition, Treatment Plan:	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.
SNV/HHA/PT/OT Visits Requested:	State the number of visits requested for each type of service authorized.
Supplies:	List all supplies authorized.
DME:	List each piece of DME authorized, check whether DME is owned or if DME is to be repaired, purchased or rented and for what length of time the equipment will be needed.
RN:	The signature/date form was completed by the RN who completed this form.
From/To Dates:	Dates (up to 60 days) of authorization period for ordered home health services.
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.
Physician Signature/ Printed Name/Date Signed/License Number:	Signature/date form signed by physician ordering home health services, physician printed name, and license number.

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B.25 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

Office Use Only:

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Click on the button above to access the new form.

Client Name:		Provider Name:		
Medicaid No:	DOB:	TPI:		DMEH TPI of HH Agency:
Date last seen by Doctor:		Agency Phone No: ( )		
Physician's Name:		Phone No:		License No:
Status: (Check One)	New Client ❒	Extension ❒		Revised Request ❒
Original SOC Date:		Revised Request Effective Date:		

Services Client Receives from other Agencies:

Diagnoses (include ICD-9 codes if PT/OT is ordered):

Function Limitations/Permitted Activities/Homebound Status:

Prescribed Meds:

Diet Ordered:	Mental Status:
Prognosis:	Rehab Potential:

Safety Precautions:

Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):

SNV Visits Requested:

HHA Visits Requested:

PT Visits Requested:

OT Visits Requested:

Supplies: ____________________

DME Item #1:	Own ❒	Repair ❒	Buy ❒	Rent ❒	How Long Needed?
DME Item #2:	Own ❒	Repair ❒	Buy ❒	Rent ❒	How Long Needed?
DME Item #3:	Own ❒	Repair ❒	Buy ❒	Rent ❒	How Long Needed?
DME Item #4:	Own ❒	Repair ❒	Buy ❒	Rent ❒	How Long Needed?

RN Signature:	Date Signed:

I anticipate home care will be required From: To:

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.

Check if this exception applies. ❒ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician Signature:	Date Signed:
Printed Physician Name:	License Number:

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B.26 Home Health Services Prior Authorization Checklist

Contact Medicaid Home Health Services at 1-800-925-8957

To facilitate the authorization process, the home health agency nurse should have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Completion of this optional form
- Evaluation of the client in the home (preferably by the same nurse requesting services)

PLEASE DO NOT SUBMIT THIS FORM TO TMHP.

Date:________________________________ Agency Nurse Name:________________________________

Client Medicaid Number:_______________ Client Name: ______________________________________

Client Medicare Number:_______________ Date Last Seen by Physician: ________________________

Start of Care Date:____________________ Date of Last Hospitalization:________________________

Date of Home Evaluation: ______________

Diagnoses:____

____

(If PT is requested, please provide ICD-9-CM diagnosis codes)

Skilled Nursing functions to be provided: ____

____

____

____

Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.): ____

____

____

Observations of home setting that may effect care (i.e. cleanliness, availability of running water, electricity and refrigeration, etc.): ____

____

____

Availability and capability of caregiver(s): ____

____

Services client receives from other sources (i.e. Primary Home Care): _______________________

____

Services Requested: ___ Skilled Nursing Frequency ______________________________

___ Home Health Services Aide Frequency ______________________________

___ Physical Therapy Frequency ______________________________

___ DME_______ Repair ________Rent ________ Purchase

________Bid #1

________Bid #2

___ Supplies: ____

TMHP Nurse: ______________________ PAN: ____

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B.27 Hospital Report (Newborn Child or Children) HHSC Form 7484

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin TX 78714-9030

Date Rec'd in Integrity Control

PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
Mother's Mailing Address – Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.

Has the mother relinquished her rights to the newborn child? . . . . ❑ Yes ❑ No

If "Yes," give date of relinquishment . . . . .____________________

Child's Attending Physician
Hospital Name
Hospital Address—Street
City, State, ZIP

Physician's Medical License No.	TPI
T X B	
Completed By (please type or print)	
Hospital Telephone No. ( )	Date Form Mailed

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B.28 Hysterectomy Acknowledgment Form

MEDICAID CLIENT IDENTIFICATION NUMBER _/_/_/_/_/_/_/_/_

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery ________________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

____ __________________

Signature of Client or Designated Representative Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ______________________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

____ ___________________

Firma del Cliente o Representante Designado Fecha

Interpreter's Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.
I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to _________________________ in ________________________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

____ ___________________

Signature of Interpreter Date

Revised 8/22/95

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B.29 Informational Inquiry Form

Today's Date ____________________

Client Information

Medicaid Number ____________________
Date of Birth ____________________
SSN ____________________
First/Last Name ____________________

Accident Information

Date of Loss ____________________
Type of Accident ____________________

Attorney Information

Name ____________________
Contact Name ____________________
Address ____________________
City/State/ZIP Code ____________________
Phone ____________________
Fax ____________________

Insurance Information

Name ____________________
Contact Name ____________________
Address ____________________
City/State/ZIP Code ____________________
Phone ____________________
Fax ____________________
Ins. Claim Number ____________________

Provider Information

Name ____________________
TPI Number ____________________
Address ____________________
City/State/ZIP Code ____________________
Phone ____________________
Fax ____________________

Mail completed form to:

HHSC/OIG/TPR Unit
INFOC
PO Box 85200
Austin, TX 78708-5200

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B.30 Medicaid Audit Request for Claims Summary

PROVIDER NAME:
TEXAS PROVIDER IDENTIFIER (TPI):

Tentative Settlement Claims Summary for Period Beginning:
and Ending:

Requesting:

Paper Copy ❐

or

Microfiche ❐

Final Settlement Claims Summary for Period Beginning:
and Ending:

Requesting:

Paper Copy ❐

or

Microfiche ❐

MAIL TO:

ATTN:

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B.31 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS]; Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]) - Initial Request

Section A: To be completed by the physician or physician staff

Client name ______________________	Physician name ______________________
Client Medicaid number ______________________	Physician provider number ______________________
Client primary diagnosis ______________________	Physician medical license number ______________________ State __________
Client respiratory diagnosis ______________________	Physician telephone number ______________________
	Physician fax number ______________________

THIS FORM HAS BEEN UPDATED.
Click on the button above to access the new form.

Section B: To be completed by the physician

Device requested: HFCWCS (ThAIRapy) IPV Cofflator (circle)

- ❑ Client had respiratory illness or complications in the past 6 months (provide additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations). Yes _____ No _____
- ❑ Client or family unable to do chest physiotherapy (provide medical reasons in narrative section). Yes _____ No _____
- ❑ Client has tried other modes of chest physiotherapy, including the use of electrical percussor therapy or flutter valve for a minimum of four months prior to the request and that the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section). Yes _____ No _____
- ❑ Device use has not resulted in, nor exacerbated any gastrointestinal, manifestations, aspiration, pulmonary manifestation, nor seizure activity. Yes _____ No _____
- ❑ Client had pulmonary function studies in last 6 months, if applicable (provide results in narrative section). Yes _____ No _____
- ❑ Client has frequently missed work, school or extracurricular activities in the last 6 months due to respiratory illnesses and ineffective chest physiotherapy (provide medical reasons in narrative section). Yes _____ No _____

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the *Texas Medicaid Provider Procedures Manual*.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.

Narrative note for medical necessity (write legibly):

Physician Signature______________________________________ Date______________________

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

B

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B.32 Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS); Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]) - Extended Request

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Section A: To be completed by the physician or physician staff

Client name ______________________	Physician name ______________________
Client Medicaid number ______________________	Physician provider number ______________________
Client primary diagnosis	Physician medical license number ______________
______________________	State ________
Client respiratory diagnosis	Physician telephone number ______________
______________________	Physician fax number ______________

Section B: To be completed by the physician

Device requested: HFCWCS (ThAIRapy) IPV Cofflator (circle)

❑ Client had respiratory illness or complications **since** initial authorization (include additional information in narrative section, i.e., nebs for respiratory secretions, I.V. antibiotics, hospitalizations)	Yes _____	No _____
❑ Physicians description/assessment of the effectiveness indicates decreased medication use, shorter hospital length of stay (LOS), decreased hospitalizations, and fewer school, work, or extracurricular activity absences due to diagnosis related complications.	Yes _____	No _____
❑ System has not exacerbated any gastrointestinal manifestations, nor caused aspiration and exacerbation of pulmonary manifestation, nor an exacerbation of seizure activity.	Yes _____	No _____
❑ Client has been **compliant** in use of device (document minutes logged per treatment, times per day of treatments, and number of days used for entire trial period).	Yes _____	No _____
❑ Client has achieved the desired health outcome with device.	Yes _____	No _____

Clients can have only one chest physiotherapy device at a time. The HFCWCS is available for purchase after the initial rental period with additional documentation. Use of these devices may affect the number of private duty nursing hours for chest physiotherapy the client is receiving through the Comprehensive Care Program (CCP). Refer to the complete policy in the Texas Medicaid (Title XIX) Home Health Services section of the *Texas Medicaid Provider Procedures Manual*.

Section C: The physician prescribing a chest physiotherapy device must complete the narrative information regarding the medical necessity as requested above, or attach a letter with this information.

Narrative note for medical necessity (write legibly):

Physician Signature____Date____________________

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

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B.33 Medicaid Certificate of Medical Necessity for CPAP/BiPAP or Oxygen Therapy

SECTION A - (To Be Completed By Physician or Physician's Staff)

Client Name:______________________ **Client Medicaid #**______________________

Physician Name:______________________

Physician Phone #______________________**Physician License #**______________________

Supplier Name ______________________

Address: ______________________

Contact Person: ______________________Medicaid TPI Number: ______________________

Phone Number: ______________________ Fax Number: ______________________

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

SECTION B (To Be Completed By Physician)

CPAP/BIPAP S REQUEST:

Diagnosis: ______________________

Date of Polysomnogram: (Polysomnogram required for all CPAP requests) ______________________

If request is for BIPAP, explanation of the inability to tolerate CPAP:

____

____

AHI/RDI:______________ Sleep Time:______________hrs Total Apneas:______________

Obstructive apneas:______________ Lowest Oxygen Saturation:______________%

BIPAP ST REQUEST:

Diagnosis:______________________

If request is for BIPAP ST:, explanation of the inability to tolerate BIPAP S:

____

____

Date of Polysomnogram: (If Applicable) ______________________

Lowest Oxygen Saturation:______________% **OR** Arterial PO2:______________mm Hg

If prescribed for central sleep apnea: Central apneas/hr:______________Longest central apnea:______________sec.

OXYGEN THERAPY REQUEST:

Diagnosis:______________________

Lowest Oxygen Saturation at rest or with exercise :______________% **OR** Arterial PO2:______________mm Hg

Lowest Oxygen Saturation during sleep:______________% **OR** Arterial PO2:______________ mm Hg

Flow rate:______________l/min Hours of treatment per day:______________(estimated)

Is oxygen therapy required for mobility within the home? Yes:________ No:________

Is oxygen therapy required for mobility when leaving the home? Yes:________ No:________

Prescribing Physician Signature:______________________Date:______________

Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

B

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B.34 Medicaid Certificate of Medical Necessity for Reduction Mammaplasty

Section A: To be completed by the physician or physician staff

Client name ______________________________

Client Medicaid # ______________________________

Client date of birth ______________________________

Client ht. and wt. ______________________________

Client breast size______________________________

(must include photograph)

Physician name ______________________________

Physician Texas medical license #________________

Physician phone #______________________________

Physician fax # ______________________________

Physician TPI # ______________________________

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Section B: To be completed by the physician

- ❑ Client has evidence of a restrictive pulmonary defect. Yes _______ No ________
  (provide results of pulmonary function studies in narrative section)
- ❑ Client has evidence [illegible] Yes ________ No ________
  (provide results of therapies tried in narrative section)
- ❑ Client has evidence of ulnar paresthesia from thoracic nerve root compression. Yes _______ No ________
  (provide results of therapies tried in narrative section)
- ❑ Client has evidence of ischemic heart disease. Yes _______ No _______
  (provide results of abnormal EKG and/or coronary angiography)
- ❑ This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer. Yes _______ No _______
- ❑ Estimated the grams of breast tissue to be removed from each breast. Rt. _______ Lt. _______
- ❑ The client is in a weight reduction program and has lost ______lbs. Yes________ No ________

Section C: Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.

Narrative note for medical necessity:

Physician signature____Date________________

Refer to the Reduction Mammaplasty policy in the *Texas Medicaid Provider Procedures Manual*, section 36.

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B.35 Nursing Addendum to Plan of Care (THSteps-CCP) (3 Pages)

Client's Name: Medicaid #: Date:

In accordance with the PDN adopted rules (Chapter 33 Early and Periodic Screening, Diagnosis and Treatment, Subchapter K. Private Duty Nursing) published in the Texas Register, December 25, 1998 (23TexReg 13077), the following criteria must be met for the authorization of PDN Services. Caregivers and alternate caregivers must also be identified for authorization to proceed.

- ❑ The client has an identified primary caregiver who provides some of the client's daily care:

  (Caregiver) Name Relationship Phone #

- ❑ The client has a designated alternate caregiver or a plan if the primary caregiver is unable to provide care:

  (Alternate) Name Relationship Phone #

- ❑ The client has a primary physician who provides ongoing health care and medical supervision.
- ❑ The place(s) where PDN services will be delivered support the health and safety of the client.
- ❑ If applicable, there are necessary backup utilities, communication, fire and safety systems available and functional.

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

DOCUMENTATION REQUIREMENTS: (1) All components of the addendum must be complete and submitted with the (2) physician's plan of care (POC) and (3) THSteps-CCP Prior authorization request to the Texas Medicaid & Healthcare Partnership (TMHP) before PDN services can be authorized. All documents must be complete and received by TMHP before review or authorization. *[Additional information may be attached.]*

1) **Nursing care plan summary:** PDN services are based on a nursing assessment and nursing care plan established by the nurse provider in collaboration with the physician, client, and family. The nursing care plan provides a systematic way to document care given, client responses to interventions, and progress toward the goals of care.

Problem List	Goals of Care	Specific Measurable Outcomes	Progress toward Goals

Additional Comments:

Client's Name:________________________ Medicaid #:______________ Date: ____________

B

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2) Summary of recent health history for initial authorization OR 90 day summary for extension of PDN services:

Include recent hospitalizations, emergency room visits, surgery (may submit a discharge summary), illnesses, changes in condition, changes in medication or treatment, family/caregiver update, other pertinent observations.

3) Rationale for PDN hours to either increase, decrease, or stay the same. Also address plans to decrease PDN hours:

Client's Name:_______________________________Medicaid #:___________________Date: ________________

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4) Schedule of services, including PDN and family/caregiver coverage and coverage from other resources:

(Codes: N=PDN hours, P=family/caregiver hours, S=School/Daycare, O=other in-home resource(s), specify name below)

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
12a							
1a							
2a							
3a							
4a							
5a							
6a							
7a							
8a							
9a							
10a							
11a							
12p							
1p							
2p							
3p							
4p							
5p							
6p							
7p							
8p							
9p							
10p							
11p							

List other in-home resources:____

5) Acknowledgement (must be signed by the primary caregiver and the nurse provider):

By signing this form, the primary caregiver and the nurse provider acknowledge:

- Discussion and receipt of information about the THSteps-CCP Private Duty Nursing service,
- PDN services may increase, decrease, stay the same, or be terminated based on a client's need for skilled care,
- PDN is not authorized for respite, child care, activities of daily living, or housekeeping,
- All required criteria from the first page of this addendum are met, and completed documentation is submitted to TMHP,
- Participation in the development of the Nursing Care Plan for this client, and
- Emergency plans are part of the client's care plan and include telephone numbers for the client's physician, ambulance, hospital, and equipment supplier and information on how to handle emergency situations.

The primary caregiver agrees to follow through with the Plan of Care as prescribed by the client's physician.
The primary caregiver agrees to learn all the skills necessary to provide care for the child in the absence of a private duty nurse.

The number of PDN hours requested is ______hrs/day OR _____hrs/week for the dates of service from ________________ to __________________.

__________________________________ __________________________
Signature of Primary Caregiver/Printed Name Date

____ __________________________
Signature of PDN Nurse Provider/Printed Name Date

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B.36 Other Insurance Form

Client Name: ______________________________

Client Medicaid Number: ______________________________

Insurance Company Name: ______________________________

Insurance Company Address: ______________________________

Insurance Company Phone #: ______________________________

Policy Holder Name: ______________________________

Policy Holder SSN: ______________________________

Employer Name: ______________________________

Group Number: ______________________________

Ins. Eff. Date: ________________ Ins. Term. Date: ________________

List any family members and their SSN or Medicaid ID numbers that are covered under this policy: ________

____

____

COMMENTS: ______________________________

____

____

CONTACT: TMHP Third Party Resources (TPR) 1-800-846-7307
TMHP Third Party Resources (TPR) fax 1-512-514-4225

MAIL CORRESPONDENCE: Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-9981

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B.37 Primary Care Case Management (PCCM) Behavioral Health Consent Form

DIRECTIONS: This is an authorization for the release of information to your primary care provider.

PLEASE FILL OUT THE INFORMATION BELOW:

I, ____

Name   Address

______________________________________ ( ) ______________________________

City, State   Phone

authorize: ____

Provider Name

to disclose to: ____

Provider Name   Address

______________________________________ ( ) ______________________________

City, State   Phone

from (date) ______________________ to (date) ______________________ the following information:

Please indicate what, if any, information you would like to release.

- ☐ Total Medical Records to be released to primary care provider
- ☐ Medication Information **Only** to be released to primary care provider
- ☐ Medical Records to health plan

I understand that my records are protected under Federal (42 CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in thirty (30) days or sixty (60) days following completion or termination of treatment, whichever is later.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS ____________ DAY OF ____________

______________________________   ______________________________

(Witness)   (Patient)

____

(Parent, Guardian, or Authorized Representative, if required)

The person signing this authorization is entitled to a copy.

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact the Texas Medicaid & Healthcare Partnership (TMHP). You can write to the Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, P.O. Box 204270, Austin, TX 78720-4270. You can also call the Texas Medicaid & Healthcare Partnership PCCM Client Helpline at 1-888-302-6688.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION, PROHIBITION ON DISCLOSURE:

If the information disclosed to you is related to substance abuse treatment, these records' confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.

Revised June 12, 2005

B

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B.38 Primary Care Case Management (PCCM) Behavioral Health Consent Form (Spanish)

INSTRUCCIONES. Esta es una autorización para la divulgación de información para su Proveedor de Cuidado Primario.

POR FAVOR, DÉ LA SIGUIENTE INFORMACIÓN:

Yo, ____
Nombre Dirección

______________________ ( )____________________
Ciudad, Estado Teléfono

autorizo a: ______________________________________
Nombre del proveedor

para que le dé a: ________________________________
Nombre del proveedor Dirección

______________________ ( )____________________
Ciudad, Estado Teléfono

la siguiente información de (fecha) ____________ a (fecha) ______________________________ :

Por favor, indique qué información quiere divulgar, si es que quiere divulgar alguna.

- ☐ Todos los expedientes médicos se pueden divulgar al Proveedor de Cuidado Primario
- ☐ **Sólo** la información sobre medicamentos se puede divulgar al Proveedor de Cuidado Primario
- ☐ Los expedientes médicos se pueden divulgar al plan de salud

Entiendo que mis expedientes están protegidos bajo Normas de Confidencialidad Estatales y Federales (42 CFR Parte 2). Esta autorización puede revocarse por escrito en cualquier momento, excepto en el caso en que el programa o la persona que hará la divulgación haya dependido de ella para tomar una acción. Al revocar la autorización, la divulgación adicional de información se detendrá inmediatamente. Las copias de archivo se consideran equivalentes al original. Esta autorización para divulgar información se vence en treinta (30) o sesenta (60) días después de que se termine o se suspenda el tratamiento, el que se llegue después.

También reconozco que se me explicó detalladamente la información que se divulgará y que doy este consentimiento por mi propia voluntad.

FIRMADO ESTE DÍA ______ DE __________________

______________________________ ______________________________
(Testigo) (Paciente)

____
(Padre, Tutor o Representante Autorizado, si se exige)

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:
Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con Texas Medicaid & Healthcare Partnership (TMHP). Puede comunicarse con el personal de Texas Medicaid & Healthcare Partnership (TMHP), Attention: State Action Request Support Manager, MC-C04, P.O. Box 204270, Austin, TX 78720-4270. También puede llamar a la Línea de Ayuda al Cliente de PCCM, 1-888-302-6688.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN
Si la información que usted ha recibido tiene que ver con el tratamiento para el abuso de sustancias, la ley federal protege la confidencialidad de estos expedientes. Las normas federales (42 CFR Parte 2) le prohiben a usted hacer cualquier otra divulgación de estos expedientes sin el consentimiento escrito específico de la persona de quien se tratan, o de otra manera permitida por dichas normas. Una autorización general para la divulgación de información médica o de otro tipo no es suficiente para divulgar expedientes relacionados con el abuso de sustancias. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente de abuso de sustancias. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

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B.39 Primary Care Case Management (PCCM) Community Health Services Referral Request Form

PCP INFORMATION

Provider Name: ____________________ Contact Name: ____________________

TPI Number: ____________________ Phone Number: ____________________

CLIENT INFORMATION

Client Name: ____________________

Medicaid ID#: ____________________

Phone Number: ____________________

Reason for Referral:

[ ] Appointment No Show [ ] Abuse of Emergency Room
[ ] Abuse of Doctor/Staff [ ] Other:
[ ] Treatment Plan Adherence ____________________

Case Management/Health Education Needs:

[ ] Asthma [ ] Childhood Illness [ ] Community Resources
[ ] Cardiac [ ] Nutrition [ ] Transportation
[ ] Dental [ ] Parenting [ ] Behavioral Psych Disorder
[ ] Diabetes [ ] Prenatal
[ ] Exercise [ ] Tobacco Use
[ ] Child/Adult with Special Health Care Needs

[ ] Other: ____________________

Comments: ____________________

CLIENT INFORMATION

Client Name: ____________________

Medicaid ID#: ____________________

Phone Number: ____________________

Reason for Referral:

[ ] Appointment No Show [ ] Abuse of Emergency Room
[ ] Abuse of Doctor/Staff [ ] Other:
[ ] Treatment Plan Adherence ____________________

Case Management/Health Education Needs:

[ ] Asthma [ ] Childhood Illness [ ] Community Resources
[ ] Cardiac [ ] Nutrition [ ] Transportation
[ ] Dental [ ] Parenting [ ] Behavioral Psych Disorder
[ ] Diabetes [ ] Prenatal
[ ] Exercise [ ] Tobacco Use
[ ] Child/Adult with Special Health Care Needs

[ ] Other: ____________________

Comments: ____________________

CLIENT INFORMATION

Client Name: ____________________

Medicaid ID#: ____________________

Phone Number: ____________________

Reason for Referral:

[ ] Appointment No Show [ ] Abuse of Emergency Room
[ ] Abuse of Doctor/Staff [ ] Other:
[ ] Treatment Plan Adherence ____________________

Case Management/Health Education Needs:

[ ] Asthma [ ] Childhood Illness [ ] Community Resources
[ ] Cardiac [ ] Nutrition [ ] Transportation
[ ] Dental [ ] Parenting [ ] Behavioral Psych Disorder
[ ] Diabetes [ ] Prenatal
[ ] Exercise [ ] Tobacco Use
[ ] Child/Adult with Special Health Care Needs

[ ] Other: ____________________

Comments: ____________________

CLIENT INFORMATION

Client Name: ____________________

Medicaid ID#: ____________________

Phone Number: ____________________

Reason for Referral:

[ ] Appointment No Show [ ] Abuse of Emergency Room
[ ] Abuse of Doctor/Staff [ ] Other:
[ ] Treatment Plan Adherence ____________________

Case Management/Health Education Needs:

[ ] Asthma [ ] Childhood Illness [ ] Community Resources
[ ] Cardiac [ ] Nutrition [ ] Transportation
[ ] Dental [ ] Parenting [ ] Behavioral Psych Disorder
[ ] Diabetes [ ] Prenatal
[ ] Exercise [ ] Tobacco Use
[ ] Child/Adult with Special Health Care Needs

[ ] Other: ____________________

Comments: ____________________

For Primary Care Case Management Clients Only
Fax to Community Health Services at (512) 302-0318
Referrals are also received by telephone at 1-888-276-0702 (M-F, 8 a.m. to 5 p.m., CST)

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B.40 Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

This form is used to obtain prior authorization (PA) for elective inpatient admission/procedures and outpatient services, update an existing inpatient or outpatient authorization, and provide notification of emergency admissions.

Phone: 1-888-302-6167 (Option 1 Inpatient, Option 2 Outpatient) Fax: 1-512-302-5039

Please check the appropriate action you are requesting

Inpatient Services:

- ☐ **Notification** (complete fields in Sec 1 excluding clinical documentation)
- ☐ **DRG or clinical update** (complete Sec 2)
- ☐ **Non Routine OB/NB** (complete Sec 1)
- ☐ **Prior Authorization of scheduled admission/procedure** (complete Sec 1)

Outpatient (OP) Services:

- ☐ **Prior authorization for outpatient services** (complete Sec 1)
- ☐ **Update/change codes from original OP PA request** (complete Sec 2)

THIS FORM HAS BEEN UPDATED.

Facility TPI #: ____________ Facility Name: ____________ Reference # (if available) ____________

PCN #____________ Client Name: ____________ DOB: ____________

Requesting (Admitting) Physician TPI #: ____________ Requesting (Admitting) Physician Name: ____________

Form Completed by: ____________ Date Completed: ____________

Click on the button above to access the new form.

Phon[illegible]

Section 1

Service Type: ☐ Outpatient Service(s) ☐ Emergent/Urgent Admit ☐ Scheduled Admission/Procedure ☐ Admit Following Observation

Date of Service: ________________________________ Procedure Code(s):____

Diagnosis Codes: Primary - ____________________________, Secondary - _________________________, _________________________,

______________________, ______________________, ___________________, ___________________, ____________________________

*DRG Code: ____Discharge Date (if available):____________________________________

Clinical Documentation Supporting Medical Necessity for a scheduled admission/procedure, outpatient services or non-routine OB/NB:

____

____

____

____

____

Section 2 Updated Information (When necessary)

Diagnosis Code(s): Primary - ________________________ Secondary -____________________, ___________________, ______________,

Date of Service: _______________ Procedure Codes: ___________________________________*DRG Code: ________________________

Clinical Documentation to Support Medical Necessity of DRG or Procedure Code Change:

____

____

____

____

Only required for DRG inpatient admission

Revised 2/27/06

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B.41 Primary Care Case Management (PCCM) Referral Form

PCP INFORMATION

Provider Name ______________________ Texas Provider Identifier (TPI) ______________________

Contact Name and Phone Number

CLIENT INFORMATION

Client Name ______________________ Date of Birth __/__/__

Client's Medicaid Number Phone

Provider Signature Referral Date __/__/__

REFERRING PROVIDER INFORMATION (If different from PCP)

Provider Name ______________________

Texas Provider Identifier (TPI) ______________________

Contact Name and Phone Number

CONSULTING PROVIDER/FACILITY

Provider/Facility Name ______________________

Appointment Time and Date ________ __/__/__ Medicaid Provider # (if known) ______________________

Address Phone

Reason for Referral:

TO THE CONSULTANT

This notice authorizes the following care:

____ Evaluation Only

____ Evaluation and Single Treatment

____ Evaluation and Treatment

Number of Treatments ____

Other (Specify) ______________________

Initial consultations are for one visit only for evaluation and development of a treatment plan unless otherwise specified. All consultations require a written report (preferably typed and attached to this form) to the PCP and phone conferences as necessary to assure continuity of care. Referrals are valid for 30 days from the time of issue and it is the consulting provider's responsibility to verify eligibility prior to delivering services. Consulting providers may not authorize secondary referrals. All requests for additional services or visits to other providers must come through the PCP. All claims are subject to retrospective review for purposes of determining eligibility, benefit coverage, appropriateness, and medical necessity. Claims payment may be affected by review findings.

Consultant Comments: ______________________

____

____

Consultant Signature ______________________ Date __/__/__

Please return findings and report to PCP listed above.

Revised May 2005

B

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B.42 Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation

Provider Name: Provider #
Address: City: Zip:
Phone: Date:

Criteria	Meets Criteria Y	N	N/A	(COP) Condition of Participation	Comments (include provider's comments regarding any criteria not met)
OFFICE APPEARANCE:					
1) APPEARS CLEAN	☐	☐		COP	
2) SIGNAGE CLEARLY VISIBLE	☐	☐			
3) IN GOOD REPAIR	☐	☐		COP	
4) NOT ODOROUS	☐	☐			
5) ADEQUATE SEATING	☐	☐		COP	
6) GOOD VISIBILITY FROM RECEPTION AREA	☐	☐			
OFFICE SPACE:					
7) REST ROOMS AVAILABLE	☐	☐		COP	
8) REST ROOMS ADEQUATE	☐	☐		COP	
9) REST ROOM(S) WHEELCHAIR ACCESSIBLE	☐	☐	☐	COP	
10) NUMBER OF EXAM ROOMS ADEQUATE	☐	☐		COP	
11) EXAM ROOMS WELL-EQUIPPED	☐	☐		COP	
EMERGENCY PREPAREDNESS:					
12) EMERGENCY EQUIPMENT AVAILABLE	☐	☐			
13) WHAT TYPES OF EQUIPMENT	☐	☐			
14) STAFF KNOWLEDGEABLE OF EQUIPMENT	☐	☐	☐	COP	
15) STAFF TRAINED IN CPR	☐	☐			
16) EMERGENCY NUMBERS POSTED	☐	☐			
SAFETY:					
17) SMOKE ALARMS	☐	☐		COP	
18) FIRE EXTINGUISHER	☐	☐		COP	
19) EXIT SIGNS	☐	☐		COP	
20) PASSAGEWAYS CLEAR	☐	☐		COP	
HANDICAPPED ACCESS:					
21) WHEELCHAIR RAMP	☐	☐		COP	
22) WIDE DOORS	☐	☐		COP	
23) ELEVATORS (N/A IF SINGLE STORY)	☐	☐	☐	COP	
STAFF:					
24) COURTEOUS	☐	☐		COP	
25) ANSWER PHONES PROMPTLY	☐	☐		COP	
26) APPEAR KNOWLEDGEABLE	☐	☐			
27) NEAT/WELL GROOMED	☐	☐			
MEDICAL RECORDS:					
28) INDIVIDUAL CHARTS FOR EACH CLIENT	☐	☐		COP	
29) STORED IN DEDICATED SPACE	☐	☐		COP	
30) PERSONAL/BIOGRAPHICAL DATA PRESENT	☐	☐		COP	
31) PROVIDER IDENTIFICATION & DATE	☐	☐		COP	
32) LEGIBLE	☐	☐		COP	
33) ALLERGIES NOTED PROMINENTLY	☐	☐		COP	
34) HEALTH ED/PREVENTIVE SVS NOTED	☐	☐		COP	
35) ADVANCE DIRECTIVES OFFERED (ADULTS)	☐	☐	☐		
36) CONFIDENTIALITY MAINTAINED	☐	☐		COP	
Determination:	☐	☐		**Reviewer:**	
ADDENDUM LEP QUESTION: Do you have access to translation services if needed for clients with limited English language skills?	☐	☐		***Offer phone #s for translation services if needed	

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B.43 Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, ZIP Code)		

1. Date Of Examination*

2. Ear Examination:
   a. Within Normal Limits ❑ Yes ❑ No
   b. Cerumen Removed ❑ Yes ❑ No
   c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❑ Yes ❑ No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ❑ Yes ❑ No

If yes, a hearing aid is medically prohibited in ❑ Right Ear ❑ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❑ Yes ❑ No

Signature* - Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

To be reimbursed for the examination, you must submit this completed form along with a claim for physician's services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

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B.44 Physician's Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)

Request Date: _________/_________/ _________	Transport Date: _________/_________/ _________
Patient's Name:	Medicaid Number:
Transported From:	Transported To:
Physician's Printed Name:	Physician License #:

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient's condition is clinically considered severely disabled and as such that transportation by any other means (including services provided through the Medicaid Medical Transportation Program or through that which is included in the rate for Long Term Care - Nursing Facilities) is contraindicated. A round-trip transport from the client's home to a scheduled medical appointment (e.g., an outpatient or freestanding dialysis or radiation facility) is covered when the client meets the definition of severely disabled.

THIS FORM HAS BEEN UPDATED.

The [illegible]HSC Medicaid Program has defined "severely disabled" as that client's physical condition [illegible] mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion).

Please complete the questions below in order for the authorization to be evaluated under Medicaid coverage criteria.

Click on the button above to access the new form.

1.) Is the patient severely disabled as defined by the above definition? ❑Yes ❑No
2.) If no, this client does not qualify for nonemergency ambulance transport.
3.) If yes, please check the appropriate medical condition listed below.

This patient:

- ❑ Requires continuous oxygen and monitoring by trained staff
- ❑ Requires airway monitoring or suction
- ❑ Requires restraints or sedation **(MUST BE EXPLAINED IN OTHER)**
- ❑ Comatose and requires trained monitoring
- ❑ Is actively seizure-prone and requires trained monitoring
- ❑ Had to remain immobile because of a fracture/possibility of a fracture that had not been set
- ❑ Patient is ventilator-dependent
- ❑ Contractures **(MUST BE EXPLAINED IN OTHER)**
- ❑ Has advanced decubitus ulcers and requires wound precautions **(MUST BE EXPLAINED IN OTHER)**
- ❑ Requires isolation precautions (VRE, MRSA, etc.) **(MUST BE EXPLAINED IN OTHER)**
- ❑ Patient requires continuous IV therapy
- ❑ Requires cardiac monitoring
- ❑ Is exhibiting signs of a decreased level of consciousness **(MUST BE EXPLAINED IN OTHER)**
- ❑ Total hip replacement requires hip precautions and cannot sit safely **(MUST BE EXPLAINED IN OTHER)**
- ❑ **Other** (explain)

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FOR A NONEMERGENCY AMBULANCE TRANSPORT FROM THE MEDICAID PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, ARE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND STATE LAWS. * **THIS AUTHORIZATION WILL BE VALID FOR 180 DAYS FROM THE DATE OF ISSUANCE AND WILL CERTIFY THAT THE PATIENT REMAINS SEVERELY DISABLED FOR THAT PERIOD OF TIME.**

_ _______/_______/________

Signature of Attending or Patient's Personal Physician Date Signed

Requesting Provider ____ TPI

Fax #

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B.45 Private Pay Agreement

I understand ____________(Provider Name)____________is accepting me as a private pay patient for the period of ______________________, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: ____

Date: ____

B

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B.46 Provider Information Change Form Instructions

Signatures:

- The provider's signature is required on the Provider Information Change Form for any and all changes requested for individual provider numbers.
- A signature by the authorized representative of a group or facility is acceptable for requested changes to group or facility provider numbers.

Address:

- Performing providers (physicians performing services within a group) may *not* change accounting information.
- For Traditional Medicaid, changes to the accounting or mailing address require a copy of the W-9 form.
- For Traditional Medicaid, a change in ZIP code requires copy of the Medicare letter.

THIS FORM HAS BEEN UPDATED.

Tax Identification Number (TIN):

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers *cannot* change the TIN.

Click on the button above to access the new form.

General:

- Forms will be returned unprocessed if the nine-digit provider number is not indicated on the Provider Information Change Form.
- The W-9 form is required for *all* name and TIN changes.
- Mail or fax the completed form to:

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

  Fax: 1-512-514-4214

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B.47 Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN), and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. *Print* or *type* all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Check the box to indicate a PCCM Provider ☐	Date:
9-digit Texas Provider Identifier (TPI):	Provider Name:

List any additional TPIs that use the same provider information:

TPI:__________ TPI:__________ TPI:__________
TPI: TPI: TPI:

Physical Address*		Accounting/Mailing Address**		Secondary Address	
City:		City:		City:	
State:	ZIP:	State:	ZIP:	State:	ZIP:
Phone: ( )		Phone: ( )		Phone: ( )	
Fax:		Fax:		Fax:	
Email:		Email:		Email:	

Type of Change: (Check the appropriate box below.)

- ☐ Change of physical address, telephone, and/or fax number
- ☐ Change of billing/mailing address, telephone, and/or fax number
- ☐ Change/Add secondary address, telephone, and/or fax number
- ☐ Change of provider status (e.g., termination from plan, moved out of area, specialist) *Explain in the Comments field*
- ☐ Other (e.g., panel closing, capacity changes, and age acceptance)

Comments:

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

Tax ID Number:	Effective Date:
Exact name reported to the IRS for this Tax ID:	

The signature and date are *required* or the form will not be processed.

Provider Signature: Date:

Mail or fax the completed form to:	Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment PO Box 200795 Austin, TX 78720-0795	Fax: 1-512-514-4214

* The physical address *cannot* be a PO Box. *Traditional Medicaid* providers who change their ZIP code *must* submit a copy of the Medicare letter along with this form.

** All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.

B

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B.48 Psychiatric Hospital Inpatient Admission Form

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

I. Identifying information: Medicaid #: Date: / /

Last name: First name: Middle initial:

Date of birth: / / Age: Sex: | Date of admission: / / **Time:**

Facility name: | Provider #: Name of contact person:

Commitment Type: *(if applicable)* Effective Date: County: Judge:

Referral source: [ ] Admitting MD [ ] MH Professional [ ] DPRS [ ] Other (list):

Current living arrangements: [ ] With parent(s) [ ] Group/foster home [ ] Other (list):

IIA. Primary symptom described in "specific observable behavior" that requires acute hospital care:
(Include: Precipitating events leading to admission)

IIB. Other relevant clinical information, including inability to benefit from less restrictive setting:
(Attach additional pages or documents, as necessary)

IIC. Psychiatric medications (Include total daily dose)	**IID. Present and past drug/alcohol usage:**	
	Name of chemical	Current use?

IIE. Past psychiatric treatment

1. Number of previous inpatient admissions: [ ] | Dates of most recent inpatient stay: / / to / /

2. Previous ambulatory/outpatient treatment (provider or facility, frequency) – If none, why:

III. Admitting diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare Plan:

Provider or Facility:

Frequency:

Signature (Attending MD): Date: / /

Print name: Provider number: Provider license number:

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B.49 Psychiatric Inpatient (Extended) Request Form

I. Identifying information:	Medicaid #:	Date: / /
Last name:	First Name:	Middle initial:
Date of birth: / / Age: Sex:	Date of admission: / /	
Facility name:	Provider Number:	Name of contact person:
Commitment Type: *(if applicable)* Effective Date:	County:	Judge:

IIA. Current status of primary symptoms that require continued acute hospital care:
(Include: 1. Date of most recent occurrence; 2. Frequency; 3. Duration; 4. Severity)

THIS FORM HAS BEEN UPDATED.

IIB. Other relevant clinical/diagnostic information about patient from past 72 hours:
(Attach additional pages or documents as necessary)

Click on the button above to access the new form.

IIC. Current psychiatric medications (Include total daily dose)	**IID. Discharge criteria:**
	1.
	2.
	3.

IIE. Describe treatment, contacts, plans (including outcome) with family, school, etc.

III. Current diagnosis (Axis I):

IV. Additional diagnosis (Axis I and Axis II):

V. Current functional assessment scores (DSM IV): GAF [ ]

VI. No. of hospital days requested: [ ] Dates: / / to / /

Projected discharge date (required): / /

VII. Aftercare plan:

Provider or Facility:

Frequency:

Signature (Attending MD):		Date: / /
Print name:	Provider number:	Provider license number:

B

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B.50 Pulse Oximeter Form

Client Name: ___________________________________ Client Medicaid No: _________________________________

DME Provider Name and Address__________________
____
____
____

Provider TPI No:_____________________________________
Provider Phone No: ___________________________________
Provider Fax No: _____________________________________

HCPCS Code	Product Name and Model Number	Retail Price
__________	______________________________________	_________________________
__________	______________________________________	_________________________

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Ne[illegible] Yes[illegible]

****** Equipment designated for clinical use only is not considered appropriate for use in the home******

O[illegible] the day to maintain oxygen saturation. This does not include: PRN use; when only used when sick; when only used when suctioning; when desaturation occurs only when crying; when desaturation occurs only with seizure activity.

******The following information must be completed by the physician ******

Diagnosis and Basis for Medical Necessity of requested services: ____________________________________

____

Dates of Service requested for Prior Authorization: From _______________ To___________________

___ Client is ventilator and/or oxygen dependent
Client is ventilator dependent ____________________________hours per day
Client is oxygen dependent________________________________hours per day

___ Client is weaning from oxygen and/or a ventilator____

___ Anticipated length of monitor need: Months________1-3 years _______ More than 3 years ___________________

___ Who will respond to monitor alarm?____

___ Can the patient's medical needs be meet with intermittent "spot check" of oxygen saturations? Yes_____ No ____

___ What is the medical basis for need of continuous monitoring?____________________________________

____

___ Is the client receiving any nursing services such as PDN, Home Health Vists, MDCP, CBA, Private Insurance
Please indicate services_______________________Number of hours/vists_________________

Signature of prescribing physician________________________________Date __________________________

Printed or typed name of physician_______________________________Phone No. ______________________

Physician License number________________________Physician Medicaid TPI _________________________

Must be submitted with a THSteps – CCP Prior Authorization Request Form

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B.51 Radiology Prior Authorization Request Form

This form is used to obtain prior authorization (PA) for elective outpatient services or update an existing outpatient authorization.

Phone: 1-800-572-2116 Fax: 1-800-572-2119

Date of Request: ___________

Please check the appropriate action requested:

☐ **CT SCAN** ☐ **CTA SCAN**
☐ **MRI SCAN** ☐ **MRA SCAN**
☐ **Update/change codes from original PA request**

Facility Medicaid No. _________________ Facility Name: _______________________ Reference No. _______________________

PCN No. ___________________________ Client Name: _______________________ DOB: ___________________________

Requesting/Referring Physician Medicaid No. ___________ Requesting/Referring Physician Name: ___________________________

[illegible]: ___________________________ [illegible]: ___________________________

THIS FORM HAS BEEN UPDATED.

SECTION 1

Service Type: ☐ Outpatient Service(s) ☐ Emergent/Urgent Procedure

Click on the button above to access the new form.

Date of Service: ____ Procedure Requested: _______________________________

Diagnosis Codes: Primary- __________________________________, Secondary- ______________________________________

Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results: ____

____

____ _________________

Requesting/Referring Physician (Signature Required) Date

____

Print Name

SECTION 2 Updated Information (when necessary)

Diagnosis Code(s): Primary- _________________________________ Secondary ____

Date of Service: ____ Procedure codes: ___________________________________

Clinical documentation to support medical necessity for procedure code change includes treatment history, treatment plan, medications, and previous imaging results: ____

____

____ _________________ ___________________________

Requesting/Referring Physician (Signature Required) Date Physician Medicaid No.

____

Print Name

(Physician must complete and sign this form prior to requesting authorization.)

B

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B.52 Request for Initial Outpatient Therapy (Form TP-1)

Form TP1 Request For Initial OUTPATIENT THERAPY	
CCP - Texas Medicaid & Healthcare Partnership **PO Box 200735** **Austin TX 78720-0735** **1-800-846-7470** **CCP FAX: 1-512-514-4212**	**Texas Medicaid & Healthcare Partnership** **CSHCN** **PO Box 200855** **Austin TX 78720-0855** **1-800-568-2413 or 1-512-514-3000** **FAX: 1-512-514-4222**
Medicaid/CCP Case #	**CSHCN Case #**
Client Name	**DOB**
Client's Address (street, city, ZIP code, county)	**Phone Number**

THIS FORM HAS BEEN UPDATED.

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No

Date of Initial Evaluation: PT_______________ OT_______________ SLP_______________

Click on the button above to access the new form.

ICD-9 code/DIAGNOSIS: ______________________________Date of onset ____________________

CATEGORY OF THERAPY BEING REQUESTED: * CSHCN only # CCP only

PT/OT for: ❑ Developmental anomalies ❑ Pre-surgery* ❑ Post-surgery* Date of surgery______________

❑ Cast Removal Date Removed___________ ❑ Serial Casting ❑ Acute Episode of Chronic Condition ❑ New Condition

❑ Specialty Clinic ❑ Home Program ❑ ADL (activities of daily living) ❑ Equipment Assessment ❑ Equipment Training;

SPEECH for: ❑ Craniofacial ❑ Developmental Anomalies ❑ New Condition ❑ Post Cochlear Implant#

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

____ PT service date(s) FROM___________TO ___________ FREQUENCY per week ________per month________

____ OT service date(s) FROM___________TO ___________FREQUENCY per week ________per month________

____ SLP service date(s) FROM ___________TO ___________ FREQUENCY per week _______per month_______

Procedure code(s) for therapy services ____

Print or Type Name

Physician ________________________ Physician's Signature ___________________________Date Signed __________

Therapist's (PT) ____________________ Therapist's Signature ___________________________Date Signed __________

Therapist's (OT) ____________________ Therapist's Signature ___________________________Date Signed __________

Therapist's (SLP) ____________________ Therapist's Signature ___________________________Date Signed __________

PROVIDER CONTACT: ______________________________________ PHONE # ( ) ____________FAX # ( ) ___________

PROVIDER'S NAME: ____

BILLING ADDRESS: ____

MEDICAID PROVIDER # ______________________________CSHCN PROVIDER #____________________

FOR OFFICE USE ONLY: Medicaid ❑ Yes ❑ No HMO ❑ Yes ❑ No Restrictions:

PAN #____ Valid____________________ To ________________

tpyextccp.tp2 – 6/10/97 **FORM TP1**

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B.53 Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2)

Form TP-2 Request For EXTENSION of OUTPATIENT THERAPY	
CCP - Texas Medicaid & Healthcare Partnership **PO Box 200735** **Austin, TX 78720-0735** **1-800-846-7470** **CCP fax: 1-512-514-4212**	**TMHP-CSHCN** **Children with Special Health Care Needs** **Services Program** **PO Box 200855** **Austin, TX 78720-0855** **1-800-568-2413 or 1-512-514-3000** **fax: 1-512-514-4222**
Medicaid/CCP Case #	**CSHCN Case #**
Client Name	**DOB**
Client's Address (street, city, zip code, county)	**Phone Number**

THIS FORM HAS BEEN UPDATED.

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No

Date of Initial Evaluation: PT ______ OT ______ SLP ______

Click on the button above to access the new form.

COPY OF THE INITIAL EVALUATION MUST BE ATTACHED

ICD-9 code/DIAGNOSIS: ______________________Date of onset ______________________

CATEGORY OF THERAPY BEING REQUESTED: * CSHCN only # CCP only

PT/OT for: ❑ Developmental anomalies ❑ Pre-surgery* ❑ Post-surgery* Date of surgery ____________

❑ Cast Removal Date Removed __________ ❑ Serial Casting ❑ Acute Episode of Chronic Condition ❑ New Condition

❑ Specialty Clinic ❑ Home Program ❑ ADL (activities of daily living) ❑ Equipment Assessment ❑ Equipment Training;

SPEECH for: ❑ Craniofacial ❑ Developmental Anomalies ❑ New Condition ❑ Post Cochlear Implant #

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

____ PT service date(s) FROM __________TO __________ FREQUENCY per week ________ per month ________

____ OT service date(s) FROM __________TO __________ FREQUENCY per week ________ per month ________

____ SLP service date(s) FROM __________TO __________ FREQUENCY per week ________ per month ________

Procedure code(s) for therapy services ____

Print or Type Name

Physician ____________________ Physician's Signature __________________________ Date Signed __________

Therapist's (PT) ________________ Therapist's Signature __________________________ Date Signed __________

Therapist's (OT) ________________ Therapist's Signature __________________________ Date Signed __________

Therapist's (SLP) ________________ Therapist's Signature __________________________ Date Signed __________

PROVIDER CONTACT: ________________________________ PHONE # ( ) __________FAX # ( ) __________

PROVIDER'S NAME: ____

BILLING ADDRESS: ____

MEDICAID PROVIDER # ______________________________CSHCN PROVIDER #______________________

FOR OFFICE USE ONLY: Medicaid ❒Yes ❒ No HMO ❒Yes ❒ No Restrictions:

TPYEXTCCP.TP2 – 6/10/97 **FORM TP-2** Page 1 of 2

B

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PAN #________________________valid________________to______________

Medicaid/CCP case #	CSHCN Case #
Client Name	DOB

CURRENT FUNCTIONAL STATUS:______________________________________

____

____

____

NEW TREATMENT GOALS: ______________________________________

____

____

____

PRIOR DATES OF SERVICE from ____________________ to ____________________

PRIOR FUNCTIONAL STATUS:______________________________________

____

____

____

PRIOR TREATMENT GOALS: ______________________________________

____

____

____

PRIOR TREATMENT PROVIDED: ______________________________________

____

____

____

TPYEXTCCP.TP2 – 6/10/97 **FORM TP-2** page 2 of 2

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B.54 Request for Extended Outpatient Psychotherapy/Counseling Form

1. Identifying information: **Medicaid #:** **Date:** / /

Last name: First name: Middle initial:

Date of birth: / / Age: Sex: Began current treatment: / /

Performing Provider: Medicaid Provider number (TPI):

Current living arrangements: ( ) with family ( ) group/foster home ( ) other:

2. Current DSM IV diagnosis (list all appropriate codes):

Axis I diagnosis:

Axis II diagnosis: GAF:

Current substance abuse? ( ) none ( ) alcohol ( ) drugs ( ) alcohol and drugs

3. Recent primary symptoms that require additional therapy/counseling:

Include date of most recent occurrence, frequency, duration, and severity:

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

4. History

Psychiatric inpatient treatment ( ) yes ( ) no Age at first admission:

Prior substance abuse? ( ) none ( ) alcohol ( ) drugs ( ) alcohol and drugs

Significant medical disorders:

5. Current psychiatric medications (include dose and frequency):

6. Treatment plan for extension:

Measurable short term goals, specific therapeutic interventions utilized and measurable expected outcome(s) of therapy:

7. Number of additional sessions requested (limit 10 per request):

List specific procedure codes requested:

How many of each type? IND Group Family

Dates from (start of extension visits): / / To (end of planned requested visits): / /

Provider signature: Date: / /

Print name:

B

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B.55 Sample Letter - XUB Computer Billing Service Inc.

XUB Computer Billing Service, Inc.
4040 Main Street
Anytown, USA 11111

Dear Sir:

This letter authorizes the XUB Computer Billing Service, Inc. to use my signature and to attest on my behalf to the requirements authorized in the following paragraphs, when submitting Medicaid claims on my behalf.

This is also to certify that information appearing on billings submitted by me for the Texas Medical Assistance Program is and will be true, accurate, and complete. I understand that payment of any Texas Medical Assistance Program claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws. These certifications are made in accordance with requirements found at 42 Code Federal Regulations 455.18 and 455.19.

I also certify that the items billed to the Texas Medical Assistance Program are and will be for services that have been and will be personally provided by me or under my personal direction, and in cases of physician services, the services, supplies, or other items billed have been and will be medically necessary for the diagnosis or treatment of the condition of the patients, and are provided without regard to race, color, sex, national origin, age, or handicap.

Additionally, I agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the Texas Medical Assistance Program. I also agree to furnish them at no cost and provide access to information regarding any payments claimed for providing such services as the State Agency, Attorney General's Office, and Department of Health and Human Services (HHS) Office may request for five years from date of service (6 years for freestanding rural health clinic; 10 years for hospital-based rural health clinic), or until any dispute is settled, whichever occurs first.

I agree to accept the amounts paid by the Medicaid Program as full payment for the services rendered for which a Medicaid benefit is provided under the Texas Medical Assistance Program.

This letter, to be retained in your files, bears my true and original signature:

____

Provider Signature, Medicaid TPI

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B.56 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Instructions

Note: *Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider's convenience. Previously it was part of the G-1B form. It is not a THSteps form.*

For information on Triple Screens, call: 1-800-687-4363 or 1-888-963-7111 x7138 or Fax: (512) 458-7139.
For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. To obtain a TPI number, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

Contact Information: Indicate the telephone number and name of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen. The fax number should indicate the number of the fax machine where the report should be sent.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, date of birth, medical records number, race/ethnicity, address, ICD diagnosis code, city, state, zip code, and country of origin.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label.

ICD diagnosis code: Indicate the diagnosis code that would help in processing, identification, and billing of this specimen.

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

In order to interpret this test, **all** patient information in this section of this form must be provided. Without the date of collection, accurate gestational age, maternal weight, maternal date of birth, maternal race, and information about maternal diabetic status, a complete assessment cannot be made. *The time and date the specimen is removed from freezer **must** be provided to determine specimen acceptability.*

Section 4. PHYSICIAN INFORMATION

Physician's name and UPIN: Give the name of the physician and their unique physician ID number (UPIN), if applicable. This information is required to bill Medicare.

Section 5. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided.

Indicate the party that will receive the bill.

Medicaid or Medicare:

- Mark the appropriate box, write in the Medicaid or Medicare number, and
- Supply a copy of the Medicaid or Medicare card.

Private Insurance:

- Mark the appropriate box,
- Supply a copy of the front and back of the insurance card, &
- Complete all fields on the form that have an asterisk (*).

DSHS Program:

- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare.
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at http://www.dshs.state.tx.us/lab/.

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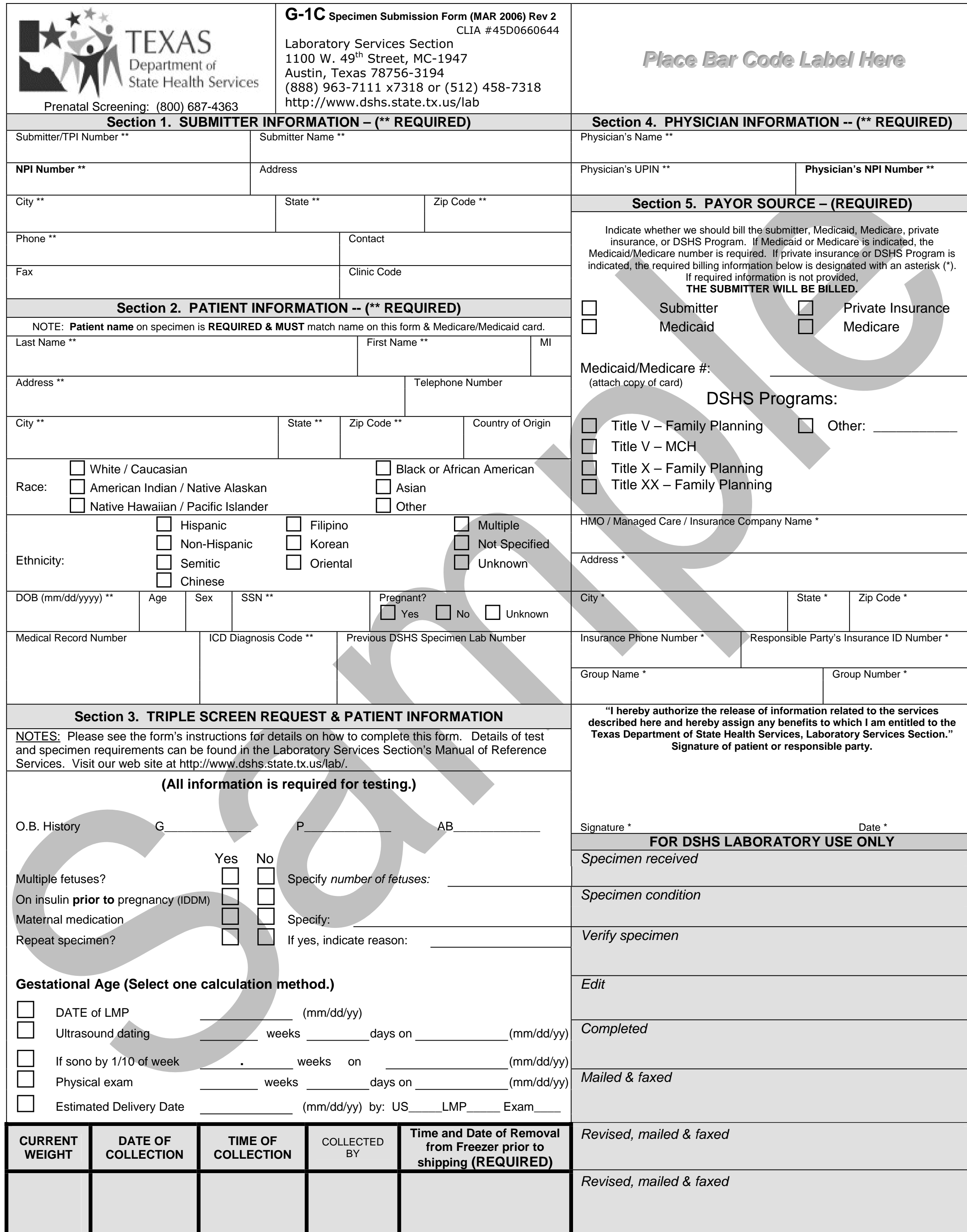
B.57 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen

Note: *Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider's convenience. Previously it was part of the G-1B form. It is not a THSteps form.*



TEXAS Department of State Health Services

Prenatal Screening: (800) 687-4363

G-1C Specimen Submission Form (MAR 2006) Rev 2
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form & Medicare/Medicaid card.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin

Race: ☐ White / Caucasian ☐ American Indian / Native Alaskan ☐ Native Hawaiian / Pacific Islander ☐ Black or African American ☐ Asian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Semitic ☐ Chinese ☐ Filipino ☐ Korean ☐ Oriental ☐ Multiple ☐ Not Specified ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Medical Record Number | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

NOTES: Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

(All information is required for testing.)

O.B. History G____________ P____________ AB____________

	Yes	No	
Multiple fetuses?	☐	☐	Specify *number of fetuses:* ____________
On insulin **prior to** pregnancy (IDDM)	☐	☐	
Maternal medication	☐	☐	Specify: ____________
Repeat specimen?	☐	☐	If yes, indicate reason: ____________

Gestational Age (Select one calculation method.)

☐ DATE of LMP ____________ (mm/dd/yy)
☐ Ultrasound dating ________ weeks ________days on ____________(mm/dd/yy)
☐ If sono by 1/10 of week ____.____ weeks on ____________(mm/dd/yy)
☐ Physical exam ________ weeks ________days on ____________(mm/dd/yy)
☐ Estimated Delivery Date ____________ (mm/dd/yy) by: US_____LMP_____ Exam____

CURRENT WEIGHT	DATE OF COLLECTION	TIME OF COLLECTION	COLLECTED BY	Time and Date of Removal from Freezer prior to shipping (REQUIRED)

Section 4. PHYSICIAN INFORMATION -- (REQUIRED)**

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private Insurance ☐ Medicaid ☐ Medicare

Medicaid/Medicare #: ____________
(attach copy of card)

DSHS Programs:

☐ Title V – Family Planning ☐ Other: ____________
☐ Title V – MCH
☐ Title X – Family Planning
☐ Title XX – Family Planning

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section." Signature of patient or responsible party.

Signature * Date *

FOR DSHS LABORATORY USE ONLY

Specimen received
Specimen condition
Verify specimen
Edit
Completed
Mailed & faxed
Revised, mailed & faxed
Revised, mailed & faxed

Sample

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B.58 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Spanish Instructions (2 Pages)

Página 1 de 2

Instrucciones para el formulario de remisión de muestras G-1C
Examen sistemático triple prenatal del suero materno

Para información sobre los exámenes sistemáticos triples, llame al: 1-800-687-4363 ó 1-888-963-7111 x7138
ó mande un fax al: (512) 458-7139.
Para información sobre el envío y el empaquetamiento de las muestras, visite nuestra página del Internet
de la Sección de Servicios de Laboratorio del *DSHS*: http://www.dshs.state.tx.us/lab/ (en inglés).

El formulario de remisión de muestras ***tiene que*** acompañar a cada muestra.
El nombre del paciente que aparece en la muestra ***tiene que*** concordar con el nombre del paciente que aparece en el formulario.
Si el campo "Fecha de recogida" no está llenado, se rechazará la muestra.

Sección 1. INFORMACIÓN SOBRE EL REMITENTE

Se requiere toda la información sobre el remitente.

Número de remitente / Número TPI, Nombre y dirección del remitente: Indique el nombre, dirección, ciudad, estado, y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta impresa de antemano, o utilice una fotocopia de un formulario original proporcionado por la Sección de Servicios de Laboratorio.

El número de remitente es un número único que la Sección de Servicios de Laboratorio del *Texas Department of State Health Services* [Departamento Estatal de Servicios de Salud de Texas, DSHS, por sus siglas en inglés] asigna a cada uno de nuestros remitentes. Para obtener un número TPI, comuníquese con *Texas Medicaid and Healthcare Partnership*, (*TMHP*, por sus siglas en inglés) al 1-800-925-9126.

Para pedir un número de remitente de la Sección de Servicios de Laboratorio del *DSHS,* un formulario original, o para cambiar la información del remitente, llame al (888) 963-7111 x7578 ó (512) 458-7578, ó mande un fax al (512) 458-7533.

Información localizadora: Indique el número de teléfono y el nombre de la persona apropiada en el centro remitente con quien el laboratorio puede comunicarse si es que se necesita más información sobre la muestra. El número de fax debe indicar el número de fax adónde se debe enviar el informe.

Código de la clínica: Favor de proporcionarlo, si se aplica. Éste es un código que el remitente proporciona si tiene una dirección postal principal y oficinas satélites. El código le ayuda al remitente a identificar cuál de los satélites remite la muestra y dónde es que pertenece el informe del laboratorio.

Sección 2. INFORMACIÓN SOBRE EL PACIENTE

Llene toda la información sobre el paciente inclusive el apellido, primer nombre, inicial del segundo nombre, fecha de nacimiento, número del expediente médico, raza / etnicidad, dirección, código diagnóstico ICD, ciudad, estado, código postal, y país de origen.

NOTE: El nombre del paciente que aparece en la muestra ***tiene que*** concordar con el nombre que aparece en el formulario.

La información que es requerida para pasarle la factura a Medicare, Medicaid, o al seguro privado ha sido marcada con dos asteriscos (**). Usted puede utilizar una etiqueta de paciente impresa de antemano.

El código diagnóstico ICD: Indique el código diagnóstico que ayudaría en el procesamiento, la identificación, y la facturación de esta muestra.

Sección 3. EXAMEN SISTEMÁTICO TRIPLE E INFORMACIÓN SOBRE EL PACIENTE

Para interpretar este examen, **toda** la información en esta sección de este formulario deberá ser proporcionada. Sin la fecha de recogida, la edad gestacional precisa, el peso materno, la fecha de nacimiento de la madre, la raza de la madre, e información sobre el estado diabético de la madre, no se puede llevar a cabo una evaluación completa. *Tiene que proporcionarse la hora y la fecha cuando se saca la muestra del congelador para determinar la aceptabilidad de la muestra.*

Sección 4. INFORMACIÓN SOBRE EL MÉDICO

Nombre del médico y UPIN: Proporcione el nombre del médico y su número único de identificación para médicos (UPIN, por sus siglas en inglés), si se aplica. Se requiere esta información para pasarle la factura a Medicare.

Sección 5. FUENTE DE PAGADOR SE LE PASARÁ LA FACTURA AL REMITENTE si no se proporciona la información requerida para la facturación**.**

Indique quién recibirá la factura.

Medicaid o Medicare:
- Marque la casilla apropiada, escriba el número de Medicaid o Medicare, y
- Provea una copia de la tarjeta de Medicaid o Medicare.

Seguro privado:
- Marque la casilla apropiada,
- Provea una copia de los dos lados de la tarjeta de seguro, y
- Llene todos los campos del formulario que tienen un asterisco (*).

Programa del DSHS:
- NO marque un programa del DSHS como la fuente de pagador si el paciente tiene Medicaid o Medicare.
- Si usted está contratando y / o está inscrito(a) en un programa del *DSHS* para proporcionar servicios que requieren análisis de laboratorio, indique qué programa es. Para descripciones de los programas, vea el Manual de

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servicios de referencia [*Manual of Reference Services*, en inglés] de la Sección de Servicios de Laboratorio en el siguiente sitio del Internet: http://www.dshs.state.tx.us/lab/.

- Si no hay ninguna otra fuente de pagador para el paciente y el paciente reúne los criterios de elegibilidad para el programa, marque el programa apropiado del *DSHS*.

HMO / Cuidado manejado / Compañía de seguros: Escriba en letra de molde el nombre, la dirección, la ciudad, el estado, y el código postal de la compañía de seguros a la cual se pasará la factura.

Firmante responsable: Escriba en letra de molde el nombre del firmante responsable, el número de identificación del seguro, el número de teléfono de la compañía de seguros, el nombre del grupo, y el número del grupo.

Firma y Fecha: Pida que la persona responsable firme y ponga la fecha para autorizar la revelación de su información, si es que el *DSHS* le mandará la factura a su seguro o HMO.

Para indicaciones específicas para las pruebas e información sobre los tipos de tubos, vea el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en nuestra página del Internet: http://www.dshs.state.tx.us/lab/.

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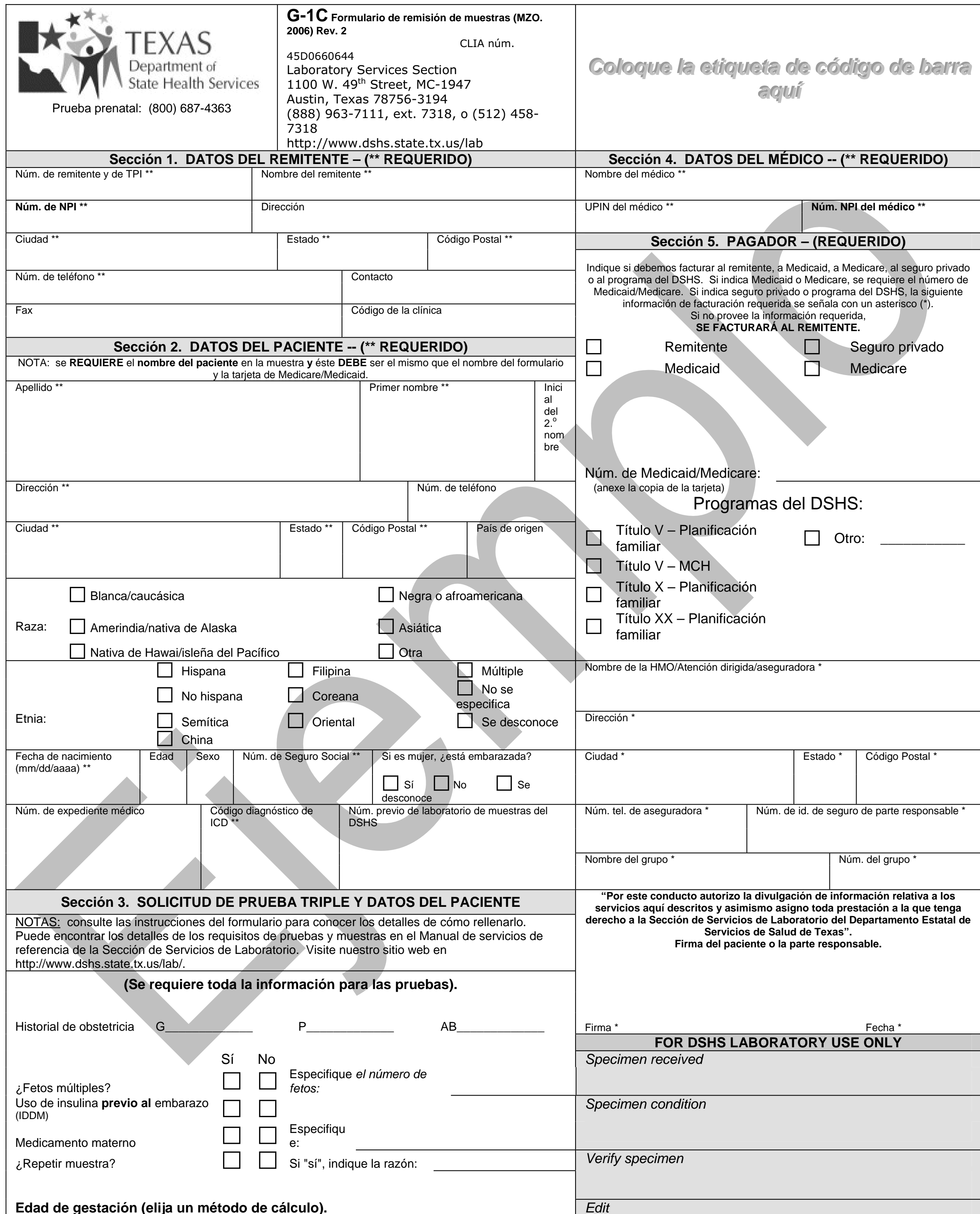
B.59 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen (Spanish, 2 Pages)



TEXAS Department of State Health Services

Prueba prenatal: (800) 687-4363

G-1C Formulario de remisión de muestras (MZO. 2006) Rev. 2

CLIA núm. 45D0660644

Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente y de TPI ** | Nombre del remitente **
Núm. de NPI ** | Dirección
Ciudad ** | Estado ** | Código Postal **
Núm. de teléfono ** | Contacto
Fax | Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario y la tarjeta de Medicare/Medicaid.

Apellido ** | Primer nombre ** | Inicial del 2.º nombre
Dirección ** | Núm. de teléfono
Ciudad ** | Estado ** | Código Postal ** | País de origen

Raza: ☐ Blanca/caucásica ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ Filipina ☐ Múltiple ☐ No hispana ☐ Coreana ☐ No se especifica ☐ Semítica ☐ Oriental ☐ Se desconoce ☐ China

Fecha de nacimiento (mm/dd/aaaa) ** | Edad | Sexo | Núm. de Seguro Social ** | Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce
Núm. de expediente médico | Código diagnóstico de ICD ** | Núm. previo de laboratorio de muestras del DSHS

Sección 3. SOLICITUD DE PRUEBA TRIPLE Y DATOS DEL PACIENTE

NOTAS: consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

(Se requiere toda la información para las pruebas).

Historial de obstetricia G____________ P____________ AB____________

	Sí	No	
¿Fetos múltiples?	☐	☐	Especifique *el número de fetos:* ____________
Uso de insulina **previo al** embarazo (IDDM)	☐	☐	
Medicamento materno	☐	☐	Especifique: ____________
¿Repetir muestra?	☐	☐	Si "sí", indique la razón: ____________

Edad de gestación (elija un método de cálculo).

Sección 4. DATOS DEL MÉDICO -- (REQUERIDO)**

Nombre del médico **
UPIN del médico ** | Núm. NPI del médico **

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*). Si no provee la información requerida, **SE FACTURARÁ AL REMITENTE.**

☐ Remitente ☐ Seguro privado ☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: ____________
(anexe la copia de la tarjeta)

Programas del DSHS:

☐ Título V – Planificación familiar ☐ Otro: ____________
☐ Título V – MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad * | Estado * | Código Postal *
Núm. tel. de aseguradora * | Núm. de id. de seguro de parte responsable *
Nombre del grupo * | Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas". Firma del paciente o la parte responsable.

Firma * Fecha *

FOR DSHS LABORATORY USE ONLY

Specimen received
Specimen condition
Verify specimen
Edit

Ejemplo

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☐ FECHA de LMP ______________ (mm/dd/aa)	
☐ Datación de ultrasonido _________ semanas __________días el ______________(mm/dd/aa)	*Completed*
☐ Si es ecografía a 1/10 de semana _______._______semanas el ___________________(mm/dd/aa)	
☐ Examen físico _________ semanas __________días el ______________(mm/dd/aa)	*Mailed & faxed*
☐ Fecha de parto calculada ______________ (mm/dd/aa) por: US_____LMP_____ Examen____	

PESO ACTUAL	FECHA DE OBTENCIÓN	HORA DE OBTENCIÓN	OBTENIDA POR	Fecha y hora de remoción del Congelador antes del envío (REQUERIDO)	*Revised, mailed & faxed*
					Revised, mailed & faxed

Ejemplo

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B.60 Statement for INITIAL Wound Therapy System In-Home Use (2 Pages)

Patient Name: ______________________________ Birthdate: ______________________________

Medicaid Number: ______________________________ Diagnosis: ______________________________

Physician Name: ______________________________ Physician Telephone Number: ______________________________

Physician Provider Number: ____________________ Home Health Agency Name: ______________________________

Physician License Number: ____________________ Provider Number: ______________________________

INDICATORS FOR INITIAL WOUND THERAPY

Must be completed by the physician familiar with the client and subscribing the wound care system. Answer "Yes" or "No" for each question and mark any answers which apply.

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

1. The patient has had one or more of the following: **YES** **NO**
   - _____ Stage III or Stage IV pressure ulcer
   - _____ diabetic ulcer
   - _____ pre-o[illegible] graft
   - _____ [illegible]
   - _____ [illegible]cen[illegible] gra[illegible]
   - _____ [illegible]
2. The patient's history reflects one or more of the following: **YES** **NO**
   - _____ previous failed wound care interventions, how long ago __________, how was it resolved ____________________
   - _____ severe coexisting chronic illness
   - _____ frequent reoccurr[illegible]nce of advanced press[illegible]re ulcers related to severely limited mobility
   - _____ [illegible]

   Admission date: _______________ Admitting diagnosis: _______________ Discharge date: _______________
3. The patient uses a pressure-reducing surface: **YES** **NO**
   - _____ non-powered mattress overlay
   - _____ powered mattress replacements
   - _____ non-powered mattress replacement
   - _____ powered bed system
   - _____ powered mattress overlay
   - _____ air fluidized bed

   NOTE: If "NO", why not? ____
4. The patient has an albumin greater than 3 mg/dl. **YES** **NO**

   Date of last albumin (within the past 30 days) : ____________________ **Result:** ____________________

   NOTE: If the patient has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional treatment which the patient is receiving: ____
5. The patient has diabetes mellitus **YES** **NO**

   Hemoglobin A1c level: _______________ **Date Hemoglobin A1c drawn (within the past 30 days):** _______________
6. The patient's wound is free of necrotic tissue. **YES** **NO**

   NOTE: If the wound has recently been debrided, identify the type and date of debridement:
   - ______ surgical Date: __________
   - _____ physical Date: __________
   - ______ chemical Date: __________
   - _____ autolytic Date: __________
7. The patient's wound is free of infection. **YES** **NO**

   NOTE: If the wound is infected, identify the wound treatment, include dosage, frequency, route and duration of any medications (including, but not limited to, antibiotics) :____

   ____
8. The patient's overall health status will allow wound healing. **YES** **NO**

   NOTE: Describe all medical conditions which might affect wound healing, address incontinence if pertinent, and what is being done to decrease contamination of the wound:____

   ____
9. Name of family member/friend/caregiver who agrees to be available to assist patient: ______________________________

Physician Signature: ______________________________ **Date:** ______________________________

B

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Patient Name: ____________________________ **Medicaid Number:** ____________________________

Physician Name: __________________________ **Physician Phone Number:** ______________________

CONTRAINDICATORS TO INITIAL WOUND THERAPY

Must be completed by the physician familiar with the client and subscribing the wound care system or the registered nurse (RN). Check any that apply.

Does the patient have any of the following conditions: **YES** **NO**

_____ fistulas to the body
_____ wound ischemia
_____ gangrene
_____ skin cancer in the margins
_____ osteomyelitis (unless being treated – describe below)
_____ presence of necrotic tissue, including bone
_____ less than six months to live

INITIAL WOUND PROFILE

Must be completed by the physician familiar with the client and subscribing the wound care system or the RN. **NOTE:** Use additional paper if more than two wounds are currently being treated.

Wound #1:

Type of wound: _____ pressure ulcer
_____ pre-operative myocutaneous flap or graft
_____ recent (within 14 days) myocutaneous flap or graft
_____ diabetic ulcer
_____ chronic open wound
_____ venous stasis ulcer

Location: _________________________________ Stage: _______________ Age of wound: ______________

Date of surgery (if flap or graft): ___________________ Type of debridement and date: ______________________________

Wound color: _______________ L x W x D: _______________ Odor: _______________ Drainage: _________________________

Tunneling (depth and position): _______________________ Undermining (depth and position): ______________________________

List all previous wound interventions: (use additional space if necessary): ____

____

____

Wound #2:

Type of wound: _____ pressure ulcer
_____ pre-operative myocutaneous flap or graft
_____ recent (within 14 days) myocutaneous flap or graft
_____ diabetic ulcer
_____ chronic open wound
_____ venous stasis ulcer

Location: _________________________________ Stage: _______________ Age of wound: _________________

Date of surgery (if flap or graft): ___________________ Type of debridement and date: ___________________________

Wound color: _______________ L x W x D: _______________ Odor: _______________ Drainage: _____________________

Tunneling (depth and position): _______________________ Undermining (depth and position): ___________________________

List all previous wound interventions: (use additional space if necessary): ____

____

____

Physician Signature: ______________________ **Date:** ____________________________________
REQUIRED

RN Signature: ____________________________ **Date:** ____________________________________
IF APPROPRIATE

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B.61 Statement for RECERTIFICATION of Wound Therapy System In-Home Use

Patient Name: ______________________________ Birthdate: ____

Medicaid Number: ___________________________ Diagnosis: ____

Physician Name: ____________________________ Physician Telephone Number:______________________________

Physician Provider Number: ____________________ Home Health Agency Name: ________________________________

Physician License Number: _____________________ Provider Number: ____

INDICATORS FOR CONTINUATION OF TREATMENT
Must be completed by the physician familiar with the client and subscribing the wound care system. Answer “Yes” or “No” for each question and any answers which apply.

1. Was the initial medical necessity justified by one of the following? **YES** **NO**

    _____ Stage III or Stage IV pressure ulcer _____ diabetic ulcer

    _____ pre-operative myocutaneous flap or graft _____ chronic open wound

    _____ venous stasis ulcer

THIS FORM HAS BEEN UPDATED.

2. Is the wound showing progress? **YES** **NO**

    _____ 30 days or longer since myocutaneous flap or graft _____ wound healed, no depth

    _____ 30 days with no demonstrated improvement _____ wound healing with improvement

Click on the button above to access the new form.

    Wound color: ______________ L x W x D: ______________ Odor: ______________ Drainage: ______________

    Tunneling (depth and position): _______________________ Undermining (depth and position): ____________________

    Wound description (ie. formation of granulation and date and type of debridement done in last 30 days):_______________

    ____

    NOTE: Include above information for each wound if more than one.

3. The patient continues to use a pressure-reducing surface: **YES** **NO**

    NOTE: If “NO”, why not? ____

4. Name of family member/friend/caregiver who continues to agree to assist patient: ____________________________________

Contraindicators to Continuation of Treatment
(Check any that apply)

1. Does the patient have any of the following conditions **YES** **NO**

    _____ fistulas to the body _____ osteomyelitis (unless being treated –describe below)

    _____ wound is ischemic _____ presence of necrotic tissue, including bone

    _____ gangrene

    _____ skin cancer in the margins _____ less than six months to live

    _____ no demonstrable improvement in wound over past 30 days

____

____

Physician Signature: ______________________________ **Date:** _______________________

B

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B.62 Sterilization Consent Form Instructions (2 Pages)

Per Title 42 *Code of Federal Regulations* (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

THIS FORM HAS BEEN UPDATED.

Clients must be at least 21 *years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery with the following exceptions:

Click on the button above to access the new form.

Exceptions: (1) Premature delivery - There must be at least 30 days between the date of consent and the client's expected date of delivery. (2) Emergency Abdominal Surgery -There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of *all* sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic
- Name of the Sterilization Operation
- Client's Date of Birth (month, day, year)
- Client's Name (first and last names are required)
- Name of Doctor or Clinic
- Name of the Sterilization Operation
- Client's Signature
- Date of Client Signature - *Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.*

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Interpreter's Statement (If applicable)

- Name of Language Used by Interpreter
- Interpreter's Signature
- Date of Interpreter's Signature (month, day, year)

Statement of Person Obtaining Consent

- Client's Name (first and last names are required)
- Name of the Sterilization Operation
- Signature of Person Obtaining Consent -The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an *original signature*, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) - Must be the same date as the client's signature date.
- Facility Name - Clinic/office where the client received the sterilization information
- Facility Address - Clinic/office where the client received the sterilization information

Physician's Statement

- Client's Name (first and last names are required)
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client's consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client's signature date must be at least 30 days prior to EDD
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required
- Physician's Signature - Stamped or computer-generated signatures are not acceptable
- Date of Physician's Signature (month, day, year) - This date must be *on or after* the date of surgery

Paperwork Reduction Act Statement

This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields

- Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below
- Date Client Signed the Consent (month, day, year)
- Provider Identifier - Including the nine-digit provider identification number will expedite the processing of the consent form
- Provider/Clinic Phone Number
- Provider/Clinic Fax Number (If available)
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX

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B.63 Sterilization Consent Form (English, 2 Pages)

Sterilization Consent Form

Fax consent to 512-514-4229

Client Medicaid or Family Planning # __ __ __ __ __ __ __ __ __

Notice: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from ______________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. **I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.** I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I [illegible] known as ______________________. The disc[illegible] bene[illegible] my questions [illegible]

THIS FORM HAS BEEN UPDATED.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____ (month), ____(day), ____ (year).

I, ______________________, hereby consent of my own free will to be sterilized by ______________________ [illegible] date of my signature below.

Click on the button above to access the new form.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Client's Signature____

Date of Signature: ___/___/_____ (month/day/year)

NOTICE: You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (mark one or more):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter Signature:_____________________ Date:___/___/_______ (month/day/year)

STATEMENT OF PERSON OBTAINING CONSENT

Before ____________________________________ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation known as a ______________________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.
Signature of person obtaining consent: ____Date:____/____/____ (month/day/year)

Facility Name:____

Facility Address:____

10/2006

Page 1 of 2

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STERILIZATION CONSENT FORM - PAGE 2

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon ________________________________ (name of individual to be sterilized), on____/____/____ at (date of sterilization: (month/day/year), I explained to him/her the nature of the sterilization operation _____________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure. (**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.) (1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed. (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery - Individual's expected date of delivery:
___/___/___ (month, day, year)

Emergency abdominal surgery:
(describe circumstances):______________________________

____

Physician's Signature:_________________________Date:____/____/____ (month/day/year)

PAPERWORK REDUCTION ACT STATEMENT

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

B

ALL FIELDS IN THIS BOX REQUIRED FOR PROCESSING

Provider Identifier: ____________________ - ___

Provider/Clinic Phone # (____)______-____________

Provider/Clinic Fax # (____)______-____________

Titled Billed (circle one): **V X XIX (Medicaid) XX**

10/2006

Page 2 of 2

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B.64 Sterilization Consent Form (Spanish, 2 Pages)

Sterilization Consent Form (Spanish) Fax consent to 512-514-4229

Medicaid or Family Planning # __ __ __ __ __ __ __ __ __

Nota: La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causará el retiro o la retención de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.

CONSENTIMIENTO PARA ESTERILIZACIÓN

Yo he solicitado y he recibido información de _____________________________ (médico o clínica) sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé

ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible. ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS. Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o. Entiendo que seré esterilizada/o por medio de una [illegible] decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el _______(mes) de ________ (día) de _________ (año).

Yo, [illegible] _________________ (médico o clínica) por el método llamado _________________. Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento. También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta forma.

Firma: ____

Fecha: ____/____/______ (mes, día , año)

Nota: Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo:

Definición de raza y origen étnico

Origen étnico:	Raza (marque según aplique):
☐ Hispano o latino	☐ Indígena americano o indígena de Alaska
☐ No hispano o latino	☐ Asiático
	☐ Negro o afroamericano
	☐ Natural de Hawaii u otras islas del Pacífico
	☐ Blanco

DECLARACIÓN DEL INTÉRPRETE

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de Consentimiento en idioma _____________ y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

Firma:_____________________ Fecha:___/___/_______ (mes, día, año)

DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO

Antes de que _____________________ (nombre de persona) firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación ___________________ para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.
Firma de la persona que obtiene el consentimiento :______________________________ Fecha:___/___/_______ (mes, día, año)

Lugar ____

10/2006

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Dirección ____

STERILIZATION CONSENT FORM (SPANISH) – PAGE 2

DECLARACIÓN DEL MÉDICO

Previamente a realizar la operación para la esterilización a _______________________________ (nombre de persona esterilizada/o), en ____/____/______ (fecha de esterilización: mes, día, año), le expliqué a él/ella los detalles de esta operación para la esterilización________________________ (especifique tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.
Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.
(Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique). (1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización. (2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

☐ Parto prematuro
Fecha prevista de parto: ____/____/____ (mes, día, año)

☐ Cirugía abdominal de urgencia
Describa las circunstancias: ______________________________

Firma del médico ___________________________________ Fecha :____/____/____ (mes, día, año)

DECLARACIÓN SOBRE LEY DE REDUCCIÓN DE TRÁMITES

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.

Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

ALL FIELDS IN THIS BOX REQUIRED FOR PROCESSING

Provider Identifier: ____________________ - ___

Provider/Clinic Phone # (____)______-____________

Provider/Clinic Fax # (____)______-____________

Titled Billed (circle one): **V** **X** **XIX (Medicaid)** **XX**

10/2006

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B.65 Synagis® (Palivizumab) Prescription Prior Authorization Request Form

Patient's Name:______________________________ Client ID:______________________
Date of Birth:______________ Gender: ☐ M ☐ F Telephone Number: (_____)______________________
Address:______________________________ City:______________ State:_____ Zip:______________
Parent/Legal Guardian (if applicable):____

Age in months at start of RSV season (as of October 1):________ Estimated gestational age at birth:________ completed weeks
Requested dates of service—From:______________ To:______________ Quantity Requested:______________________

☐ Clients less than 24 months chronological age at the start of the RSV season can qualify based on criteria to the right. Diagnoses and conditions must be clearly documented in the client's medical record.

[illegible]ate [illegible] th on [illegible] after 03/3[illegible]/200[illegible].

(See Medicaid Bulletin #199 – Nov/Dec 2006 for details related to congenital heart and chronic lung disease diagnoses.)

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

☐ Hemodynamically significant heart disease: (specify ICD-9-CM code):
____

OR

☐ Chronic lung disease (CLD)*: (specify ICD-9-CM code):
____

AND

Req[illegible] the [illegible] within [illegible] past [illegible]:
- ☐ Supplemental oxygen
- ☐ Digitalis
- ☐ Steroids (systemic or inhaled)
- ☐ Diuretics
- ☐ Mechanical ventilation

*C[illegible] treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RSD). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.

☐ Clients less than 12 months chronological age at the start of the RSV season can qualify based on criteria to the right.

Date of birth on or after 09/30/05.

☐ ≤ 28 completed weeks gestational age at birth (specify ICD-9-CM code):

☐ Clients less than 6 months of age at the start of RSV season can qualify based on criteria to the right. Diagnoses, conditions, and risk factors must be clearly documented in client's medical record.

Date of birth on or after 03/31/2006.

☐ 29 to 32 completed weeks gestational age at birth (specify ICD-9-CM code):
____

OR

☐ 32 to 35 completed weeks gestational age (specify ICD-9 code):: ____________________
WITH the following documented in the patient's medical record:
☐ Severe neuromuscular disease (including chronic respiratory failure, 51883)

OR

☐ Significant congenital anomalies of the airway expected to compromise respiratory reserve
____

AND *two* of the following:
- ☐ Direct exposure to tobacco smoke or other air pollution
- ☐ Attends child care
- ☐ Direct contact with siblings who attend school or child care

Additional clinical information about medical necessity that is not provided above:______________________________
____
____

Physician Name (printed):______________________________ Date:______________
Address:______________________________ City:______________ State:_____ Zip:______________
Telephone: (_____)________________ Fax: (_____)________________

Physician Signature:____

Texas License Number:______________________ Texas Provider Identifier:______________________

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B.66 Synagis® (Palivizumab) Prescription Form

TEXAS MEDICAID VENDOR DRUG PROGRAM
SYNAGIS® (PALIVIZUMAB) PRESCRIPTION FORM

Patient's Name ________________________________ Texas Medicaid Recipient Number _ _ _ _ _ _ _ _ _ _ _
Date of Birth ________________________________ Gender: ☐ Male ☐ Female
Address (Street) ____
City __________________ State _____ ZIP ________ Phone ___________ Phone _____________
Parent/Legal Guardian Name **(if applicable)** ____

AGE IN MONTHS AT START OF RSV SEASON (AS OF NOVEMBER 1ST) ____________	ESTIMATED GESTATIONAL AGE AT BIRTH: ____________ COMPLETED WEEKS
CHRONOLOGICAL AGE AT START OF RSV SEASON	**GESTATIONAL AGE AT BIRTH OR DISEASE STATE**
☐ IF < 24 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT. DATE OF BIRTH ON OR AFTER 11/02/2003 (SEE MEDICAID BULLETIN #190 FOR DETAILS RELATED TO CONGENITAL HEART DISEASE DIAGNOSES.)	☐ HEMODYNAMICALLY SIGNIFICANT HEART DISEASE: (SPECIFY ICD-9 CODE(S)) ____________________ **OR** ☐ CHRONIC LUNG DISEASE: (SPECIFY ICD-9 CODE(S) ____________________ **AND** AT LEAST ONE OF THE FOLLOWING: ☐ REQUIRED ROUTINE SUPPLEMENTAL OXYGEN WITHIN PAST 6 MONTHS: ☐ REQUIRED ANY OF THE FOLLOWING THERAPIES WITHIN THE PAST 6 MONTHS: ☐ IPRATROPIUM ☐ INHALED BETA 2 AGONIST ☐ METHYLXANTHINES ☐ STEROIDS (systemic or inhaled) ☐ SYMPATHOMIMETICS (e.g., epinephrine, isoproterenol)
☐ IF ≤ 12 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT DATE OF BIRTH ON OR AFTER 10/02/2004	☐ ≤ 28 COMPLETED WEEKS GESTATIONAL AGE AT BIRTH: (SPECIFY ICD-9 CODE): ____________________
☐ IF ≤ 6 MONTHS CHRONOLOGICAL AGE, CAN QUALIFY BASED ON CRITERIA TO THE RIGHT DATE OF BIRTH ON OR AFTER 04/02/2005	☐ BETWEEN 28 & 31 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY iCD-9 CODE): ____________________ ☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE): ____________________ AND ONE OF THE FOLLOWING: ☐ SEVERE NEUROMUSCULAR DISEASE: (SPECIFY): ____________________ ☐ CONGENITAL AIRWAY ANOMALY: (SPECIFY) : ____________________ ☐ BETWEEN 32 & 35 COMPLETED WEEKS GESTATIONAL AGE (SPECIFY ICD-9 CODE): ____________________ AND TWO OF THE FOLLOWING: ☐ DIRECT EXPOSURE TO TOBACCO SMOKE OR OTHER AIR POLLUTION ☐ ATTENDS CHILD CARE ☐ DIRECT CONTACT WITH SIBLINGS WHO ATTEND SCHOOL OR CHILD CARE
ADDITIONAL CLINICAL INFORMATION PERTAINING TO MEDICAL NECESSITY NOT OTHERWISE PROVIDED ABOVE:	

Rx: ☐ **Synagis ® (palivizumab) 50mg and/or 100mg vials and Sterile Water for injection 10ml**
Sig: Reconstitute as directed and inject 15mg/kg one time per month. **Quantity:** QS for weight based dosing

☐ Syringes 1ml 25G 5/8" ☐ Syringes 3ml 20G 1"
☐ Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed ☐ Known Allergies: ____________________
☐ Other: ____
Sig: ____ **Refills:** ______________

Physician Name (printed) ______________________________ Date ____________________

Address ____

City __________________ State _________ ZIP _______ Phone______________________

Physician Signature ______________________________ Texas License No. ______________

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B.67 Texas Medicaid & Healthcare Partnership Electronic Remittance and Status (ER&S) Agreement (2 Pages)

Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:

* *These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.*

☐ **Set up INITIALLY** (first time). Use Production User ID*: ____________ (9 digits)

☐ **CHANGE** Production User ID FROM: ____________ (9 digits)

TO: ____________ (9 digits)

☐ **REMOVE** Production ID Remove: ____________ (9 digits)

** *The TMHP **Production User ID** (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.*

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Provider Name *(must match TPI number)* | ***BILLING*** TPI Number | Provider Tax ID Number

Provider's Physical Address | Provider Phone Number

Provider Contact Name *(if other than provider)* | Provider Contact Title | Contact Phone Number

Do not complete this block UNLESS the ER&S will be downloaded by anyone OTHER than the provider.

Name of Business Organization to Receive ER&S | Business Organization Phone Number

Business Organization Contact Name | Business Organization Contact Phone No.

Business Organization Address | Business Organization Tax ID

Check each box after reading and understanding the following statements.

If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638.

All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

☐ I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

☐ I (we) understand that paper–formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.

☐ I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature | **Date**

Title | **Email Address (if applicable)**

DO NOT WRITE IN THIS AREA — For Office Use

Input By: ____________ Input Date: ____________ Mailbox ID: ____________

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Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed.

Incomplete agreements cannot be processed.

Mail to: Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk MC–B14
PO Box 204270
Austin, TX 78720-4270

Fax to: (512) 514-4228
OR
(512) 514-4230

B

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B.68 Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section I

*Note: Please complete all information in the manner requested to ensure timely processing. **Otherwise additional information will be requested.*
This form is to be used for request of EITHER Intrathecal Baclofen or Morphine pump.
SECTION 1: THE FOLLOWING MUST BE PROVIDED BY THE TREATING PHYSICIAN:

CLIENT NAME (LAST, FIRST, M.I.) ____ MEDICAID NUMBER ____ DATE OF BIRTH ____

CPT CODE(S) WITH DESCRIPTION OF PROCEDURE(S) REQUESTED: ____________________

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

DATES OF SERVICE BEING REQUESTED FROM: ____ TO: ____

DIAGNOSIS OR ICD-9 CODE(S) AS RELATED TO PRESCRIPTION: ____

PERFORMING PROVIDER NAME ____ PROVIDER SPECIALTY ____

PERFORMING PROVIDER ADDRESS: ____________________

PERFORMING PROVIDER PHONE NUMBER: ____________________
(INCLUDING AREA CODE)

PERFORMING PROVIDER TEXAS IDENTIFIER: ____________________

NAME/LOCATION/PHONE NUMBER OF FACILITY WHERE PROCEDURE IS TO BE PERFORMED:
(ONLY APPLICABLE IF DIFFERENT FROM PROVIDER ADDRESS)

____

____

FACILITY TPI ____

ORIGINAL PHYSICIAN SIGNATURE (STAMPED SIGNATURES NOT ACCEPTED) ____ PRINTED NAME OF PHYSICIAN ____ DATE SIGNED ____

**The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.

Eff. 01/29/99 PAGE 1 OF 2

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B.69 Texas Medicaid Prior Authorization Request Form: Intrathecal Baclofen or Morphine Pump Section II

*Note: Please complete all information in the manner requested to ensure timely processing. **Otherwise additional information will be requested. This form is to be used for request of EITHER Intrathecal Baclofen or Morphine pump.*

CLIENT NAME (LAST, FIRST, M.I.)	MEDICAID NUMBER	DATE OF BIRTH

SECTION 2: PLEASE ATTACH THE FOLLOWING INFORMATION AS IT APPLIES TO THIS REQUEST. THIS INFORMATION MUST BE SIGNED AND DATED BY THE PHYSICIAN (STAMPED SIGNATURES WILL NOT BE ACCEPTED):

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

1. History and Physical - include the following information:

A. AGE OF ONSET OF SIGNS/SYMPTOMS WHICH ARE DIRECTLY RELATED TO THIS REQUEST (IF REQUESTING BACLOFEN, SPECIFY MUSCLE GROUPS AFFECTED, DEGREE OF SPASTICITY, PARALYSIS, ETC.)
B. PRIOR HOSPITALIZATIONS/TREATMENTS FOR THESE SYMPTOMS OR DIAGNOSES
C. OTHER DIAGNOSES
D. CURRENT LEVEL OF FUNCTIONING (ADLS)
E. PERTINENT LAB/X-RAY RESULTS
F. CLIENT'S WEIGHT (IN KILOGRAMS)
G. FAMILY AND/OR CLIENT'S ROLE/PARTICIPATION/COMPLIANCE WITH CLIENT'S CARE
H. MEDICATIONS (NAME, DOSAGE, ROUTE, AND FREQUENCY)
I. RESPONSE OF CLIENT TO PRIOR TREATMENTS (MEDICATIONS)/SURGERY/ BACLOFEN/MORPHINE PUMP

2. PLAN OF CARE - INCLUDE INFORMATION PERTINENT TO THE TREATMENT PLAN. YOU DO NOT NEED TO DUPLICATE INFORMATION ALREADY CONTAINED IN THE "HISTORY AND PHYSICAL." YOU MAY ATTACH YOUR MEDICAL CHART "PLAN OF CARE" FOR THIS SECTION IF IT IS SUCCINCT, COMPLETE, AND RESPONDS TO ALL OF THESE QUESTIONS.

A. MEDICAL/SURGICAL MANAGEMENT OF CLIENT (CURRENT TREATMENT PLAN)
   1. MEDICAL PLAN OF CARE (MEDICATIONS, THERAPY, CONSULTS)
   2. SURGICAL PLAN OF CARE (E.G., CONSULTS, SCHEDULED SURGERIES)
   3. RECOMMENDATION AND PLAN OF CARE WITH A BACLOFEN/MORPHINE PUMP
   (including expected schedule of treatment, anticipated drug dosage, and volume and response evaluation, and if requesting Baclofen - muscle groups to be treated)
   4. FOLLOW-UP PLAN AND ANY ALTERNATIVES LONG-TERM
B. ARE THERE ANY OTHER TREATMENTS, WHICH YOU EXPECT TO BE TRIED, IF THE BACLOFEN/MORPHINE IS INEFFECTIVE?
C. LIST NAMES, SPECIALTIES, AND PHONE NUMBERS OF OTHER PHYSICIANS INVOLVED IN THE MULTIDISCIPLINARY CARE OF THIS CLIENT

** The completion of this form does not guarantee prior authorization. Once this information is reviewed and a determination has been made, you will receive a written response to the prior authorization request. If a prior authorization number is issued, it will be included in the response.

Eff. 01/29/99 PAGE 2 OF 2

B

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B.70 Texas Medicaid Refund Information Form

Please attach this completed form to your refund check made payable to TMHP, include a copy of the Medicaid Remittance and Status (R&S) report, and mail to the following address:

Texas Medicaid & Healthcare Partnership
Financial Department
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

THIS FORM HAS BEEN UPDATED.

Date: ______________________ Refunding provider's name: ______________________

Provider's TPI: ______________________ Provider contact name: ______________________

Provider's telephone number with extension: ______________________

Provider's e-mail address: ______________________

Click on the button above to access the new form.

Claim Information:

Medicaid claim number (from *R&S*) refund should be applied to: ______________________

Patient's name: ______________________

Patient's Medicaid number: ______________________

Date(s) of service: ______________________

Reason for the Refund:

_____ Other insurance paid $____________ on this claim. **Attach EOB.** If no EOB available, complete the following:

Insurance company name: ______________________

Address: ______________________

Telephone number: ______________________ Policy number: ______________________

_____ TMHP audit identified overpayment
_____ Duplicate Medicaid payment
_____ Claim paid on the wrong patient's Medicaid ID number
_____ Claim paid on the wrong provider's Medicaid TPI
_____ Above-named person is not our patient
_____ Billing error
_____ Service was not rendered as billed
_____ Late credit for blood or pharmacy
_____ Medicare adjusted payment
_____ Patient's Medicare eligibility
_____ Other (describe in detail): ______________________

____

____

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B.71 TDHconnect Order Form

TDHconnect is the versatile, reliable, and free Windows-based claims submission software provided by TMHP. Technical support, upgrades, and training for TDHconnect are also available free from TMHP. Providers can use the software to submit claims, eligibility requests, claim status inquiries, adjustments, appeals, and to retrieve Electronic Remittance and Status (ER&S) reports. TDHconnect training can be obtained through the Provider Relations workshops. Information about these workshops and other classes related to Medicaid billing can be found at www.tmhp.com\Providers under TMHP Provider Services Representatives and TMHP Provider Workshops. Technical support for TDHconnect is available weekdays from 7a.m. to 7p.m. through the Electronic Data Interchange (EDI) Helpdesk at 1-888-863-3638. Technical support, software updates, and training are provided free of charge.

Mailing Information

Provider or Organization Name **Provider Number**

Contact Name **Contact Number**

Address

City **State** **Zip Code**

The TDHconnect software and Quick Start Guide should arrive within 15 business days of TMHP's receipt of the order form. *Overnight and 2nd Day services are available through UPS at the expense of the person(s) ordering TDHconnect. Orders received without a valid UPS account number or for any other package service will be sent through standard U.S. Mail. A signature is required for all UPS orders.*

- ☐ **Standard mail delivery**
- ☐ **UPS Overnight** ***at provider's expense***
- ☐ **UPS 2nd Day Air** ***at provider's expense***

UPS Account Number: ______________________________

Authorized Signature **Title**

Date **Telephone**

Fax Number:	1-512-514-4228 or 1-512-514-4230
Mailing Address:	Texas Medicaid & Healthcare Partnership Attention: EDI Helpdesk MC-B14 P.O. Box 204270 Austin, TX 78720-4270

Hardware and Software Requirements for TDHconnect

Platforms	400 MHz or greater processor is recommended with 256MB of RAM	
	Windows 98, Windows ME, Windows XP Home, Windows XP Pro, Windows NT 4.0 with Service Pack 5 or later, and Windows 2000 Pro	
Hard Drive	Free space of 100MB for installation and 50MB per database	
Peripherals	CD-ROM Drive	Any speed
	Display	800 X 600 VGA, 256 or more colors
	Connectivity	9600bps minimum dial-up modem or Internet connection
Software	Adobe Acrobat Reader—latest version (Version 4.05 is included on the TDHconnect installation disk)	
	Internet Explorer—Version 6.0 or later	

B

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B.72 THSteps-CCP Prior Authorization Request Form

******If any portion of this form is incomplete, it will be returned.******

Request for: ❑ DME ❑ Supplies ❑ Private Duty Nursing ❑ Inpatient Rehabilitation ❑ Other

Client Name (Last, First, MI) _____ Medicaid Number (PCN) _____ Date of Birth _____

Name of Supplier/Vendor _____ TPI _____ Phone Number _____

Phone Number _____

FAX Number _____

Address of Supplier/Vendor

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Diagnosis and Medical Necessity of requested services:

Dates of service from _____ to _____

HCPCS Code	Brief Description of requested services	Retail Price

Note: HCPCS codes and description must be provided

By prescribing the identified DME and/or medical supplies, I certify to the following:

❑ The client is under 21 years of age **AND**

❑ The prescribed items are appropriate and can safely be used by the client when used as prescribed

For Private Duty Nursing, I certify:

❑ The client's medical condition is sufficiently stable to permit safe delivery of private duty nursing as described in the plan of care.

Signature of prescribing physician _____ Date _____

Printed or typed name of physician _____

Fax completed form to 1-512-514-4212

For TMHP Use Only

Or mail to:

CCP
PO Box 200735
Austin, TX 78720-0735

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B.73 THSteps-CCP Prior Authorization Private Duty Nursing 4 or 6 Month Authorization

Name____ Medicaid #__________________

The following criteria must be met before seeking a 4 or 6 month authorization of PDN services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

_____Client has received PDN services for at least one year.

_____Client has had no new significant diagnosis, treatment, illness/injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.

_____There has been no change in the PDN requests in the previous 6 months.

_____Client's physician and primary caregiver (parent) do not anticipate any significant changes in the client's condition for the requested authorization period.

_____The nurse provider will ensure that a new Physician Plan of Care is obtained every 60 days and will be maintained with the client's record.

THIS FORM HAS BEEN UPDATED.

_____The nurse provider will advise TMHP-CCP of any *significant* changes in the client's condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.

_____The client's primary caregiver, personal physician and nurse provider understand that the authorization may be changed during the authorization period if the client's condition or skilled needs change significantly.

Click on the button above to access the new form.

All required acknowledgments must be signed and dated:

I have read and understand the above information.

____ ____

(signature of **parent/primary caregiver**) Date

****

Brief statement of why a 4 or 6 month extension is appropriate for this client:

____

I have discussed the above information with the client's parent/primary caregiver.

____ ____

(signature of the **nurse provider**) Date

****

To be completed by the **client's physician**:

The above services are medically necessary, the client's condition is stable and this request supports the client's health and safety needs.

____ ____

(signature of **client's physician**) Date

____ ____

Printed name Telephone Number

____ ____

Mailing address City, State, ZIP code, Fax #

Fax completed request to TMHP-CCP at 1-512-514-4212

****

For TMHP-CCP use: Approved ______ Denied ______ Reviewer _________ Date _______

April 26, 2000

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B.74 THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy

Child's Name:		DOB:	Medicaid #:
Has the child received therapy in the last year from the public school system? ❒ Yes ❒ No			
Indicate the date of initial evaluation:	PT	OT	SLP
Diagnoses:			
Requested Treatment Plan: Indicate the date(s) of service and frequency per week or month:			
PT Service Date(s) FROM:	TO:	Frequency Per Week:	Per Month:
OT Service Date(s) FROM:	TO:	Frequency Per Week:	Per Month:
SLP Service Date(s) FROM:	TO:	Frequency Per Week:	Per Month:
New Application: Have treatment goals been developed? ❒ Yes ❒ No			
Is the child capable of making measurable progress? ❒ Yes ❒ No			
Renewal Application: Has the child made measurable progress during this period? ❒ Yes ❒ No			
Is the child capable of making continued measurable progress during this period? ❒ Yes ❒ No			
Provider's Name:			
Billing Address (Street or PO Box)	City	State	ZIP
Physician's Name: (Please Print)	Signature	TPI	Date
Therapist's Name (PT): (Please Print)	Signature	TPI	Date
Therapist's Name (OT): (Please Print)	Signature	TPI	Date
Therapist's Name (SLP): (Please Print)	Signature	TPI	Date

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

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B.75 THSteps Dental Mandatory Prior Authorization Request Form

Submit to:

THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

APPROVED

DENIED

NOTE: ALL INFORMATION IS REQUIRED – PRINT CLEARLY OR TYPE

THIS FORM HAS BEEN UPDATED.

Click on the button above to access the new form.

Patient's Name and Address	Sex M ( ) F ( )	Patient's Birth Date Medicaid Number

CHECK DIAGNOSTIC TOOLS SUBMITTED FOR REVIEW WITH AUTHORIZATION REQUEST.
****

FOR RESTORATIVE AND ICFMR:	FOR ORTHODONTIC CASE, DIAGNOSTIC TOOLS MAILED:	
Panorex ( )	Models ( )	Cephlometric X-ray ( )
FMX X-ray ( )	HLD ( )	TMJ X-ray ( )
Periapicals ( )	Panorex ( )	Photos ( )
Documentation ( )	Documentations ( )	Other:

DATE OF SERVICE DIAGNOSTIC TOOLS WERE PRODUCED:

PROCEDURE CODE	TOOTH # OR LETTER	SURFACE	CHARGE
			Total

NOTE: ALL INFORMATION REQUIRED – PRINT CLEARLY OR TYPE

Signature of Dentist: Date:	TPI	Dentist Address and ZIP Telephone Number

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B

B.76 THSteps Dental Criteria for Dental Therapy Under General Anesthesia (2 Pages)

Total points needed to justify treatment under general anesthesia=22.

Age of patient at time of examination	Points
Less than 4 years of age	8
4 and 5 years of age	6
6 and 7 years of age	4
8 years of age and older	2

Treatment Requirements (Carious and/or Abscessed Teeth)	Points
1-2 teeth or one sextant	3
3-4 teeth or 2-3 sextants	6
5-8 teeth or 4 sextants	9
9 or more teeth or 5-6 sextants	12

Behavior of Patient**	Points
Definitely negative–unable to complete exam, patient unable to cooperate due to lack of physical or emotional maturity, and/or disability	10
Somewhat negative–defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs	4
Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal reponses and are not indications for treatment under general anesthesia	0
** Requires that narrative fully describing circumstances be present in the patient's chart	

Additional Factors**	Points
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**	15
Failed conscious sedation**	15
Medically compromising, handicapping condition**	15
** Requires that narrative fully describing circumstances be present in the patient's chart	

I understand and agree with the dentist's assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE: ____DATE: ________________

Patients in need of general anesthesia who do not meet the 22-point threshold, by report, will require prior authorization.

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the patient chart. The patient chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST'S SIGNATURE: ____

DATE: ________________License No. ____________________________

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Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child's Dental Record.

Elements: Note those required* and those as appropriate**:

1) * Patient's Demographics including Date of Birth
2) * Relevant Dental and Medical Health History
   ** including Medical Evaluation Justifying Relevant Medical Condition(s)
3) * Dental Radiographs, Intraoral/Perioral Photography, and/or Diagram of Dental Pathology
4) * Proposed Dental Plan of Care
5) * Signed Consent by Parent/Guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of general anesthesia for dental care has been explained.
6) ** Description of Relevant Behavior and Reference Scale
7) ** Other Relevant Narrative Justifying Need for General Anesthesia
8) * Completed Criteria for Dental Therapy Under General Anesthesia form
9) * The dentist's attestation statement and signature may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the chart as a stand-alone form:

"I attest that the patient's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the patient's record and is available in my office."

REQUESTING DENTIST'S SIGNATURE: ____________________________DATE: ________________

B

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B.77 THSteps Referral Form Instructions

The referral form assists in relaying correct and pertinent information to the person or agency receiving the referral. It may be mailed or hand-carried by the client. When the form is returned, it should be placed in the client's record.

Receiving/Referring Agencies
The name and address of both agencies should be completed to allow communication if additional information is necessary and to return a completed referral. If the referral is to a physician and the client is not able to name the physician who will be seen, this space may be completed MD/DO.

Identifying Information
This section concerning patient information should be as complete as possible. This section will assist the receiving agency to locate the client.

Reason for Referral
This section should contain information which is relevant to the referral. It may contain an assessment with request for further evaluation, or a request for intervention by a physician, hospital, or other agency involved with the client. Other information pertinent to the referral, such as family history or involvement with other agencies, may also be included.

Release of Information
This section must be signed.

Findings/Services Rendered
This final section provided the receiving agency the vehicle with which to transmit information back to originator of referral. Form may be mailed or carried by the client.

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B.78 THSteps Referral Form

Referral date:______________________

TO: Name and address of receiving agency or person

FROM: Name and address of person or referring agency

Client's name:_______________________________

Address:__________________________________

Telephone:________________________________

Name of spouse/parent/guardian

____

Social Security number:________________

Birth date: ___________Sex: (M)____(F)____

DIRECTIONS TO HOME:_________________

____

Marital status: S M W D Sep. Unk.

REASON FOR REFERRAL:

RETURN RESPONSE REQUESTED

____

Signature/Title

Signature signifies receipt/knowledge of this referral and authorizes the referring agency to release information necessary for its completion, and the referring agency is released from all legal responsibility that may arise from this act.

____

Signature of Client/Parent/Guardian

FINDINGS AND SERVICES RENDERED:

____

Signature/Title

____

Date

1) White - Receiving Agency

2) Yellow - Receiving Agency Response

3) Pink - Client Record

Note: Instructions (L-29a) for use of Referral Form should accompany the document. (HHSC) L-29 Rev. (6/91)

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B.79 Tort Response Form

Client Information

Today's Date ______/_______/_______ Medicaid #______________________________

Client's Date of Birth ______/______/______ SSN_________/___________/______________

Client's Last Name ______________________ First Name______________________________

Information Provided By:

Attorney _____ Insurance _____ Provider _____ Recipient _____ HHSC ______ Other ______

Name _____________________________ Phone #:_________________________

Accident Information

Date of Loss ______/________/________ Type of Accident__________________

Case Comments____

Attorney Information

Attorney's Name ____

Attorney's Address ____

Attorney's Phone (____) _________________ Attorney's Fax (____)_______________

Insurance Information

Insurance Company Name ____

Address ____

Adjuster's Name _______________________ Claim #:_________________________

Insured ___________________________ Policy #: _________________________

Phone (____) _______________________ Fax (____)_______________________

Fax or Mail completed copy to:

Texas Medicaid & Healthcare Partnership
Tort Department
PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-514-4225

October 2005

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B.80 Ventilator Service Agreement

Client Name: ____________________________ Client Medicaid Number: _______________________________

Provider Name: ___________________________ Medicaid Provider Number: ____________________________

Date of Ventilator Purchase: _________________ Date of Request: ____________________________________

Ventilator Make: ___________________________ Ventilator Model Number: _____________________________

Ventilator Serial Number: ____

The Manufacturer's recommended preventive maintenance schedule for the ventilator make and model must be submitted with the Ventilator Service Agreement request.

If this is a renewal Ventilator Service Agreement, in addition to the above, the following documentation must also be submitted:

1. Documentation of the monthly ventilator service procedures performed by a respiratory therapist and client assessments by a respiratory therapist.
2. Description of ventilator preventive maintenance performed during the last ventilator service agreement period:

____

____

____

____

____

Provider responsibilities for maintaining the ventilator service agreement Include:

1. Ensure routine service procedures outlined by the ventilator manufacturer are followed.

2. Provide all internal filters, all external filters and all ventilator circuits, (with the exhalation valve), as part of the ventilator service agreement payment.

3. Provide a respiratory therapist and a back-up ventilator on a 24-hour on call basis.

4. Provide monthly visits to the client's home by a respiratory therapist to perform routine service procedures, monitor functioning of the ventilator system and assess client's status. The provider must maintain documentation of monthly visits in accordance with Medicaid Records Retention Policy.

5. Provide a substitute ventilator while the manufacturers recommended preventative maintenance is being performed on the client owned ventilator.

The ventilator service agreement must be prior authorized every six (6) months.

____ ______________________
Provider Representative Signature Date

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B.81 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, ____, certify that:

Printed Name of Medicaid Client

(Check all that apply:)

_____ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. **I will be responsible for any balance for eyewear beyond Medicaid program benefits.**

My selection(s) beyond Medicaid benefits were:

1.____

2.____

3.____

4.____

______ The glasses that are being replaced were unintentionally lost or destroyed.

______ I picked up/received the eyewear.

____ ____

Medicaid Client Signature Witness Signature

____ ____

Date Date

____

Medicaid Client Identification Number

____

Medicaid TPI

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B.82 Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

Yo, ____,declaro que:

Nombre de cliente de Medicaid

(Marque todos los que apliquen)

_____ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. **Yo entiendo que tendré que pagar por la diferencia.**

La selección(es) de lentes que escogí fue:

1.____

2.____

3.____

4.____

_____ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionadamente.

_____ Yo recibí los lentes.

____ ____

Firma de Testigos Firma del Cliente

____ ____

Fecha Fecha

____

El número de identificación de Medicaid

____

Identificación de proveedor de Texas

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B.83 Wheelchair/Scooter/Stroller Seating Assessment Form (THSteps-CCP/ Home Health Services) (Next 6 Pages)

Instructions
A current wheelchair seating assessment conducted by a physician, physical or occupational therapist must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair. Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price. Complete Sections I-VI for manual wheelchairs. Complete Sections I-VII for power wheelchairs.

Client Information	
First name:	Last name:
Medicaid number:	Date of birth:
Diagnosis:	
Height:	Weight:

I. Neurological Factors
Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other
Describe client's muscle tone:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:
Describe reflexes present:

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II. Postural Control				
Head control:	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk control:	☐ Good	☐ Fair	☐ Poor	☐ None
Upper extremities:	☐ Good	☐ Fair	☐ Poor	☐ None
Lower extremities:	☐ Good	☐ Fair	☐ Poor	☐ None

III. Medical/Surgical History And Plans:

Is there history of decubitis/skin breakdown? ☐ Yes ☐ No
If yes, please explain:

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):

Describe other physical limitations or concerns (i.e., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:

Ambulatory status:	☐ Nonambulatory	☐ With assistance
	☐ Short distances only	☐ Community ambulatory
Indicate the client's ambulation potential:	☐ Expected within 1 year	
	☐ Not expected	
	☐ Expected in future within ___ years	

B

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IV. Functional Assessment:

Wheelchair Ambulation: Is client totally dependent upon wheelchair? ☐ Yes ☐ No
If no, please explain:

Indicate the client's transfer capabilities:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent

Is the client tube fed? ☐ Yes ☐ No
If yes, please explain:

Feeding:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent
Dressing:	☐ Maximum assistance	☐ Moderate assistance
	☐ Minimum assistance	☐ Independent

Describe other activities performed while in wheelchair:

V. Environmental Assessment

Describe where client resides:

Is the home accessible to the wheelchair? ☐ Yes ☐ No

Are ramps available in the home setting? ☐ Yes ☐ No

Describe the client's educational/vocational setting:

Is the school accessible to the wheelchair? ☐ Yes ☐ No

Are there ramps available in the school setting? ☐ Yes ☐ No

If client is in school, has a school therapist been involved in the assessment? ☐ Yes ☐ No

Name of school therapist:

Name of school:

School therapist's telephone number:

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V. Environmental Assessment
Describe how the wheelchair will be transported:
Describe where the wheelchair will be stored (home and/or school):
Describe other types of equipment which will interface with the wheelchair:

VI. Requested Equipment:	
Describe client's current seating system, including the mobility base and the age of the seating system:	
Describe why current seating system is not meeting client's needs:	
Describe the equipment requested:	
Describe the medical necessity for mobility base and seating system requested:	
Describe the growth potential of equipment requested in number of years:	
Describe any anticipated modifications/changes to the equipment within the next three years:	
Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:
Physician/Therapist's telephone number: ( ) -	
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

B

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VII. POWER WHEELCHAIRS:
Complete if a power wheelchair is being requested

Describe the medical necessity for power vs. manual wheelchair:
(Justify any accessories such as power tilt or recline)

Is client unable to operate a manual chair even when adapted? ☐ Yes ☐ No

Is self propulsion possible but activity is extremely labored? ☐ Yes ☐ No
If yes, please explain:

Is self propulsion possible but contrary to treatment regimen? ☐ Yes ☐ No
If yes, please explain:

How will the power wheelchair be operated (hand, chin, etc.)?

Has the client been evaluated with the proposed drive controls?

Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?

Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others?
☐ Yes ☐ No

Is the caregiver capable of caring for a power wheelchair and understanding how it operates?
☐ Yes ☐ No

How will training for the power equipment be accomplished?

Physician/Therapist's name:	Physician/Therapist's signature:
Physician/Therapist's title:	Date:

Physician/Therapist's telephone number: ( ) -

Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):

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Home Health/CCP Measuring Worksheet

General Information	
Client's name:	Date of birth:
Client's Medicaid number:	Height:
Date when measured:	Weight:
Measurer's name:	Measurer's telephone number: ( ) -

Measurements

1:	Top of head to bottom of buttocks
2:	Top of shoulder to bottom of buttocks
3:	Arm pit to bottom of buttocks
4:	Elbow to bottom of buttocks
5:	Back of buttocks to back of knee
6:	Foot length
7:	Head width
8:	Shoulder width
9:	Arm pit to arm pit
10:	Hip width
11:	Distance to bottom of left leg (popliteal to heel)
12:	Distance to bottom of right leg (popliteal to heel)

Additional Comments

B

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Appendix

C

THSteps Forms

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C.1 Claim Forms

Providers must order CMS-1500, HCFA-1450 (UB-92), and ADA Dental Claims Forms from the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim forms are located in "Claims Filing" on page 5-1.

Refer to: "CMS-1500 Claim Filing Instructions" on page 5-24

"CMS-1500 Blank Claim Form" on page 5-26

"HCFA-1450 (UB-92) Claim Filing Instructions" on page 5-32

"HCFA-1450 (UB-92) Blank Claim Form" on page 5-33

"2002 ADA Dental Claim Filing Instructions" on page 5-43

"2002 ADA Dental Claim Form" on page 5-44

C.2 Child Health Clinical Records

The use of forms ECH 1–7, ECH 13–15, and WIC-42 is optional. These forms were developed to assist providers in documenting all components of the medical checkup and can be downloaded from the THSteps website at http://secure.thstepsproducts.com/forms/ths_forms.htm. Lead poisoning screening questionnaires can be downloaded from the Childhood Lead Poisoning Prevention Program website at www.dshs.state.tx.us/lead/providers.shtm. Tuberculosis screening questionnaires can be downloaded from the Tuberculosis Elimination Division website, www.dshs.state.tx.us/idcu/disease/tb/forms/default.asp#clinic. These forms are also available within this chapter.

Forms CH-9W through CH-12W are only available by calling THSteps at 1-512-458-7745.

Stock Number	Form
CH-9W	Growth Chart - Infant Girl
CH-10W	Growth Chart - Infant Boy
CH-11W	Growth Chart - Child Girl
CH-12W	Growth Chart - Child Boy
ECH-1	Child Health History
ECH-2	Preventive Health Visit - Birth to 1 Month
ECH-3	Preventive Health Visit - 2–6 Months
ECH-4	Preventive Health Visit - 7–12 Months
ECH-5	Preventive Health Visit - 13 Months to 2 Years
ECH-6	Preventive Health Visit - 3–5 Years
ECH-7	Preventive Health Visit - 6–10 Years
ECH-13	24-Hour Dietary Recall and Assessment for Children - 1 Through 4 Years
ECH-14	24-Hour Dietary Recall and Assessment for Children - 5 Through 9 Years
ECH-15	24-Hour Dietary Recall and Assessment for Teens - 10 Through 20 Years (Nonpregnant Teens)
WIC-42	24-Hour Dietary Recall and Assessment for Infants - Birth Through 11 Months
	Texas Health Steps Primary Parent Questionnaire Risk Assessment for Lead Exposure
	Texas Health Steps Abbreviated Parent Questionnaire Risk Assessment for Lead Exposure
	TB Questionnaire

The Adolescent Health Program developed a series of health forms to assist health care providers in providing quality and comprehensive services for teens: Characteristic Behaviors of Adolescence, Adolescent Development Table, and Tips for Interviewing Adolescents. These forms are available on the Adolescent Health Program website at www.dshs.state.tx.us/adolescent/resources.shtm, or call 1-512-458-7745 for copies.

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C.3 Child Health History (2 Pages)

Child Health History

Department of State Health Services
Child Health Record
Preventive Health Visit

Pregnancy and Birth

G ___ P ___ AB ____
Total number of living children ________Weight gain/loss__________
Mother's age at birth ________________
Number of years between previous pregnancy and this child _______
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider_______________________________________
Vitamins: ____Y __ N Iron: ____Y __N
If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course:___ Y____N*
*If yes, proceed with "Child's Medical History.

Maternal Complications

____Vaginal bleeding
____Anemia
____Hypertension
____Rh negative
____Diabetes
____Premature labor
____Injury/hospitalization/surgery
____Flu-like illness or high temp.
____Kidney or bladder infection
____STDs
____Hepatitis (A, B, or C)
____Exposure to TB
____Exposure to lead/chemicals
____Dental disease

Maternal Substance Use

____OTC meds_________________________________
____Prescription meds _________________________
____Tobacco ________________________________
____Alcohol ________________________________
____Street drugs _____________________________
____Caffeine ________________________________

Family Medical History

Abbreviations for relatives listed below.

M - Mother	MGM - Maternal Grandmother	PGM - Paternal Grandmother
F - Father	MGF - Maternal Grandfather	PGF - Paternal Grandfather
S - Sibling	MA - Maternal Aunt	PA - Paternal Aunt
	MU - Maternal Uncle	PU - Paternal Uncle

____ Anemia//blood disorder
____ Heart disease before age 50
____ Cholesterol req. treatment
____ Hypertension/stroke
____ Asthma/allergy
____ Cancer
____ Diabetes
____ Epilepsy/seizures
____ Kidney problems
____ Muscle/bone disease
____ Genetic disease or major birth defects
____ Childhood hearing impairment
____ Tuberculosis
Y N HIV + individual in household **(do not identify)**
____ Other immunosuppression
____ Dental decay
____ Alcohol/drug abuse
____ Tobacco use
____ Learning disorder
____ Mental retardation
____ Psychiatric disorder
____ Physical/sexual/emotional abuse
____ Domestic violence
____ Other

Explanation of positive history:

Client Information

Name: ____
DOB: _______ / _______/ ______Age: _________Sex: _________
SSN/Record No.: ____________________________________
Race/Ethnicity: _____________________________________
Informant/Relationship: ______________________________
Medical Home: ______________________________________

Birth/Delivery

Place of birth ______________________________________
Birth attendant _____________________________________
Hours of labor______________________________________

____Term
____Premature (Weeks)________
____More than 2 weeks overdue

Type of delivery:
____Vaginal
____C-Section
____Forceps

Complications:
____Breech
____Multiple birth
____Other

Explanation/Other:

Nursery Course

Birth Weight _________ Birth Length ________ FOC _________

____Difficulty with initial breathing
____Heart murmur
____Infection
____Transfusion
____Jaundice req. treatment
____Seizures

Age at discharge: _________ICN ____________ days
Newborn blood screening (date/location):
1. ____
2. ____

Newborn hearing test (in hospital): ____ Normal ______Abnormal
Type of test: ____ ABR ____OAE ____Unknown
Referral made: ____Y ____N
Comments:

Child's Medical History

Immunizations current: ___Y ___N __ Record unavailable
Dental care/sealants current: ___Y ___N

____Trauma/injuries
____Hospitalizations
____Surgery
____Medications
____Anemia
____Early childhood caries
____Hepatitis
____Strep throat
____Ear infections
____Bladder/kidney infections
____Pneumonia
____Developmental delays
____Vision problems
____Hearing problems
____Seizures
____Environmental toxin exposure (lead, etc.)
____Allergies
____Asthma
____Eczema
____Substance use (alcohol, drug, tobacco)
____Other

Explanation:

Date: ________________Signature/Title: ______________________________Signature/Title_________________________________

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Child Health History

If used for documentation:______________________________

Patient's Name: ______________________________

Date: ______________________________

Progress Notes

TEXAS Department of State Health Services

ECH-1

Rev. 9/04

C

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C.4 Child Health Record (Birth–1 Month) (2 Pages)

Birth–1 Month

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ______________________________
Total children living in home: ______________________________
Primary caretaker for this child: ___________________________
Relationship: ____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____ P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: ___________________________
Standardized Observational Screen: ___________________________
Other: ____
Further assessment needed: _____ Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____ Y _____ N
Explain:
Major illness, injury, hospitalization, surgery (state when and describe):

Medications taken regularly — Type/Reason:

Physical Examination

Temp _________ Pulse ____________ Resp ____________
FOC __________ Height ___________ Weight ___________
(%)___________ (%) ______________ (%) ______________

N	A	NE		N	A	NE	
___	___	___	Appearance	___	___	___	Heart/pulses
___	___	___	Head/fontanels	___	___	___	Lungs
___	___	___	Skin/nodes	___	___	___	Abdomen
___	___	___	Eyes (RR)	___	___	___	Genitalia/anus
___	___	___	Ears	___	___	___	Spine/hips
___	___	___	Nose	___	___	___	Extremities
___	___	___	Mouth/throat				Neurologic:
___	___	___	Teeth	___	___	___	Muscle tone
___	___	___	Neck	___	___	___	DTRs
___	___	___	Chest/breasts	___	___	___	Primitive reflexes

Additional documentation:

Client Information

Name: ____
DOB: _______ / _______ / ______ Age: __________ Sex: __________
SSN/Record No.: _____________________________________
Race/Ethnicity: ______________________________________
Informant/Relationship _______________________________
Medical Home: _______________________________________

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____ Y _____ N
*If answered yes, further assessment needed.
Breast-fed: Number of feedings in last 24 hours: _______________
Length of feedings: _______________ WIC: _____ Y _____ N
Formula-fed: Type: ____
Iron fortified: _____ Y _____ N
Ounces consumed in 24 hours: _______ Fluoride: _____ Y _____ N
Solid foods introduced at age:

Sensory

Vision Screen: _____ Normal _____ Abnormal
Hearing Screen: _____ Normal _____ Abnormal
Screen used: _____ Hearing Checklist for Parents

Health Education

Injury Prevention
___ Car safety restraints
___ Crib safety
___ Burns
___ Falls
___ Drowning/bath safety
___ 911
___ Sleep position (SIDS)
___ Passive smoking

Behavior
___ Crying/colic
___ Sleeping
___ Infant temperature

Health Promotion
___ Care of skin, umbilical cord, circumcision
___ Family planning
___ Well-child care
___ When to call doctor

Nutrition
___ Breastfeeding
___ No solids until 4 months
___ Formula preparation
___ Infant held for bottle
___ No bottle in bed

Assessment

Plan

WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Newborn Screening: _____ Up to date ____ To be done today
Next appointment:

Date: _______________ Signature/Title: ______________________________ Signature/Title ___________________________________

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Birth–1 Month

If used for documentation:______________________________________
Patient's Name: ____
Date: ____

Key Elements

Systems Review

Skin: Rashes, infections, jaundice, cyanosis
Ears: Hearing or ear problems
Eyes: Eye discharge, excessive tearing
Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, circumcision, number of wet diapers
Neuromuscular: Seizures, sucking reflex, swallowing
Musculoskeletal: Range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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ECH-2

Rev. 9/04

C

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C.5 Child Health Record (2–6 Months) (2 Pages)

2–6 Months

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother _____ Father _____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ______________________________
Total children living in home: ______________________________
Primary caretaker for this child: ______________________________
Relationship: ______________________________
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P _____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: ______________________________
Standardized Observational Screen: ______________________________
Other: ______________________________
Further assessment needed: _____Y _____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems
or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit)

Medications taken regularly — Type/Reason:

Physical Examination

Hct/Hgb ______ Lead ____________
Temp ________ Pulse ____________ Resp ____________
FOC ________ Height ____________ Weight ____________
(%)________ (%) ____________ (%) ____________

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes (RR)	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine/hips
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				Neurologic:
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts	____	__	___	Primitive reflexes

Additional documentation:

Client Information

Name: ______________________________
DOB: _______ / _______ / _______ Age: __________ Sex: __________
SSN/Record No.: ______________________________
Race/Ethnicity: ______________________________
Informant/Relationship ______________________________
Medical Home: ______________________________

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____Y _____N
*If answered yes, further assessment needed.
Breast-fed: Number of feedings in last 24 hours: ______________
Length of feedings: ______________ WIC: _____Y _____N
Formula-fed: Type: ______________________________
Iron fortified: _____Y _____N
Ounces consumed in 24 hours: _______ Fluoride: _____Y _____N
Solid foods introduced at age:

Sensory

Vision Screen: _____Normal _____ Abnormal
Hearing Screen: _____Normal _____ Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Car safety restraints
____Falls, Infant walker
____Burns
____Choking management
____Sleep position (SIDS)
____Passive smoking
____Pool/bath safety

Behavior
____Parent/infant interaction
____Sleeping
____Inappropriate expectations
____Daycare/babysitters

Health Promotion
____Immunizations
____Thermometer use, Tylenol
____Teething, wipe teeth
____When to call doctor
____Well-child care
____Family planning

Nutrition
____Breastfeeding
____No solids until 4 months
____Formula preparation
____Infant held (no bottle in bed)

Assessment

Plan

WIC: ____Referred ___ Refused _ ___ N/A
Immunizations: Up to date To be given today ___ Deferred
Explain:
Lab:
Newborn Screening: Up to date ____ To be done today
Next appointment

Date: ______________ Signature/Title: ______________________________ Signature/Title ______________________________

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2–6 Months

If used for documentation:______________________
Patient's Name: ______________________
Date: ______________________

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, excessive tearing
Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, number of wet diapers
Neuromuscular: Seizures, coordinated movements
Musculoskeletal: Fractures, range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C

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C.6 Child Health Record (7–12 Months) (2 Pages)

7–12 Months

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother _____ Father _____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ____________________
Total children living in home: ____________________
Primary caretaker for this child: ____________________
Relationship: ____________________
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P _____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: ____________________
Standardized Observational Screen: ____________________
Other: ____________________
Further assessment needed: _____Y _____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit)

Medications taken regularly — Type/Reason:

Physical Examination

Temp _________ Pulse ___________ Resp ___________
FOC _________ Height ___________ Weight ___________
(%) _________ (%) ___________ (%) ___________

N	A	NE		N	A	NE	
___	___	___	Appearance	___	___	___	Heart/pulses
___	___	___	Head/fontanels	___	___	___	Lungs
___	___	___	Skin/nodes	___	___	___	Abdomen
___	___	___	Eyes	___	___	___	Genitalia/anus
___	___	___	Ears	___	___	___	Spine/hips
___	___	___	Nose	___	___	___	Extremities
___	___	___	Mouth/throat				Neurologic:
___	___	___	Teeth	___	___	___	Muscle tone
___	___	___	Neck	___	___	___	DTRs
___	___	___	Chest/breasts				

Additional documentation:

Client Information

Name: ____________________
DOB: _______ / _______ / _______ Age: __________ Sex: __________
SSN/Record No.: ____________________
Race/Ethnicity: ____________________
Informant/Relationship ____________________
Medical Home: ____________________

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* _____Y _____N
*If answered yes, further assessment needed.
Breast-fed: Number of feedings in last 24 hours: ____________
Length of feedings: ____________ WIC: _____Y _____N
Formula-fed: Type: ____________________
Iron fortified: _____Y _____N
Ounces consumed in 24 hours: _______ Fluoride: _____Y _____N
Solid foods introduced at age:

Sensory

Vision Screen: _____Normal _____ Abnormal
Hearing Screen: _____Normal _____ Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
___Car safety restraints
___Falls (stairs, gates)
___Choking management
___Water safety/temp
___Poisoning
___Child proofing
___Passive smoking

Behavior
___Parent/infant interaction expectations
___Speech development
___Sleep
___Separation protest
___Daycare

Health Promotion
___Immunizations
___Teething
___Cleaning teeth
___When to call doctor
___Well-child care
___Dental appointment
___Family planning

Nutrition
___Breastfeeding support
___Introduction of solids
___No bottle in bed
___Off bottle by 1 year

Assessment

Plan

TB: ___ Y ___N Dental referral made: ___ Y ___ N
WIC: ___ Referred ___Refused ___ N/A
Immunizations: ___ Up to date ___To be given today ___ Deferred
Explain:
Lab:
Newborn Screening: ___ Up to date ___To be done today
Hct/Hgb ___Lead ____________
Hep C (if 12 months old or older and born to HCV infected woman) ____________________
Next appointment:

Date: ____________ Signature/Title: ____________________ Signature/Title ____________________

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7–12 Months

If used for documentation:______________________________________
Patient's Name: ____
Date: ____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream
Neuromuscular: Coordination
Musculoskeletal: Fractures
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C.7 Child Health Record (13 Months–2 Years) (2 Pages)

13 Months–2 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother _____ Father _____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ____________________
Total children living in home: ____________________
Primary caretaker for this child: ____________________
Relationship: ____________________
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P _____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: ____________________
Standardized Observational Screen: ____________________
Other: ____________________
Further assessment needed: _____Y _____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit)

Medications taken regularly — Type/Reason:

Dental Care:

Physical Examination

Temp _________ Pulse _________ Resp _________
FOC _________ Height _________ Weight _________
(%) _________ (%) _________ (%) _________

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine/hips
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				Neurologic:
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts				

Additional documentation:

Client Information

Name: ____________________
DOB: _____ / _____ / _____ Age: _________ Sex: _________
SSN/Record No.: ____________________
Race/Ethnicity: ____________________
Informant/Relationship ____________________
Medical Home: ____________________

Nutrition

Problems: special diet, inappropriate weight gain, anemic, chronic GI problems, major food allergies, refusal of any food group, developmental* _____Y _____N
*If answered yes, further assessment needed.
Usual Servings Per Day:
____Dairy __ Formula ___Breast ___Vegetables WIC: ___Y __ N
____Breads, cereal, rice, and pasta
____Meat, poultry, fish, eggs, and dry beans
____Fruits

Sensory

Vision Screen: _____Normal _____ Abnormal
Hearing Screen: _____Normal _____ Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Car safety restraints
____Choking, unsafe toys
____Poisoning
____Burns
____Water safety/temp
____Supervised play
____Electrical injury
____Passive smoking

Behavior
____Parent/infant interaction
____Social interaction
____Limit TV
____Set limits

____Sibling rivalry
____Toilet training

Health Promotion
____Immunizations
____Smoking in home
____Well-child care
____Dental care, appointment
____Family planning
____Daycare

Nutrition
____Healthy diet/snacks
____Iron-rich foods
____Physical activity
____Weaning
____Off bottle by age 1

Assessment

Plan

Dental referral made: ___Y ___ N
WIC: ____Referred ___ Refused ___ N/A
Immunizations: ____Up to date ___ To be given today ___ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead ____________
Hep C (if 12 months old or older and born to HCV infected woman) ____________________
Next appointment:

Date: _____________ Signature/Title: ____________________ Signature/Title ____________________

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13 Months–2 Years

If used for documentation:______________________________________
Patient's Name: ____
Date: ____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency
Genitourinary: Urinary frequency, (male) normal stream, dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.
Feelings: Angry, sad, fearful, sullen, anxious, cries excessively or too little
Behavior: Overactivity, listlessness, harms others, sexually acts out, refuses to talk
Social Interaction: Withdrawn, clings excessively
Thinking: Mistrustful, distracted, problems concentrating
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C.8 Child Health Record (3–5 Years) (2 Pages)

3–5 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: ______
DOB: ____ / ____ / ____ Age: ______ Sex: ______
SSN/Record No.: ______
Race/Ethnicity: ______
Informant/Relationship ______
Medical Home: ______

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ______
Total children living in home: ______
Primary caretaker for this child: ______
Relationship: ______
Family's concerns/problems:

Development

Parent's concerns:

Developmental Screening: _____P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: ______
Standardized Observational Screen: ______
Other: ______
Further assessment needed: _____Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____ Y _____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit)

Medications taken regularly — Type/Reason:

Dental Care:

Physical Examination

Temp ______ Pulse ______ Resp ______
BP ______ Height ______ Weight ______
(%) ______ (%) ______ (%) ______

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus
____	__	___	Ears	____	__	___	Spine
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				Neurologic:
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts				

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental* _____ Y _____ N
*If answered yes, further assessment needed.
Usual Servings Per Day:
____Dairy __ Vegetables__ WIC: ___Y __ N
____Breads, cereal, rice, and pasta Flouride Supplements: ___Y __ N
____Meat, poultry, fish, eggs, and dry beans
____Fruits Vitamins: ___Y __ N

Sensory

Vision Screen: _____Normal ____ Abnormal
Hearing Screen: _____Normal ____ Abnormal
Hearing Screen Used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Car safety restraints
____Poisoning
____Fire safety
____Firearms
____Street, water, bicycle safety
____Scissors/sharp objects
____Stranger safety
____Teach telephone no. & address
____Self-safety
____Passive smoking

Behavior
____Talk/read with child
____Exploration
____Limit television
____Discipline, consistency

____Toilet training
____Social interaction
____School readiness
____Sex education

Health Promotion
____Immunizations
____Well-child care
____Dental care, appointment
____Family planning
____Daycare

Nutrition
____Healthy diet/snacks
____Junk food
____Iron-rich foods
____Physical activity

Assessment

Plan

Dental referral made: ___Y ___ N
WIC: ____Referred ___ Refused ___ N/A
Immunizations: ___Up to date ___ To be given today ___ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead ______
Next appointment:

Date: ______ Signature/Title: ______ Signature/Title ______

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3–5 Years

If used for documentation:______________________________________
Patient's Name: ____
Date: ____

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, blinking, tearing
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, soiling
Genitourinary: Dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.
Feelings: Out of control, angry, sad, fearful, sullen, anxious
Behavior: Overactive, listlessness, harms others or property, sexually acts out, impulsive, frequently provokes other children, self-abuses
Social Interaction: Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally
Thinking: Mistrustful, distracted, easily frustrated
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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C.9 Child Health Record (6-10 Years) (2 Pages)

6–10 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

_____ No change in household since last visit
Child lives with:
_____ Mother ____ Father ____ Stepparent _____ Grandparent
_____ Other
Total adults living in home: ____________________
Total children living in home: ____________________
Primary caretaker for this child: ____________________
Relationship: ____________________
Family's concerns/problems:

Mental Health

(+ indicates need for futher assessment)

____Sleep Problems
____Behavior/problems
____Relationship problems with parents, siblings, peers
____Problems in school
Grade Level____________
____Special education classes
____No/excessive extracurricular activities
____Substance abuse/use
____Self-concept problems

Comments:

Child's Health

Allergies:
Does the system review note any problems or parent concerns: _____Y _____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

Dental Care/sealants:

Physical Examination

Temp _________ Pulse ____________ Resp ____________
BP ___________ Height ___________ Weight ___________
(%)___________ (%) ______________ (%)______________

N	A	NE		N	A	NE	
____	__	___	Appearance	____	__	___	Heart/pulses
____	__	___	Head/fontanels	____	__	___	Lungs
____	__	___	Skin/nodes	____	__	___	Abdomen
____	__	___	Eyes	____	__	___	Genitalia/anus (Tanner stage)
____	__	___	Ears	____	__	___	Spine
____	__	___	Nose	____	__	___	Extremities
____	__	___	Mouth/throat				**Neurologic:**
____	__	___	Teeth	____	__	___	Muscle tone
____	__	___	Neck	____	__	___	DTRs
____	__	___	Chest/breasts (Tanner stage)				

Additional documentation:

Client Information

Name: ____________________
DOB: _______ / _______/ ______ Age: _________ Sex: __________
SSN/Record No.: ____________________
Race/Ethnicity: ____________________
Informant/Relationship: ____________________
Medical Home: ____________________

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group* _____Y _____N
*If answered yes, further assessment needed.
Usual Servings Per Day:
____Dairy ____Vegetables __ Fruits
____Breads, cereal, rice, and pasta
____Meat, poultry, fish, eggs, and dry beans

Sensory

Vision Screen: _____Normal ____ Abnormal
Hearing Screen: _____Normal ____ Abnormal
Screen used: _____Hearing Checklist for Parents

Health Education

Injury Prevention
____Seat belt/auto safety
____Bicycles/ATV
____Athletics
____Water safety
____Smoke detectors
____Firearm safety

Behavior
____Substance abuse
____Tobacco use
____Security
____Discipline patterns
____Responsibility
____Communication/conflict resolution

Health Promotion
____Limit TV viewing
____Passive smoking
____Regular exercise
____Pubertal changes/sexuality
____Dental care/sealants

Nutrition
____Healthy diet/snacks
____Junk food
____Iron-rich foods

Assessment

Plan

Dental referral made: ___Y ___N
Immunizations: ___Up to date ___To be given today ___ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead_____________
Next appointment:

Date: _______________ Signature/Title: ______________________________ Signature/Title ______________________________

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6–10 Years

If used for documentation:_______________________
Patient's Name: _______________________
Date: _______________________

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, blinking, tearing
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, encopresis
Genitourinary: Dysuria, pubescent changes, penile/vaginal discharge or spotting, enuresis
Neuromuscular: Seizures
Musculoskeletal: Fractures, sprains, sport injuries

Progress Notes

ECH-7

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C.10 24-Hour Dietary Recall, Assessment for Infants (Birth–11 Months) (2 Pages)

Diet History for Infants Birth through 11 Months

Dietary Recall and Assessment

(Provide all answers except in shaded areas)

Name: ______________________

DOB: ____________ Age: __________

Assessment Questions for Infants	Risk Conditions Defined	Code
All Infants: Is your infant following therapeutic diet/special feeding instructions? Yes ______ No ___ Describe: ______ Does your infant have any developmental feeding problems? .... Yes _____ No ____ Describe: ______	**Developmental, Sensory or Motor Disabilities Interfering with the Ability To Eat** Disabilities that restrict the ability to intake, chew, or swallow food or require tube-feeding to meet nutritional needs	362
Breastfed Infant (Total or Partial): How many feedings in past 24 hours ______ Length ______	**Infrequent Breastfeeding as Sole Source of Nutrients:** Totally breastfed (no formula/solids) ■ younger than 2 months – less than 8 feedings in 24 hours ■ 2 months or older – less than 6 feedings in 24 hours	418
Problems with breastfeeding? ______ How many wet diapers per day? ______	**Breastfeeding Complications/Potential Complications:** ■ jaundice, weak/ineffective suck, latching difficulties ■ less than 6 wet diapers per day	603
Formula-Fed Infant: Brand/type of formula or milk: ______ ____ Powder _____ Concentrated _____ Ready-to-Use	**Feeding Cow's Milk**	413
Is formula iron fortified? .... Yes _____ No ____ If NO, is your infant taking iron drops? .... Yes _____ No ____	**Inappropriate Infant Feeding:** ■ feeding goat's milk, sheep's milk, imitation milks, or substitute milks ■ formula feeding only ■ 0-6 months – feeding low iron formula without iron supplementation	411
How is formula diluted and mixed? ______	**Improper Dilution of Formula**	415
Is anything added to the formula besides water? .... Yes _____ No ____	**Adding honey**	411
	Adding corn syrup, sugar...	416
Bottle-Fed Infant, Breastmilk and/or Formula: Number of bottles made at one time ______ Amount of breastmilk/formula in each bottle ______ Amount of breastmilk/formula consumed at each feeding ______ Number of bottles consumed in 24 hours ______ Total amount of breastmilk/formula consumed in 24 hours ______ How long does one can of formula last? ______	**Inappropriate Infant Feeding** Inadequate Amount, Nonbreastfed Only: ■ 0-3 months – less than 20 oz. in 24 hours ■ 4-5 months – less than 26 oz. in 24 hours ■ 6-11 months – less than 24 oz. in 24 hours Excessive amount, Nonbreastfed Only: ■ 0-4 months – more than 40 oz. in 24 hours ■ 5-9 months – more than 36 oz. in 24 hours ■ 10-11 months – more than 32 oz. in 24 hours	411
Is water boiled before it is mixed with formula? .... Yes _____ No ____ What is done with leftover breastmilk/formula in the bottle? ______ How are bottles/equipment cleaned? ______ How are bottles of breastmilk/formula stored? ______	**Lack of Sanitation in Preparation, Handling, and Storage** ■ Younger than 3 months and water not boiled ■ unsafe water ■ no stove, refrigerator, or freezer ■ feeding formula or breastmilk that has been handled and/or stored improperly	417
Do you... ■ put the baby to bed with a bottle? .... Yes ____ No ___ ■ prop the bottle? .... Yes ____ No ___ ■ let the baby crawl or walk around with the bottle or use the bottle to pacify the baby? .... Yes ____ No ___ ■ use the bottle to feed liquids other than breastmilk, formula, or water? .... Yes ____ No ___	**Inappropriate Use of Nursing Bottles** ■ yes to any	419
All Infants: Have any foods/beverages other than formula/breastmilk been introduced? ______	**Early Introduction of Solid Foods** ■ solids introduced before 4 months	412
If yes, during what month? ______ Do you give juice to your infant? .... Yes _____ No ____ If yes, how much? ______	**Inappropriate Infant Feeding** ■ no solids introduced by 7 months ■ more than 10 oz./day full-strength juice	411
Continue to the next section on the other side.	**No Dependable Source of Iron After 6 Months** no iron-fortified formula, cereal, meats or oral iron	414

Recall taken by: ______________________ Date: __________

Recall assessed by: ______________________

WIC-42 Rev. 11/2000

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Name ______________________________ **Date:** ____________________

24-Hour Infant Diet Recall

What foods/beverages, other than breastmilk or formula, have you given the baby in the last 24 hours? (List amounts.)	**No Dependable Source of Iron After 6 Months** ■ no iron-fortified formula, iron-fortified cereals, meats, or oral iron supplements **Vegan Diets** ■ no animal or dairy products **Highly Restrictive Diets** ■ very low in calories, severely limits intake or important food sources of nutrients, restricts timing or combination of foods, or other high-risk eating patterns	414 402 403
Is your baby finger feeding or eating finger foods? .... Yes _____ No ____	**Inappropriate Infant Feeding** ■ 7–9 months — infant not beginning to finger feed ■ fed or feeding foods that could cause choking	411
How are solid foods fed to baby? ______________________________	**Inappropriate Infant Feeding** ■ feeding solids in the bottle or infant feeder ■ use a syringe-type feeder ■ not using a spoon for solids	411
Do you ... give water? .... Yes_____ No_____ How much?________________ give tea or coffee? .... Yes _____ No ____ give colas or other sweetened beverages? .... Yes _____ No ____ give other high calorie nonnutritious foods? (corn syrup, sugar, or salt) .... Yes _____ No ____	**Feeding Foods Low in Essential Nutrients** ■ more than four oz. of water per day ■ any amount of tea, coffee, cola, or caffeine-containing foods ■ any sweetened beverages or high-calorie foods	416
give honey? .... Yes _____ No ____	**Inappropriate Infant Feeding** ■ give honey	411

WIC Health History for Infants

Please answer the following questions:		**Comments (For Staff Use Only)**	**NV**	**Code**
Was your infant born with any medical problems? .... Yes _____ No ____				
Has your infant ever had any health problems? .... Yes _____ No ____				
Has your infant been in the hospital (other than when born) or the emergency room? .... Yes _____ No ____				
Is your infant on a special diet for medical reasons? .... Yes _____ No ____				
Are there any foods that you limit, avoid, or do not give your infant for any reason? .... Yes _____ No ____				
Is your infant taking any medications? .... Yes _____ No ____				357
Has your infant had: surgery? .... Yes _____ No ____ burns? .... Yes _____ No ____ serious injury? .... Yes _____ No ____				359
Do you give your infant: herbal medicine? .... Yes _____ No ____ herbal tea? .... Yes _____ No ____ vitamins/minerals? .... Yes _____ No ____		(Inappropriate or Excessive) (Fluoride)		423 424
Do you have: a working stove? .... Yes _____ No ____ a working refrigerator? .... Yes _____ No ____ running water? .... Yes _____ No ____				
Are you afraid that someone you know may injure or harm your infant? .... Yes _____ No ____		**National Domestic Violence Hotline** **1-800-799-7233**		901
Where does your infant get health care? Doctor: ______________________ Shots: ______________________ Clinic: ______________________	How long since the last health care visit? ____ 1 - 3 months? ____ 4 - 6 months? ____ 7 - 9 months? ____ 10-12 months?			

C

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C.11 24-Hour Dietary Recall and Assessment for Children (1–4 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Children 1 Through 4 Years

Name____________________
DOB__________ **Age**______
SSN/Record No.______________
Required for Child Health

Medical Risks

*Is child underweight or overweight, or does child have poor growth? ☐ Yes ☐ No
If yes, list:
*Does child have anemia? ☐ Yes ☐ No
*Does child have lead poisoning? ☐ Yes ☐ No
*Does child have chronic vomiting, diarrhea, or constipation? ☐ Yes ☐ No
If yes, list:

Resources

Working stove and refrigerator? ☐ Yes ☐ No
☐ WIC ☐ Food Stamps
☐ Meals in child care ☐ Head Start
☐ Summer food program ☐ Food pantry or soup kitchen
Do you need help in obtaining food? ☐ Yes ☐ No

Feeding Skills

Is child weaned from bottle by 18 months? ☐ Yes ☐ No
Is child able to feed self after 2 years? ☐ Yes ☐ No ☐ N/A
*Does child have any feeding problems? ☐ Yes ☐ No
Check all that apply:
☐ sucking ☐ chewing ☐ choking
☐ swallowing ☐ gagging ☐ other (specify):

Dietary Practices

*Is child on a therapeutic or special diet? ☐ Yes ☐ No
If yes, describe: Prescribed by:
*Any major food allergies? ☐ Yes ☐ No
If yes, list: Symptoms:
*Any food groups refused or omitted? ☐ Yes ☐ No
If yes, list:
Does child eat dirt, clay, paint chips, or other non-foods? ☐ Yes ☐ No
Does child under 3 eat hot dogs, grapes, nuts, popcorn, or hard candies? ☐ Yes ☐ No ☐ N/A
Does child or family eat or avoid any special foods for religious or health reasons? ☐ Yes ☐ No
If yes, describe:

Health Habits

Hours of TV per day:
How many minutes per day is child physically active?
What type of activity?
How many meals given daily?
Are meals eaten with family? ☐ Yes ☐ No
Are snacks given? ☐ Yes ☐ No
If yes, list:
How many snacks per day, including beverages such as fruit juice, fruit drinks, or sodas?
How often do you brush and floss child's teeth?
Encouraged to clean plate? ☐ Yes ☐ No
Vitamin/mineral pills? ☐ Yes ☐ No
If yes, list brand or type:

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by:
Recall assessed by: **Date:**

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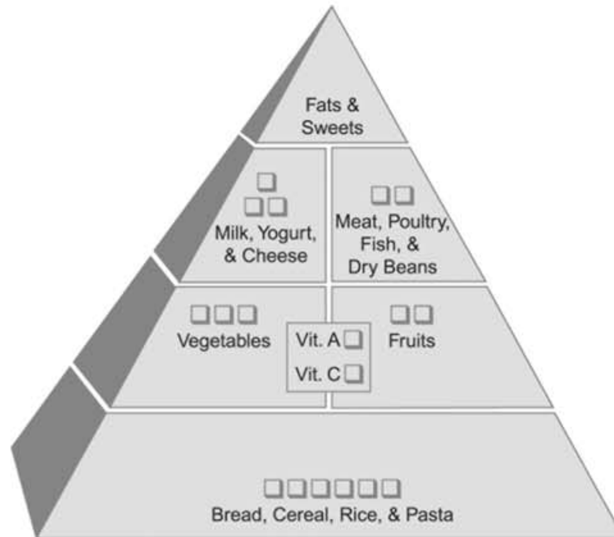
Nutrition Education

- ☐ weaning from bottle
- ☐ foods that cause choking
- ☐ dental health
- ☐ whole milk only (< 2 yrs.)
- ☐ GI disturbances
- ☐ feeding skills
- ☐ obesity prevention/treatment
- ☐ healthy diet
- ☐ iron-rich foods
- ☐ inadequate/excessive intake of: ____________________
- ☐ pica / lead poisoning
- ☐ healthy snacks
- ☐ low-fat eating (> 2 yrs.) for heart health
- ☐ physical activity
- ☐ other: ____________________

Date: ______________ Counseled by: ____________________



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

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C.12 24-Hour Dietary Recall and Assessment for Children (5–9 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Children 5 Through 9 Years

Name________________
DOB________ **Age**______
SSN/Record No.__________
Required for Child Health

Medical Risks

*Is child underweight or overweight, or does child have poor growth? ☐ Yes ☐ No
If yes, list:
*Does child have anemia? ☐ Yes ☐ No
*Does child have lead poisoning? ☐ Yes ☐ No
*Does child have chronic vomiting, diarrhea, or constipation? ☐ Yes ☐ No
If yes, list:

Resources

Working stove and refrigerator? ☐ Yes ☐ No
☐ School breakfast ☐ Food Stamps
☐ School lunch ☐ Food pantry or soup kitchen
☐ Summer food program
Do you need help in obtaining food? ☐ Yes ☐ No

Dietary Practices

*Is child on a therapeutic or special diet? ☐ Yes ☐ No
If yes, describe: Prescribed by:
GI problems with milk products? ☐ Yes ☐ No
*Any major food allergies? ☐ Yes ☐ No
If yes, list: Symptoms:
*Any food groups refused? ☐ Yes ☐ No
If yes, list:
Does child or family eat or avoid any special foods for religious or health reasons? ☐ Yes ☐ No
If yes, describe:

Health Habits

Hours of TV per day:
How many minutes per day is child physically active?
What type of activity?
How many meals given daily?
Are meals eaten with family? ☐ Yes ☐ No
Are snacks given? ☐ Yes ☐ No
If yes, list:
How many snacks per day?
How often are the child's teeth brushed and flossed?
Encouraged to clean plate? ☐ Yes ☐ No
Vitamin/mineral pills? ☐ Yes ☐ No
If yes, list brand or type:

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: ________________

Recall assessed by: ________________ **Date:**________

ECH-14 Rev. 8/04

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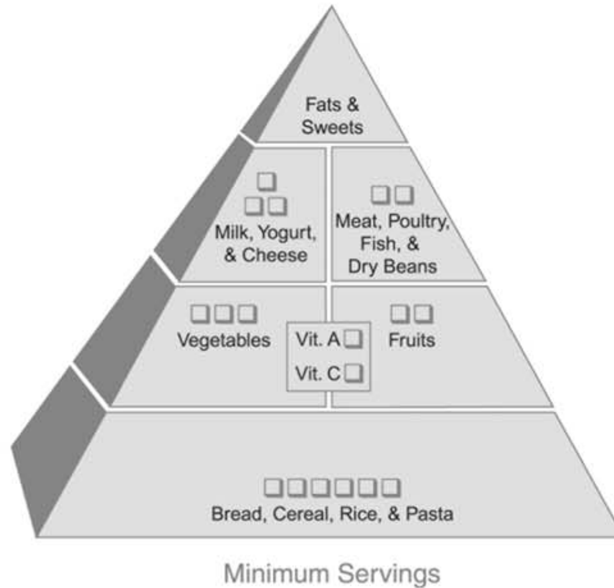
Nutrition Education

- ☐ physical activity
- ☐ iron-rich foods
- ☐ GI disturbances or problems with milk
- ☐ weight management
- ☐ healthy diet
- ☐ other:____________________
- ☐ healthy snacks
- ☐ dental health
- ☐ low-fat eating for heart health
- ☐ inadequate/excessive intake of:____________________

Date: ____________ Counseled by: ____________________



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

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C

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C.13 24-Hour Dietary Recall and Assessment for Children (10–20 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Ages 10 Through 20 Years (Nonpregnant)

Name ______________________________

DOB ______________ Age __________

SSN/Record No. ____________________

Required for Child / Teen Health

Medical Risks

*Is child or teen underweight or overweight, or does child or teen have poor growth? ☐ Yes ☐ No

If yes, list: ______________________________

*Does child or teen have anemia? ☐ Yes ☐ No

*Does child or teen have lead poisoning? ☐ Yes ☐ No

*Does child or teen have chronic vomiting, diarrhea, or constipation? ☐ Yes ☐ No

If yes, list: ______________________________

Resources

Working stove and refrigerator? ☐ Yes ☐ No

☐ School breakfast ☐ Food Stamps

☐ School lunch ☐ Food pantry or soup kitchen

☐ Summer food program

Do you need help in obtaining food? ☐ Yes ☐ No

Weight-Loss Practices

How do you feel about your weight? ☐ Good ☐ Bad

*Any restrictive dieting practices? ☐ Yes ☐ No

Check all that apply:

☐ Skipped meals ☐ Vomiting ☐ Excessive exercise

☐ Diet pills ☐ Laxatives

Diet supplements or fad diets? ☐ Yes ☐ No

If yes, describe: ______________________________

Do you feel your eating is out of control? ☐ Yes ☐ No

Dietary Practices

*Any therapeutic/special diet? ☐ Yes ☐ No

If yes, describe: ____________________ Prescribed by: ______________

GI problems with milk products? ☐ Yes ☐ No

*Any major food allergies? ☐ Yes ☐ No

If yes, list: ____________________ Symptoms: ______________

*Any food groups refused? ☐ Yes ☐ No

If yes, list: ______________________________

Do you eat or avoid any special foods for religious or health reasons? ☐ Yes ☐ No

If yes, describe: ______________________________

Health Habits

Hours of TV per day: ______________________________

How many minutes per day are you physically active? ______________________________

How many meals given daily? ______________________________

Snacks eaten daily, including beverages such as sports drinks or sodas? ☐ Yes ☐ No

If yes, list: ______________________________

How many snacks per day? ______________________________

"Fast food" eaten: ______________________________

Alcohol/tobacco/street drugs? ☐ Yes ☐ No

If yes, what kind? ______________ How often? ______________ How much? ______________

Vitamin/mineral pills? ☐ Yes ☐ No

If yes, list brand or type: ☐ Yes ☐ No

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: ______________________________

Recall assessed by: ______________________________ **Date:** ______________

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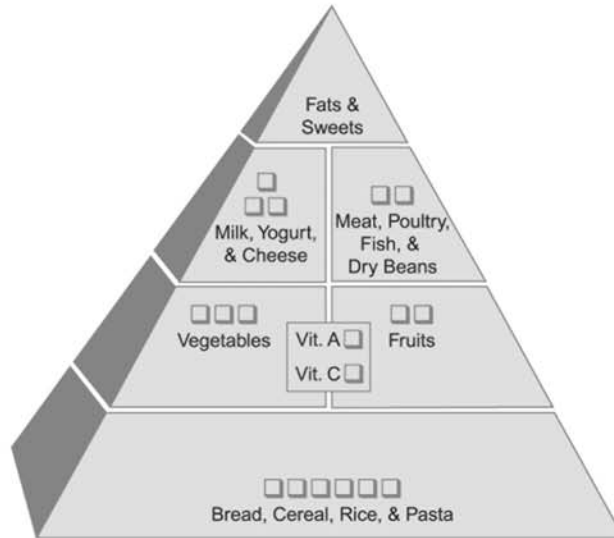
Counseled on

- ☐ healthy diet
- ☐ weight mangement / fad diets
- ☐ nutrition for sports
- ☐ eating regular meals 3×/day
- ☐ healthy snacks
- ☐ healthy "fast food" choices
- ☐ iron-rich foods
- ☐ calcium-rich foods
- ☐ physical activity
- ☐ inadequate/excessive intake of: ____________________
- ☐ smoking/alcohol/drugs
- ☐ GI disturbances or problems with milk
- ☐ low-fat eating for heart health
- ☐ physical activity
- ☐ other: ____________________

Date: ____________ Counseled by: ____________________



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

ECH-15

Rev. 8/04

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C

C.14 Hearing Checklist for Parents

Hearing Checklist for Parents

Client Information

Name: ______________________

DOB: ______/________/ ______Age:___________Sex: ______________

SSN/Record No.:______________________

Race/Ethnicity:______________________

Informant/Relationship: ______________________

Medical Home: ______________________

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	❑	❑	Does your baby get quiet for a moment when you talk to him/her?
	❑	❑	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	❑	❑	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	❑	❑	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	❑	❑	Does your baby stop and pay attention when you say "no" or call his/her name?
	❑	❑	Does your baby move his/her head around to try and find out where a new sound is coming from?
	❑	❑	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	❑	❑	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	❑	❑	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	❑	❑	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	❑	❑	Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?
25 to 36 months	❑	❑	Does your child answer different kinds of questions ("When...," "Who...," "What...,")?
	❑	❑	Does your child notice different sounds (telephone ringing, shouting, doorbell)?

If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

Date of visit	Age	Result	Signature of Provider
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8/05

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C.15 Hearing Checklist for Parents (Spanish)

Lista de comprobación de audición para los padres

Información del cliente

Nombre: ______________________________

Fecha de Nac.:_________/ _______/________________Edad:_______Sexo: ________

No. de SS/Expediente: ______________________________

Raza o etnicidad: ______________________________

Informante/Parentesco:______________________________

Médico personal: ______________________________

De 0 a 3 años	Sí	No	
De 0 a 3 meses	❑	❑	¿Su bebé se tranquiliza por un momento cuando le habla?
	❑	❑	¿Su bebé actúa sorprendido o deja de moverse por un momento cuando hay ruidos fuertes repentinos?
De 4 a 6 meses	❑	❑	¿Su bebé dirige la mirada o gira la cabeza hacia el sonido de su voz si no la está viendo?
	❑	❑	¿Su bebé sonríe o deja de llorar cuando le habla usted u otra persona que él conoce?
De 7 a 9 meses	❑	❑	¿Su bebé deja de hacer lo que está haciendo y pone atención cuando le dice "no" o lo llama por su nombre?
	❑	❑	¿Su bebé gira la cabeza hacia todos lados y trata de encontrar de dónde viene algún sonido nuevo?
	❑	❑	¿Su bebé hace sonidos repetidos ("gu-gú, da-dá")?
De 10 a 15 meses	❑	❑	¿Su bebé le da a usted juguetes u otros objetos (la botella) cuando se los pide, sin tener que usar gestos (extender la mano o señalar)?
	❑	❑	¿Su bebé señala con el dedo objetos familiares si se lo pide ("el perro", "la luz")?
De 16 a 24 meses	❑	❑	¿Su hijo usa principalmente la voz para conseguir lo que quiere o cuando quiere comunicarse con usted?
	❑	❑	¿Su hijo puede ir a buscar objetos familiares guardados en lugares regulares si usted se lo pide ("Vé por tus zapatos")?
De 25 a 36 meses	❑	❑	¿Su hijo responde a diferentes tipos de preguntas ("Cuándo", "Quién", "Qué")?
	❑	❑	¿Su hijo distingue sonidos diferentes (el timbre del teléfono, gritos, el timbre de la puerta)?

Si contestó "No" a cualquiera de las preguntas anteriores pida a su médico un examen auditivo para su bebé. Se puede examinar a los bebés tan pronto como el día de su nacimiento.

Fecha de la visita	Edad	Resultado	Firma del proveedor
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Departamento de servicios m dicos estatales
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8/05

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C.16 Mental Health Interview Tool/Referral Form (Ages 0–2 Years)

Mental Health Interview Tool/Referral Form

Ages 0 to 2

Child's Name: ____________________

Birth Date: ____________________

Date: ____________________

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings: Does your child display feelings that concern you or seem out of the ordinary?

Infants
- ❏ Anxious
- ❏ Cries excessively
- ❏ Cries too little

1 to 2 Years
- ❏ Irritable
- ❏ Angry
- ❏ Sad
- ❏ Fearful
- ❏ Sullen
- ❏ Anxious
- ❏ Cries excessively
- ❏ Cries too little

Behavior: Does your child display behavior that concerns you or seems out of the ordinary for his/her age?

Infants
- ❏ Overactive
- ❏ Listlessness

1 to 2 Years
- ❏ Overactive
- ❏ Listlessness
- ❏ Harms others
- ❏ Frequent temper tantrums

Social Interaction: Do you have concerns about how your child gets along with you? Other family members or adults? Siblings?

Infants
- ❏ No eye contact or smile
- ❏ Stiffens and arches
- ❏ Not responsive

1 to 2 Years
- ❏ * No eye contact or smile
- ❏ Clings excessively
- ❏ Not responsive
- ❏ Language delay

Thinking: Do you think your child's development is normal for age?

Infants (> 8 months)
- ❏ No communication skills (pointing to request an object) or efforts to make words

1 to 2 Year
- ❏ Mistrustful
- ❏ Problems concentrating or paying attention

Physical Problems: Do you have any concerns about your child's physical health? If physical problems exist, have they been medically evaluated?

Infants to 2 Years
- ❏ Low weight or weight loss
- ❏ Frequent vomiting
- ❏ Eating problem (poor appetite, eats nonfoods)
- ❏ Sleeping problem (frequent night waking)
- ❏ Lethargic

Other: Are there any situations which are causing your family particular stress at this time?
Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse?
If yes, what form, when, treatment initiated, etc.?
Did the mother of this child use drugs or drink alcohol during the pregnancy?

Comments:

Signature/Title: ____________________

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C.17 Mental Health Interview Tool/Referral Form (Ages 0–2 Years) (Spanish)

Instrumento para la Evaluación de la Salud Mental y Formulario para Tratamiento con un Especialista

Nombre del Niño:________________________
Fecha de Nacimiento: ____________________
Fecha: ________________________________

De Recién Nacido a 2 Años de Edad

*Para los niños que pertenecen a este grupo usted obtendrá información de los padres/personas encargadas y de sus propias observaciones del bebé. Marque las características que le preocupen. *La presencia de alguno de estos síntomas o comportamientos puede indicar que el niño está en una crisis, y se debe haces un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos: ¿Muestra su niño sentimientos que le preocupan o que parezcan extraños?

Recién Nacidos
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

De 1 a 2 Años
- ❑ Se irrita
- ❑ Se enoja
- ❑ Está triste
- ❑ Tiene miedo
- ❑ Malhumorado
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

Comportamientos: ¿Muestra su niño un compartamiento que le preocupa o que parezca extraño para su edad?

Recién Nacidos
- ❑ Es demasiado activo
- ❑ Es indiferente

De 1 a 2 Años
- ❑ Es demasiado activo
- ❑ Es indiferente
- ❑ Lastima a los demás
- ❑ Hace berrinches temperamentales frecuentemente

Interacciones Sociales: ¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia o adultos? ¿Con sus hermanos?

Recién Nacidos
- ❑ No ve a los ojos ni sonríe
- ❑ Se pone tieso y se dobla arqueando la espalada
- ❑ No muestra mucho interés

De 1 a 2 Años
- ❑ *No ve a los ojos ni sonríe
- ❑ Se pega a usted excesivamente
- ❑ No muestra mucho interés
- ❑ Está atrasado en el lenguaje

Pensamientos: ¿Cree usted que el desarrollo de su niño es normal para su edad?

Recién Nacidos (>8 meses)
- ❑ No tiene habilidad para comunicarse (apunta para pedir un objeto) ni se esfuerza para decir palabras

De 1 a 2 Años
- ❑ No tiene confianza
- ❑ Tiene problemas para concentrarse o para poner atención

Problemas Físicos: ¿Se preocupa sobre la salud física de su niño? Si existen problemas físicos, ¿han sido evaluados médicamente?

Recién Nacidos a 2 Años
- ❑ Peso bajo o pérdida de peso
- ❑ Se vomita frecuentemente
- ❑ Tiene problemas para comer (poco apetito, come alimentos que no son saludables)
- ❑ Tiene problemas para dormir (se despierta frecuentemente por las noches)
- ❑ Es letárgico

Otra: ¿Hay alguna situación que le esté causando a su familia cierta tensión ahora?
¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional?
Si contesta sí, ¿de qué manera?, ¿cuándo?, ¿se ha comenzado algún tratamiento?, etc.
¿Usó la mamá de este niño drogas o tomó bebidas alcohólicas durante su embarazo?

Comentarios:

Firma/Titulo de su puesto:____

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C.18 Mental Health Interview Tool/Referral Form (Ages 3-9 Years)

Mental Health Interview Tool/Referral Form

Ages 3 to 9

Child's Name: ___________________________
Birth Date: ______________________________
Date: ____________________________________

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child's behavior. If possible, interview the parent alone when asking questions about sexual or physical abuse. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Does your child display feelings that concern you or seem out of the ordinary for age?

- ❑ Restless
- ❑ Sad or cries easily
- ❑ Excessively guilty
- ❑ Lack of remorse
- ❑ Irritable, angers or temper tantrums easily
- ❑ Sullen
- ❑ Fearful or anxious

Behavior:

Does your child frequently display behavior that seems out of the ordinary for age?

- ❑ Problems in school
- ❑ * Harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ Engages in sexual play with others, toys, animals
- ❑ * Destroys possessions or other property
- ❑ Steals
- ❑ Refuses to talk
- ❑ * Sets fires
- ❑ Overactive
- ❑ * Self-destructive
- ❑ * Has been in trouble with the police (older child)

Social Interaction:

Do you have concerns about how child gets along with you, other family members, playmates, other adults?

- ❑ Withdraws including no eye contact
- ❑ Clings excessively
- ❑ Difficulty making and keeping friends
- ❑ Defiant, a discipline problem
- ❑ Severe or frequent tantrums
- ❑ Aggressive
- ❑ Argues excessively
- ❑ Refuses to go to school
- ❑ Prefers to be alone

Thinking:

Have you noticed any of the following to be a problem for your child?

- ❑ * Frequently confused
- ❑ Daydreams excessively
- ❑ Distracted, doesn't pay attention
- ❑ * Bizarre thoughts
- ❑ Mistrustful
- ❑ * Sees or hears things that are not there (excluding imaginary friends in younger children)
- ❑ Blames others for his/her misdeeds or thoughts
- ❑ * Talks about death
- ❑ * Frequent memory loss
- ❑ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❑ Daytime wetting
- ❑ Soils pants
- ❑ Refusal to eat
- ❑ Headaches
- ❑ Excessive weight loss or gain
- ❑ Sleep problems, nightmares, sleep-walking, early waking
- ❑ Vomits frequently
- ❑ Frequent stomachaches
- ❑ Lacks energy

Other:

Is this child accident-prone?
Are there any situations that are causing your family particular stress?
Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.
* Is this child at risk for out-of-home placement because of behavior problems?

Comments:

Signature/Title: ____

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C.19 Mental Health Interview Tool/Referral Form (Ages 3–9 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y
Formulario para Tratamiento con un Especialista
De 3 a 9 Años de Edad

Nombre del Niño:_______________________
Fecha de Nacimiento: ___________________
Fecha: _________________________________

*Para los niños que pertenecen a este grupo usted obtendrá informatción de los padres/tudor y de sus propias observaciones del comportamiento del niño. Si es posible, entreviste a los padres solos cuando haga preguntas sobre el abuso sexual o físico. Marque las características que le preocupen. *La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Muestra su niño sentimientos que le preocupan o que parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Muestra mucha culpabilidad
- ❑ No tiene remordimiento
- ❑ Se irrita, enoja, o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Tiene miedo o está ansioso

Comportamiento:

¿Muestra su niño frecuentemente un comportamiento que le parezca extraño para su edad?

- ❑ Problemas en la escuela
- ❑ *Lastima a otros niños o a animales
- ❑ No tien interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Enciende fuegos
- ❑ Es demasiado activo
- ❑ *Tiene un comportamiento de autodestrucción
- ❑ *Ha tenido problemas con la policía (con otro niño)

Interacción Sociales:

¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia? ¿Con otros adultos? o ¿Con sus amigos de juego?

- ❑ Se retira sin dirgir la mirada a los ojos
- ❑ Se pega a usted excesivamente
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Hace berrinches temperamentales fuertes o frecuentemente
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela
- ❑ Prefiere estar solo

Pensamientos:

¿Ha notado si alguno de los siguientes es un problem para su niño?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ *Tiene pensamientos raros
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí (excepto los amigos) imaginarios en niños más pequeños
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ *Habla sobre la muerte
- ❑ *Pierde la memoria frecuentemente
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

C

Problemas Físicos:

¿Le preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ Se orina durante el día
- ❑ Se ensucia
- ❑ Se niega a comer
- ❑ Tiene dolores de cabeza
- ❑ Pérdida o aumento de peso excesivo
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano
- ❑ Se vomita frecuentemente
- ❑ Tiene dolores de estómago frecuentemente
- ❑ No tiene energía

Otros:

¿Tiende este niño a tener accidentes? ¿Hay alguna situación que le esté causando a su familia tensión en particular? ¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí. ¿En que forma? ¿Cuando? ¿Tipo de tratamiento?, etc. *¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

Comentarios:

Firma/Titulo de su puesto:____

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C.20 Mental Health Interview Tool/Referral Form (Ages 10–12 Years)

Mental Health Parent Questionnaire

Ages 10 to 12 Years

Child's Name: ____________________________

Birth Date: ______________________________

Today's Date: ____________________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child (do you) show feelings that concern you or seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is guilty ❑ Is irritable or angers easily	❑ Is sullen ❑ Is fearful ❑ Is bored

Behavior	Does your child (do you) often do things that seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Threatens or harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Is involved in sexual activity ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is overactive ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child (you) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With other children? ❑ Yes ❑ No	
	❑ Prefers to be alone ❑ Has a hard time making and keeping friends ❑ Is defiant, a disciplinary problem	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school

Thinking	Are any of these a problem for your child (you)? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death or suicide a lot ❑ Often cannot remember things

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C.21 Mental Health Interview Tool/Referral Form (Ages 10–12 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y
Formulario para Tratamiento con un Especialista
De 10 a 12 Años de Edad

Nombre del Niño:_______________________
Fecha de Nacimiento: ___________________
Fecha: ______________________________

*Ambos, el niño y los padres podrán proveer información, y es importante incorporar al niño en la entrevista. En cada sección, se le hace una pregunta ejemplar a los padres. Obtenga, lo mejor que pueda, la percepción del niño sobre la respuesta de sus padres con una pregunta como “¿Estás de acuerdo con lo que dice tu mamá?” Sería conveniente dedicar tiempo para hablar solamente con el tutor del niño. Se debe entrevistar al niño solo cuando se hagan preguntas sobre el abuso sexual o físico y sobre el abuso de sustancias como las drogas y las bebidas alcohólicas. Marque las características que le preocupan. *La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Tiene su niño (tienes) sentimientos que le (te) preocupupan o que parezcan extraños para su (tu) edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Tien miedo o está ansioso
- ❑ Se aburre

Comportamiento:

¿Se (Te) comporta(s) de una manera que parecen extrañas para su (tu) edad?

- ❑ Problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a animales
- ❑ No tiene interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ *Enciende fuegos
- ❑ Es demasiado activo
- ❑ *Ha tenido problemas con la policía
- ❑ *Tiene un comportamiento de autodestrucción

Interacción Sociales:

¿Se preocupa(s) sobre cómo se (te) lleva(s) su niño con los

miembros de la familia? ¿Con otros adultos? ¿O niños?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer o tener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:

¿Ha(s) notado si alguno de los siguientes es un problem para su niño (ti)?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ *Habla sobre la muerte o el suicidio
- ❑ *Pierde la memoria frecuentemente
- ❑ *Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le (te) preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, se despierta seguido por la noche

Otros:

¿Es este niño (Eres) propenso a tener accidentes? ¿Hay alguna situación que le esté causando a su (tu) familia tensión en particular? ¿Ha sido este niño (Has sido tu) o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí, ¿Que tipo?, ¿Cuándo?, ¿Tipo de tratamiento?

- ❑ *¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?
- ❑ ¿Ha sido este niño tratado por problemas de salud mental o por el abuso de sustancias como drogas y bebidas alcohólicas?

Preguntas Sobre el Abuso de Sustancias: ________ ____________

(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el abuso de sustancias como drogas y bebidas alcóholicas.)

- ❑ Ha sido identificado como un problema

Comentarios:

Firma/Titulo de su puesto:____

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C.22 Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

Mental Health Interview Tool/Referral Form

Ages 13 to 20

Child's Name: ___________________________

Birth Date: ______________________________

Date: ___________________________________

*You may begin with a joint interview or begin with separate interviews with the parent/caregiver and adolescent. It is preferable to interview the adolescent first. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Do you (does your teen) have feelings that concern you or seem out of the ordinary for (their) age?

- ❏ Restless
- ❏ Sad or cries easily
- ❏ Guilty
- ❏ Irritable or angers easily
- ❏ Sullen
- ❏ Fearful or anxious
- ❏ Bored

Behavior:

Do you (does your child) behave in ways that seems out of the ordinary for your (their) age?

- ❏ Problems at school or work
- ❏ * Threatens or harms other children or animals
- ❏ Lacks interest in things s/he used to enjoy
- ❏ Engages in sexual play with others, toys, animals
- ❏ * Destroys possessions or other property
- ❏ Steals
- ❏ Refuses to talk
- ❏ * Sets fires
- ❏ Overactive
- ❏ * Has been in trouble with the police
- ❏ * Self-destructive

Social Interaction:

Do you have concerns about how (you) your child gets along with family members, other adults, or peers?

- ❏ Prefers to be alone
- ❏ Difficulty making and keeping friends
- ❏ Defiant, a discipline problem
- ❏ Aggressive
- ❏ Argues excessively
- ❏ Refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for you (your child)?

- ❏ * Frequently confused
- ❏ Daydreams excessively
- ❏ Distracted, doesn't pay attention
- ❏ Mistrustful
- ❏ * Sees or hears things that are not there
- ❏ Blames others for his/her misdeeds or thoughts
- ❏ * Talks about death or suicide
- ❏ * Frequent memory loss
- ❏ * Bizarre thoughts
- ❏ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❏ Lacks energy
- ❏ Uses laxatives
- ❏ Vomits frequently
- ❏ Food refusal, secretive eating
- ❏ Frequent stomachaches
- ❏ Headaches
- ❏ Excessive weight loss or gain
- ❏ Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Are you (is this child) accident-prone?
Are there any situations that are causing your family particular stress?
Have you (has this child) or your (his/her) parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- ❏ * Are you (is this child) at risk for out-of-home placement because of behavior problems?
- ❏ Have you (has this child) been treated for mental health problems or substance abuse?

Substance Abuse Questions:

(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- ❏ Has been identified as a problem

Comments:

Signature/Title: ____

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C.23 Mental Health Interview Tool/Referral Form (Ages 13–20 Years) (Spanish)

Instrumento para la Entrevista sobre la Salud Mental/
Formulario para Tratamiento con un Especialista
De 13 a 20 Años

Nombre del Adolescente:___________________
Fecha de Nacimiento: ____________________
Fecha: _________________________________

Para los Padres: *Usted puede empezar con una entrevista con ambos el tutor y el adolescente. Es preferible que entreviste al adolescente primero. Marque las características que le preocupen. * La presencia de alguno de estos síntomas o comportamientos puede indicar que el adolescente está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Tiene su adolescente sentimientos que le preocupan o que le parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo o ansiedad
- ❑ Se aburre

Comportamiento:

¿Se comporta su adolescente de una manera que parece extraña para su edad?

- ❑ Tiene problemas en la escuela o en el trabajo
- ❑ *Amenaza o lastima a otros niños o a animales
- ❑ No le interesan las cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con jugetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ *Provoca incendios
- ❑ Es demasiado activo
- ❑ *Ha tenido problemas con la policía
- ❑ *Tiene un comportamiento de autodestrucción

Interacciones Sociales:

¿Le preocupan cómo se lleva su adolescente con los miembros de la familia? ¿con otros adultos? ¿con su grupo social?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:

¿Ha notado si alguno de los siguientes es un problema para su adolescente?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo malo que hizo o por sus pensamientos
- ❑ *Habla sobre la muerte el suicidio
- ❑ *Frecuentemente pierde la memoria
- ❑ *Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le preocupan algunas de las siguientes señales físicas? ¿Han sido evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come en secreto
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado peso excesivamente
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, frecuentemente camina en la noche

Otros:

¿Tiende a tener accidentes? ¿Hay alguna situación que le esté causando a su familia cierta tensión? ¿Ha sido es adolescente o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma? ¿cuándo? ¿tipo de tratamiento?, etc.

* ¿Corre el riesgo de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

¿Ha sido tratado por problemas de la salud mental o por el abuso de sustancias como bebidas alcohólicas o drogas?

Preguntas sobre el abuso de sustancias: *(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el uso de sustancias.)*

- ❑ El abuso de sustancias como bebidas alcohólicas y drogas ha sido identificado como un problema.

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Comentarios:

Firma/Titulo de su puesto:____

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C.24 Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages Birth to 2 Years

Child's Name: ___________________________
Birth Date: ______________________________
Today's Date: ____________________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No	
	Infants	1 to 2 Years
	❑ Fearful ❑ Cries too much ❑ Cries too little	❑ Is irritable ❑ Fearful ❑ Is angry ❑ Cries too little ❑ Is sad ❑ Cries too much ❑ Is sullen

Behavior	Does your child do things that concern you or seem strange for their age? ❑ Yes ❑ No	
	Infants	1 to 2 Years
	❑ Is overactive ❑ Is listless (has little energy)	❑ Is overactive ❑ Harms others ❑ Is listless (has little energy) ❑ Has temper tantrums often

Social Interaction	Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No With other family members or adults? ❑ Yes ❑ No With brothers and sisters? ❑ Yes ❑ No	
	Infants	1 to 2 Years
	❑ Does not make eye contact or smile ❑ Stiffens and arches back ❑ Does not respond to you	❑ Does not make eye contact or smile ❑ Does not respond to you ❑ Clings to you too much ❑ Does not say any words yet

Thinking	Do you think your child is as bright and thinks as clearly as others their age? ❑ Yes ❑ No	
	Infants	1 to 2 Years
	❑ (>8 months) Does not point to or ask for things or try to make words	❑ Does not trust others ❑ Has problems concentrating or paying attention

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Physical	Problems	
		Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No
		Infants to 2 Years ❑ Is low weight or has a lot of weight ❑ Vomits (throws up) often ❑ Has eating problems (poor appetite, eats non-foods) ❑ Has sleeping problems (wakes a lot at night) ❑ Has little energy

Other	
	Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________________ When? ________ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Did the mother of this child use drugs or alcohol during the pregnancy? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: ____________ Signature: ____

Relation to patient: ____

C

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C.25 Mental Health Questionnaire (Ages Birth–2 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

Nombre del Niño:________________________________
Fecha de Nacimiento: ___________________________
Fecha: ____

De Recién Nacido a 2 Años de Edad

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su bebé. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su bebé. Favor de marcar todas las características abajo que son ciertas para su bebé. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su bebé sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

Bebés	**De 1 a 2 Años**	
❑ Siente miedo	❑ Es de mal carácter	❑ Siente miedo
❑ Llora mucho	❑ Es enojón	❑ Llora muy poco
❑ Llora muy poco	❑ Es triste	❑ Llora mucho
	❑ Es malhumorado	

COMPORTAMIENTO

¿Hace su bebé cosas que le preocupan o que parezcan extrañas para su edad? ❑ Sí ❑ No

Bebés	**De 1 a 2 Años**
❑ Es demasiado activo	❑ Es demasiado activo
❑ Es indiferente (tiene poca energía)	❑ Es indiferente (tiene poca energía)
	❑ Lastima a otros
	❑ Hace berrinches frecuentemente

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su bebé con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus hermanos o hermanas? ❑ Sí ❑ No

Bebés	**De 1 a 2 Años**
❑ No ve a los ojos ni sonríe	❑ No ve a los ojos ni sonríe
❑ Se pone tieso y se dobla arqueando la espalda	❑ La mayoría del tiempo no se le despega
❑ No le responde	❑ No le responde
	❑ Todavía no dice ninguna palabra

PENSAMIENTOS

¿Piensa usted que su nino es tan inteligente y que piensa tan claramente como otros niños de su edad? ❑ Sí ❑ No

Bebés	**De 1 a 2 Años**
❑ (>8 meses) No pide ni senala a las cosas o trata de decir palabras	❑ No le tiene confianza a otros
	❑ Tiene problemas para concentrarse y poner atención

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<table>
<tr><td rowspan="2">PROBLEMAS FISICOS</td><td>¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No
Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No</td></tr>
<tr><td>De recién nacidos a 2 Años
❑ Es de peso bajo o ha perdido mucho peso
❑ Se vomita frecuentemente
❑ Tiene problemas para comer (muy poco apetito, come alimentos que no son saludables)
❑ Tiene problemas para dormir (se despierta mucho durante la noche)
❑ Tiene muy poca energía</td></tr>
<tr><td>OTROS</td><td>¿Hay algo que le esté causando tensión a su familia ahora? ❑ Sí ❑ No
¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, ¿en qué forma?____________________ ¿Cuándo?____________ ❑ Sí ❑ No
¿Empezó el tratamiento? ❑ Sí ❑ No
¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño? ❑ Sí ❑ No</td></tr>
<tr><td colspan="2">Comentarios: (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)</td></tr>
</table>

Fecha:_____________ Firma:____

Parentesco con el paciente:______________________________________

C

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C.26 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 3 to 9 Years

Child's Name: ____________________________

Birth Date: ______________________________

Today's Date: ____________________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is overly guilty ❑ Lacks remorse	❑ Is irritable, angers or temper tantrums easily ❑ Is sullen ❑ Fearful

Behavior	Does your child do things that seem strange for their age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Plays sexual games with others, toys, animals ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is over-active ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No With other family members or adults? ❑ Yes ❑ No With playmates? ❑ Yes ❑ No	
	❑ Withdraws and does not look into peoples' eyes ❑ Clings to you too much ❑ Has a hard time making and keeping friends ❑ Is defiant, has a disciplinary problem ❑ Severe or frequent tantrums	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school ❑ Prefers to be alone

Thinking	Are any of these a problem for your child? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death a lot ❑ Often cannot remember things

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Physical Problems	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No	
	❑ Has daytime wetting ❑ Soils pants ❑ Will not eat ❑ Has headaches ❑ Has lost or gained a lot of weight	❑ Has sleeping problems, nightmares, sleep-walking, early waking ❑ Vomits (throws up) often ❑ Has stomach aches often ❑ Lacks energy

Other	
	Is this child accident-prone? ❑ Yes ❑ No Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________________ When? ________ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Is this child at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: ____________ Signature: ____

Relation to patient: ____

C

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C.27 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 3 a 9 Años de Edad

Nombre del Niño:______________________________
Fecha de Nacimiento: __________________________
Fecha: ____

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su niño. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que sean ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente muy culpable
- ❑ No tiene remordimiento
- ❑ Es de mal carácter, enojón o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Juega juegos sexuales con otros niños, juguetes, o animales
- ❑ Destruye cosas personales u ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus compañeros de juego? ❑ Sí ❑ No

- ❑ Se aleja y no ve a nadie a los ojos
- ❑ La mayoría del tiempo no se le despega
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Hace berrinches tempermentales fuertes o frecuentemente
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela
- ❑ Prefiere estar solo

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte
- ❑ Frecuentemente no se acuerda de cosas

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<table>
<tr><td rowspan="2">PROBLEMAS FISICOS</td><td>¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No
Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No</td></tr>
<tr><td>❑ Se orina durante el día
❑ Ensucia sus pantalones
❑ No quiere comer
❑ Tiene dolores de cabeza
❑ Ha perdido o aumentado mucho de peso
❑ Tiene problemas para dormir, pesadillas, se despierta temprano y sonámbulo
❑ Se vomita frecuentemente
❑ Tiene dolores de estómago frecuentemente
❑ No tiene energía</td></tr>
<tr><td>OTROS</td><td>¿Es propenso este niño a tener accidentes? ❑ Sí ❑ No
¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No
¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?
Si sí, ¿en qué forma?_________________ ❑ Sí ❑ No
¿Cuándo? ___________ ¿Empezó el tratamiento? ❑ Sí ❑ No
¿Corre el riesgo este niño de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No</td></tr>
<tr><td colspan="2">Comentario: (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)</td></tr>
</table>

Fecha:______________ Firma:____

Parentesco con el paciente:____

C

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C.28 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 10 to 12 Years

Child's Name: ______________________________

Birth Date: ______________________________

Today's Date: ______________________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child (do you) show feelings that concern you or seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is guilty ❑ Is irritable or angers easily	❑ Is sullen ❑ Is fearful ❑ Is bored

Behavior	Does your child (do you) often do things that seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Threatens or harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Is involved in sexual activity ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is overactive ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child (you) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With other children? ❑ Yes ❑ No	
	❑ Prefers to be alone ❑ Has a hard time making and keeping friends ❑ Is defiant, a disciplinary problem	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school

Thinking	Are any of these a problem for your child (you)? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death or suicide a lot ❑ Often cannot remember things

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<table>
<tr><td rowspan="2">Physical Problems</td><td colspan="2">Do you have any concerns about these things? ❑ Yes ❑ No
If you think your child (you) may have a health problem, has he/she (have you) seen a doctor or nurse about the problem? ❑ Yes ❑ No</td></tr>
<tr><td>❑ Lacks energy
❑ Uses laxatives
❑ Vomits (throws up) often
❑ Won't eat in front of people, sneaks food later
❑ Has stomach aches often</td><td>❑ Has headaches
❑ Has lost or gained a lot of weight
❑ Has sleeping problems, nightmares, sleep-walking, early waking, frequent night waking</td></tr>
</table>

<table>
<tr><td>Other</td><td>Is your child (you) accident-prone? ❑ Yes ❑ No
Is anything causing your family stress right now? ❑ Yes ❑ No
Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________________ When? ________ ❑ Yes ❑ No
Treatment initiated? ❑ Yes ❑ No
Is this child (are you) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No
Does your child (do you) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No
Has this child (have you) been treated for mental health problems or substance abuse? ❑ Yes ❑ No</td></tr>
</table>

Comments: *(Please write anything else you want us to know about in this space.)*

Date: ____________ Signature: ____

Relation to patient: ____

C

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C.29 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 10 a 12 Años de Edad

Nombre del Niño: ________________________________

Fecha de Nacimiento: ____________________________

Fecha: ____

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su hijo. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que son ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

❑ Es inquieto	❑ Es malhumorado
❑ Es triste o llora fácilmente	❑ Siente miedo
❑ Se siente culpable	❑ Se aburre
❑ Es de mal carácter o se enoja fácilmente	

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

❑ Tiene problemas en la escuela	❑ Se niega a hablar
❑ Amenaza o lastima a otros niños o a los animales	❑ Provoca incendios
❑ No le interesan las cosas que antes le gustaban	❑ Es demasiado activo
❑ Participa en actividades sexuales	❑ Se lastima
❑ Destruye cosas personales o ajenas	❑ Ha tenido problemas con la policía
❑ Roba	

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con otros niños? ❑ Sí ❑ No

❑ Prefiere estar solo	❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
❑ Se le dificulta hacer y mantener amistades	❑ Discute mucho
❑ Es desafiante, tiene un problema de disciplina	❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

❑ Se confunde frecuentemente (no entiende lo que está pasando)	❑ No le tiene confianza a los demás
❑ Sueña mucho despierto	❑ Mira u oye cosas que no están allí
❑ Se distrae, no pone atención	❑ Culpa a otros por algo que hizo mal o por sus pensamientos
❑ Tiene pensamientos muy extraños	❑ Habla mucho sobre la muerte o del suicidio
❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)	❑ Frecuentemente no se acuerda de cosas

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<table>
<tr><td rowspan="2">PROBLEMAS FISICOS</td><td>¿Se preocupa usted sobre los siguientes problemas físicos? ❏ Sí ❏ No
Si piensa que su niño tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera debido a ese problema? ❏ Sí ❏ No</td></tr>
<tr><td>❏ La falta energía
❏ Usa laxantes
❏ Se vomita frecuentemente
❏ No come delante de la gente, come después a escondidas
❏ Tiene dolores de estómago frecuentemente
❏ Tiene dolores de cabeza
❏ Ha perdido o aumentado mucho peso
❏ Tiene problemas para dormir, pesadillas, sonambulismo, despierta temprano, despierta seguido por la noche</td></tr>
<tr><td>OTROS</td><td>¿Es propenso a tener accidentes su niño? ❏ Sí ❏ No
¿Hay algo que le está causando tensión a su familia ahora? ❏ Sí ❏ No
¿Ha sido este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?
Si sí, ¿en qué forma?________________ ¿Cuándo? ___________ ❏ Sí ❏ No
¿Empezó el tratamiento? ❏ Sí ❏ No
¿Corre este niño el riesgo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❏ Sí ❏ No
¿Toma bebidas alcohólicas o usa drogas su niño (incluyendo las de la calle y las que se venden sin receta)? ❏ Sí ❏ No
¿Ha recibido su niño tratamiento por problemas de la salud mental o por el abuso de sustancia como las drogas y bebidas alcohólicas? ❏ Sí ❏ No</td></tr>
<tr><td colspan="2">Comentario: (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)</td></tr>
</table>

Fecha:_____________ Firma:____

Parentesco con el paciente:____

C

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C.30 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 13 to 20 Years

Teen's Name: ___________________________

Birth Date: ______________________________

Today's Date: ___________________________

To the Teen or Parent: *If you will assist us by filling out this form, we can help you find your (your teen's) strengths and any problem areas, too. Your answers will help us to know if we need to talk with you (your teen) and find out more about you (your teen). Please check all items below that are true for you (your teen). Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Do you (does your teen) show feelings that concern you or seem strange for your (their) age? ❑ Yes ❑ No	
	❑Restless ❑Sad or cry easily ❑Guilty ❑ Irritable or angered easily	❑ Sullen ❑ Fearful ❑ Bored

Behavior	Do you (does your teen) often do things that seem strange for your (their) age? ❑ Yes ❑ No	
	❑ Have problems in school or work ❑ Threaten or harm other children or animals ❑ Lack interest in things you used to enjoy ❑ Is involved in sexual activity ❑ Destroy possessions or other property ❑ Steal	❑ Refuse to talk ❑ Set fires ❑ Over-active ❑ Hurt yourself ❑ Have been in trouble with the police

Social Interaction	Do you have any concerns about how you (your teen) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With peers? ❑ Yes ❑ No	
	❑ Prefer to be alone ❑ Have a hard time making and keeping friends ❑ Defiant, a disciplinary problem	❑ Pick on others a lot or often get into fights (hitting, etc.) ❑ Argue too much ❑ Will not go to school

Thinking	Are any of these a problem for you (your teen)? ❑ Yes ❑ No	
	❑ Frequently confused (does not understand what is going on) ❑ Daydream a lot ❑ Distracted, do not pay attention ❑ Have very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Do not trust others ❑ See or hear things that are not there ❑ Blame others for your misdeeds or thoughts ❑ Talk about death or suicide a lot ❑ Often cannot remember things

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<table>
<tr><td rowspan="2">Physical</td><td rowspan="2">Problems</td><td colspan="2">Do you have any concerns about these things? ❑ Yes ❑ No
If you think you (your teen) may have a health problem, have you (has he/she) seen a doctor or nurse about the problem? ❑ Yes ❑ No</td></tr>
<tr><td>❑ Lack energy
❑ Use laxatives
❑ Vomit (throw up) often
❑ Won't eat in front of people, sneak food later
❑ Have stomachaches often</td><td>❑ Have headaches
❑ Have lost or gained a lot of weight
❑ Have sleeping problems, nightmares, sleep-walking, early waking, frequent night waking</td></tr>
</table>

<table>
<tr><td>Other</td><td>Are you (is your teen) accident-prone? ❑ Yes ❑ No
Is anything causing your family stress right now? ❑ Yes ❑ No
Have you (has your teen) or your parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________________ When? ________ ❑ Yes ❑ No
Treatment initiated? ❑ Yes ❑ No
Are you (is this teen) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No
Do you (does your child) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No
Have you (has this teen) been treated for mental health problems or substance abuse? ❑ Yes ❑ No</td></tr>
</table>

Comments: *(Please write anything else you want us to know about in this space.)*

Date: ____________ Signature: ____

Relation to patient: ____

C

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C.31 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 13 a 20 Años de Edad

Nombre del Adolescente:________________________
Fecha de Nacimiento: ________________________
Fecha: ________________________________

Para los Padres: *Si nos ayuda llenando este formulario, podremos ayudarle a encontrar las áreas fuertes que tenga su hijo y también cualquier área problématica. Sus respuestas nos ayudarán a saber si necesitamos hablar con su hijo y saber más sobre él. Favor de marcar todas las características abajo que son ciertas para su hijo. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos*.

SENTIMIENTOS

¿Tiene su hijo sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

❑ Es inquieto	❑ Es malhumorado
❑ Es triste o llora fácilmente	❑ Siente miedo
❑ Se siente culpable	❑ Se aburre
❑ Es irrita o enoja fácilmente	

COMPORTAMIENTO

¿Hace su hijo cosas frecuentemente que le parezcan extrañas para su edad? ❑ Sí ❑ No

❑ Tiene problemas en la escuela o en el trabajo	❑ Se niega a hablar
❑ Amenaza o lastima a otros niños o a los animales	❑ Provoca incendios
❑ No le interesan las cosas que antes le gustaban	❑ Es demasiado activo
❑ Está envuelto en actividades sexuales	❑ Se lastima
❑ Destruye cosas personales u otras cosas ajenas	❑ Ha tenido problemas con la policía
❑ Roba	

INTERACCIONES SOCIALES

¿Le preocupa cómo se lleva su hijo con los miembros de la familia? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con su grupo social? ❑ Sí ❑ No

❑ Prefiere estar solo	❑ Molesta mucho a otros o frecuentemente se pelea (pegando, etc.)
❑ Se le dificulta hacer y mantener amistades	❑ Discute mucho
❑ Es desafiante, tiene un problema de disciplina	❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su hijo? ❑ Sí ❑ No

❑ Se confunde frecuentemente (no entiende lo que está pasando)	❑ No le tiene confianza a los demás
❑ Sueña mucho despierto	❑ Mira u oye cosas que no están allí
❑ Se distrae, no pone atención	❑ Culpa a otros por algo que hizo mal o por sus pensamientos
❑ Tiene pensamientos muy extraños	❑ Habla mucho sobre la muerte o el suicidio
❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)	❑ Frecuentemente no se acuerda de cosas

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PROBLEMAS FISICOS	¿Se preocupa por estas cosas?	❑ Sí ❑ No
	Si piensa que su hijo tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera por este problema?	❑ Sí ❑ No
	❑ No tiene energía	❑ Tiene dolores de cabeza
	❑ Usa laxantes	❑ Ha perdido o aumentado mucho peso
	❑ Se vomita frecuentemente	❑ Tiene problemas para dormir, pesadillas, se despierta temprano, sonámbulo y frecuentemente despierta durante la noche
	❑ No come delante de la gente, come después a escondidas	
	❑ Tiene dolores de estómago frecuentemente	
OTROS	¿Es su hijo propenso a tener accidentes?	❑ Sí ❑ No
	¿Hay algo que le está causando tensión a su familia ahora?	❑ Sí ❑ No
	¿Ha sido su hijo o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?	❑ Sí ❑ No
	Si sí, ¿en qué forma?________________ ¿Cuándo? ___________	
	¿Empezó el tratamiento?	❑ Sí ❑ No
	¿Corre el riesgo su hijo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento?	❑ Sí ❑ No
	¿Toma su hijo bebidas alcohólicas o drogas (incluyendo las de la calle y las que se venden sin receta)?	❑ Sí ❑ No
	¿Ha recibido su hijo tratamiento por problemas de la salud mental o por el abuso de sustancias como drogas o bebidas alcohólicas?	❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha:_____________ Firma:____

Parentesco con el paciente:_______________________________________

C

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C.32 Recommended Childhood Immunization Schedule, 2006 (2 Pages)

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2006

Vaccine ▼ / Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–14 years	15 years	16–18 years
Hepatitis B[1]	HepB	HepB		*HepB[1]*		HepB					HepB Series			
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP			DTaP		DTaP	Tdap		Tdap	
Haemophilus influenzae type b[3]			Hib	Hib	*Hib[3]*	Hib								
Inactivated Poliovirus			IPV	IPV		IPV				IPV				
Measles, Mumps, Rubella[4]						MMR				MMR		MMR		
Varicella[5]							Varicella				Varicella			
Meningococcal[6]							Vaccines within broken line are for selected populations		MPSV4		MCV4		MCV4 / MCV4	
Pneumococcal[7]			PCV	PCV	PCV	PCV			PCV		PPV			
Influenza[8]						Influenza (Yearly)					Influenza (Yearly)			
Hepatitis A[9]										HepA Series				

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. ▇ Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **www.vaers.hhs.gov** or by telephone, **800-822-7967**.

▇ Range of recommended ages ▇ Catch-up immunization ▇ 11–12 year old assessment

1. **Hepatitis B vaccine (HepB).** ***AT BIRTH:*** **All newborns** should receive monovalent HepB soon after birth and before hospital discharge. **Infants born to mothers who are HBsAg-positive** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. **Infants born to mothers whose HBsAg status is unknown** should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **For infants born to HBsAg-negative mothers,** the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. ***FOLLOWING THE BIRTHDOSE:*** The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. It is permissible to administer 4 doses of HepB (e.g., when combination vaccines are given after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. **Infants born to HBsAg-positive mothers** should be tested for HBsAg and antibody to HBsAg after completion of the HepB series, at age 9–18 months (generally at the next well-child visit after completion of the vaccine series).

2. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years.

   Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap – adolescent preparation) is recommended at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13–18 years who missed the 11–12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent **tetanus and diphtheria toxoids (Td)** are recommended every 10 years.

3. ***Haemophilus influenzae*** **type b conjugate vaccine (Hib).** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.

4. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.

5. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.

6. **Meningococcal vaccine (MCV4).** Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although **meningococcal polysaccharide vaccine (MPSV4)** is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see *MMWR* 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2–10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.

7. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000; 49(RR-9):1-35.

8. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2005;54[RR-8]:1-55). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2005;54(RR-8):1-55. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

9. **Hepatitis A vaccine (HepA).** HepA is recommended for all children at 1 year of age (i.e., 12–23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children 2–18 years of age are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of 1-year-old children should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups (see *MMWR* 1999; 48[RR-12]1-37).

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

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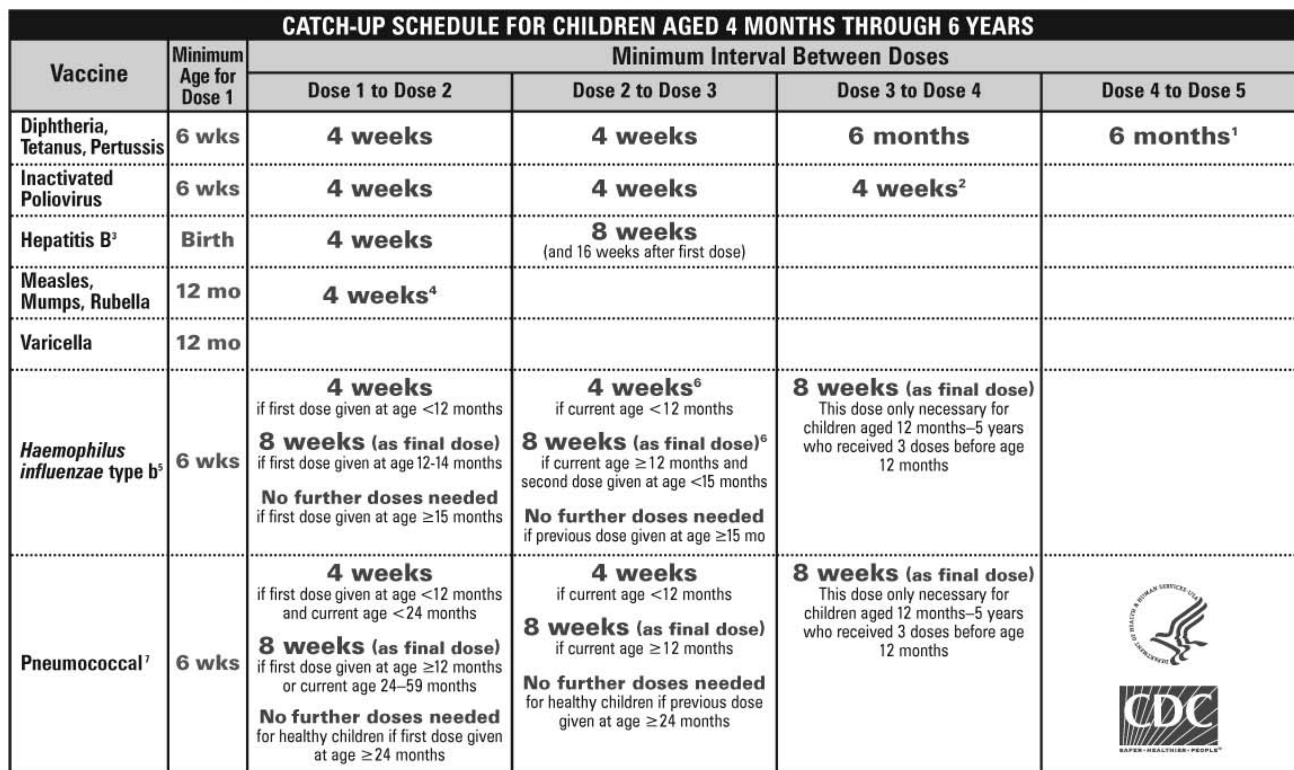
Recommended Immunization Schedule for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

UNITED STATES • 2006

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.



CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months[1]
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks[2]	
Hepatitis B[3]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks[4]			
Varicella	12 mo				
Haemophilus influenzae type b[5]	6 wks	**4 weeks** if first dose given at age <12 months **8 weeks (as final dose)** if first dose given at age 12-14 months **No further doses needed** if first dose given at age ≥15 months	**4 weeks[6]** if current age <12 months **8 weeks (as final dose)[6]** if current age ≥12 months and second dose given at age <15 months **No further doses needed** if previous dose given at age ≥15 mo	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 wks	**4 weeks** if first dose given at age <12 months and current age <24 months **8 weeks (as final dose)** if first dose given at age ≥12 months or current age 24–59 months **No further doses needed** for healthy children if first dose given at age ≥24 months	**4 weeks** if current age <12 months **8 weeks (as final dose)** if current age ≥12 months **No further doses needed** for healthy children if previous dose given at age ≥24 months	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	CDC SAFER·HEALTHIER·PEOPLE

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria[8]	4 weeks	6 months	**6 months** if first dose given at age <12 months and current age <11 years; otherwise **5 years**
Inactivated Poliovirus[9]	4 weeks	4 weeks	IPV[2,9]
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella[10]	4 weeks		

1. **DTaP.** The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.
2. **IPV.** For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.
3. **HepB.** Administer the 3-dose series to all children and adolescents <19 years of age if they were not previously vaccinated.
4. **MMR.** The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
5. **Hib.** Vaccine is not generally recommended for children aged ≥5 years.
6. **Hib.** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
7. **PCV.** Vaccine is not generally recommended for children aged ≥5 years.
8. **Td.** Adolescent tetanus, diphtheria, and pertussis vaccine (Tdap) may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A five-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. See ACIP recommendations for further information.
9. **IPV.** Vaccine is not generally recommended for persons aged ≥18 years.
10. **Varicella.** Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.hhs.gov or call the 24-hour national toll-free information line 800-822-7967. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or contact 800-CDC-INFO (800-232-4636) (In English, En Español — 24/7)

C

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C.33 Screening Schedule for Elevated Blood Lead Levels

Age of child	May use detailed parent questionnaire	May use abbreviated parent questionnaire	Blood lead test required	Conditions
6 months	yes			
12 months			yes	
18 months	yes			
24 months			yes	
3, 4, 5, and 6 years	yes, if any answer on abbreviated parent questionnaire is “yes”	yes		If a child has no record of a blood lead level test, administer one this visit.

Note: *A “yes” or “I don’t know” answer to any question on any parent questionnaire indicates that a blood lead test should be administered.*

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C.34 Guidelines for Using the Detailed Parent Questionnaire: Risk Assessment for Lead Exposure

Guidelines for Using the
DETAILED PARENT QUESTIONNAIRE
Risk Assessment for Lead Exposure

IMPORTANT: When you have completed this questionnaire, please fax or mail a copy to the Texas Childhood Lead Poisoning Prevention Program.

Target population — You must administer a blood lead test to all children at ages 12 months and 24 months. You also must administer a blood lead test to a child between 36 and 72 months (3-6 years) of age if the child has no record of a blood lead test.

- ➢ Use this Detailed Parent Questionnaire at child's 6 month and 18 month doctor visits.
- ➢ At child's 3, 4, 5, and 6 year doctor visits, in lieu of a blood lead test you may use this Detailed Parent Questionnaire in the following situations:

  Child was tested at 12 and 24 months, and
  - has never had an elevated blood lead level test result, but
  - has had a "Yes" answer to any question on the Abbreviated Parent Questionnaire

Local community — You may know of situations in the child's community that could contribute to risk for lead exposure. Add questions about those situations to the interview document and ask them in any subsequent interview of the child's parent/guardian.

Additional topics for discussion and education can be found on the Physician Checklist for Parent Education Topics (form Pb-104).

"No" answers — If the answer to every question is an unqualified "No," the child may be considered at "low risk" for lead exposure.

"Yes" answer(s) — If the answer to any question is "Yes," the child is at "high risk" for lead exposure. Administer a blood lead test regardless of any previous blood lead test results. Continue testing the child according to the recommended periodicity schedule.

"I don't know" answers — If the answer to any question is "I don't know," clarifiy the the question or the topic. If the parent remains unsure after discussion, consider the response a "Yes" answer, and administer a blood lead test.

Spanish-speaking patients — This questionnaire is available in both English and Spanish.

Obtaining questionnaires — You may photocopy this questionnaire or download from the Texas Childhood Lead Poisoning Prevention Program site at http://www.dshs.state.tx.us/lead.

Texas Childhood Lead Poisoning Prevention Program
Epidemiology and Surveillance Unit • Department of State Health Services
1100 West 49th Street • Austin, TX 78756 • Fax 1-512-458-7699

C

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C.35 Detailed Parent Questionnaire: Risk Assessment for Lead Exposure (2 Pages)

Patient's Name: ______________________________

Date Questionnaire Administered: ______________________________

DETAILED PARENT QUESTIONNAIRE

RISK ASSESSMENT FOR LEAD EXPOSURE

1. Do you live in or often visit a house that was probably built before 1978?

   YES ☐ NO ☐ I DON'T KNOW ☐

2. Does your child live in or often visit a house that is being painted, remodeled, or having the paint scraped or sanded?

   YES ☐ NO ☐ I DON'T KNOW ☐

3. Does your child eat or chew on non-food things like paint chips or dirt?

   YES ☐ NO ☐ I DON'T KNOW ☐

4. Have any other members of the family or your child's playmates had high blood leads as far as you know?

   YES ☐ NO ☐ I DON'T KNOW ☐

5. Does your family live near or does your child play near any of these (circle the ones that apply):

   Smelter
   Hazardous waste site
   Lead industry
   Place where batteries are manufactured or repaired
   House construction site
   Heavily traveled major highway
   Place where cars are abandoned or repaired?

6. Do you give your child, or have you ever given your child, any of these products from another country:

   MEDICINES like greta or azarcon for empacho, alarcon, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, or rueda?

   YES ☐ NO ☐ I DON'T KNOW ☐

   NUTRITIONAL PILLS OTHER THAN VITAMINS?

   YES ☐ NO ☐ I DON'T KNOW ☐

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7. Does anyone living in your house work at a place where any of these things happen or have a hobby that involves these things (circle the ones that apply):

Radiator repair	Brass/copper foundry
Lead industry	Valve and pipe fittings
Welding	Bridge, tunnel and elevated highway construction
Battery manufacture or repair	Industrial machinery and equipment
House construction or repair	Re-loading bullets or making fishing weights
Smelting	Refinishing furniture
Chemical preparation	Burning lead-painted wood
Making pottery	Automotive repair shop
Going to a firing range	
Stained glass with lead solder	

8. Does anybody that your child spends a lot of time with (outside of your home) do any of these things or work at a place where these things are done?

   YES ☐ NO ☐ I DON'T KNOW ☐

9. Is imported or glazed pottery, or a Mexican bean pot, used to cook or store your food?

   YES ☐ NO ☐ I DON'T KNOW ☐

10. Does your child eat foods canned or packaged (such as candy) outside the U.S.?

   YES ☐ NO ☐ I DON'T KNOW ☐

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C.36 Detailed Parent Questionnaire: Risk Assessment for Lead Exposure (2 Pages) (Spanish)

Nombre del Paciente: ______________________________

Fecha de Administración del Cuestionario: ______________________________

CUESTIONARIO DETALLADO PARA LOS PADRES

1. ¿Vive usted en o visita frecuentemente alguna casa que probablemente haya sido construida antes de 1978?

   SÍ ☐ NO ☐ NO LO SÉ ☐

2. ¿Vive su hijo(a) en o visita frecuentemente una casa que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?

   SÍ ☐ NO ☐ NO LO SÉ ☐

3. ¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura o tierra?

   SÍ ☐ NO ☐ NO LO SÉ ☐

4. ¿Hasta donde que usted sepa, existe algún otro miembro de la familia o compañeritos de juego que hayan tenido altos niveles de plomo en la sangre?

   SÍ ☐ NO ☐ NO LO SÉ ☐

5. ¿Su familia vive cerca o su hijo(a) juega cerca de alguno de los siguientes lugares? (encierre en un círculo la respuesta)

   Fundición

   Sitio de desperdicios peligrosos

   Industria de plomo

   Lugar donde se fabrican o reparan baterías

   Sitio de construcción de una casa

   Autopista con mucho tráfico

   Lugar donde los autos son reparados o abandonados

6. ¿Le da o le ha dado usted alguna vez a su hijo(a) alguno de los siguientes productos provenientes de otro país?

   MEDICINAS tales como greta, o azarcón para el empacho, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, o rueda?

   SÍ ☐ NO ☐ NO LO SÉ ☐

   PÍLDORAS NUTRICIONALES QUE NO SEAN VITAMINAS

   SÍ ☐ NO ☐ NO LO SÉ ☐

TEXAS Department of State Health Services

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7. ¿Hay alguna persona viviendo en su casa que trabaje en un lugar donde se realice alguna de las cosas que describimos a continuación o que tengan un pasatiempo que involucre alguna de los siguientes? (encierre en un círculo la respuesta):
   Reparación de radiadores
   Industria del plomo
   Soldadura
   Fabricación o reparación de baterías
   Construcción o reparación de casas
   Fundición (de metales)
   Preparación de químicos
   Fabricación de cerámica
   Ir a un campo de tiro
   Fabricación de vitrales con soldadura de plomo
   Fundición de latón /cobre
   Partes sueltas para tubos de cañerías y válvulas
   Construcción de una autopista elevada, puente, túnel
   Equipo y maquinaria industrial
   Recargo de balas de armas de fuego o fabricación de pesas para pescar
   Terminado de muebles
   Quema de madera pintada con plomo
   Taller mecánico para autos

8. ¿Alguna persona con quien su hijo pasa largo tiempo, hace alguna de estas cosas o trabaja en lugares (fuera de la casa) donde se realizen las actividades antes mencionadas?
   SÍ ☐ NO ☐ NO LO SÉ ☐

9. ¿Usa usted productos de cerámica importada o con recubrimiento de barniz, o una olla para frijoles de México, para cocinar o para guardar su comida?
   SÍ ☐ NO ☐ NO LO SÉ ☐

10. ¿Come su hijo(a) productos enlatados o empacados (tales como dulces) fuera de los Estados Unidos?
   SÍ ☐ NO ☐ NO LO SÉ ☐

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C.37 Guidelines for Using the Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure

Guidelines for Using the ABBREVIATED PARENT QUESTIONNAIRE

Risk Assessment for Lead Exposure

IMPORTANT: When you have completed this questionnaire, please fax or mail a copy to the Texas Childhood Lead Poisoning Prevention Program

Target population — You must administer a blood lead test to all children at ages 12 months and 24 months. You also must administer a blood lead test to a child between 36 and 72 months (3-6 years) of age if the child has no record of a blood lead test.

- At child's 3, 4, 5, and 6 year doctor visits, in lieu of a blood lead test you may use this Abbreviated Parent Questionnaire in the following situations:

  Child was tested at 12 and 24 months, and
  - has never had an elevated blood lead level test result, and
  - has never had a "Yes" answer to any question on this questionnaire

Local community — You may know of situations in the child's community that could contribute to risk for lead exposure. Add questions about those situations to the interview document and ask them in any subsequent interview of the child's parent/guardian.

Additional topics for discussion and education can be found on the Physician Checklist for Parent Education Topics (form Pb-104).

"No" answers — If the answer to every question is an unqualified "No," the child may be considered at "low risk" for lead exposure

"Yes" answer(s) — If the answer to any question is "Yes," the child is at "high risk" for lead exposure. Ask parent the questions on the Detailed Parent Questionnaire or administer a blood lead test.

"I don't know" answers — If the answer to any question is "I don't know," clarify the question or the topic. If the parent remains unsure after discussion, consider the response a "Yes" answer and use the Detailed Parent Questionnaire or administer a blood lead test.

Spanish-speaking patients — This questionnaire is available in both English and Spanish.

Obtaining questionnaires — You may photocopy this questionnaire or download from the Texas Childhood Lead Poisoning Prevention Program site at http://www.dshs.state.tx.us/lead.

Texas Childhood Lead Poisoning Prevention Program
Epidemiology and Surveillance Unit • Department of State Health Services
1100 West 49th Street • Austin, TX 78756 • Fax 1-512-458-7699

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C.38 Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure

Patient's Name: ______________________________

Date Questionnaire Administered: ______________________________

ABBREVIATED PARENT QUESTIONNAIRE

RISK ASSESSMENT FOR LEAD EXPOSURE

1. Has your residence changed since your child's last lead screen?

   YES ☐ NO ☐

2. Has your child changed babysitters or daycare centers since the last lead screen?

   YES ☐ NO ☐

3. Has anyone in your home changed jobs since your child's last lead screen?

   YES ☐ NO ☐

   If yes, new job is: ______________________________

4. Has anyone in your home been:

   Re-loading bullets
   Making pottery
   Making stained glass
   Refinishing furniture
   Working on autos
   Going to a firing range

   YES ☐ NO ☐

5. Since the last lead screen, has your child been around any home remodeling or houses that are having the paint removed?

   YES ☐ NO ☐

6. Are you giving your child medications produced outside the United States, like Greta or Azarcón?

   YES ☐ NO ☐

07/05

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C.39 Detailed Parent Questionnaire: Risk Assessment for Lead Exposure (Spanish)

Nombre del paciente: ____________________

Fecha de administración del cuestionario: ____________________

CUESTIONARIO ABREVIADO PARA LOS PADRES

EVALUACIÓN DE RIESGO POR EXPOSICIÓN AL PLOMO

1. ¿Se ha cambiado de domicilio desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ☐ NO ☐

2. ¿Ha cambiado a su hijo(a) de niñera o de guardería desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ☐ NO ☐

3. ¿Alguna de las personas que vive en su casa ha cambiado de trabajo desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ☐ NO ☐

   Si contestó "sí," escriba el nombre del nuevo trabajo: ____________________

4. Alguna persona en su casa ha estado:

   Recargando balas en armas
   Trabajando con cerámica
   Trabajando con vitrales
   Trabajando en el terminado de muebles
   Trabajando en automóviles
   Yendo a un campo de tiro

   SÍ ☐ NO ☐

5. ¿Desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre ha estado él en cualquier casa que se esté remodelando o casas donde estén quitando la pintura?

   SÍ ☐ NO ☐

6. ¿Le está dando a su hijo(a) algún medicamento producido fuera de los Estados Unidos, tales como Greta o Azarcón?

   SÍ ☐ NO ☐

07/05

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C.40 San Antonio State Chest Hospital Cervical Cancer Cytology Laboratory

Women's Health Laboratories
2303 S.E. Military Dr., Bldg 533, Suite #1
San Antonio, TX 78223-3597
Phone (210) 531-4596 Toll-Free (888) 440-5002
FAX (210) 531-4506
CLIA: 45D0911298 / CAP: 2140102

Please Print Legibly

Patient Name Last	First	M.I.	Date of Birth
Street Address	City	State	Zip
Patient Phone	Patient ID	SSN	
Sex: Female Male	Race: W H B AI Asian Other:		
Clinic Code	Clinic: FP MTY AH DYS THS STD CD TB	Ordering Clinician	
Date Collected (time if applicable)	ICD9 #1 / ICD9 #2 / ICD9 #3	Attending Physician (if applicable)	

Clinical Consultant Available

Patient Funding:
Title V Title X Title XX
THS BCCCP TB Elim
SDI STD/HIV Indigent
Medicaid Medicare IPP
Recipient Number:___________________
Service Contract Bill Patient
Private Insurance. Please include copy of patient's insurance card, front and back.

CLINICAL HISTORY / NARRATIVE: ______________________________

LMP:____________	High Risk	Prev Abn	Hormone	Pregnant	Post Partum	PMP
Cryo	Hysterectomy	Prior Bx	LEEP	Laser	Chemo	IUD
Tuberculosis	Diabetes	Anemia	Hypertension	Hx of STD	Tubal Ligation	Colposcopy

Surgical Pathology: Biopsy 88305 Leep 88307 **(please include colposcopy or exam form)** Leep at _____________ Leep at ________
Cx Bx at ________ Cx Bx at ________ ECC EMB Other ________________ Other __________

Cytology

Test	Code
❑ Pap Smear *	88150
❑ Liquid Based Pap *	88142
❑ NonGyn Cytology *	88160

*** For all above please state Site(s):**
❑ Cervix ❑ Endocervix
❑ Vagina
❑ Other:

HPV Testing

Test	Code
❑ HPV	87621
❑ HPV reflex	87621

STD Screen

Test	Code
❑ DNA probe CT/GC	87490/87590
❑ Amp DNA CT/GC	87491/87591
❑ HSV I&II Rpd Mtd*	87252/87274

*** For above please state Site:**

Panels ***See back for Panels***

Test	Code
❑ Basic Metabolic Panel	80048
❑ Comprehensive Panel	80053
❑ Electrolyte Panel	80051
❑ Acute Hepatitis Panel	80074
❑ Hepatic Function	80076
❑ Lipid Panel	80061
❑ High Risk Panel	custom
❑ OB Panel	80055
❑ OB Panel w/out CBC	custom
❑ Iron Panel	custom
❑ Triple Screen (attach MSAFP form)	
❑ AFP Serum	82105
❑ ßhCG Quantitative	84702
❑ Free Estriol	82677

Drug Screen: ❑ 3test ❑ 7test
❑ Glucose. Gest.2spec. 82947/82950

Test	Code
❑ Glucose,2 spec.	82950
❑ Glucose,3 spec.	82951
❑ Glucose,4 spec.	82951/82952
❑ Glucose,5 spec.	82951/82952 x2

Microbiology

Test	Code
❑ Occult Blood, Stool	82270
❑ Urine Culture clean catch	87086
❑ Bacteria Culture *	87070
❑ Gram Stain *	87205
❑ Grp B Strep DNA probe *	87149
❑ Acid Fast Smear *	87206
❑ Acid Fast Culture *	87015/87116
❑ KOH Exam *	87210/87220
❑ Fungal Culture *	87101/87102

*** For all above please state Site:**

Note: If indicated, ID & Sensitivity will be performed with additional charges.

Hematology

Test	Code
❑ CBC w/Auto Diff	85025
❑ CBC Manual Diff	85023
❑ Hemoglobin	85018
❑ Hematocrit	85014
❑ Reticulocyte count	85044
❑ Sickle cell screen	85660

Chemistry

Test	Code
❑ Albumin	82040
❑ Alkaline Phos	84075
❑ Amylase	82150
❑ ALT	84460
❑ AST	84450
❑ Bilirubin, Direct	82248
❑ Bilirubin, Total	82247
❑ BUN	84520

Chemistry (continued)

Test	Code
❑ Calcium	82310
❑ Cholest, HDL	83718
❑ Cholest, Tot.	82465
❑ Creatinine	82565
❑ Ferritin	82728
❑ FSH	83001
❑ Glu, Fasting	82947
❑ Glu, Random	82947
❑ Glu, 1hr	82947
❑ Glu, 2hr pp	82947
❑ HCG, Quant	84702
❑ HCG, Qual	84703
❑ Iron, Total	83540
❑ Iron, TIBC.	83550
❑ LH	83002
❑ Potassium	84132
❑ Prolactin	84146
❑ Sodium	84295
❑ T3, Uptake	84479
❑ Thyroxin (T4)	84436
❑ Triglycerides	84478
❑ TSH	84443
❑ Uric Acid	84550

Transfusion Medicine

Test	Code
❑ ABO, Rh	86900/86901
❑ Antibody Screen	86850
❑ Direct Coombs	86880
❑ Cord Blood	

TB Elimination Testing

Test	Code
❑ LFT – 4 Test	custom
❑ LFT – 6 Test	custom

Other Testing

❑
❑
❑
❑

Reference

Test	Code
❑ CEA	82378
❑ Hgb A1C	83036
❑ PSA	84153
❑ T3, Total	84480
❑ T4, Free	84439
❑ HSV I & II Ab serum	86695/86696

Immunology

Test	Code
❑ ANA	86255
❑ Hep A Ab, IgM	86709
❑ Hep A Ab, Total	86708
❑ Hep Bs Ab	86706
❑ Hep Bs Ag	87340
❑ Hep Bc Ab	86704
❑ Hep C Ab	86803
❑ HIV, Oral	86701
❑ HIV, Serum	86701
❑ WesternBlot (reflex)	86689
❑ RPR w/reflex IgG	86592
❑ Rubella Ab	86762
❑ Rheumatoid Factor	86430
❑ Mono Screen	86308

Urinalysis

Test	Code
❑ Urinalysis w/o Scope	81003
❑ UA w/Scope & Culture If indicated	81000/87086
❑ Urine Culture	87086

FOR LAB USE ONLY:

Red	___	Urine Cup	___
GrayTop	___	Gray UR	___
Yellow	___	Yellow UR	___
Purple	___	Cltr Swab	___
Serum	___	Digene	___
SST	___	SurePath	___
Other	___	Amp	___

Clinic Name & Address:

WHL-Public500(M47) Revised: 06/04

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Laboratory Protocols

CBC w/Auto Diff Reflex:
- Abnormal CBC: Manual Diff reported
- A CBC is abnormal when it meets the approved criteria. (Criteria available upon request.)

Urinalysis Reflex:
- Abnormal UA: microscopic and /or confirmatory testing performed when abnormal results are observed for protein, nitrite, leukocyte esterase and/or blood.

Urine Culture Reflex:
Abnormal UA with positive nitrite, leukocyte esterase, >5 WBC's or >2+ bacteria: Culture performed.

TSH Reflex:
- Abnormal TSH (<0.1 or >10.0 mIU/ml): Free T4 performed.

RPR:
- Positive Syphilis IgG AB, AB Index and RPR quantitative (titer).

Rheumatoid Factor Reflex:
- Positive RA Factor: titer performed.

HIV Reflex:
- Positive HIV: Western Blot performed.

Hepatitis B Surface Ag (HBsAg) Reflex:
- HbsAg borderline or positive samples will be confirmed by neutralization.

Hepatitis B Surface Ab (HbsAB):
- Positive: Semi-quantitative value reported for immune status.

Antibody Screen Reflex:
- Positive AB Screen: antibody identification will be performed.

Direct Coombs (DAT) Reflex:
- Positive DAT: IgG, C3 testing.

Cryptococci Reflex:
- Positive: Titer performed.

ANA Screen Reflex:
- Positive: anti-DNA testing performed (reference lab).

Panels

80048 Basic Metabolic Panel (BMP)
Calcium
CO2
Chloride
Creatinine
Glucose
Potassium
Sodium
Urea Nitrogen (BUN)

80053 Comprehensive Metabolic Panel (CMP)

Albumin	Calcium
Alk. Phosphatase	ALT (SGPT)
Bilirubin (total)	AST (SGOT)
CO2	Sodium
Chloride	Potassium
Creatinine	Total Protein
Glucose	Urea Nitrogen (BUN)

80051 Electrolyte Panel
Sodium
Potassium
Chloride
CO2
Anion Gap (Calculated)

80074 Acute Hepatitis Panel
Hepatitis A antibody, IgM
Hepatitis B core antibody, IgM
Hepatitis B Surface antigen
Hepatitis C antibody

80076 Hepatic Function Panel
Albumin
Bilirubin (total)
Bilirubin (direct)
Alk. Phosphatase
Total Protein
ALT (SGPT)
AST (SGOT)

80061 Lipid Panel
Cholesterol
HDL
Triglycerides

Custom High Risk Panel

Glucose	**82947**
Cholesterol	**82465**
Triglycerides	**84478**

80055 OB Panel
CBC w/diff
Hepatitis B surface antigen
Rubella antibody
RPR
Antibody Screen, RBC
ABO/Rh

Custom OB Panel without CBC
Hepatitis B surface antigen
Rubella antibody
RPR
Antibody Screen, RBC
ABO/Rh

Custom Iron Panel

Iron, Total	**83550**
TIBC	**83550**
Transferrin Sat.	
Ferritin	**82728**

80100 Urine Drug Screen Panel 3
Cocaine
THC
Opiates

80100 Urine Drug Screen Panel 7

Amphetamines	Methadone
Barbiturates	Opiates
Benzodiazepines	THC
Cocaine	

82947/82950 Glucose, Gest. 2 specimens
Glucose, Fasting BS
Glucose, 1hr

82950 Glucose, 2 specimens
Glucose, Fasting BS
Glucose, 2hr

82951 Glucose, 3 specimens
Glucose, Fasting BS
Glucose, 1hr
Glucose, 2hr

82951/82952 Glucose, 4 specimens
Glucose, Fasting BS
Glucose, 1hr
Glucose, 2hr
Glucose, 3hr

82951/82952 x2 Glucose, 5 specimens

Glucose, Fasting BS	
Glucose, 1hr	Glucose, 3hr
Glucose, 2hr	Glucose, 4hr

Triple Screen

AFP Serum	**82105**
hCG Quantitative	**84702**
Free Estriol	**82677**

Custom LFT 4 (TB Elimination)

ALT (SGPT)	**84460**
AST (SGOT)	**84450**
Bilirubin, Total	**82247**
Alk. Phosphatase	**84075**

Custom LFT 6 (TB Elimination)

ALT (SGPT)	**84460**
AST (SGOT)	**84450**
Bilirubin, Total	**82247**
Alk. Phosphatase	**84075**
BUN	**84520**
Creatinine	**82565**

Note: *Medicare does not pay for routine screening tests (except PAP smears and some occult blood tests, please see current Medicare guidelines for approved screening intervals). Medicare will only pay for tests that are medically necessary for the diagnosis or treatment of the patient. The ordering physician must obtain a signed Advance Beneficiary Notice, (ABN), prior to submitting specimen to the laboratory if it is believed that Medicare is likely to deny payment. Components of panels may be ordered individually and billed separately to ensure physicians have adequate choice when making decisions regarding which tests are medically necessary for an individual patient. Physicians shall provide ICD-9 codes for all tests or panels in the space provided. The Office of the Inspector General takes the position that a physician who orders medically unnecessary tests may be subject to civil penalties.*

Microbiology CPT codes for additional procedures (such as susceptibility testing, sero-typing, etc) will be billed in addition to primary culture codes when appropriate.

The M47 test requisition form is only a partial list of tests available. If a test you require is not listed on the requisition form please call 1-888-440-5002 for information.

WHL-Public500 (M47) Page2 Revised: 6/04

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C.41 Specimen Submission Form G-1B, Biochemistry, Instructions (2 Pages)

March 2006 Page 1 of 2

Biochemistry and Genetics

G-1B Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number, name, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race, ethnicity, date of birth (DOB), age, sex, social security number (SSN), pregnant, date of collection, time of collection, collected by, medical record number, ICD diagnosis code, and previous DSHS lab specimen number.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). These fields must be completed.

Date of birth (DOB) and Age: Please list both the date of birth and age of the patient. If date of birth is not available, give the age of the patient and tell us whether the age is in days, months, or years.

Pregnant: If patient is a female, please indicate if she is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

Date of collection/Time of collection: Indicate the date and time the specimen was collected from the patient and who collected the specimen. Do not give the date the specimen was sent to DSHS. If the Date of Collection field is not completed, the specimen will be rejected.

Medical record number: Provide the identification number for matching purposes.

ICD diagnosis code: Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

Previous DSHS specimen lab number: If this patient has had a previous specimen submitted to the DSHS Laboratory, please provide the DSHS lab specimen number.

Section 3. SPECIMEN TYPE

Specimen type: Please indicate the type of specimen that you are submitting.

Section 4. CLINICAL CHEMISTRY

Test Requested: Check or specify the specific test(s) to be performed by the Laboratory Services Section.

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Reflex testing (antibody (Ab) identification (ID), antigen (Ag) type, and titer) will be performed on positive antibody screens.

Hyperlipidemia and Glucose: _The time and date the specimen is removed from FREEZER **must** be provided to determine specimen acceptability. Please circle FREEZER._

RhoGAM (HDN) Screening: _The time and date the specimen is removed from the REFRIGERATOR **must** be provided if the specimen will not be received within 24 hours. Please circle REFRIGERATOR. **Do not freeze specimens for HDN testing**._

Section 5. PHYSICIAN INFORMATION

Physician's name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 6. PAYOR SOURCE

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided**.**

Indicate the party that will receive the bill.

Medicaid or Medicare:
- Mark the appropriate box, write in the Medicaid or Medicare number, and
- Supply a copy of the Medicaid or Medicare card.

Private Insurance:
- Mark the appropriate box,
- Supply a copy of the front and back of the insurance card, and
- Complete all fields on the form that have an asterisk (*).

DSHS Program:
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare, except for THSteps.
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.
- For THSteps, check *both THSteps **and** Medicaid* as the Payor Source. Supply a copy of the Medicaid card.
- For Title V, check either Family Planning or MCH.
- For BID, EIP, and ELC programs, check the "Other" box and list the program's name in the space provided.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

Section 7. NEWBORN REFERENCE TESTING

Test Requested: Check or specify the specific test to be performed by the Laboratory Services Section.

Section 8. DNA STUDIES

Select the requested test. The genes analyzed are phenylalanine hydroxylase for phenylketonuria testing and β-Globin for hemoglobin testing.

For phenylketonuria tests, select either Full Mutation Analysis or Carrier Mutation Analysis.

- Select Full Mutation Analysis to identify any possible mutations.
- Select Carrier Mutation Analysis to test specifically for the mutations already identified in a family member. If submitting a specimen for carrier mutation analysis, please provide the following information on the back of the form: *full name of family member(s) who have been tested, their test results, their date of birth, and relationship to the patient*. In addition, *draw a pedigree* showing the relationship and clinical diagnosis of each family member participating in the study.

For all hemoglobin DNA studies, select the Hemoglobin DNA Study box and write the name of the requested test(s) on the line. Available tests include:

- Beta Globin 6 mutation panel (Hb S, Hb C, Hb E, Hb D, beta-thalassemias -29 & -88)
- Beta Globin 5 mutation panel (Hb S, Hb C, Hb E, beta-thalassemias -29 & -88)
- Hemoglobin S&C mutation test
- Hemoglobin E mutation test
- Hemoglobin D mutation test
- Beta thalassemia -29 and -88 mutation test
- Beta Globin sequencing (from -105 of cap site to IVS-1-60)
- Beta Globin sequencing (from -105 of cap site to IVS-1-60) added to other test

---

For specific test instructions and information about tube types, see the Laboratory Services Section Manual of Reference Services on our web site at http://www.dshs.state.tx.us/lab/.

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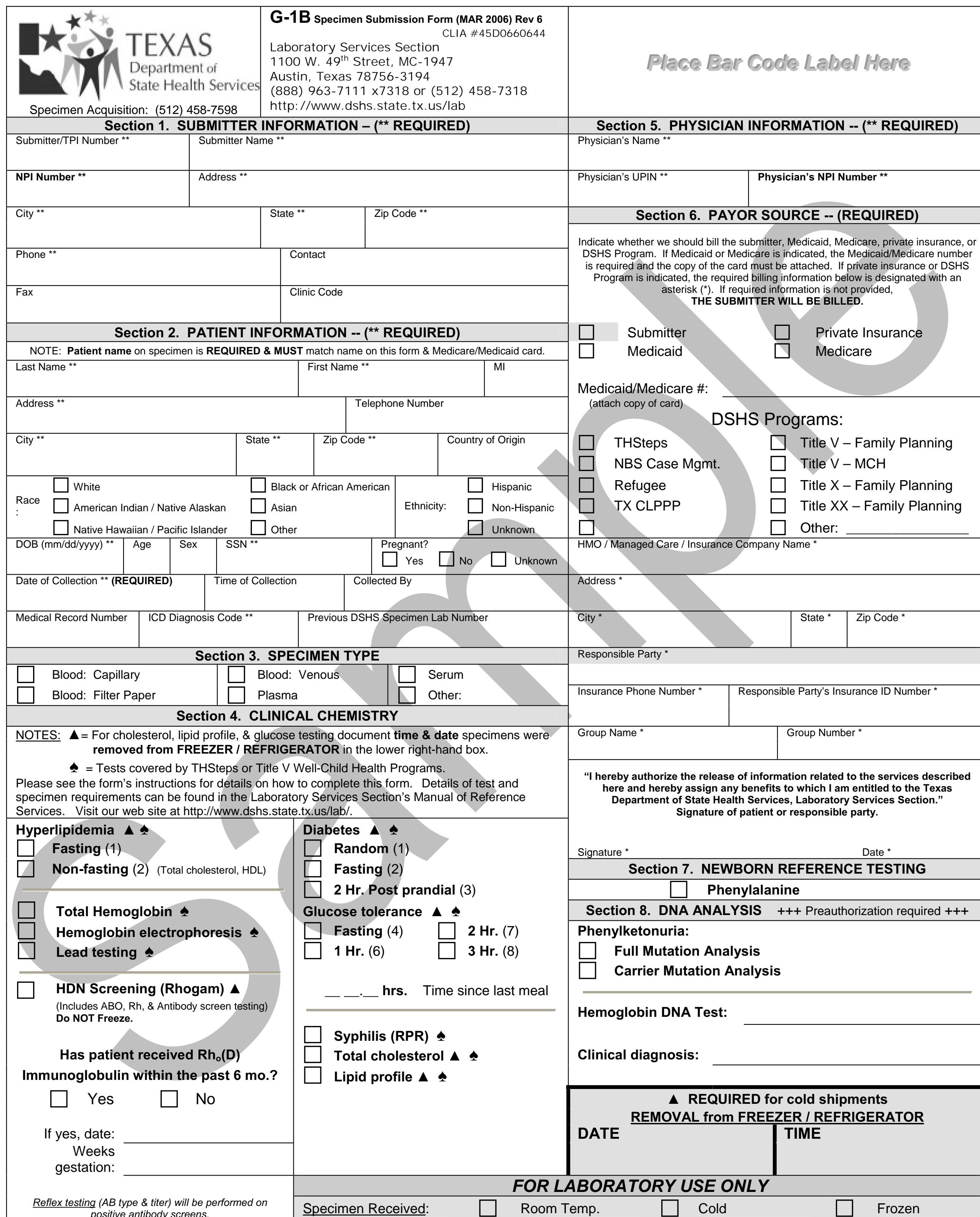
C.42 Specimen Submission Form G-1B, Biochemistry



TEXAS Department of State Health Services

Specimen Acquisition: (512) 458-7598

G-1B Specimen Submission Form (MAR 2006) Rev 6
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address **
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form & Medicare/Medicaid card.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown

Date of Collection ** (REQUIRED) | Time of Collection | Collected By

Medical Record Number | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number

Section 3. SPECIMEN TYPE

☐ Blood: Capillary ☐ Blood: Venous ☐ Serum
☐ Blood: Filter Paper ☐ Plasma ☐ Other:

Section 4. CLINICAL CHEMISTRY

NOTES: ▲= For cholesterol, lipid profile, & glucose testing document **time & date** specimens were **removed from FREEZER / REFRIGERATOR** in the lower right-hand box.

♠ = Tests covered by THSteps or Title V Well-Child Health Programs.

Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

Hyperlipidemia ▲ ♠
☐ **Fasting** (1)
☐ **Non-fasting** (2) (Total cholesterol, HDL)

☐ **Total Hemoglobin ♠**
☐ **Hemoglobin electrophoresis ♠**
☐ **Lead testing ♠**

☐ **HDN Screening (Rhogam) ▲**
(Includes ABO, Rh, & Antibody screen testing)
Do NOT Freeze.

Has patient received Rh_o(D) Immunoglobulin within the past 6 mo.?
☐ Yes ☐ No

If yes, date: ______
Weeks gestation: ______

Reflex testing (AB type & titer) will be performed on positive antibody screens.

Diabetes ▲ ♠
☐ **Random** (1)
☐ **Fasting** (2)
☐ **2 Hr. Post prandial** (3)

Glucose tolerance ▲ ♠
☐ **Fasting** (4) ☐ **2 Hr.** (7)
☐ **1 Hr.** (6) ☐ **3 Hr.** (8)

__ __.__ **hrs.** Time since last meal

☐ **Syphilis (RPR) ♠**
☐ **Total cholesterol ▲ ♠**
☐ **Lipid profile ▲ ♠**

Section 5. PHYSICIAN INFORMATION -- (REQUIRED)**

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 6. PAYOR SOURCE -- (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required and the copy of the card must be attached. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #:
(attach copy of card)

DSHS Programs:
☐ THSteps ☐ Title V – Family Planning
☐ NBS Case Mgmt. ☐ Title V – MCH
☐ Refugee ☐ Title X – Family Planning
☐ TX CLPPP ☐ Title XX – Family Planning
☐ ☐ Other: ______

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Responsible Party *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section." Signature of patient or responsible party.

Signature * | Date *

Section 7. NEWBORN REFERENCE TESTING
☐ **Phenylalanine**

Section 8. DNA ANALYSIS +++ Preauthorization required +++

Phenylketonuria:
☐ **Full Mutation Analysis**
☐ **Carrier Mutation Analysis**

Hemoglobin DNA Test: ______

Clinical diagnosis: ______

▲ REQUIRED for cold shipments
REMOVAL from FREEZER / REFRIGERATOR
DATE | **TIME**

FOR LABORATORY USE ONLY
Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

C

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C.43 Specimen Submission Form G-1B, Biochemistry, Spanish Instructions (3 Pages)

Marzo de 2006 Página 1 de 3

Bioquímica y genética

Instrucciones del formulario de remisión de muestras G-1B

Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TP y nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: a partir del 23 de mayo de 2007, todos los proveedores de salud deberán usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original provisto por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número telefónico, nombre y número de fax de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluido el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, país de origen, raza, etnia, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, fecha de obtención, hora de obtención, quién la obtuvo, número de expediente médico, código diagnóstico de ICD y número previo del laboratorio de muestras del DSHS.

NOTA: el nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Se deben rellenar esos campos.

Fecha de nacimiento y edad: indique tanto la fecha de nacimiento como la edad del paciente. Si la fecha de nacimiento no está disponible, proporcione la edad del paciente y díganos si la edad es en días, meses o años.

Si es mujer y está embarazada: si el paciente es mujer, sírvase indicar si está embarazada marcando ya sea "Sí", "No" o "Se desconoce". El embarazo puede afectar algunos resultados de pruebas.

Fecha de obtención/hora de obtención: indique la fecha y hora en que se obtuvo la muestra del paciente y quién obtuvo la muestra. No proporcione la fecha en que se envió la muestra al DSHS. Si no se rellena el campo Fecha de obtención, se rechazará la muestra.

Núm. de expediente médico: proporcione el número de identificación para propósitos de cotejo.

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Código diagnóstico de ICD: indique el código diagnóstico que ayudaría a procesar, identificar y facturar la muestra.

Número previo del laboratorio de muestras del DSHS: si se ha remitido una muestra del paciente anteriormente al laboratorio del DSHS, sírvase proporcionar el número de muestra del laboratorio del DSHS.

Sección 3. TIPO DE MUESTRA

Tipo de muestra: sírvase indicar el tipo de muestra que remite.

Sección 4. QUÍMICA CLÍNICA

Prueba solicitada: marque o especifique la o las pruebas específicas a realizar la Sección de Servicios de Laboratorio.

Se realizarán pruebas secundarias (identificación (ID) de anticuerpos (Ab), tipo de antígenos (Ag) y titulación) a las pruebas de anticuerpos positivas.

Hiperlipemia y glucosa: *se **debe** proporcionar la fecha y hora de remoción de la muestra del CONGELADOR para determinar la aceptabilidad de la muestra. Sírvase encerrar en un círculo la palabra CONGELADOR.*

Prueba de enfermedad hemolítica perinatal (EHP) (RhoGAM): *se **debe** proporcionar la fecha y hora de remoción de la muestra del REFRIGERADOR si no se recibirá la muestra en 24 horas. Sírvase encerrar en un círculo la palabra REFRIGERADOR. **No congele las muestras para la prueba de HDN**.*

Sección 5. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número de identificación único del médico (Unique Physician ID Number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esta información para facturar a Medicare y al seguro.

Sección 6. PAGADOR

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida**.**

Indique la parte que recibirá la factura.

Medicaid o Medicare:

- Marque la casilla correspondiente, escriba el número de Medicaid o Medicare y
- Provea una copia de la tarjeta de Medicaid o Medicare.

Seguro privado:

- Marque la casilla correspondiente,
- Provea una copia del frente y reverso de la tarjeta de seguro y
- Rellene todos los campos del formulario que tengan asterisco (*).

Programa del DSHS:

- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare, a menos que sea Pasos Sanos de Texas.
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación en el programa, marque el programa del DSHS correspondiente.
- Si es Pasos Sanos de Texas, marque tanto *Pasos Sanos de Texas **como** Medicaid* como pagadores. Proporcione una copia de la tarjeta de Medicaid.
- Si es el título V, marque ya sea Planificación familiar o MCH.
- Si son programas de BID, EIP y ELC, marque la casilla "Otro" e indique el nombre del programa en el espacio provisto.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

Sección 7. PRUEBAS DE REFERENCIA DE RECIÉN NACIDOS

Prueba solicitada: marque o especifique la prueba específica que ha de realizar la Sección de Servicios de Laboratorio.

Sección 8. ESTUDIOS DE ADN

Seleccione la prueba solicitada. Se analizan los genes de fenilalanina hidroxilasa en la prueba de fenilcetonuria y β-globina en pruebas de hemoglobina.

Para las pruebas de fenilcetonuria, seleccione ya sea el Análisis de mutación completa o Análisis de mutación de portador.

- Seleccione Análisis de mutación completa para identificar toda mutación posible.
- Seleccione Análisis de mutación de portador para la prueba específica de mutaciones ya identificadas en un familiar. Si remite una muestra para análisis de mutación de portador, sírvase proporcionar la siguiente información al reverso del formulario: *el nombre completo del o los familiares a quienes se ha hecho la prueba, los resultados*

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de sus pruebas, su fecha de nacimiento y parentesco con el paciente. Además, *dibuje un árbol genealógico* que denote el parentesco y diagnóstico clínico de cada familiar que participe en el estudio.

Para todos los estudios de ADN de hemoglobina, seleccione la casilla Estudio de ADN de hemoglobina y escriba en la línea el nombre de la o las pruebas solicitadas. Los análisis disponibles incluyen:

- Panel de mutación de betaglobina 6 (Hb S, Hb C, Hb E, Hb D, betatalasemia 29 y 88)
- Panel de mutación de betaglobina 5 (Hb S, Hb C, Hb E, betatalasemia 29 y 88)
- Prueba de mutación de hemoglobina S y C
- Prueba de mutación de hemoglobina E
- Prueba de mutación de hemoglobina D
- Prueba de mutación de betatalasemia 29 y 88
- Secuenciación de betaglobina (del punto inicial 105 a IVS-1 posición 60)
- Secuenciación de betaglobina (del punto inicial 105 a IVS-1 posición 60) agregada a otra prueba

---

Puede encontrar instrucciones de pruebas e información específica sobre los tipos de probetas de ensayo en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en nuestro sitio web en http://www.dshs.state.tx.us/lab/.

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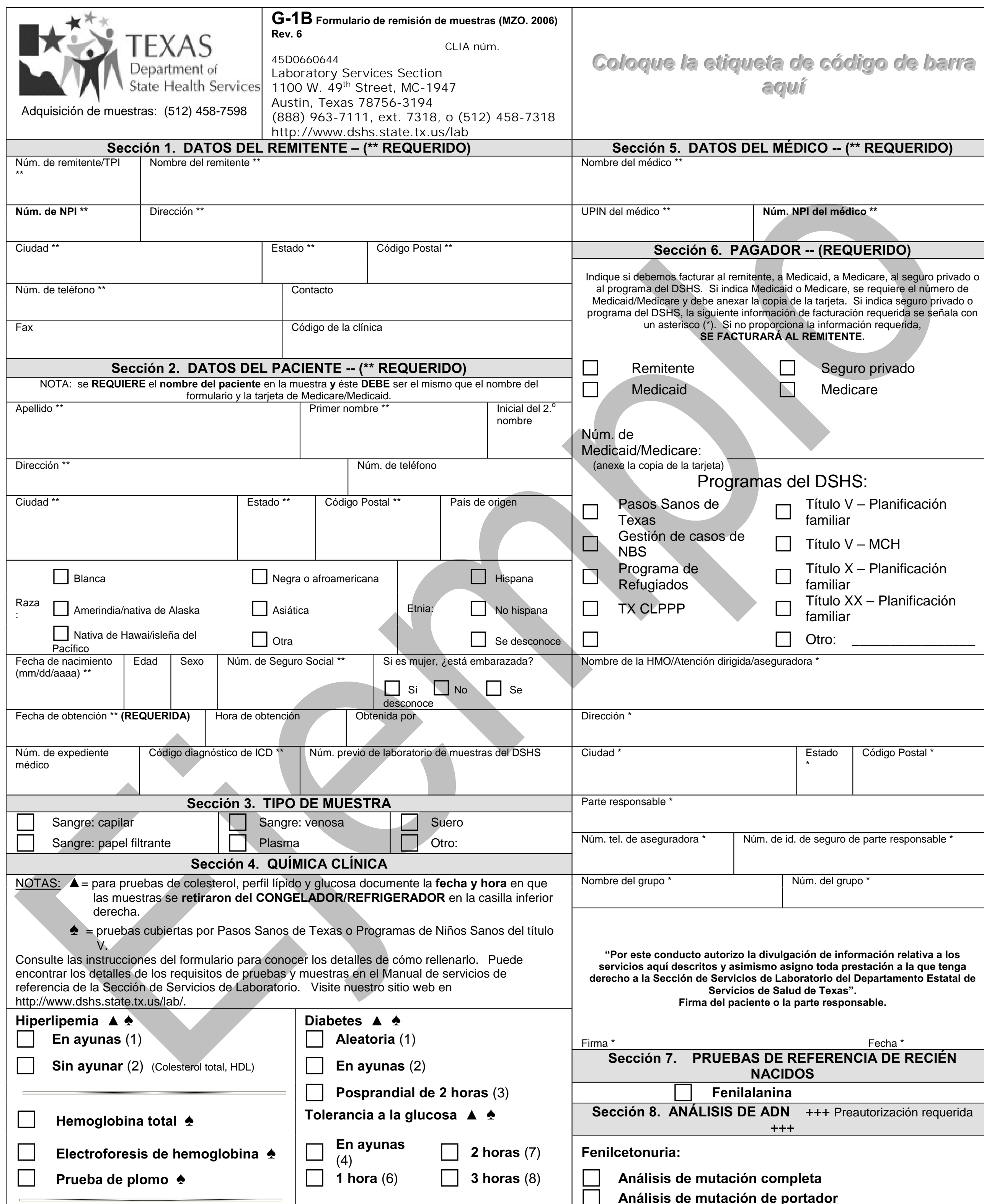
C.44 Specimen Submission Form G-1B, Biochemistry (Spanish, 2 Pages)



TEXAS Department of State Health Services

Adquisición de muestras: (512) 458-7598

G-1B Formulario de remisión de muestras (MZO. 2006) Rev. 6
CLIA núm. 45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente/TPI ** | Nombre del remitente **
Núm. de NPI ** | Dirección **
Ciudad ** | Estado ** | Código Postal **
Núm. de teléfono ** | Contacto
Fax | Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario y la tarjeta de Medicare/Medicaid.

Apellido ** | Primer nombre ** | Inicial del 2.º nombre
Dirección ** | Núm. de teléfono
Ciudad ** | Estado ** | Código Postal ** | País de origen

Raza: ☐ Blanca ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra

Etnia: ☐ Hispana ☐ No hispana ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) ** | Edad | Sexo | Núm. de Seguro Social ** | Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Fecha de obtención ** (REQUERIDA) | Hora de obtención | Obtenida por

Núm. de expediente médico | Código diagnóstico de ICD ** | Núm. previo de laboratorio de muestras del DSHS

Sección 3. TIPO DE MUESTRA

☐ Sangre: capilar ☐ Sangre: venosa ☐ Suero
☐ Sangre: papel filtrante ☐ Plasma ☐ Otro:

Sección 4. QUÍMICA CLÍNICA

NOTAS: ▲= para pruebas de colesterol, perfil lípido y glucosa documente la **fecha y hora** en que las muestras se **retiraron del CONGELADOR/REFRIGERADOR** en la casilla inferior derecha.

♠ = pruebas cubiertas por Pasos Sanos de Texas o Programas de Niños Sanos del título V.

Consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

Hiperlipemia ▲ ♠
☐ **En ayunas** (1)
☐ **Sin ayunar** (2) (Colesterol total, HDL)

☐ **Hemoglobina total ♠**
☐ **Electroforesis de hemoglobina ♠**
☐ **Prueba de plomo ♠**

Diabetes ▲ ♠
☐ **Aleatoria** (1)
☐ **En ayunas** (2)
☐ **Posprandial de 2 horas** (3)

Tolerancia a la glucosa ▲ ♠
☐ **En ayunas** (4) ☐ **2 horas** (7)
☐ **1 hora** (6) ☐ **3 horas** (8)

Sección 5. DATOS DEL MÉDICO -- (REQUERIDO)**

Nombre del médico **
UPIN del médico ** | **Núm. NPI del médico ****

Sección 6. PAGADOR -- (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare y debe anexar la copia de la tarjeta. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*). Si no proporciona la información requerida, **SE FACTURARÁ AL REMITENTE.**

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: (anexe la copia de la tarjeta)

Programas del DSHS:

☐ Pasos Sanos de Texas ☐ Título V – Planificación familiar
☐ Gestión de casos de NBS ☐ Título V – MCH
☐ Programa de Refugiados ☐ Título X – Planificación familiar
☐ TX CLPPP ☐ Título XX – Planificación familiar
☐ ☐ Otro: ________________

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad * | Estado * | Código Postal *
Parte responsable *
Núm. tel. de aseguradora * | Núm. de id. de seguro de parte responsable *
Nombre del grupo * | Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas". Firma del paciente o la parte responsable.

Firma * Fecha *

Sección 7. PRUEBAS DE REFERENCIA DE RECIÉN NACIDOS

☐ **Fenilalanina**

Sección 8. ANÁLISIS DE ADN +++ Preautorización requerida +++

Fenilcetonuria:
☐ **Análisis de mutación completa**
☐ **Análisis de mutación de portador**

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☐ **Prueba de enfermedad hemolítica perinatal (EHP) (Rhogam) ▲** (Incluye prueba de ABO, Rh y anticuerpos) **NO se congele.** **¿Recibió el paciente inmunoglobulina Rh_o(D) en los últimos 6 meses?** ☐ Sí ☐ No Si "sí", la fecha: ______ Semanas de gestación: ______ *Se realizarán pruebas secundarias (tipo Ab y de titulación) a las pruebas de anticuerpos positivas.*	__ __.__ **horas.** Tiempo desde el último alimento. ☐ **Sífilis (RPR) ♠** ☐ **Colesterol total ▲ ♠** ☐ **Perfil de lípidos ▲ ♠**	**Prueba de ADN de hemoglobina:** ______ **Diagnóstico clínico:** ______ **▲ REQUERIDO para envíos fríos** **REMOCIÓN del CONGELADOR/REFRIGERADOR** **FECHA** **HORA**
	FOR LABORATORY USE ONLY Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen	

Ejemplo

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C.45 Specimen Submission Form G-2A, Serology and Virology, Instructions (2 Pages)

March 2006 Page 1 of 2

G-2A Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number, name, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, telephone number, date of birth (DOB), age, sex, social security number (SSN), pregnant, race, ethnicity, medical record number, ICD diagnosis code, country of origin, date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label. *For anonymous HIV testing, indicate only the state, zip code, date of birth, and patient ID number.*

Patient Name: If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen form must match the name on the insurance card.

Date of birth (DOB) and Age: Please list both the date of birth and age of the patient. If date of birth is not available, give the age of the patient and tell us whether the age is in days, months, or years.

Pregnant: If patient is a female, please indicate is she is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

Date of Collection/Time of Collection: Indicate the date and time the specimen was collected from the patient or other source and who collected the specimen. Do not give the date the specimen was sent to DSHS. If the Date of Collection field is not completed, the specimen will be rejected.

Medical Record # / Alien # / CUI: Provide the identification number for matching purposes. For HIV screening, this number may be the eight-digit CDC number assigned to the patient. The CDC form sticker may be placed anywhere on the lower part of the form, as long as it does not obscure any tests ordered. CUI is the Clinic Unique Identifier number.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, provide the DSHS specimen lab number.

ICD Diagnosis Code, Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable): Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

Inpatient or Outpatient (if applicable): Indicate if the patient is currently admitted to a hospital (required for TB patients).

Outbreak/Surveillance (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box. If this form is being submitted for flu surveillance, the following patient information is required: Date of Onset, Date of Collection, Diagnosis/Symptoms, and Risk. Dates must be entered into the **Date of Onset** and **Date of Collection** boxes. In the **Diagnosis/Symptoms** box, list all the symptoms from the following list that apply: 1) malaise, 2) sore throat, 3) nasal congestion, 4) fever, 5) chills, 6) cough, 7) headache, 8) myalgia. In the **Risk** box, indicate whether the patient received the flu vaccine this season and the date given.

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Section 3. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate. Tests requiring Acute/Convalescent sera and dates are indicated with a '§' in the testing area of the form.

Section 4. PHYSICIAN INFORMATION

Physician's Name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 5. PAYOR SOURCE

Indicate the party that will receive the bill.

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or multiple payor boxes are checked**.**

Checking Medicaid or Medicare:

- Mark the appropriate box.
- Write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the card, the submitter will be billed.

Checking Private Insurance:

- Mark the appropriate box.
- Complete all fields on the form that have an asterisk (*).
- If the private insurance information is not provided on the specimen form, the submitter will be billed.

Checking a DSHS Program:

- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare, except for THSteps.
- For THSteps, check THSteps as the Payor Source. Write the patient's Medicaid number in the appropriate field.
- For Title V, must check either Family Planning or MCH (Maternal & Child Health).
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.
- For anonymous HIV/STD testing, check the HIV/STD Program as Payor Source. The sections for HMO/Managed care/Insurance company name, Responsible Party, Signature, and Date information are not required.
- For BIDS (Border & Infectious Disease Surveillance), EIP (Emerging Infections Program), and ELC (Epidemiology & Laboratory Capacity) programs, check the "Other" box and list the program's name in the space provided.

HMO / Managed Care / Insurance Company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed.

Responsible Party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

TEST

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Reference Serology/Immunology" or "Virology" or "HIV/HCV Screening". For specific test instructions, see the Laboratory Services Section Manual of Reference Services.

6. REFERENCE SEROLOGY/IMMUNOLOGY

If acute viral hepatitis is suspected based on the clinical symptoms and elevated serum amino transferase (ALT/AST), order Hepatitis Acute Panel which consists of 4 tests including Hepatitis B surface Ag (HBsAg), Hepatitis B core IgM (anti-HBc IgM), Hepatitis A IgM (anti-HAV), and Hepatitis C IgG (anti-HCV).

Fungal panel includes:

Histoplasma capsulatum (Mycelial phase)
Histoplasma capsulatum (Yeast phase)
Coccidioides immitis
Blastomyces dermatitidis

Aspergillosis testing includes:

Aspergillus flavus
Aspergillus fumigatus
Aspergillus niger
Aspergillus terreus

7. HIV/HCV SCREENING

Justification: Justification is required under 'Western blot only' for performing the requested test. Otherwise it will reflex to additional testing which will add to the final bill.

8. SYPHLIS SEROLOGY

Justification: Justification is required under 'RPR syphilis confirmation' for performing the requested test. Otherwise it will reflex to additional testing which will add to the final bill.

11. MOLECULAR STUDIES

PCR for: / PFGE for: Write the name of the organism requested for testing.

Other: Write any other special test request.

For special test requests, contact Molecular Biology at (888) 963-7111 x7735 or (512) 458-7735 prior to submitting specimens.

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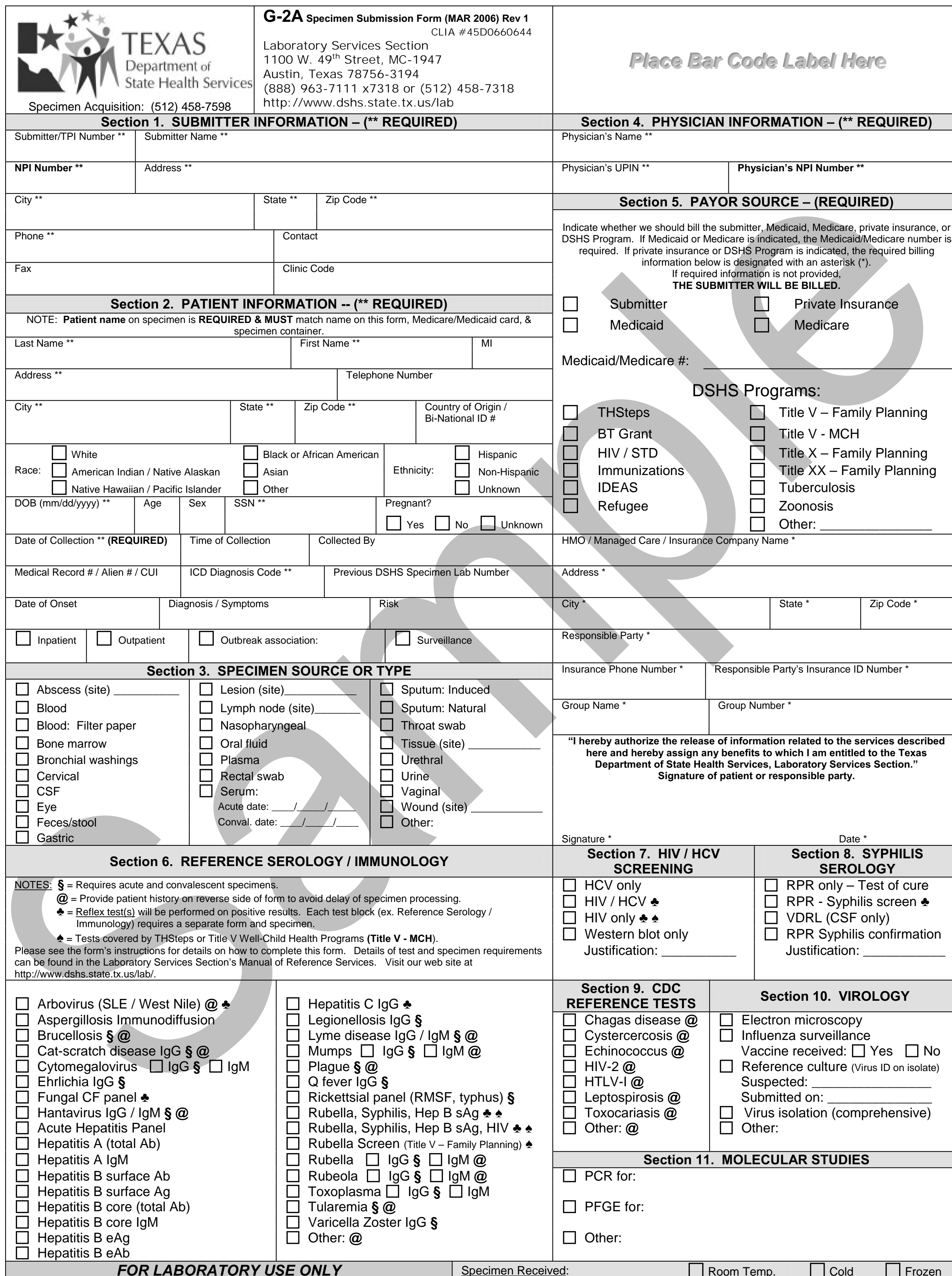
C.46 Specimen Submission Form G-2A, Serology and Virology



TEXAS Department of State Health Services

Specimen Acquisition: (512) 458-7598

G-2A Specimen Submission Form (MAR 2006) Rev 1
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number ** | Submitter Name **
**NPI Number ** ** | Address **
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin / Bi-National ID #

Race: ☐ White ☐ Black or African American ☐ American Indian / Native Alaskan ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Date of Collection ** **(REQUIRED)** | Time of Collection | Collected By
Medical Record # / Alien # / CUI | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number
Date of Onset | Diagnosis / Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Section 3. SPECIMEN SOURCE OR TYPE

☐ Abscess (site) __________
☐ Blood
☐ Blood: Filter paper
☐ Bone marrow
☐ Bronchial washings
☐ Cervical
☐ CSF
☐ Eye
☐ Feces/stool
☐ Gastric
☐ Lesion (site)___________
☐ Lymph node (site)_______
☐ Nasopharyngeal
☐ Oral fluid
☐ Plasma
☐ Rectal swab
☐ Serum:
Acute date: ____/_____/_____
Conval. date: ____/_____/____
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat swab
☐ Tissue (site) ___________
☐ Urethral
☐ Urine
☐ Vaginal
☐ Wound (site) ___________
☐ Other:

Section 4. PHYSICIAN INFORMATION – (REQUIRED)**

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*).
If required information is not provided,
THE SUBMITTER WILL BE BILLED.

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: ______________________

DSHS Programs:

☐ THSteps ☐ Title V – Family Planning
☐ BT Grant ☐ Title V - MCH
☐ HIV / STD ☐ Title X – Family Planning
☐ Immunizations ☐ Title XX – Family Planning
☐ IDEAS ☐ Tuberculosis
☐ Refugee ☐ Zoonosis
☐ Other: _______________

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Responsible Party *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section."
Signature of patient or responsible party.

Signature * Date *

Section 6. REFERENCE SEROLOGY / IMMUNOLOGY

NOTES: **§** = Requires acute and convalescent specimens.
@ = Provide patient history on reverse side of form to avoid delay of specimen processing.
♣ = Reflex test(s) will be performed on positive results. Each test block (ex. Reference Serology / Immunology) requires a separate form and specimen.
♠ = Tests covered by THSteps or Title V Well-Child Health Programs (**Title V - MCH**).
Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

☐ Arbovirus (SLE / West Nile) @ ♣
☐ Aspergillosis Immunodiffusion
☐ Brucellosis § @
☐ Cat-scratch disease IgG § @
☐ Cytomegalovirus ☐ IgG § ☐ IgM
☐ Ehrlichia IgG §
☐ Fungal CF panel ♣
☐ Hantavirus IgG / IgM § @
☐ Acute Hepatitis Panel
☐ Hepatitis A (total Ab)
☐ Hepatitis A IgM
☐ Hepatitis B surface Ab
☐ Hepatitis B surface Ag
☐ Hepatitis B core (total Ab)
☐ Hepatitis B core IgM
☐ Hepatitis B eAg
☐ Hepatitis B eAb
☐ Hepatitis C IgG ♣
☐ Legionellosis IgG §
☐ Lyme disease IgG / IgM § @
☐ Mumps ☐ IgG § ☐ IgM @
☐ Plague § @
☐ Q fever IgG §
☐ Rickettsial panel (RMSF, typhus) §
☐ Rubella, Syphilis, Hep B sAg ♣ ♠
☐ Rubella, Syphilis, Hep B sAg, HIV ♣ ♠
☐ Rubella Screen (Title V – Family Planning) ♠
☐ Rubella ☐ IgG § ☐ IgM @
☐ Rubeola ☐ IgG § ☐ IgM @
☐ Toxoplasma ☐ IgG § ☐ IgM
☐ Tularemia § @
☐ Varicella Zoster IgG §
☐ Other: @

Section 7. HIV / HCV SCREENING

☐ HCV only
☐ HIV / HCV ♣
☐ HIV only ♣ ♠
☐ Western blot only
Justification: __________

Section 8. SYPHILIS SEROLOGY

☐ RPR only – Test of cure
☐ RPR - Syphilis screen ♣
☐ VDRL (CSF only)
☐ RPR Syphilis confirmation
Justification: ___________

Section 9. CDC REFERENCE TESTS

☐ Chagas disease @
☐ Cystercercosis @
☐ Echinococcus @
☐ HIV-2 @
☐ HTLV-I @
☐ Leptospirosis @
☐ Toxocariasis @
☐ Other: @

Section 10. VIROLOGY

☐ Electron microscopy
☐ Influenza surveillance
Vaccine received: ☐ Yes ☐ No
☐ Reference culture (Virus ID on isolate)
Suspected: ________________
Submitted on: ______________
☐ Virus isolation (comprehensive)
☐ Other:

Section 11. MOLECULAR STUDIES

☐ PCR for:
☐ PFGE for:
☐ Other:

FOR LABORATORY USE ONLY Specimen Received: ☐ Room Temp. ☐ Cold ☐ Frozen

Sample

C

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C.47 Specimen Submission Form G-2A, Serology and Virology, Spanish Instructions (3 Pages)

Marzo de 2006 Página 1 de 3

Instrucciones del formulario de remisión de muestras G-2A

Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TPI, nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: A partir del 23 de mayo de 2007, todos los proveedores de salud deben usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original proporcionado por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número de teléfono, nombre y número de fax de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra o el aislamiento.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluida la fecha de obtención, la hora de obtención, el número previo del laboratorio de muestras del DSHS, el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, la raza, etnia, número de expediente médico, código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo y marque ya sea paciente interno/externo, asociación de brote o vigilancia.

NOTA: el nombre del paciente de la muestra *debe* ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Puede utilizar una etiqueta de paciente preimpresa. *Para pruebas de VIH anónimas, indique solamente el estado, código postal, fecha de nacimiento y el número de identificación del paciente.*

Nombre del paciente: si al paciente lo cubre Medicaid, Medicare o un seguro privado, el nombre del formulario de muestras debe ser el mismo que el nombre en la tarjeta de seguro.

Fecha de nacimiento y edad: indique tanto la fecha de nacimiento como la edad del paciente. Si la fecha de nacimiento no está disponible, proporcione la edad del paciente y díganos si la edad es en días, meses o años.

Si es mujer y está embarazada: si el paciente es mujer, indique si está embarazada marcando ya sea Sí, No o Se desconoce. El embarazo puede afectar algunos resultados de pruebas.

Fecha de obtención/hora de obtención: indique la fecha y hora en que se obtuvo la muestra del paciente y quién obtuvo la muestra. No proporcione la fecha en que se remitió la muestra al DSHS. Si no se rellena el campo Fecha de obtención, se rechazará la muestra.

Núm. de expediente médico/núm. de extranjero/CUI: proporcione el número de identificación para propósitos de cotejo. Para pruebas de VIH, ese número puede ser el número de CDC de 8 dígitos asignado al paciente. Se puede colocar la etiqueta del formulario de CDC en cualquier lugar de la parte inferior del formulario, en tanto no oculte ninguna prueba solicitada. CUI (Clinic Unique Identifier) es el número único identificador de clínicas.

Número previo del laboratorio de muestras del DSHS: si se ha remitido una muestra del paciente anteriormente al laboratorio del DSHS, sírvase proporcionar el número del laboratorio de muestras del DSHS.

Código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo (de ser aplicable): indique el código diagnóstico o resultados que ayudarían a procesar, identificar y facturar la muestra o el aislamiento. Si el país de origen del paciente

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no es los Estados Unidos, sírvase proporcionar el país de origen del paciente.

Paciente interno o externo (de ser aplicable): indique si el paciente está hospitalizado actualmente (requerido para pacientes tuberculosos).

Brote/vigilancia (de ser aplicable): díganos si la muestra o aislamiento es parte de un brote o grupo y si la muestra es de vigilancia rutinaria. Si se remite la muestra debido a un brote, escriba el nombre asociado del brote al lado de la casilla de brote. Si se está remitiendo el formulario para vigilancia de gripe, se requiere la siguiente información del paciente: fecha de aparición, fecha de obtención, diagnóstico/síntomas y riesgo. Se deben ingresar fechas en las casillas **Fecha de aparición** y **Fecha de obtención**. En la casilla **Diagnóstico/síntomas**, liste todos los síntomas correspondientes de la siguiente lista: 1) malestar general, 2) dolor de garganta, 3) congestión nasal, 4) fiebre, 5) escalofríos, 6) tos, 7) dolor de cabeza, 8) mialgia. En la casilla **Riesgo**, indique si el paciente recibió la vacuna contra la gripe esta temporada y la fecha en que la recibió.

Sección 3. FUENTE O TIPO DE MUESTRA

Fuente o tipo de muestra: indique el tipo de material que remite o la fuente de la muestra o el aislamiento. Las pruebas que requieran suero agudo/convaleciente y fechas están señaladas con '§' en el área de pruebas del formulario.

Sección 4. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número identificador único del médico (unique physician ID number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esa información para facturar a Medicare y al seguro.

Sección 5. PAGADOR

Indique la parte que recibirá la factura.

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida o si se marcan múltiples casillas de pagador**.**

Marcación de Medicaid o Medicare:

- Marque la casilla correspondiente.
- Escriba el número de Medicaid o Medicare.
- Si el nombre del paciente del formulario no es el mismo que el nombre de la tarjeta, se facturará al remitente.

Marcación de seguro privado:

- Marque la casilla correspondiente.
- Rellene todos los campos del formulario que tengan asterisco (*).
- Si no proporciona los datos del seguro privado en el formulario de la muestra, se facturará al remitente.

Marcación de programa del DSHS:

- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare, a menos que sea Pasos Sanos de Texas.
- Si es Pasos Sanos de Texas, marque Pasos Sanos de Texas como pagador. Escriba el número de Medicaid en el campo correspondiente.
- Para Título V, debe marcar ya sea Planificación familiar o MCH (Salud Materna e Infantil, Maternal & Child Health).
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación del programa, marque el programa del DSHS correspondiente.
- Para pruebas anónimas de VIH/enfermedades venéreas, marque Programa de VIH/enfermedades venéreas como el pagador. No se requieren las secciones Nombre de la HMO/Atención dirigida/aseguradora, Parte responsable, Firma y Fecha.
- Para los programas BIDS (Vigilancia de Enfermedades Infecciosas y Fronterizas, Border & Infectious Disease Surveillance), EIP (Programa de Infecciones Emergentes, Emerging Infections Program) y ELC (Capacidad Epidemiológica y de Laboratorio, Epidemiology & Laboratory Capacity), marque la casilla "Otro" y liste el nombre del programa en el espacio provisto.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará. Si no proporciona todos los datos del seguro en el formulario de la muestra, se facturará al remitente.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

PRUEBA

Prueba solicitada: marque o especifique la o las pruebas específicas que ha de realizar la Sección de Servicios de Laboratorio del DSHS. Cada sección de pruebas requiere un formulario Y una muestra por separado. "Serología/inmunología referencial" o "Virología" o "Prueba de VIH/VHC" serían ejemplos de secciones separadas. Puede consultar instrucciones de pruebas específicas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio.

6. SEROLOGÍA/INMUNOLOGÍA REFERENCIAL

Si se sospecha que se padece hepatitis viral aguda por los síntomas clínicos y la aminotransferencia de suero elevada (ALT/AST), solicite el Panel de hepatitis aguda que consiste de 4 pruebas incluida la Ag superficial de hepatitis B (HBsAg), IgM básico de hepatitis B (antiHBc IgM), Hepatitis A IgM (antiHAV) y Hepatitis C IgG (antiHCV).

El panel micótico incluye:

Histoplasma capsulatum (fase micelial)
Histoplasma capsulatum (fase levaduriforme)
Coccidioides immitis
Blastomyces dermatitidis

Las pruebas para aspergilosis incluyen:

Aspergillus flavus
Aspergillus fumigatus
Aspergillus niger
Aspergillus terreus

7. PRUEBA DE VIH/VHC

C

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Justificación: se requiere justificación bajo 'Inmunotransferencia solamente' para realizar la prueba solicitada. De otra forma se harán pruebas adicionales, lo que aumentará la factura final.

8. SEROLOGÍA SIFILÍTICA

Justificación: se requiere justificación bajo 'Confirmación de sífilis RPR' para realizar la prueba solicitada. De otra forma se harán pruebas adicionales, lo que aumentará la factura final.

11. ESTUDIOS MOLECULARES

PCR para:/PFGE para: escriba el nombre del organismo solicitado para prueba.

Otro: escriba cualquier otra solicitud de prueba especial.

Para solicitudes de pruebas especiales, llame a Biología Molecular al (888) 963-7111, extensión 7735, o (512) 458-7735 antes de remitir las muestras.

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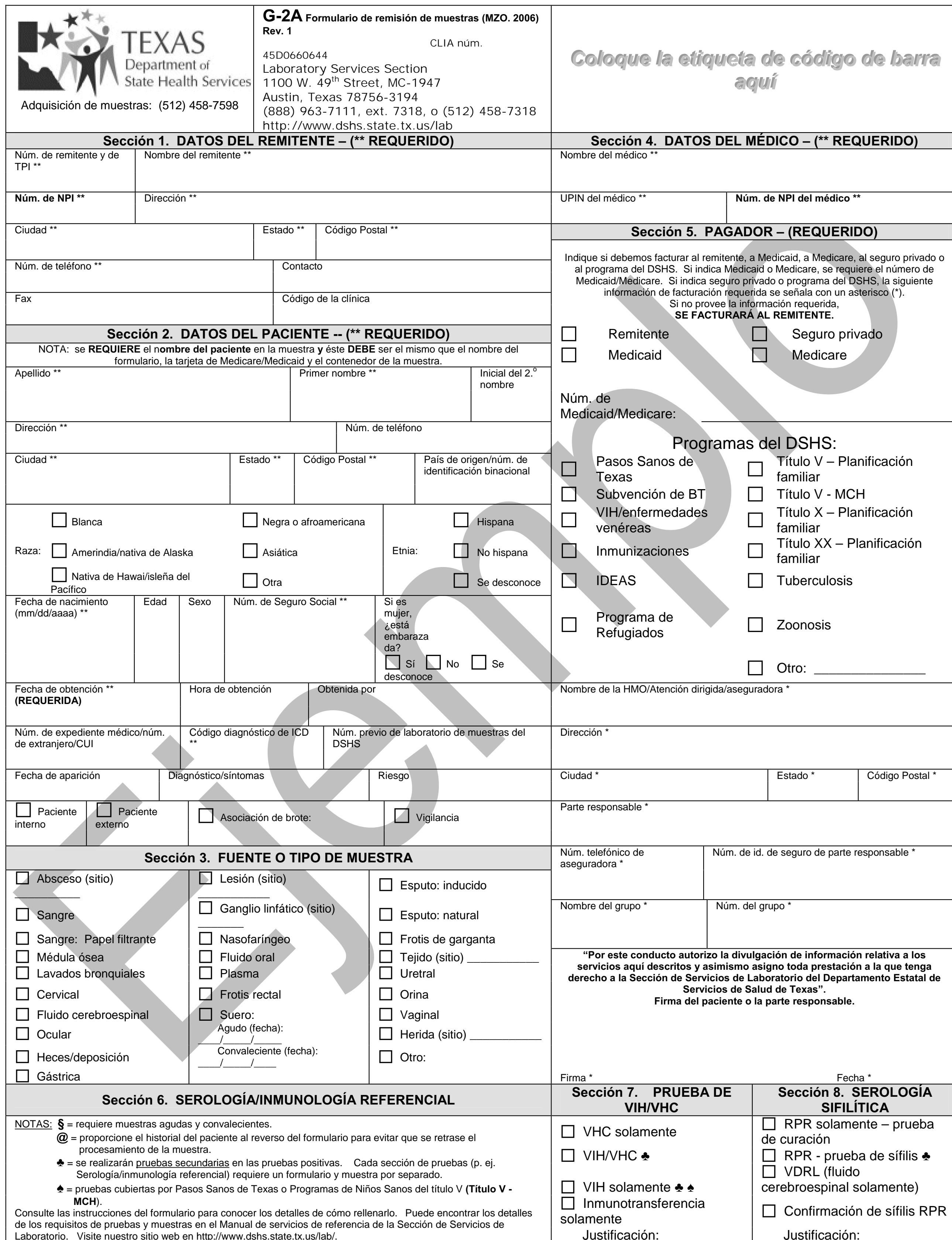
C.48 Specimen Submission Form G-2A, Serology and Virology (Spanish, 2 Pages)



TEXAS Department of State Health Services

Adquisición de muestras: (512) 458-7598

G-2A Formulario de remisión de muestras (MZO. 2006) Rev. 1

CLIA núm. 45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente y de TPI ** | Nombre del remitente **
Núm. de NPI ** | Dirección **
Ciudad ** | Estado ** | Código Postal **
Núm. de teléfono ** | Contacto
Fax | Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario, la tarjeta de Medicare/Medicaid y el contenedor de la muestra.

Apellido ** | Primer nombre ** | Inicial del 2.º nombre
Dirección ** | Núm. de teléfono
Ciudad ** | Estado ** | Código Postal ** | País de origen/núm. de identificación binacional

Raza: ☐ Blanca ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra
Etnia: ☐ Hispana ☐ No hispana ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) ** | Edad | Sexo | Núm. de Seguro Social ** | Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Fecha de obtención ** **(REQUERIDA)** | Hora de obtención | Obtenida por
Núm. de expediente médico/núm. de extranjero/CUI | Código diagnóstico de ICD ** | Núm. previo de laboratorio de muestras del DSHS
Fecha de aparición | Diagnóstico/síntomas | Riesgo
☐ Paciente interno ☐ Paciente externo ☐ Asociación de brote: ☐ Vigilancia

Sección 3. FUENTE O TIPO DE MUESTRA

☐ Absceso (sitio) ____________
☐ Sangre
☐ Sangre: Papel filtrante
☐ Médula ósea
☐ Lavados bronquiales
☐ Cervical
☐ Fluido cerebroespinal
☐ Ocular
☐ Heces/deposición
☐ Gástrica
☐ Lesión (sitio) ____________
☐ Ganglio linfático (sitio) ________
☐ Nasofaríngeo
☐ Fluido oral
☐ Plasma
☐ Frotis rectal
☐ Suero: Agudo (fecha): ____/_____/_____ Convaleciente (fecha): ____/_____/____
☐ Esputo: inducido
☐ Esputo: natural
☐ Frotis de garganta
☐ Tejido (sitio) ___________
☐ Uretral
☐ Orina
☐ Vaginal
☐ Herida (sitio) ___________
☐ Otro:

Sección 4. DATOS DEL MÉDICO – (REQUERIDO)**

Nombre del médico **
UPIN del médico ** | **Núm. de NPI del médico ****

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*). Si no provee la información requerida, **SE FACTURARÁ AL REMITENTE.**

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare:

Programas del DSHS:

☐ Pasos Sanos de Texas ☐ Título V – Planificación familiar
☐ Subvención de BT ☐ Título V - MCH
☐ VIH/enfermedades venéreas ☐ Título X – Planificación familiar
☐ Inmunizaciones ☐ Título XX – Planificación familiar
☐ IDEAS ☐ Tuberculosis
☐ Programa de Refugiados ☐ Zoonosis
☐ Otro: _______________

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad * | Estado * | Código Postal *
Parte responsable *
Núm. telefónico de aseguradora * | Núm. de id. de seguro de parte responsable *
Nombre del grupo * | Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas". Firma del paciente o la parte responsable.

Firma * Fecha *

Sección 6. SEROLOGÍA/INMUNOLOGÍA REFERENCIAL

NOTAS: § = requiere muestras agudas y convalecientes.
@ = proporcione el historial del paciente al reverso del formulario para evitar que se retrase el procesamiento de la muestra.
♣ = se realizarán pruebas secundarias en las pruebas positivas. Cada sección de pruebas (p. ej. Serología/inmunología referencial) requiere un formulario y muestra por separado.
♠ = pruebas cubiertas por Pasos Sanos de Texas o Programas de Niños Sanos del título V (**Título V - MCH**).
Consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

Sección 7. PRUEBA DE VIH/VHC

☐ VHC solamente
☐ VIH/VHC ♣
☐ VIH solamente ♣ ♠
☐ Inmunotransferencia solamente
Justificación: __________

Sección 8. SEROLOGÍA SIFILÍTICA

☐ RPR solamente – prueba de curación
☐ RPR - prueba de sífilis ♣
☐ VDRL (fluido cerebroespinal solamente)
☐ Confirmación de sífilis RPR
Justificación: ___________

Ejemplo

C

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		Sección 9. PRUEBAS REFERENCIALES DE CDC	Sección 10. VIROLOGÍA
☐ Arbovirus (SLE/Nilo Occidental) @ ♣ ☐ Inmunodifusión Asper gillus ☐ Brucelosis § @ ☐ Linforeticulosis benigna IgG § @ ☐ Citomegalovirus ☐ IgG § ☐ IgM ☐ Erliquia IgG § ☐ Panel micótico CF ♣ ☐ Hantavirus IgG/IgM § @ ☐ Panel de hepatitis aguda ☐ Hepatitis A (Ab total) ☐ Hepatitis A IgM ☐ Ab superficial de hepatitis B ☐ Ag superficial de hepatitis B ☐ Hepatitis B básica (Ab total) ☐ IgM básico de hepatitis B ☐ Hepatitis B eAg ☐ Hepatitis B eAb	☐ Hepatitis C IgG ♣ ☐ Legionelosis IgG § ☐ Borreliosis IgG/IgM § @ ☐ Paperas ☐ IgG § ☐ IgM @ ☐ Peste § @ ☐ Fiebre Q IgG § ☐ Panel riquetsial (RMSF, tifus) § ☐ Rubeola, sífilis, hepatitis B sAg ♣ ♠ ☐ Rubeola, sífilis, hepatitis B sAg, VIH ♣ ♠ ☐ Prueba de rubeola (Título V – Planificación familiar) ♠ ☐ Rubeola ☐ IgG § ☐ IgM @ ☐ Rubeola ☐ IgG § ☐ IgM @ ☐ Toxoplasma ☐ IgG § ☐ IgM ☐ Tularemia § @ ☐ Varicela zoster IgG § ☐ Otro: @	☐ Mal de Chagas @ ☐ Cisticercosis @ ☐ Equinococus @ ☐ VIH-2 @ ☐ HTLV-I @ ☐ Leptospirosis @ ☐ Toxocariasis @ ☐ Otro: @ **Sección 11. ESTUDIOS MOLECULARES** ☐ PCR para: ☐ PFGE para: ☐ Otro:	☐ Microscopía electrónica ☐ Vigilancia de gripe Vacuna recibida: ☐ Sí ☐ No ☐ Cultivo referencial (Identificación de virus aislado) Sospecha: ________________ Remitido el: ______________ ☐ Aislamiento viral (exhaustivo) ☐ Otro:
FOR LABORATORY USE ONLY	Specimen Received:	☐ Room Temp. ☐ Cold	☐ Frozen

Ejemplo

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C.49 Specimen Submission Form G-2B, Bacteriology and Parasitology, Instructions (2 Pages)

March 2006 Page 1 of 2

G-2B Specimen Submission Form's Instructions

For mailing and specimen packaging information, visit DSHS Laboratory Services Section's web page at http://www.dshs.state.tx.us/lab/.

The specimen submission form ***must*** accompany each specimen.
The patient's name listed on the specimen ***must*** match the patient's name listed on the form.
If the Date of Collection field is not completed, the specimen will be rejected.

Place Bar Code Label Here: Place the specimen bar code label that will be used to identify and track the specimen in the DSHS laboratory information management system. If you are performing remote entry, place specimen bar code label here.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that the Texas Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submitter number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter's name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number, name, and fax number of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen/isolate.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including date of collection, time of collection, previous DSHS specimen lab number, last name, first name, middle initial, address, city, state, zip code, telephone number, date of birth (DOB), age, sex, social security number (SSN), pregnant, race, ethnicity, medical record number, ICD diagnosis code, country of origin, date of onset, diagnosis/symptoms, risk, and mark either inpatient/outpatient, outbreak association, and/or surveillance.

NOTE: The patient's name listed on the specimen ***must*** match the patient's name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label.

Patient Name: If patient is covered by Medicaid, Medicare, or Private Insurance, the name on the specimen form must match the name on the insurance card.

Date of birth (DOB) and Age: Please list both the date of birth and age of the patient. If date of birth is not available, give the age of the patient and tell us whether the age is in days, months, or years.

Pregnant: If patient is a female, please indicate is she is pregnant by marking either Yes, No, or Unknown. Pregnancy can affect some test results.

Date of collection/Time of collection: Indicate the date and time the specimen was collected from the patient or other source and who collected the specimen. Do not give the date the specimen was sent to DSHS. If the Date of Collection field is not completed, the specimen will be rejected.

Medical Record # / Alien # / CUI: Provide the identification number for matching purposes. CUI is the Clinic Unique Identifier number.

Previous DSHS Specimen Lab Number: If this patient has had a previous specimen submitted to the DSHS Laboratory, provide the DSHS specimen lab number.

ICD Diagnosis Code, Country of Origin, Date of Onset, Diagnosis/Symptoms, and Risk (if applicable): Indicate the diagnosis code or findings that would help in processing, identifying, and billing of this specimen/isolate. If the patient's country of origin is not the U.S., then please provide the patient's country of origin.

Inpatient or Outpatient (if applicable): Indicate if the patient is currently admitted to a hospital (required for TB patients).

Outbreak/Surveillance (if applicable): Tell us whether the specimen/isolate is part of an outbreak or cluster, or if the specimen is for routine surveillance. If the specimen is being submitted because of an outbreak, write in the associated name of the outbreak next to the outbreak box.

Section 3. SPECIMEN SOURCE OR TYPE

Specimen Source or Type: Indicate the kind of material you are submitting or the source of the specimen or isolate. For mycobacteriology specimens, complete this section or the specimen will be rejected.

For tuberculosis treatment, a specimen source or type MUST be provided for specimens used for the diagnosis or monitoring of TB.

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March 2006 Page 2 of 2

DO NOT leave this section blank. For specimens other than those listed, check the "Other" box and write in the site and source selected from the TB Elimination Division's list of Anatomic Sites and Corresponding Specimen Sources, which can be obtained from your local or regional health department.

Section 4. PHYSICIAN INFORMATION

Physician's name, UPIN, and NPI Number: Give the name of the physician and their unique physician ID number (UPIN) and NPI number, if applicable. Beginning May 23, 2007, the NPI number will replace the UPIN. This information is required to bill Medicare and insurance.

Section 5. PAYOR SOURCE

Indicate the party that will receive the bill.

THE SUBMITTER WILL BE BILLED, if the required billing information is not provided or multiple payor boxes are checked**.**

Checking Medicaid or Medicare:
- Mark the appropriate box.
- Write in the Medicaid or Medicare number.
- If the patient name on the form does not match the name on the card, the submitter will be billed.

Checking Private Insurance:
- Mark the appropriate box.
- Complete all fields on the form that have an asterisk (*).
- If the private insurance information is not provided on the specimen form, the submitter will be billed.

Checking a DSHS Program:
- If you are contracting and/or enrolled with a DSHS program to provide services that require laboratory testing, please indicate which program. For program descriptions, see the Laboratory Services Section's Manual of Reference Services located on the web site at http://www.dshs.state.tx.us/lab/.
- Do NOT check a DSHS program as a Payor Source if the patient has Medicaid or Medicare, except for THSteps.
- For THSteps, check THSteps as the Payor Source. Write the patient's Medicaid number in the appropriate field.
- For Title V, must check either Family Planning or MCH (Maternal & Child Health).
- If there is no other Payor Source for the patient and the patient meets the program's eligibility criteria, check the appropriate DSHS program.
- For BIDS (Border & Infectious Disease Surveillance), EIP (Emerging Infections Program), and ELC (Epidemiology & Laboratory Capacity) programs, check the "Other" box and list the program's name in the space provided.

HMO / Managed care / Insurance company: Print the name, address, city, state, and zip code of the insurance company to be billed. If all insurance information is not provided on the specimen form, the submitter will be billed.

Responsible party: Print the name of the responsible party, the insurance ID number, insurance company's phone number, group name, and group number.

Signature and Date: Have the responsible party sign and date to authorize the release of their information, if DSHS is to bill their insurance or HMO.

TEST

Test Requested: Check or specify the specific test(s) to be performed by the DSHS Laboratory Services Section. Each test block requires a separate form AND a separate specimen. Examples of separate blocks are "Bacteriology" or "Mycobacteriology/Mycology" or "Parasitology". For specific test instructions, see the Laboratory Services Section Manual of Reference Services.

6. BACTERIOLOGY

DNA Gen Probe for Gonorrhea (GC)/Chlamydia: Please follow the instructions listed below when submitting *Neisseria gonorrhoeae* and *Chlamydia trachomatis* specimens.

Under the "Bacteriology" section of the form:

1. Under "Clinical specimens:"
   a. Check the box marked "Gonorrhea/Chlamydia (genetic probe)", if submitting a sample in a GEN-PROBE specimen collection kit.
   b. Check the box marked "Gonorrhea culture", if the specimen is a clinical sample submitted on a transport media such as Remel Transgrow, Remel GC transport media, GemBec Plates, etc.
2. Under "Pure cultures:"
   a. If *Neisseria gonorrhoeae* is isolated and a pure culture is being submitted, please check the box "Aerobe ID only" under "Pure Cultures". Please either hand write in GC or *Neisseria gonorrhoeae* next to the "Aerobe ID: Organism suspected" or attach a copy of any lab work performed at your facility.

Toxin/Other: If requesting Clostridium toxin, please be aware that this test is performed on *Clostridium species, not C. perfringens*.

7. MOLECULAR STUDIES

PCR for: / PFGE for: Write the name of the organism requested for testing.

Other: Write any other special test request.

For special test requests, contact Molecular Biology at (888) 963-7111 x7735 or (512) 458-7735 prior to submitting specimens.

11. PARASITOLOGY

Other: If requesting ID on suspected *Naegleria fowleri*, *Acanthamoeba species*, *Pneumocystis carinii, Leishmania species, Toxoplasma gondii, Trypanosoma species,* or cultures for amebiasis, mark "Other" and write the name the organism suspected. Before submitting the specimen, please notify the Laboratory by calling: (888) 963-7111 x7560 or (512) 458-7560.

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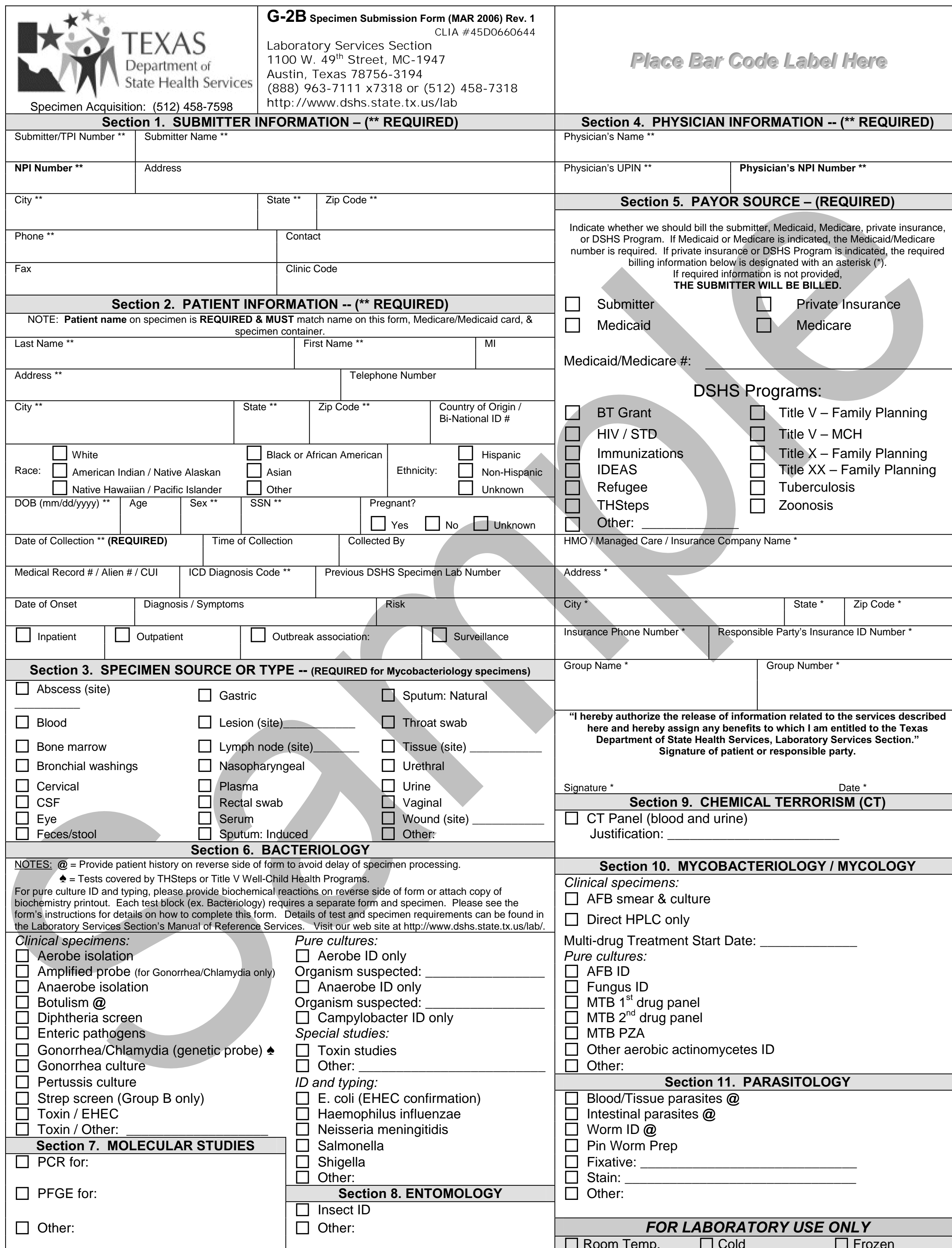
C.50 Specimen Submission Form G-2B, Bacteriology and Parasitology



TEXAS Department of State Health Services

Specimen Acquisition: (512) 458-7598

G-2B Specimen Submission Form (MAR 2006) Rev. 1
CLIA #45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111 x7318 or (512) 458-7318
http://www.dshs.state.tx.us/lab

Place Bar Code Label Here

Sample

Section 1. SUBMITTER INFORMATION – (REQUIRED)**

Submitter/TPI Number ** | Submitter Name **
NPI Number ** | Address
City ** | State ** | Zip Code **
Phone ** | Contact
Fax | Clinic Code

Section 2. PATIENT INFORMATION -- (REQUIRED)**

NOTE: **Patient name** on specimen is **REQUIRED & MUST** match name on this form, Medicare/Medicaid card, & specimen container.

Last Name ** | First Name ** | MI
Address ** | Telephone Number
City ** | State ** | Zip Code ** | Country of Origin / Bi-National ID #

Race: ☐ White ☐ American Indian / Native Alaskan ☐ Native Hawaiian / Pacific Islander ☐ Black or African American ☐ Asian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

DOB (mm/dd/yyyy) ** | Age | Sex ** | SSN ** | Pregnant? ☐ Yes ☐ No ☐ Unknown
Date of Collection ** (REQUIRED) | Time of Collection | Collected By
Medical Record # / Alien # / CUI | ICD Diagnosis Code ** | Previous DSHS Specimen Lab Number
Date of Onset | Diagnosis / Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Section 3. SPECIMEN SOURCE OR TYPE -- (REQUIRED for Mycobacteriology specimens)

☐ Abscess (site) __________
☐ Blood
☐ Bone marrow
☐ Bronchial washings
☐ Cervical
☐ CSF
☐ Eye
☐ Feces/stool
☐ Gastric
☐ Lesion (site)__________
☐ Lymph node (site)________
☐ Nasopharyngeal
☐ Plasma
☐ Rectal swab
☐ Serum
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat swab
☐ Tissue (site) __________
☐ Urethral
☐ Urine
☐ Vaginal
☐ Wound (site) __________
☐ Other:

Section 4. PHYSICIAN INFORMATION -- (REQUIRED)**

Physician's Name **
Physician's UPIN ** | **Physician's NPI Number ****

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private Insurance
☐ Medicaid ☐ Medicare

Medicaid/Medicare #: ______________

DSHS Programs:

☐ BT Grant
☐ HIV / STD
☐ Immunizations
☐ IDEAS
☐ Refugee
☐ THSteps
☐ Other: ______________
☐ Title V – Family Planning
☐ Title V – MCH
☐ Title X – Family Planning
☐ Title XX – Family Planning
☐ Tuberculosis
☐ Zoonosis

HMO / Managed Care / Insurance Company Name *
Address *
City * | State * | Zip Code *
Insurance Phone Number * | Responsible Party's Insurance ID Number *
Group Name * | Group Number *

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section." Signature of patient or responsible party.

Signature * | Date *

Section 6. BACTERIOLOGY

NOTES: @ = Provide patient history on reverse side of form to avoid delay of specimen processing.
♠ = Tests covered by THSteps or Title V Well-Child Health Programs.
For pure culture ID and typing, please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test block (ex. Bacteriology) requires a separate form and specimen. Please see the form's instructions for details on how to complete this form. Details of test and specimen requirements can be found in the Laboratory Services Section's Manual of Reference Services. Visit our web site at http://www.dshs.state.tx.us/lab/.

Clinical specimens:
☐ Aerobe isolation
☐ Amplified probe (for Gonorrhea/Chlamydia only)
☐ Anaerobe isolation
☐ Botulism @
☐ Diphtheria screen
☐ Enteric pathogens
☐ Gonorrhea/Chlamydia (genetic probe) ♠
☐ Gonorrhea culture
☐ Pertussis culture
☐ Strep screen (Group B only)
☐ Toxin / EHEC
☐ Toxin / Other: ________________

Pure cultures:
☐ Aerobe ID only
Organism suspected: ______________
☐ Anaerobe ID only
Organism suspected: ______________
☐ Campylobacter ID only

Special studies:
☐ Toxin studies
☐ Other: ____________________

ID and typing:
☐ E. coli (EHEC confirmation)
☐ Haemophilus influenzae
☐ Neisseria meningitidis
☐ Salmonella
☐ Shigella
☐ Other:

Section 7. MOLECULAR STUDIES

☐ PCR for:
☐ PFGE for:
☐ Other:

Section 8. ENTOMOLOGY

☐ Insect ID
☐ Other:

Section 9. CHEMICAL TERRORISM (CT)

☐ CT Panel (blood and urine)
Justification: ____________________

Section 10. MYCOBACTERIOLOGY / MYCOLOGY

Clinical specimens:
☐ AFB smear & culture
☐ Direct HPLC only

Multi-drug Treatment Start Date: ___________

Pure cultures:
☐ AFB ID
☐ Fungus ID
☐ MTB 1st drug panel
☐ MTB 2nd drug panel
☐ MTB PZA
☐ Other aerobic actinomycetes ID
☐ Other:

Section 11. PARASITOLOGY

☐ Blood/Tissue parasites @
☐ Intestinal parasites @
☐ Worm ID @
☐ Pin Worm Prep
☐ Fixative: ____________________
☐ Stain: ____________________
☐ Other:

FOR LABORATORY USE ONLY

☐ Room Temp. ☐ Cold ☐ Frozen

C

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C.51 Specimen Submission Form G-2B, Bacteriology and Parasitology, Spanish Instructions (3 Pages)

Marzo de 2006 Página 1 de 3

Instrucciones del formulario de remisión de muestras G-2B

Para obtener información sobre envíos por correo y el embalaje de las muestras, visite la página web de la Sección de Servicios de Laboratorio del DSHS en http://www.dshs.state.tx.us/lab/.

Debe acompañar cada muestra con un formulario de remisión de muestras.
El nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.
Si no rellena el campo Fecha de obtención, se rechazará la muestra.

Coloque la etiqueta de código de barra aquí: coloque la etiqueta de código de barra de la muestra a ser usada para identificar y ubicar la muestra en el sistema de administración de datos del laboratorio del DSHS. Si está ingresando remotamente, coloque la etiqueta de código de barra de la muestra aquí.

Sección 1. DATOS DEL REMITENTE

Se requieren todos los datos del remitente.

Número de remitente y de TPI, nombre y dirección del remitente: el número de remitente es un número único que la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas (Texas Department of State Health Services [DSHS]) asigna a cada uno de nuestros remitentes. Para muestras de Pasos Sanos de Texas (Texas Health Steps [THSteps]), utilice el número Identificador de proveedor de Texas (Texas Provider Identifier [TPI]) preasignado. Para obtener un número de TPI e inscribirse en Pasos Sanos de Texas, llame a la Asociación de Medicaid y Salud de Texas (Texas and Healthcare Partnership [TMHP]) al 1-800-925-9126.

Para solicitar un número de remitente a la Sección de Servicios de Laboratorio del DSHS, el formulario original o para cambiar los datos del remitente, sírvase llamar al (888) 963-7111, extensión 7578, o al (512) 458-7578 o mandar un fax al (512) 458-7533.

Núm. de NPI: a partir del 23 de mayo de 2007, todos los proveedores de salud deben usar el número Identificador de proveedor nacional (National Provider Identifier [NPI]) y ya no se usará el número de TPI u otro número de remitente. El número NPI es el nuevo identificador nacional oficial para proveedores de salud adoptado por los Centros de Servicios de Medicaid y Medicare (Centers for Medicare & Medicaid Services [CMS]) de conformidad con la Ley de Transferibilidad y Responsabilidad de Seguros Médicos (Health Insurance Portability and Accountability Act [HIPAA]) de 1996. Para obtener un número de NPI, llame al Sistema Nacional de Enumeración de Planes y Proveedores (National Plan and Provider Enumeration System [NPPES]) gratis al (800) 465-3203 o visite su sitio web en https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indique el nombre, dirección, ciudad, estado y código postal del remitente. Escriba claramente en letra de molde, utilice una etiqueta preimpresa o utilice una fotocopia del formulario original proporcionado por la Sección de Servicios de Laboratorio.

Datos de contacto: indique el número de teléfono, nombre y número de fax de la persona a contactar en el centro remitente en caso de que el laboratorio necesite información adicional sobre la muestra o el aislamiento.

Código de la clínica: sírvase proporcionarlo, de ser aplicable. Se trata de un código que el remitente provee para ayudar a identificar cuál oficina satélite remite una muestra y para ayudar al remitente a identificar adónde pertenece el informe de laboratorio, si el remitente tuviese una dirección de correo postal primaria con oficinas satélite.

Sección 2. DATOS DEL PACIENTE

Rellene todos los datos del paciente incluida la fecha de obtención, la hora de obtención, el número previo del laboratorio de muestras del DSHS, el apellido, el nombre, la inicial del segundo nombre, la dirección, ciudad, estado, código postal, número telefónico, fecha de nacimiento, edad, sexo, número de Seguro Social, si es mujer si está embarazada, la raza, etnia, número de expediente médico, código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo y marque ya sea paciente interno/externo, asociación de brote o vigilancia.

NOTA: el nombre del paciente de la muestra ***debe*** ser el mismo que el nombre del paciente del formulario.

La información requerida para facturar a Medicare, Medicaid o un seguro privado ha sido señalada con doble asterisco (**). Puede utilizar una etiqueta de paciente preimpresa.

Nombre del paciente: si al paciente lo cubre Medicaid, Medicare o un seguro privado, el nombre del formulario de muestras <u>debe</u> ser el mismo que el nombre de la tarjeta de seguro.

Fecha de nacimiento y edad: indique tanto la fecha de nacimiento como la edad del paciente. Si la fecha de nacimiento no está disponible, proporcione la edad del paciente y díganos si la edad es en días, meses o años.

Si es mujer y está embarazada: si el paciente es mujer, indique si está embarazada marcando ya sea Sí, No o Se desconoce. El embarazo puede afectar algunos resultados de pruebas.

Fecha de obtención/hora de obtención: indique la fecha y hora en que se obtuvo la muestra del paciente y quién obtuvo la muestra. No proporcione la fecha en que se remitió la muestra al DSHS. <u>Si no se rellena el campo Fecha de obtención, se rechazará la muestra</u>.

Núm. de expediente médico/núm. de extranjero/CUI: proporcione el número de identificación para propósitos de cotejo. CUI (Clinic Unique Identifier) es el número único identificador de clínicas.

Número previo del laboratorio de muestras del DSHS: si se ha remitido una muestra del paciente anteriormente al laboratorio del DSHS, sírvase proporcionar el número del laboratorio de muestras del DSHS.

Código diagnóstico de ICD, país de origen, fecha de aparición, diagnóstico/síntomas y riesgo (de ser aplicable): indique el código diagnóstico o resultados que ayudarían a procesar, identificar y facturar la muestra o el aislamiento. Si el país de origen del paciente no es los Estados Unidos, sírvase proporcionar el país de origen del paciente.

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Paciente interno o externo (de ser aplicable): indique si el paciente está hospitalizado actualmente (requerido para pacientes tuberculosos).

Brote/vigilancia (de ser aplicable): díganos si la muestra o aislamiento es parte de un brote o grupo y si la muestra es de vigilancia rutinaria. Si se remite la muestra debido a un brote, escriba el nombre asociado del brote al lado de la casilla de brote.

Sección 3. FUENTE O TIPO DE MUESTRA

Fuente o tipo de muestra: indique el tipo de material que remite o la fuente de la muestra o el aislamiento. Para muestras de micobacteriología, rellene esta sección o se rechazará la muestra.

Para tratamiento tuberculoso, se DEBE proporcionar la fuente o tipo de muestra de las muestras usadas en el diagnóstico o control de tuberculosis. NO deje en blanco esta sección. Para muestras distintas a las de la lista, marque la casilla “Otra” y escriba el sitio y fuente seleccionados de la lista de Sitios anatómicos y fuentes de muestras correspondientes de la División de Eliminación de Tuberculosis, que puede obtenerse del departamento de salud local o regional.

Sección 4. DATOS DEL MÉDICO

Nombre y número de UPIN y NPI del médico: dé el nombre del médico y el número identificador único del médico (unique physician ID number [UPIN]) y el número NPI, de ser aplicable. A partir del 23 de mayo de 2007, el número NPI reemplazará al UPIN. Se requiere esa información para facturar a Medicare y al seguro.

Sección 5. PAGADOR

Indique la parte que recibirá la factura.

SE FACTURARÁ AL REMITENTE, si no se proporciona la información de facturación requerida o si se marcan múltiples casillas de pagador**.**

Marcación de Medicaid o Medicare:

- Marque la casilla correspondiente.
- Escriba el número de Medicaid o Medicare.
- Si el nombre del paciente del formulario no es el mismo que el nombre de la tarjeta, se facturará al remitente.

Marcación de seguro privado:

- Marque la casilla correspondiente.
- Rellene todos los campos del formulario que tengan asterisco (*).
- Si no proporciona los datos del seguro privado en el formulario de la muestra, se facturará al remitente.

Marcación de programa del DSHS:

- Si está contratado o inscrito en un programa del DSHS para proporcionar servicios que requieran pruebas de laboratorio, sírvase indicar qué programa es. Encontrará las descripciones de los programas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio en el sitio web http://www.dshs.state.tx.us/lab/.
- NO marque un programa del DSHS como Pagador si el paciente cuenta con Medicaid o Medicare, a menos que sea Pasos Sanos de Texas.
- Si es Pasos Sanos de Texas, marque Pasos Sanos de Texas como pagador. Escriba el número de Medicaid en el campo correspondiente.
- Para Título V, debe marcar ya sea Planificación familiar o MCH (Salud Materna e Infantil, Maternal & Child Health).
- Si no existe otro Pagador del paciente y el paciente reúne los criterios de participación del programa , marque el programa del DSHS correspondiente.
- Para los programas BIDS (Vigilancia de Enfermedades Infecciosas y Fronterizas, Border & Infectious Disease Surveillance), EIP (Programa de Infecciones Emergentes, Emerging Infections Program) y ELC (Capacidad Epidemiológica y de Laboratorio, Epidemiology & Laboratory Capacity), marque la casilla “Otro” y liste el nombre del programa en el espacio provisto.

HMO/Atención dirigida/aseguradora: ponga en letra de molde el nombre, dirección, ciudad, estado y código postal de la aseguradora a la que se facturará. Si no proporciona todos los datos del seguro en el formulario de la muestra, se facturará al remitente.

Parte responsable: ponga en letra de molde el nombre de la parte responsable, el número de identificación del seguro, el número telefónico de la aseguradora, el nombre del grupo y el número del grupo.

Firma y fecha: haga que la parte responsable firme y feche para autorizar la divulgación de los datos de la misma, si DSHS ha de facturar al seguro o HMO de ésta.

PRUEBA

Prueba solicitada: marque o especifique la o las pruebas específicas que ha de realizar la Sección de Servicios de Laboratorio del DSHS. Cada sección de pruebas requiere un formulario Y una muestra por separado. "Bacteriología” o “Micobacteriología/micología” o “Parasitología” serían ejemplos de secciones separadas. Puede consultar instrucciones de pruebas específicas en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio.

6. BACTERIOLOGÍA

Sonda general de ADN de gonorrea (GC)/clamidia: sírvase seguir las siguientes instrucciones al remitir muestras de *Neisseria gonorrhoeae* y *Chlamydia trachomatis*.

Bajo la sección “Bacteriología” del formulario:

1. Bajo “Muestras clínicas”:
   a. Marque la casilla “Gonorrea/clamidia (sonda genética)”, si remite una muestra en un equipo de obtención de muestras GEN-PROBE.
   b. Marque la casilla “Cultivo de gonorrea”, si la muestra es una muestra clínica remitida en un medio de transporte como Remel Transgrow, medio de transporte Remel GC, bandejas GemBec, etc.
2. Bajo “Cultivos puros”:
   a. Si se aísla *Neisseria gonorrhoeae* y se remite un cultivo puro, sírvase marcar la casilla “Identificación aeróbica solamente” bajo “Cultivos puros”. Sírvase ya sea escribir GC o *Neisseria gonorrhoeae* junto a “Identificación aeróbica: sospecha de organismo” o adjunte una copia del trabajo de laboratorio realizado en su centro.

Toxina/otra: si pide la prueba de toxina de Clostridium, sírvase tomar en cuenta que la prueba se realiza en *las especies de Clostridium y no en C. perfringens*.

C

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7. ESTUDIOS MOLECULARES

PCR para:/PFGE para: escriba el nombre del organismo solicitado para prueba.

Otro: ponga cualquier otra solicitud de prueba especial.

Para solicitudes de pruebas especiales, llame a Biología Molecular al (888) 963-7111, extensión 7735, o (512) 458-7735 antes de remitir las muestras.

11. PARASITOLOGÍA

Otro: si solicita identificación de sospecha de *Naegleria fowleri*, *especies de Acanthamoeba*, *Pneumocystis carinii, especies de Leishmania, Toxoplasma gondii, especies de Trypanosoma* o cultivos de amebiasis, marque “Otro” y escriba el nombre del organismo bajo sospecha. Antes de remitir la muestra, sírvase informar al laboratorio llamando al: (888) 963-7111, extensión 7560, o (512) 458-7560.

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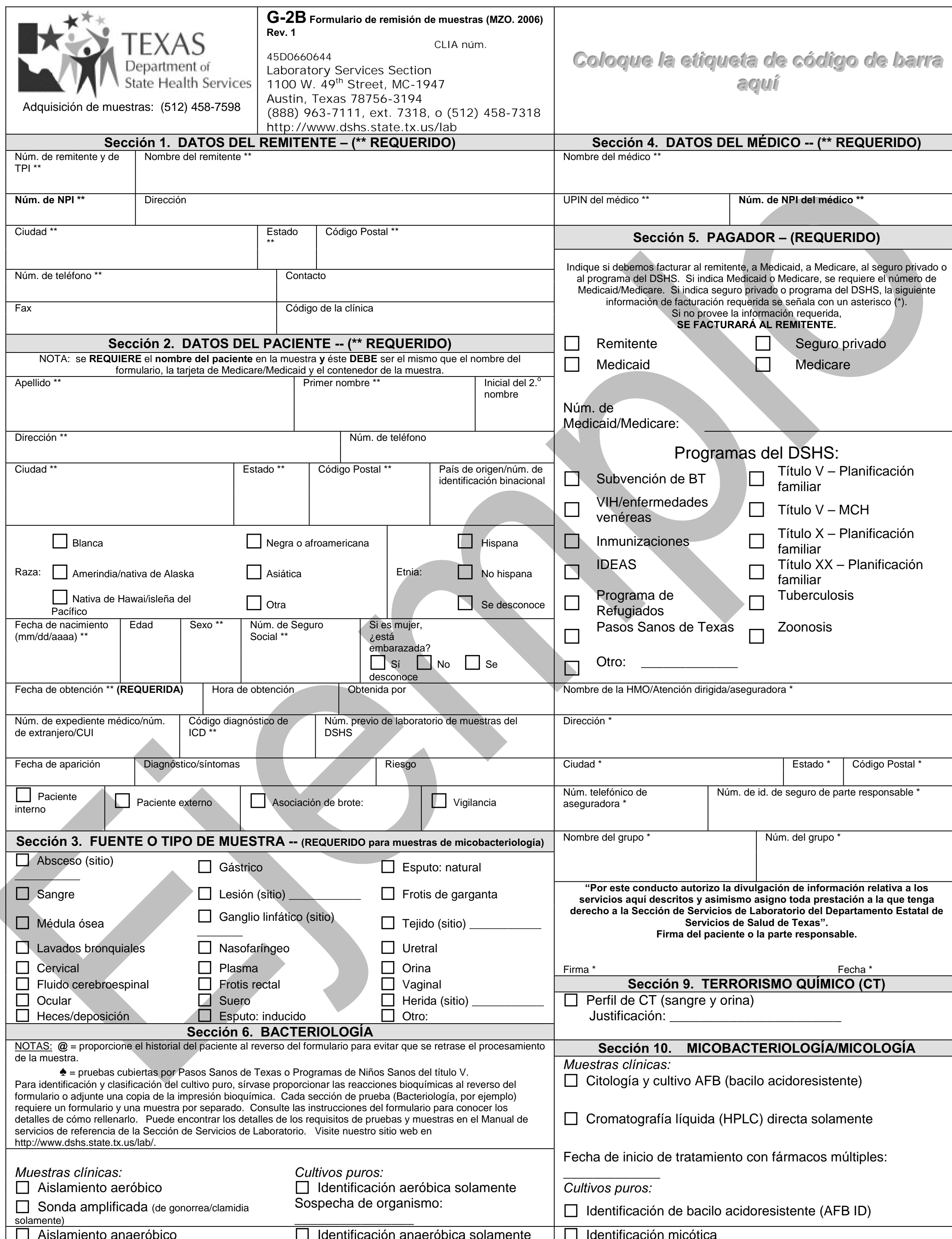
C.52 Specimen Submission Form G-2B, Bacteriology and Parasitology (Spanish, 2 Pages)



TEXAS Department of State Health Services

Adquisición de muestras: (512) 458-7598

G-2B **Formulario de remisión de muestras (MZO. 2006)**
Rev. 1

CLIA núm. 45D0660644
Laboratory Services Section
1100 W. 49th Street, MC-1947
Austin, Texas 78756-3194
(888) 963-7111, ext. 7318, o (512) 458-7318
http://www.dshs.state.tx.us/lab

Coloque la etiqueta de código de barra aquí

Sección 1. DATOS DEL REMITENTE – (REQUERIDO)**

Núm. de remitente y de TPI ** | Nombre del remitente **
Núm. de NPI ** | Dirección
Ciudad ** | Estado ** | Código Postal **
Núm. de teléfono ** | Contacto
Fax | Código de la clínica

Sección 2. DATOS DEL PACIENTE -- (REQUERIDO)**

NOTA: se **REQUIERE** el **nombre del paciente** en la muestra **y** éste **DEBE** ser el mismo que el nombre del formulario, la tarjeta de Medicare/Medicaid y el contenedor de la muestra.

Apellido ** | Primer nombre ** | Inicial del 2.º nombre
Dirección ** | Núm. de teléfono
Ciudad ** | Estado ** | Código Postal ** | País de origen/núm. de identificación binacional

Raza: ☐ Blanca ☐ Negra o afroamericana ☐ Amerindia/nativa de Alaska ☐ Asiática ☐ Nativa de Hawai/isleña del Pacífico ☐ Otra
Etnia: ☐ Hispana ☐ No hispana ☐ Se desconoce

Fecha de nacimiento (mm/dd/aaaa) ** | Edad | Sexo ** | Núm. de Seguro Social ** | Si es mujer, ¿está embarazada? ☐ Sí ☐ No ☐ Se desconoce

Fecha de obtención ** **(REQUERIDA)** | Hora de obtención | Obtenida por
Núm. de expediente médico/núm. de extranjero/CUI | Código diagnóstico de ICD ** | Núm. previo de laboratorio de muestras del DSHS
Fecha de aparición | Diagnóstico/síntomas | Riesgo

☐ Paciente interno ☐ Paciente externo ☐ Asociación de brote: ☐ Vigilancia

Sección 3. FUENTE O TIPO DE MUESTRA -- (REQUERIDO para muestras de micobacteriología)

☐ Absceso (sitio) __________
☐ Sangre
☐ Médula ósea
☐ Lavados bronquiales
☐ Cervical
☐ Fluido cerebroespinal
☐ Ocular
☐ Heces/deposición
☐ Gástrico
☐ Lesión (sitio) ___________
☐ Ganglio linfático (sitio) ________
☐ Nasofaríngeo
☐ Plasma
☐ Frotis rectal
☐ Suero
☐ Esputo: inducido
☐ Esputo: natural
☐ Frotis de garganta
☐ Tejido (sitio) ___________
☐ Uretral
☐ Orina
☐ Vaginal
☐ Herida (sitio) ___________
☐ Otro:

Sección 6. BACTERIOLOGÍA

NOTAS: @ = proporcione el historial del paciente al reverso del formulario para evitar que se retrase el procesamiento de la muestra.
♠ = pruebas cubiertas por Pasos Sanos de Texas o Programas de Niños Sanos del título V.
Para identificación y clasificación del cultivo puro, sírvase proporcionar las reacciones bioquímicas al reverso del formulario o adjunte una copia de la impresión bioquímica. Cada sección de prueba (Bacteriología, por ejemplo) requiere un formulario y una muestra por separado. Consulte las instrucciones del formulario para conocer los detalles de cómo rellenarlo. Puede encontrar los detalles de los requisitos de pruebas y muestras en el Manual de servicios de referencia de la Sección de Servicios de Laboratorio. Visite nuestro sitio web en http://www.dshs.state.tx.us/lab/.

Muestras clínicas:
☐ Aislamiento aeróbico
☐ Sonda amplificada (de gonorrea/clamidia solamente)
☐ Aislamiento anaeróbico

Cultivos puros:
☐ Identificación aeróbica solamente
Sospecha de organismo: ________________
☐ Identificación anaeróbica solamente

Sección 4. DATOS DEL MÉDICO -- (REQUERIDO)**

Nombre del médico **
UPIN del médico ** | **Núm. de NPI del médico ****

Sección 5. PAGADOR – (REQUERIDO)

Indique si debemos facturar al remitente, a Medicaid, a Medicare, al seguro privado o al programa del DSHS. Si indica Medicaid o Medicare, se requiere el número de Medicaid/Medicare. Si indica seguro privado o programa del DSHS, la siguiente información de facturación requerida se señala con un asterisco (*).
Si no provee la información requerida,
SE FACTURARÁ AL REMITENTE.

☐ Remitente ☐ Seguro privado
☐ Medicaid ☐ Medicare

Núm. de Medicaid/Medicare: ____________

Programas del DSHS:
☐ Subvención de BT
☐ VIH/enfermedades venéreas
☐ Inmunizaciones
☐ IDEAS
☐ Programa de Refugiados
☐ Pasos Sanos de Texas
☐ Otro: ______________
☐ Título V – Planificación familiar
☐ Título V – MCH
☐ Título X – Planificación familiar
☐ Título XX – Planificación familiar
☐ Tuberculosis
☐ Zoonosis

Nombre de la HMO/Atención dirigida/aseguradora *
Dirección *
Ciudad * | Estado * | Código Postal *
Núm. telefónico de aseguradora * | Núm. de id. de seguro de parte responsable *
Nombre del grupo * | Núm. del grupo *

"Por este conducto autorizo la divulgación de información relativa a los servicios aquí descritos y asimismo asigno toda prestación a la que tenga derecho a la Sección de Servicios de Laboratorio del Departamento Estatal de Servicios de Salud de Texas".
Firma del paciente o la parte responsable.

Firma * Fecha *

Sección 9. TERRORISMO QUÍMICO (CT)

☐ Perfil de CT (sangre y orina)
Justificación: ________________________

Sección 10. MICOBACTERIOLOGÍA/MICOLOGÍA

Muestras clínicas:
☐ Citología y cultivo AFB (bacilo acidoresistente)
☐ Cromatografía líquida (HPLC) directa solamente

Fecha de inicio de tratamiento con fármacos múltiples: _____________

Cultivos puros:
☐ Identificación de bacilo acidoresistente (AFB ID)
☐ Identificación micótica

Ejemplo

C

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☐ Botulismo **@**	Sospecha de organismo: ________________	☐ MTB: primer panel de fármacos
☐ Prueba de difteria	☐ Identificación de Campylobacter solamente	☐ MTB: segundo panel de fármacos
☐ Patógenos entéricos	*Estudios especiales:*	☐ MTB PZA
☐ Gonorrea/clamidia (sonda genética) ♠	☐ Estudios tóxicos	☐ Identificación de otros actinomicetos aeróbicos
☐ Cultivo de gonorrea	☐ Otro: ___________________________	☐ Otro:
☐ Cultivo de tos ferina	*Identificación y clasificación:*	**Sección 11. PARASITOLOGÍA**
☐ Prueba de estreptococo (sólo grupo B)	☐ E. coli (confirmación de EHEC)	☐ Parásitos en sangre/tejidos **@**
☐ Toxina/EHEC	☐ Haemophilus influenzae	☐ Parásitos intestinales **@**
☐ Toxina/otra: ____________________	☐ Neisseria meningitidis	☐ Identificación de lombrices **@**
Sección 7. ESTUDIOS MOLECULARES	☐ Salmonela	☐ Preparación de lombriz intestinal
☐ PCR para:	☐ Shigella	☐ Fijador: ______________________________
	☐ Otro:	☐ Coloración: _________________________________
☐ PFGE para:	**Sección 8. ENTOMOLOGÍA**	☐ Otro:
	☐ Identificación de insectos	
☐ Otro:	☐ Otro:	***FOR LABORATORY USE ONLY***
		☐ Room Temp. ☐ Cold ☐ Frozen

Ejemplo

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C.53 Guidelines: Tuberculosis Skin Testing (2 Pages)

DEPARTMENT OF STATE HEALTH SERVICES
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Purpose:

The tuberculosis intradermal skin test is used to detect tuberculosis infection.

- To detect infection, either past or present, with *Mycobacterium tuberculosis*.
- To serve as a diagnostic procedure in selected patients.

Equipment:

- PPD (purified protein derivative) tuberculin antigen
- Tuberculin syringe
- 1/4” to 1/2”, 27-gauge needle
- Alcohol sponge or swab

Procedures:

Nursing Action:	Rationale/Amplification:
1. Determine if patient has ever had BCG vaccine, a previously positive skin test, recent viral disease or immunization with a live virus vaccine within the last 30 days, immunosuppression by disease, drugs, or steroids.	1. A history of BCG vaccine should be documented but does not cancel the need for tuberculin skin testing.
2. Draw up 0.1 ml of PPD-tuberculin into tuberculin syringe. Each 0.1 ml should contain 5 TU (tuberculin units of PPD-tuberculin).	2. Use immediately to avoid adsorption onto the plastic/glass syringe.
3. Cleanse the skin of the volar (palm side) surface of the **left** arm with alcohol. Allow to dry.	3. An intradermal test may be applied at any site but the use of the left arm is practiced universally to facilitate identifying the location of the injection site by the health care worker who reads the test. If the test is applied at another site, document the exact site of injection.
4. Stretch the skin taut.	4. Facilitates the introduction of the needle.
5. Hold the tuberculin syringe close to the skin, bevel up, so that the hub of the needle touches it as the needle is introduced.	5. Holding the syringe in this way will reduce the needle angle at the skin surface, promoting the correct entry for a proper intradermal injection.
6. Inject the tuberculin into the superficial layer of the skin to form a wheal 6mm to 10 mm in diameter.	6. If no wheal appears (because the injection was made too deep), or the wheal is smaller than 6 mm (because the needle was not under the skin and part of the antigen leaked on the outer surface of the skin), reapply test at another site at least five centimeters (two inches) from the original site.

To Read the Test:	Further Clarification to Reading the Test:
1. Read the test within 48–72 hours.	1. Tuberculin skin tests are tests of delayed hypersensitivity.
2. Have a good light available. Flex the forearm slightly at the elbow.	
3. Inspect for the presence of induration. Inspect from a side view against the light. Inspect by direct light.	3. Induration refers to hardening or thickening of the tissues.
4. Palpate: lightly rub the finger across the injection site from the area of normal skin to the area of induration. Outline the diameter of induration.	
5. Measure the maximum transverse diameter of induration (not erythema) in millimeters with a flexible ruler.	5. Erythema (redness) without induration is generally considered to be of no significance.

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DEPARTMENT OF STATE HEALTH SERVICES
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Procedures

Interpretation

1. Negative reaction: An induration of 0–< 5 mm

2. Positive Reaction:
   a. An induration of 5 mm or more is considered to be positive for:
      1) HIV-positive persons
      2) Recent contacts of TB case
      3) Individuals with fibrotic changes on chest radiograph consistent with old TB
      4) Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of > 15 mg/d Prednisone for > 1 month)
   b. An induration of 10 mm or more is considered to be positive for:
      1) Recent arrivals (< 5 yr) from high-prevalence countries
      2) Injection drug users
      3) Residents and employees* of high-risk congregate settings: prisons and jails, nursing homes and other healthcare facilities, residential facilites for AIDS patients, and homeless shelters
      4) Mycobacteriology laboratory personnel
      5) Persons with clinical conditions that make them high-risk: silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head or neck and lung), weight loss of > 10 % of ideal body weight, gastrectomy, jejunoileal bypass
      6) Children < 4 yrs of age or infants, children, and adolescents exposed to adults in high-risk categories
   c. An induration of 15 mm or more is considered to be positive in individuals with no risk factors for tuberculosis

1. This shows either a lack of tuberculin sensitivity or a low grade sensitivity that most likely is not caused by M. tuberculosis. A negative test does not rule out the presence of tuberculosis. Because of the possibility of a false-negative result, the tuberculin skin test should never be used to exclude the possibility of active disease among persons for whom the diagnosis is being considered.

2a. A positive reaction indicates that a patient has had contact with the bacillus that causes tuberculosis. It does not necessarily mean that active disease is present in the lung; however, further evaluation is required.
Individuals who are in close contact with persons with active tuberculosis and who have reactions ≥ 5 mm should be considered positive and be evalutated for treatment of either latent tuberculosis infection or active tuberculosis disease.

2b. Individuals with skin test results of ≥ 10 mm should be evaluated for treatment of either latent tuberculosis infection or active tuberculosis disease.
Note: For persons with negative tuberculin skin test reactions who undergo repeat skin testing (e.g., healthcare workers), an increase in reaction size of 10 mm or more within a period of 2 yrs should be considered a skin test conversion indicative of recent infection with *M. tuberculosis*. In some individuals who have been infected with nontuberculous mycobacteria or have undergone BCG vaccination, the skin test may show some degree of induration. For these individuals, a conversion to "positive" is defined as an increase in induration by 10 mm on subsequent tests.

2b3. * For persons who are otherwise at low risk and are tested at entry into employment, a reaction of > 15 mm induration is considered positive.

Documentation

1. Record name of antigen, manufacturer, lot number, date of testing, and date of reading.
2. Record site of application of test if applied at site other than the left volar surface.
3. Record the size of induration.

References

1. Diagnostic Standards and Classification of Tuberculosis in Adults and Children, *Am J Respir Crit Care Med*; 161, pp 1376–1395, 2000
2. Interactive Core Curriculum on Tuberculosis: What the Clinician Should Know, CDC, 2004, www.cdc.gov/nchstp/tb/webcourses/CoreCurr/index.htm
3. Mantoux Tuberculin Skin Test Facilitator Guide, CDC, 2003, www.cdc.gov/nchstp/tb/pubs/Mantoux/tableofcontents.htm

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C.54 Tuberculosis (TB) Screening and Education Tool

This screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing. In areas of high TB prevalence, the screening tool need not be done at visits for which tuberculin skin testing is required: 1 year of age, once between 4 through 6 years of age, and once between 11 through 17 years of age.

The questions in this screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the child's community may need to be added.

- If all the answers are unqualified negatives, the child is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is "Yes" or "I don't know," the child should be tuberculin skin tested.
- In the case of the child for whom an answer in the past of "Yes" or "I don't know" prompted a skin test, which was negative, the skin test *may* not have to be repeated annually.
- The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- Bacillus of Calmette and Guérin (BCG) vaccinated children should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Children who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of children who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB.
- A chest X-ray to rule out active disease.
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present.
- A report to the local health authority for investigation to find the source of the infection.

Feel free to photocopy the screening and education tool from this publication.

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C.55 TB Questionnaire

Name of Child____Date of Birth ________________

Organization administering questionnaire_______________________________________ Date_______________________

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?______________________________________			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

For school/healthcare provider use only
****
PPD administered Yes___ No___
If yes,
Date administered _____/_____/______ Date read ______/______/_______ Result of PPD test __________ mm response

Type of service provider (i.e. school, Health Steps, other clinics) ____

PPD provider ____ _______________________________________
signature printed name

Provider phone number ____________________________________

City ____ County ____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider ____

EF12-11494 TB Questionnaire for Children (Rev. 08/04)

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C.56 Cuestionario Para la Detección de Tuberculosis

Nombre del niño o niña ____

Organización ________________________________ Fecha ______________

La Tuberculosis (TB) es una enfermedad causada por gérmenes de TB y en la mayoriá de los casos es trasmitida por una persona adulta con tuberculosis pulmonar activa. Se transmite a otra persona por la tos y por el estornudo al expelir gérmenes de TB al aire que pueden ser respirados por los niños.

Los adultos que tienen la enfermedad activa casi siempre tienen varios de los siguientes síntomas: tos con duración de más de dos semanas, pérdida de apetito, pérdida de peso de diez libras o más en un período corto de tiempo, fiebre, escalofríos y sudores nocturnos.

Una persona puede tener gérmenes de TB en su cuerpo pero no tener la enfermedad activa. Esto se llama infección latente de TB (o LTBI por su sigla en inglés).

La TB es prevenible y curable. La prueba tuberculínica, también llamada PPD o prueba de Mantoux, se utiliza para saber si su niño o niña ha sido infectado/a con el germen de TB. No se recomienda ninguna vacuna para prevenir la tuberculosis. La prueba tuberculínica no es una vacuna contra la tuberculosis.

Necesitamos de su ayuda para saber si su niño/niña ha sido expuesto/a a la tuberculosis.

	Sí	No	No se sabe
La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos severa (con más de dos semanas de duración), o tos con sangre. ¿Es de su conocimiento si: su niño o niña ha estado cerca de algún adulto con esos síntomas o problemas? su niño o niña ha tenido algunos de estos síntomas o problemas? su niño o niña ha estado cerca de alguna persona enferma de tuberculosis?			
¿Su niño o niña nació en México en o cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia?			
¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia durante el último año por más de 3 semanas? Si su respuesta es positiva, favor de especificar a qué país o países.			
¿Es de su conocimiento, si su niño o niña pasó un tiempo (más de 3 semanas) con alguna persona que es o ha sido usuario de droga intravenosa (IV), infectado por VIH, en la prisión, o haya llegado recientemente a los Estados Unidos?			

¿A su niño o niña se le ha realizado la prueba tuberculínica recientemente? Sí___ (si sí, especifique la fecha ____/____) No___
¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina? Sí___ (si sí, especifique la fecha ____/____) No___

Solamente para uso de la escuela o del proveedor de servicios médicos
****
¿Se administró PPD? Sí___ No___
Si sí,
Fecha en que fue administrada_____/_____/_____ Fecha de lectura _____/______/_____ Resultado de la prueba_____ mm

Tipo de proveedor de servicio (ej.: escuela, Health Steps, otras clínicas) ______________________

Administrador de PPD ______________________ ______________________
firma nombre en letra de molde (imprenta)

Número de teléfono del administrador de PPD ____________________

Ciudad________________________ Condado____________________

Si resultó positivo, ¿se refirió al proveedor de servicios de salud? Sí___ No___

Si sí, nombre del proveedor (médico o clínica, etc.) ______________________________

TEXAS Department of State Health Services

EF12-11494A (Rev. 08/04)

C

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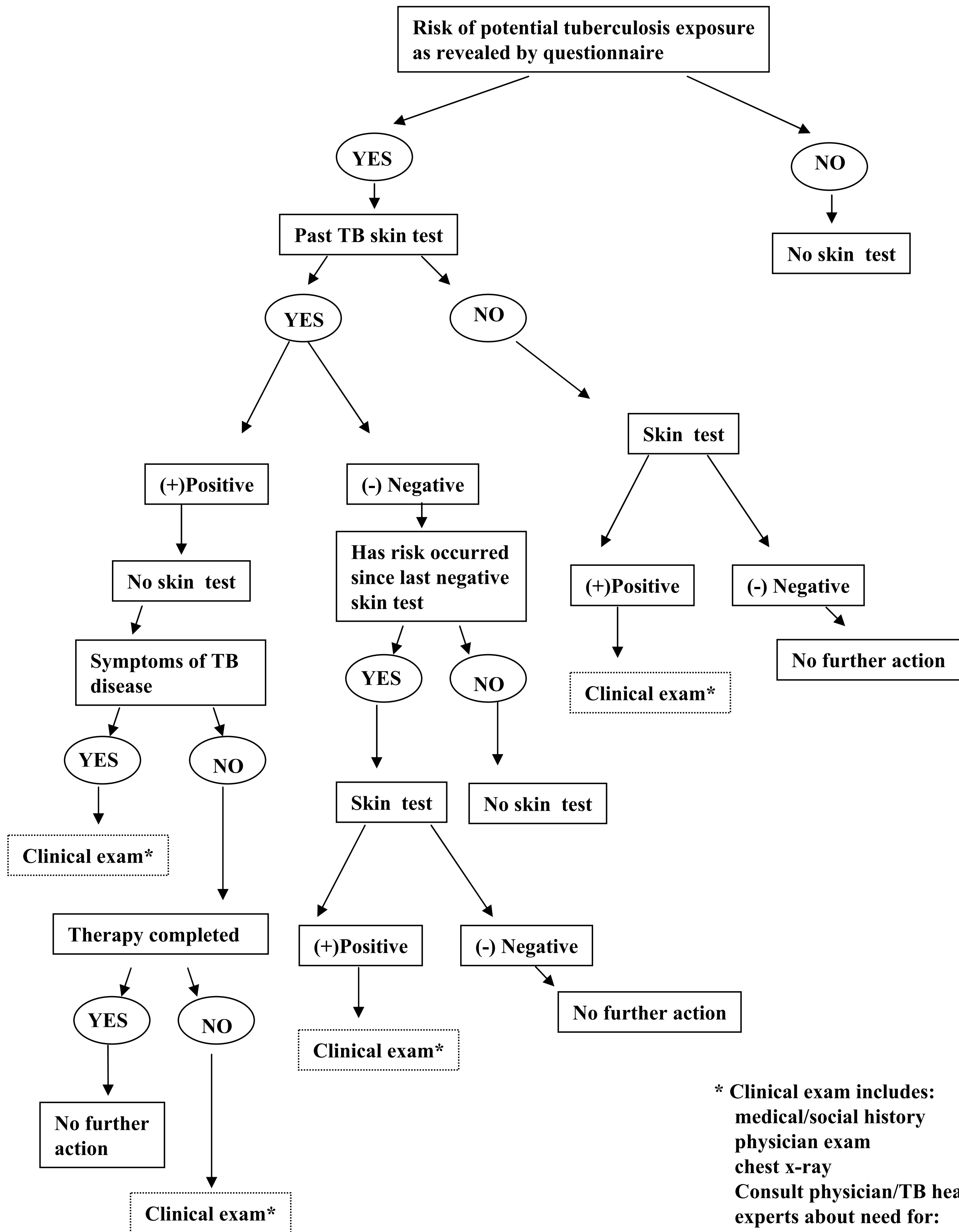
C.57 How to Determine TB Risk



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C.58 PPD Agreement for Texas Health Steps Providers

Infectious Disease Control Unit
PPD Agreement for Texas Health Steps Providers

Please Print
Facility Name: ____

Address: ___________________________(City, State)_______________(Zip)__________

Provider Name: ______________________________ Provider Title: ____________________

Contact Name: ______________________________ Contact Title: ____________________

Contact Phone: ______________________________ Contact Fax: ____________________

In order to receive State-supplied PPD at no cost to me, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization of which I am the physician in charge or equivalent, agree to the following:

1. I agree to provide/arrange training for all personnel in administering, reading, and recording the TB skin test results. I agree to instruct all patients that the TB skin test is a two (2)-part test and they must return in 48 to 72 hours for their test to be read by trained personnel so the test result can be documented. I agree to have all results documented in millimeters and a negative test will be recorded as 0 mm not negative. I agree to supply written documentation of the training to administer TB skin testing, reading and recording upon request of the health department issuing the PPD.
2. I agree to do the screening for TB risk factors on each patient and **ONLY** place the TB skin test on those patients that have a **TB risk factor or have some other medical necessity that is documented in their chart or are entering foster care**.
3. I agree to submit TB-400 forms or refer clients to the health department for medical evaluation or additional follow-up when they have latent TB infection (positive skin test result and a negative chest x-ray).
4. In accordance with the Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter A, I shall report to the local health authority any known or suspected case of TB within one working day and any new diagnosis of latent TB infection within one week.
5. I agree to submit the Monthly Tuberculin Skin Testing Form (EF12-12168). This form will be sent at the first of each month showing our TB testing numbers for the previous month. I agree to monitor my stock levels so that emergency orders will be kept to a minimum.
6. As a private clinic or health care facility, I agree to use this PPD only for TB screening of children as part of a Texas Health Steps medical check-up and to identify and document TB risk factors before placing the PPD.
7. Either the State or I may terminate this agreement at any time. My failure or the failure of any others outlined above to comply with these requirements will be grounds for the State to terminate this agreement.

____ ______________________

Provider Signature Date
Sign and Return to:

A copy of this agreement will be returned to you.

____ ______________________

Health Department Representative Signature Date

EF12-12105 PPD Agreement (Rev. 6/05)

C

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C.59 TVFC Patient Eligibility Screening Record

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: ______________________________

Child's Name:

____
Last Name First Name MI

Child's Date of Birth: ________/________/________

Parent/Guardian/Individual of Record:

____
Last Name First Name MI

Provider's/Clinic's Name:

____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one)*:

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance, or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage) *, or
- ☐ (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
- ☐ (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
- ☐ **None of the above, not eligible for TVFC vaccine**

Signature: ______________________________ Date: ____________________

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Texas Department of State Health Services
Immunization Branch

Stock No. C-10
Revised 09/05

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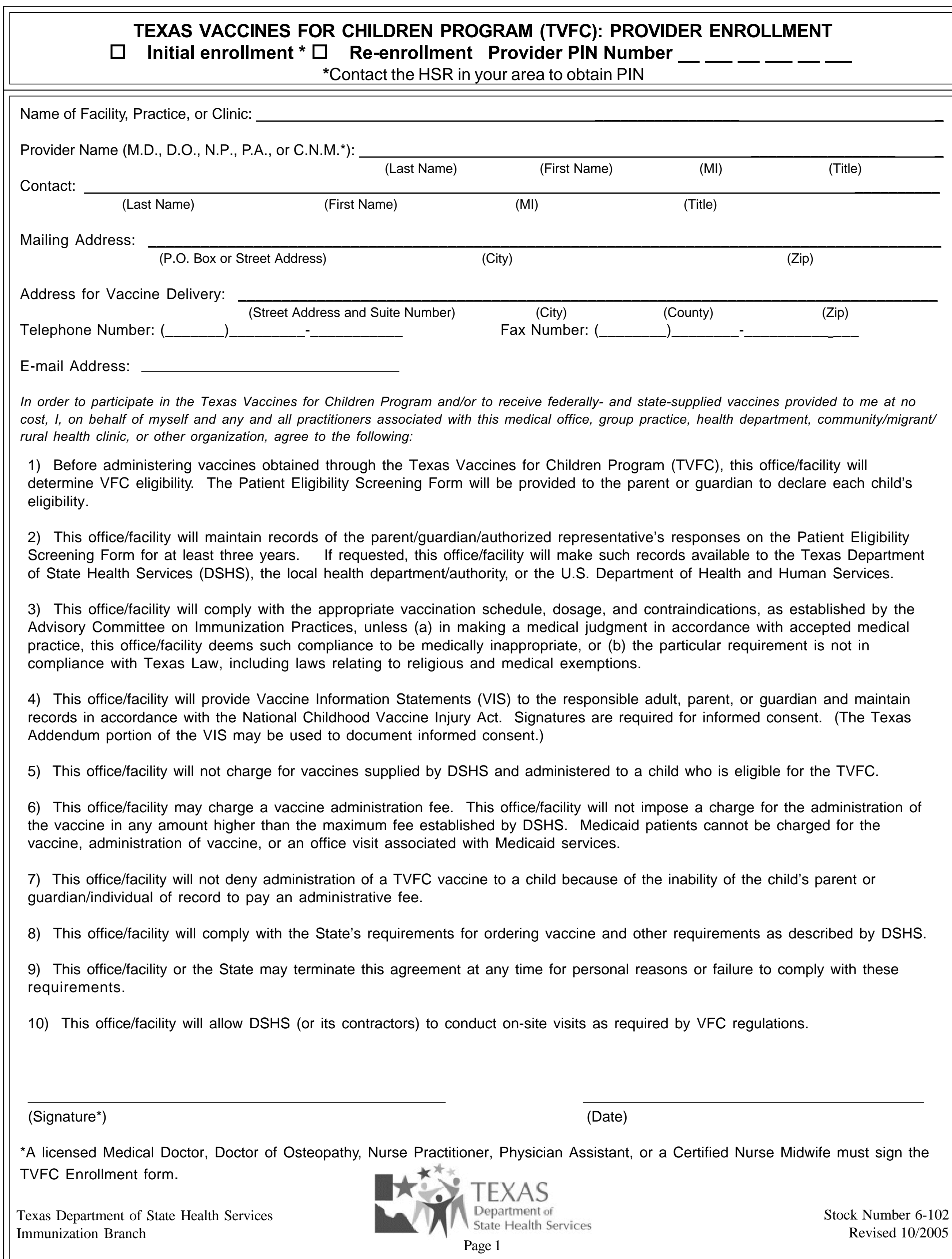
C.60 TVFC Provider Enrollment (3 Pages)



TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

☐ Initial enrollment * ☐ Re-enrollment Provider PIN Number __ __ __ __ __ __

*Contact the HSR in your area to obtain PIN

Name of Facility, Practice, or Clinic: ____________________

Provider Name (M.D., D.O., N.P., P.A., or C.N.M.*): ____________________
(Last Name) (First Name) (MI) (Title)

Contact: ____________________
(Last Name) (First Name) (MI) (Title)

Mailing Address: ____________________
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: ____________________
(Street Address and Suite Number) (City) (County) (Zip)

Telephone Number: (_______)_________-___________ Fax Number: (________)________-___________

E-mail Address: ____________________

In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/ rural health clinic, or other organization, agree to the following:

1) Before administering vaccines obtained through the Texas Vaccines for Children Program (TVFC), this office/facility will determine VFC eligibility. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.

2) This office/facility will maintain records of the parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.

3) This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.

4) This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)

5) This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.

6) This office/facility may charge a vaccine administration fee. This office/facility will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee established by DSHS. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services.

7) This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.

8) This office/facility will comply with the State's requirements for ordering vaccine and other requirements as described by DSHS.

9) This office/facility or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

10) This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

______________________ ______________________
(Signature*) (Date)

*A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife must sign the TVFC Enrollment form.

Texas Department of State Health Services
Immunization Branch

Stock Number 6-102
Revised 10/2005

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TEXAS VACCINES FOR CHILDREN PROGRAM
PROVIDER PROFILE FOR PIN ___ ___ ___ ___ ___ ___

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic?
(Circle one) YES NO

Type of Clinic: (√check one)

- ☐ Public Health Department/District
- ☐ Public Hospital
- ☐ Other Public Clinic
- ☐ Private Hospital
- ☐ Private Practice (Individual or Group)
- ☐ Other Private Clinic

PATIENT PROFILE:

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1-6 years	7-18 years	Total
Enrolled in Medicaid.				
Uninsured. *(Note: Children enrolled in Health Maintenance Organizations are considered insured)*				
American Indians.				
Alaskan Natives.				
Underinsured. (Has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage)				
(For Public Health Clinic Use ONLY) Children who do not meet any of the above criteria, but still receive vaccinations at **public health clinics.**				
Children who receive benefits from the Children's Health Insurance Plan (CHIP).				
Children who are vaccinated in your practice, but are **NOT** TVFC-eligible.				
TOTAL PATIENTS: (Add columns)				

TEXAS VACCINES FOR CHILDREN PROGRAM
PROVIDER LIST

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (List provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)

TEXAS Department of State Health Services

Texas Department of State Health Services
Immunization Branch

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Revised 10/2005

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TEXAS VACCINES FOR CHILDREN PROGRAM
Provider List-Addendum for PIN ___ ___ ___ ___ ___ ___

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (List provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	National Provider Identification	Medical License Number	Specialty (Family Medicine, Pediatrics, etc.)

Texas Department of State Health Services
Immunization Branch

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Revised 10/2005

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C.61 TVFC Questions and Answers (3 Pages)

Texas Vaccines For Children Program

Questions and Answers

Texas Vaccines For Children Program

Question 1: *What is the Texas Vaccines For Children Program (TVFC)?*

Answer: *This is our version of the Federal Vaccines For Children (VFC) Program. The TVFC was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to providers, in order to immunize children who meet the eligibility requirements.*

Why Enroll?

Question 2: *Why should a health care provider enroll in the TVFC Program?*

Answer:

- *You can get free vaccine for your eligible patients.*
- *You will not need to refer patients to public clinics for vaccines.*
- *You can provide immunizations to your patients as part of a comprehensive care package, this will enhance the opportunity for patients to find a medical home.*

Patients Served

Question 3: *Once enrolled, are providers required to immunize children who are not their patients?*

Answer: *No. You control whom you see in your practice.*

Children Who Qualify

Question 4: *Which children qualify for free vaccines?*

Answer: *All children are eligible for free vaccine, except:*

- *Children with insurance that pays for immunization services, and*
- *Children whose parents or guardians are able to pay for copayments or deductibles for immunization services.*

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Texas Vaccines For Children Program

Questions and Answers

CHIP Enrollment

Question 5: Are children who are enrolled in CHIP eligible?

Answer: Yes, through special arrangement CHIP children are also eligible.

Medicaid Enrollment

Question 6: To participate in TVFC, must providers enroll as a state Medicaid provider?

Answer: No. However, if you are enrolled in the state Medicaid Program, you must enroll in the TVFC Program in order to receive free vaccine.

Question 7: Will the Texas Medicaid Program reimburse private practitioners for vaccines administered to Medicaid patients?

Answer: No. Medicaid reimburses for the administration fee. The Medicaid vaccine administration fee is $5.00 per vaccine dose administered.

Vaccine Related Fees

Question 8: Why are there fee caps on what providers can charge to administer the vaccine?

Answer: Federal Legislation requires fee caps for administration on a statewide basis that balance the provider's financial need and the patient's ability to pay.

Question 8: Will TVFC pay an administration fee for non-Medicaid, TVFC eligible children?

Answer: No. For non-Medicaid, TVFC eligible children, providers can charge a maximum of $14.85 per vaccine; administration fee may not exceed this amount. (Combination vaccines such as DTaP are considered one vaccine.)

Texas Department of State Health Services
Immunization Division

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Revised 07/2005

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Texas Vaccines For Children Program

Questions and Answers

Question 10: *Will providers be required to increase the amount of vaccine information materials they provide to parents because of the TVFC Program?*

Answer: *No. Materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.*

Eligibility Status

Question 11: *Must providers ask the patient's eligibility status each time the patient comes for a vaccine visit?*

Answer: *No. Providers need only update eligibility status whenever there is reason to believe a child's eligibility status has changed.*

Question 12: *How are providers expected to verify responses for vaccine eligibility?*

Answer: *Providers are not expected to do anything more than ask the patient what the child's eligibility status is and then record the response. The parent can complete the Patient Eligibility Screening Form.*

Question 13: *Why must providers complete a Provider Profile describing patients by eligibility category?*

Answer: *This information allows the Texas Department of State Health Services to determine how the cost of vaccine will be divided among state and federal funds. Each year, you may find your profile information has changed. The Provider Profile must be updated annually, in accordance with Federal requirements.*

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Claim Form Examples

Note: *This section contains claim form examples* only. *These examples are not accurate depictions of claim form data required for claims adjudication. Refer to Section 4 "Claims Filing" for information about completing claim forms for submission to TMHP.*

Claims prepared by computer billing services or office-based computers may have "Signature on File" printed in the signature block. Printing of the provider's name instead of "Signature on File" is not acceptable.

Refer to: "Provider Signature on Claims" on page 5-23 for more details.

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D.2 Ambulance 2 . . . . D-3
D.3 Ambulance 3 . . . . D-4
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D.7 Blind Children's Vocational Discovery and Development Program (BCVDDP) D-6
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D.9 Case Management for Children and Pregnant Women (CPW) D-7
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D.11 Certified Registered Nurse Anesthetist (CRNA) D-8
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D.35 Licensed Clinical Social Worker (LCSW) D-20

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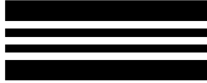
D.1 Ambulance 1

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pye, Sherrie

3. PATIENT'S BIRTH DATE MM DD YY: 02 02 1970 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 341 Tosser Way

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Houston STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 77485 TELEPHONE (Include Area Code): (123) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 879.3
2. 459.
3. 958.0
4. 780.09

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	3	9	A0429	SH	1	40 00	1				
2	01 01 2007	01 01 2007	3	9	A0422		1	20 00	1				
3	01 01 2007	01 01 2007	3	9	A0382		2	2 00	2				
4	01 01 2007	01 01 2007	3	9	A0382		1	15 00	5				
5	01 01 2007	01 01 2007	3	9	A0425	ET		48 00	8				
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 123 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Junction Hospital
332 Junction Street
Houston, TX 77883

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Spindle Ambulance
4000 Main Street
Houston, TX 77883

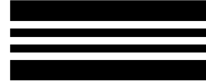
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.2 Ambulance 2

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Catherine

3. PATIENT'S BIRTH DATE MM DD YY: 05 28 1964 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 338 West Boone

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Belvedere STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 77435 TELEPHONE (Include Area Code): (123) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 585.9
2. 344.00
3. V13.5
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	5	9	A0382		1	15 00	1				
2	01 01 2007	01 01 2007	5	9	A0428	RG	1	150 00	1				
3	01 01 2007	01 01 2007	5	9	A0425		1	125 00	50				
4	01 01 2007	01 01 2007	5	9	A0422		1	30 00	1				
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 320 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Duke Wellington

SIGNED DATE 01 08 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Get Well Hospital
9929 Seventh Street
Anytown, TX 77883

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Wellington Ambulance
2222 Tulia
Randall, TX 77777

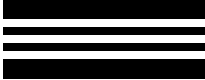
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.3 Ambulance 3

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Tracy, Bill

3. PATIENT'S BIRTH DATE MM DD YY: 05 02 1960 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 2242 Spencer

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY: San Antonio STATE: TX

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY STATE

ZIP CODE: 78228 TELEPHONE (Include Area Code): (123) 555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 994 7 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	3	9	A0429	RH	1	200 00	1				
01 01 2007	01 01 2007	3	9	A0425	ET	1	30 00	6				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 230 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mike Harrahan 01 10 2007

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Texas Hospital
209 West 45th Street
Anywhere, TX 78500

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Harrahan Ambulance
345 Morning Star
San Antonio, TX 77777

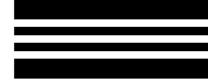
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.4 Ambulatory Surgical Center

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Reddig, Sarah J.

3. PATIENT'S BIRTH DATE MM DD YY: 08 12 1927 SEX M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 901 East Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY: Del Rio STATE: TX

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY STATE

ZIP CODE: 78840 TELEPHONE (Include Area Code): (123) 555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Charles Sotos, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9876543-21

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3669 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	5	F	66984	LT	1	750 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 750 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Raquel Del Sol 01 10 2007

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Del Rio Surgery Center
345 Morning Star
San Antonio, TX 77777
210-555-1234

PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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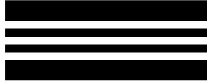
CPT only copyright 2005 American Medical Association. All rights reserved.

D.5 Anesthesia

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stirney, Brenda K.
3. PATIENT'S BIRTH DATE MM DD YY: 01 04 1960 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 1200 N. Main Street
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):
CITY: Bay City — STATE: TX
8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY — STATE
ZIP CODE: 12345 — TELEPHONE (Include Area Code): (123) 555-1234
ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] — PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED **Signature on File**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — MM DD YY: 04 03 2004
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [ ] — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 641.01
2. 646.21
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1. 01 01 2007	01 01 2007	3	7	00857 AA	1	500 00					
				Time: 53 minutes							
2											
3											
4											
5											
6											

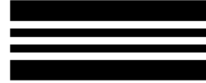
PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 123456
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 500 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Susan Johnson, M.D.
SIGNED — DATE 01 08 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Doctor's Hospital
3321 Medical Drive
Bay City, TX 77414
1234567-89
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Susan Johnson, M.D.
438 Norlins Way
Bay City, TX 77414
PIN# — GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.6 Birthing Center

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Nora K.
3. PATIENT'S BIRTH DATE MM DD YY: 12 01 1974 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 901 East Street
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):
CITY: San Antonio — STATE: TX
8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY — STATE
ZIP CODE: 78218 — TELEPHONE (Include Area Code): (210) 555-1234
ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] — PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — MM DD YY: 04 03 2006
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Mary Smith, CNM
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [X] — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 650. ___
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1. 01 01 2007	01 01 2007	7	P	59409	1	503 84	1				
2											
3											
4											
5											
6											

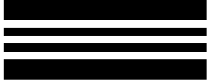
PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 503 84
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Sally Jones
SIGNED — DATE 01 09 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
South Texas Birthing Center
1118 Rio Grande
San Antonio, TX 78201
PIN# — GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.7 Blind Children's Vocational Discovery and Development Program (BCVDDP)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) [X] (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Martin, Joel M.

3. PATIENT'S BIRTH DATE MM DD YY: 12 20 1992 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 563 Magicians Ct.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Pharr STATE: TX

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 78535 TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 369 . 00
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2007	01 01 2007	2	1	G9012	1	100 00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Richard Glass
SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

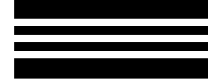
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Texas Commission for the Blind
1200 Front St.
Pharr, TX 78201
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.8 Case Management for Early Childhood Intervention (ECI)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) [X] (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Monroe, Angela T.

3. PATIENT'S BIRTH DATE MM DD YY: 07 16 2005 SEX M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 12 Rodeo Drive

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Blanco STATE: TX

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 78606 TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 315 . 9
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2007	01 01 2007	2	1	G9012	1	141 83	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 141 83

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Tom White
SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ECI Program
1223 Baltic Ave.
Blanco, TX 78606
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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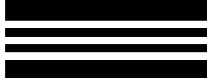
CPT only copyright 2005 American Medical Association. All rights reserved.

D.9 Case Management for Children and Pregnant Women (CPW)

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Barton, Josie M.
3. PATIENT'S BIRTH DATE MM DD YY: 10 15 2000 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 300 Atlantic Ave.
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)
CITY: Paris STATE: TX
8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY / STATE
ZIP CODE: 75460 TELEPHONE (Include Area Code): (903) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ____ DATE ____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 343 80   3. ___ . __
2. ___ . __   4. ___ . __
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 9892126567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	1	G9012	U2 U5	1	60 00	1				1765432-08
01 25 2007	01 25 2007	1	1	G9012	TS U5	1	60 00	1				1765432-08
02 10 2007	02 10 2007	9	1	G9012	TS	1	20 00	1				1765432-08

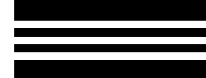
25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE: $ 140 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robert Jackson
SIGNED DATE 02 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
123 Case Management Inc.
1200 Medical Circle
Paris, TX 75460
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.10 Certified Nurse-Midwife (CNM)

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Green, Kelly J.
3. PATIENT'S BIRTH DATE MM DD YY: 06 10 1970 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 901 East Street
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)
CITY: San Antonio STATE: TX
8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY / STATE
ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE ____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 04 02 2006
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V22 0   3. ___ . __
2. 650   4. ___ . __
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	2	99211	TH	1	22 80					
01 08 2007	01 08 2007	2	2	59410		2	700 00					

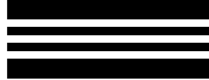
25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO
28. TOTAL CHARGE: $ 722 80
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Alicia Thomas, CNM
SIGNED DATE 01 17 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Sisters of Mercy Hospital
1242 Bogen Blvd.
Texas City, TX 77592
1234567-89
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Alicia Thomas, CNM
184 Marron Way
Texas City, TX 77592
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.11 Certified Registered Nurse Anesthetist (CRNA)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Janet M.

3. PATIENT'S BIRTH DATE MM DD YY: 06 05 1956 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 800 Avenue C

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Austin STATE: TX

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY STATE

ZIP CODE: 78710 TELEPHONE (Include Area Code): (512) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V25 2
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	3	7	00950 QX 2S	1	131 75	55 minutes				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 131 75

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Sarah Jones RN, CRNA

SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Texas Hospital
1234 Medical Way
Austin, TX 78712
1234567-89

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Sarah Jones RN, CRNA
1234 Main Street
Austin, TX 78712

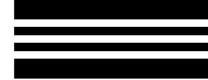
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.12 Certified Respiratory Care Practitioner (CRCP)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hanson, Patricia A.

3. PATIENT'S BIRTH DATE MM DD YY: 05 27 1963 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 422 Pine Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Laredo STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (210) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY 12 29 98 ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: B.J. Higgins, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 518 5
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 123456789

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 07 2007	2	1	99503	1	466 76	7				
2	01 12 2007	01 12 2007	2	1	99503	1	1111 26	1				
3	01 16 2007	01 16 2007	2	1	99503	1	66 68	1				
4	01 20 2007	01 20 2007	2	1	99503	1	66 68	1				
5	01 21 2007	01 21 2007	2	1	99503	1	854 15	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 2565 53

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Julie Harris, RCP

SIGNED DATE 01 24 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Julie Harris, RCP
1204 East Ave.
Laredo, TX 78041

PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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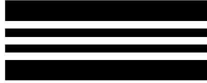
CPT only copyright 2005 American Medical Association. All rights reserved.

D.13 Chemical Dependency Treatment Facility

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John
3. PATIENT'S BIRTH DATE MM DD YY: 03 17 1980 SEX M [X] F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 920 Chaning Way
6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)
CITY: Dallas STATE: TX
8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student
CITY / STATE
ZIP CODE: 75235 TELEPHONE (Include Area Code): (123) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES [X] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Samuel Jones, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 304 . 90
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	5	9	H0005 | HF	1	16 00	1				
01 01 2007	01 01 2007	5	9	H0004 | HF	1	47 00					

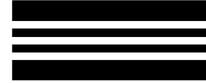
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO
28. TOTAL CHARGE: $ 63 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Joe Harris
SIGNED DATE: 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Chemical Dependency of Texas
111 Medical Way
Dallas, TX 75213
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.14 Chiropractic Services

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Clara
3. PATIENT'S BIRTH DATE MM DD YY: 09 23 1986 SEX M F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1424 Ridgeway
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)
CITY: West STATE: TX
8. PATIENT STATUS: Single [X] Married / Other; Employed / Full-Time Student / Part-Time Student
CITY / STATE
ZIP CODE: 78212 TELEPHONE (Include Area Code): (817) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES [X] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839 . 03 Acute subluxation of spine-C3 x-rays 12/01/2004
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	1	98941 | AT	1	25 00					
01 03 2007	01 03 2007	1	1	98940 | AT	1	25 00					

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO
28. TOTAL CHARGE: $ 50 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Carl Smith, DC
SIGNED DATE: 01 15 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Carl Smith, D.C.
3207 Main Street
West, TX 78213
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.15 Comprehensive Outpatient Rehabilitation Facility (CORF) (THSteps-CCP Only)

APPROVED OMB NO. 0938-0279

Rehabilitation Health Center
2600 West Drive
Texarkana, TX 75503
903-555-1234

3 PATIENT CONTROL NO.: 12345
4 TYPE OF BILL: 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 01232006 THROUGH: 01292006
7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11
12 PATIENT NAME: Freeman, Angela
13 PATIENT ADDRESS: 9504 Dale St., Houston, TX 77057
14 BIRTHDATE: 03241995
15 SEX: F
16 MS
ADMISSION 17 DATE: 01232007
18 HR: 10
19 TYPE 20 SRC 21 D HR 22 STAT
23 MEDICAL RECORD NO.: 123456
CONDITION CODES 24 25 26 27 28 29 30 31
32–35 OCCURRENCE CODE DATE; 36 OCCURRENCE SPAN CODE FROM THROUGH; 37
38
39 VALUE CODES CODE AMOUNT; 40 VALUE CODES CODE AMOUNT; 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
424	Comp. Outpatient Therapy Eval.	1-97001	01232007	1	40 00		
440	Speech Therapy	1-92506	01252007	1	50 00		
420	Physical Therapy	1-97110	01292007	1	45 00		
		Total Charges			135 00		

50 PAYER: Medicaid
51 PROVIDER NO.: 9876543-21
52 REL INFO 53 ASG BEN 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56
57 DUE FROM PATIENT ▶
58 INSURED'S NAME: Hearn, Jennifer K.
59 P. REL
60 CERT. - SSN - HIC. - ID NO.: 123456789
61 GROUP NAME 62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES: 123456789
64 ESC 65 EMPLOYER NAME 66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.: 34210
68–75 CODE
76 ADM. DIAG. CD.: 34210
77 E-CODE 78
79 P.C. 80 PRINCIPAL PROCEDURE CODE DATE; 81 OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID: TXBE1234
83 OTHER PHYS. ID
84 REMARKS: Hemplegia, Spastic
85 PROVIDER REPRESENTATIVE: X *John Smith, MD*
86 DATE: 02 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.16 Dental (Doctor of Dentistry)

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER — (Medicaid #) X
1a. INSURED'S I.D. NUMBER: 123456789
2. PATIENT'S NAME: Sanches, Donna K.
3. PATIENT'S BIRTH DATE: 02 14 1943 SEX: F X
4. INSURED'S NAME
5. PATIENT'S ADDRESS: 8001 Austin Place
6. PATIENT RELATIONSHIP TO INSURED: Self X
7. INSURED'S ADDRESS
CITY: East STATE: TX
8. PATIENT STATUS: Married X
ZIP CODE: 72342 TELEPHONE: (817) 555-1234
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? NO X; b. AUTO ACCIDENT? NO X; c. OTHER ACCIDENT? NO X
10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: **Signature on File** DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jeff Jones, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? NO X
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 208 00 2. 522 5
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 099011997

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	2	41850		2	52 94	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 123456
27. ACCEPT ASSIGNMENT? YES X
28. TOTAL CHARGE: $ 52 94
29. AMOUNT PAID 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: **Signature on File** DATE: 01 01 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: John Brown, D.D.S., 1414 Green St., East, TX 72341; GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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D.17 Diagnosis and Treatment (Referral from THSteps Checkup)

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Braunfeld, Gerald
3. PATIENT'S BIRTH DATE (MM DD YY): 04 09 1994 — SEX: M [X] F
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 2608 Best Street
6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street):
CITY: Dallas — STATE: TX
8. PATIENT STATUS: Single / Married / Other
CITY / STATE
ZIP CODE: 75227 — TELEPHONE (Include Area Code): (123) 555-1234
Employed / Full-Time Student / Part-Time Student
ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [X] NO
a. INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M F
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M F
b. AUTO ACCIDENT?: YES [X] NO — PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT?: YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?: YES / NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ______ DATE ______
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM — TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Sidney Medical Clinic
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM — TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?: YES / NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 493 90
2.
3.
4.
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	99213		1	40 00	1				
2	01 01 2007	01 01 2007	1	4	71010		1	45 00	1				
3	01 01 2007	01 01 2007	1	1	J0170		1	18 00	1				
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 1234567890
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): [X] YES / NO
28. TOTAL CHARGE: $ 103 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on File
SIGNED — DATE: 01 09 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Norman Joseph, M.D.
105 Medical Parkway
Anytown, TX 77711
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.18 Dialysis Training

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gilbert, Melinda
3. PATIENT'S BIRTH DATE (MM DD YY): 06 14 1963 — SEX: M F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 9901 Channing Cross
6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street):
CITY: Bryan — STATE: TX
8. PATIENT STATUS: Single / Married / Other
CITY / STATE
ZIP CODE: 77081 — TELEPHONE (Include Area Code): (409) 555-1234
Employed / Full-Time Student / Part-Time Student
ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [X] NO
a. INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M F
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) — SEX: M F
b. AUTO ACCIDENT?: YES [X] NO — PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT?: YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?: YES / NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ______ DATE ______
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY): 12 01 2006
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM — TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM — TO
19. RESERVED FOR LOCAL USE: ONSET 120198
20. OUTSIDE LAB?: YES [X] NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 727 06
2.
3.
4.
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	90989	AT	1	500 00					1234567-89
2													
3													
4													
5													
6													

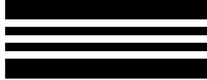
25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): [X] YES / NO
28. TOTAL CHARGE: $ 500 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Justin Blake
SIGNED — DATE: 01 08 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
The Blake Clinic
911 Medical Drive
Bryan, TX 77082
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.19 Durable Medical Equipment (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Williams, Sarah M.

3. PATIENT'S BIRTH DATE MM DD YY: 09 14 1987 — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1201 Carning Place

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Plano — STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY — STATE

ZIP CODE: 75432 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Paul Burnes, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 854 00
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 999266123

24.	A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	01	2007	01	01	2007	2	9	B9998		1	120 00	1				
2	01	01	2007	01	01	2007	2	9	A4529		1	15 00	50				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER — SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234567

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 135 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

David Patton

SIGNED — DATE: 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

General Supply Company
1902 Bunker Hill
Hillsboro, TX 74932

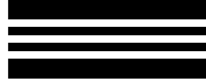
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.20 Early Childhood Intervention (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA — CARRIER

1. MEDICARE (Medicare #) [X] | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Clark, Amy B.

3. PATIENT'S BIRTH DATE MM DD YY: 03 24 2005 — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 632 Baker Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Austin — STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY — STATE

ZIP CODE: 78757 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jim Blanks, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 783 40
2. 315 31
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 611660000

24.	A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	05	2007	01	05	2007	1	1	97003	TL	1	30 00	1				
2	01	05	2007	01	05	2007	1	1	97532	TL	1	25 00	2				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER — SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 55 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Julie Brown

SIGNED — DATE: 02 01 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Early Child hood Clinic
123 Springdale Drive
Austin, TX 78759
512-555-1234

PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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D.21 Family Planning Claim Form

Family Planning 2017 Claim Form

1. Family Planning Program: V ☐ XIX ☐ XX ☐
1a. Title X Only: Full Pay ☐ Partial Pay ☐ No Pay ☐
2. Provider Number/TPI: 1234567-89

3. Provider Name: Joe Smith
4. Eligibility Date (V or XX) (MM/DD/CCYY): 01/02/2007
5. Family Planning No. (Medicaid PCN if XIX)

6. Patient's Name (Last Name, First Name, Middle Initial): Pye, Sherrie
7. Address (Street, City, State): 341 Tosser Way, Houston, TX
7a. ZIP code: 77485

8. County of Residence: Harris
9. Date of Birth (MM/DD/CCYY): 02/02/1970
10. Sex: F ☒ M ☐
11. Patient Status: New Patient ☒ Established Patient ☐
12. Patient's Social Security Number: 123 - 45 - 6789

13. Race (Code #): 1 — White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5) Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)
13a. Ethnicity: 0 — Hispanic (5) Non-Hispanic (0)
14. Marital Status: 3 — (1) Married (2) Never Married (3) Formerly Married

15. Family Income (All): $ 1
15a. Family Size: 2

16. Number Times Pregnant: 1
17. Number Live Births: 1
18. Number Living Children: 1

19. Primary Birth Control Method Before Initial Visit: G
20. Primary Birth Control Method at End of This Visit: A

a=Oral Contraceptive, b=1-Month hormonal injection, c=3-Month hormonal injection, d=Cervical cap/diaphragm, e=Abstinence, f= Hormonal Implant, g=Male condom, h=Female condom, i=Hormonal/Contraceptive patch, j=Spermicide (used alone), k=Intrauterine device (IUD), l=Vaginal ring, m=Fertility awareness method (FAM), n=Sterilization, o=Contraceptive sponge, p=Other method, q=Method unknown, r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r): ☐
a=Refused, b=Pregnant, c=Inconclusive Preg Test, d=Seeking Preg, e=Infertile, f=Rely on Partner, g=Medical

22. Is There Other Insurance Available? Y ☐ N ☐ If Y, Complete Items 23 – 25a
23. Other Insurance Name and Address

24. Insured's Policy/Group No.
25. Other Insurance Pd. Amt. $
25a. Date of Notification

26. Name of Referring Provider
27. ID No. of Referring Provider
28. Level of Practitioner: Physician ☐ Nurse ☐ Mid Level ☐ Other ☐

29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)
1. V25 . 09
2. .
3. .
4. .

30. Authorization Number
31. Date of Occurrence (MM / DD / CCYY)

32. A From MM	From DD	From CCYY	To MM	To DD	To CCYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
01	02	2007	01	02	2007	1	1	99203	FP	1	1	$48 27	

33. Federal Tax ID Number/EIN
34. Patient's Account No. (optional)
35. Patient Co-Pay Assessed (V, X or XX) $
36. **Total Charges**: $48.27

37. Signature of Physician or Supplier
Date: 01/02/2007
Signed: Joe Smith

38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)

39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.: Joe Smith, 1234 Oak Drive, Houston, Texas 77485, (281)123-4567

Form Revised: January 2005

D.22 Family Planning Services for Hospitals, FQHCs

Refer to: The Family Planning section to determine which claim form to complete.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Federally Qualified Health
1242 Medical Drive
The Colony, Texas 75321

3 PATIENT CONTROL NO.: 12345678
4 TYPE OF BILL: 731
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Kent, Sara L.
13 PATIENT ADDRESS: 1234 Bartland Way, Plano, Texas 75011

14 BIRTHDATE: 02141976 | 15 SEX: F | 16 MS | ADMISSION 17 DATE: 01012007 | 18 HR: 11 | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO.: 123456789 | CONDITION CODES 24 25 26 27 28 29 30 | 31

32–35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38 | 39–41 VALUE CODES CODE AMOUNT (a b c d)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
520	Annual Family Planning Exam	1-99203 FP	01012007	1	47 57		
307	Urinalysis	5-81015 FP	01012007	1	4 31		
		Total Charges			51 88		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicaid	9876543-21					

57 DUE FROM PATIENT ▶

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Kent, Sara L.		123456789		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
1234567890			

67 PRIN. DIAG. CD.: V2509 | 68–75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE (A, B, C, D, E)

82 ATTENDING PHYS. ID: TXBE1234
83 OTHER PHYS. ID (A)
OTHER PHYS. ID (B)

84 REMARKS: Annual Family Planning Exam

85 PROVIDER REPRESENTATIVE: X John Smith, MD
86 DATE: 01 01 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.23 FQHC Encounter (T1015)

APPROVED OMB NO. 0938-0279

Field	Value
1 (Provider)	Rio Grande Community 1200 Medical Circle Rio Grande, Texas 78582
3 PATIENT CONTROL NO.	12345678
4 TYPE OF BILL	731
12 PATIENT NAME	Bates, Jason M.
13 PATIENT ADDRESS	1403 Reese Lane, Rio Grande, Texas 78582
14 BIRTHDATE	11031989
15 SEX	M
17 ADMISSION DATE	01012007
18 HR	10
23 MEDICAL RECORD NO.	A12345

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
520	Encounter	1-T1015	01012007	1	35 00	
		Total Charges			35 00	

Field	Value
50 PAYER	Medicaid
51 PROVIDER NO.	9876543-21
58 INSURED'S NAME	Bates, Jason M.
60 CERT. - SSN - HIC. - ID NO.	123456789
63 TREATMENT AUTHORIZATION CODES	1234567890
67 PRIN. DIAG. CD.	07799
82 ATTENDING PHYS. ID	TXBC1234
84 REMARKS	Conjunctivitis
85 PROVIDER REPRESENTATIVE	X John Smith, MD
86 DATE	01 01 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.24 FQHC Follow-Up

APPROVED OMB NO. 0938-0279

Field	Value
1 (Provider)	Valley Health Center 105 Medical Avenue Valley, Texas 78321
3 PATIENT CONTROL NO.	12345678
4 TYPE OF BILL	731
12 PATIENT NAME	Turner, Margie C.
13 PATIENT ADDRESS	1902 Park Place, Valley, Texas 78321
14 BIRTHDATE	01041975
15 SEX	F
17 ADMISSION DATE	01012007
18 HR	13
23 MEDICAL RECORD NO.	123456

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
520	Antepartum Encounter	1-T1015	01012007	1	25 00	
520	Delivery	1-T1015	01012007	1	550 00	
		Total Charges			575 00	

Field	Value
50 PAYER	Medicaid
51 PROVIDER NO.	9876543-21
58 INSURED'S NAME	Turner, Margie C.
60 CERT. - SSN - HIC. - ID NO.	123456789
63 TREATMENT AUTHORIZATION CODES	1234567890
67 PRIN. DIAG. CD.	V221
68 CODE	V302
82 ATTENDING PHYS. ID	TXBE1234
84 REMARKS	Pregnancy, Delivery
85 PROVIDER REPRESENTATIVE	X John Smith, MD
86 DATE	01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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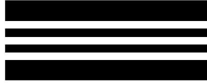
CPT only copyright 2005 American Medical Association. All rights reserved.

D.25 Genetics

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Kelly, Ethel W.
3. PATIENT'S BIRTH DATE MM DD YY: 08 16 1958 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1604 Major Circle
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)
CITY: Webster STATE: TX
8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY / STATE
ZIP CODE: 77591 TELEPHONE (Include Area Code): (210) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Christopher Casey, MD
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 659 53
2. .
3. .
4. .
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	G	99244	TG		100 00	1				0123456-78
01 01 2007	01 01 2007	1	G	99404	TG		50 00	1				0123456-78
01 01 2007	01 01 2007	1	G	84999			200 00	1				0123456-78

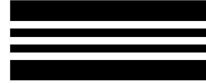
25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]
26. PATIENT'S ACCOUNT NO.: 1234L5
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 350 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jane Smith, MD 01 10 2007
SIGNED DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Genetics Clinic, 1221 Robin Blvd., Webster, TX 77598
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.26 Hearing Aid Assessments

PLEASE DO NOT STAPLE IN THIS AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jackson, Robert K.
3. PATIENT'S BIRTH DATE MM DD YY: 10 26 1999 SEX M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 460 Jennings Lane
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)
CITY: Palestine STATE: TX
8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY / STATE
ZIP CODE: 75801 TELEPHONE (Include Area Code): (409) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 389 9
2. .
3. .
4. .
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	R	V5010		1	62 12	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]
26. PATIENT'S ACCOUNT NO.: 123456
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 62 12
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Tom White 01 10 2007
SIGNED DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: The Hearing Aid Store/Service Ctr., 432 New Pines, Palestine, TX 75801
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.27 Home Health Services DME/Medical Supplies

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Mary Lou
3. PATIENT'S BIRTH DATE MM DD YY: 11 22 1933 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, Mary Lou
5. PATIENT'S ADDRESS (No., Street): 123 North Main Street
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 123 North Main Street
CITY: Dallas STATE: TX
8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: Dallas STATE: TX
ZIP CODE: 75236 TELEPHONE (Include Area Code): (214) 555-1234
ZIP CODE: 75236 TELEPHONE (INCLUDE AREA CODE): (214) 555-1234
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): N/A
10. IS PATIENT'S CONDITION RELATED TO: IDDM, Asthma
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY: 11 22 1933 SEX M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ______ DATE ______
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ______

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Home Health Services Associates
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 493 90
2. 250 00
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 7123220000

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	07 01 2007	08 31 2007	02	1	A9150			5 00	00				
2													
3													
4													
5													
6													

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 451 23 4567
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 5 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jane Doe 07 01 2007
SIGNED DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Home Health Services Associates & DME, 555 Broadway, Dallas, TX 75234, 214-234-7900
PIN# GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.28 Home Health Services Skilled Nursing Visit

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Home Nursing Services
2214 Health Care
Dallas, Texas 75235

2
3 PATIENT CONTROL NO.: 12345678
4 TYPE OF BILL: 331
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11
12 PATIENT NAME: Lake, William W
13 PATIENT ADDRESS: 2200 Trape Lane Harlingen, TX 78550
14 BIRTHDATE: 02141948 | 15 SEX: M | 16 MS | ADMISSION 17 DATE: 01012007 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO.: 123456 | CONDITION CODES 24 25 26 27 28 29 30 | 31
32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C
38
39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT (a b c d)

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3	550	Skilled Nursing Visit	C-G0154	01012007	1	50 00		
4								
5	550	Skilled Nursing Visit (PRN)	C-G0154	01012007	1	50 00		
6								
7	570	Home Health Aide	C-G0156	01012007	1	40 00		
8								
9								
10								
11			Total Charges			140 00		
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	All Health Insurance						
B	Medicaid	9876543-21					
C							

57 **DUE FROM PATIENT ▶**

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Lake, Susan K.	S	123456789	All Mart Corp.	G1234
B	Lake, William W.		123456789		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			All Mart Corp.	1200 Hwy. 6, Dallas, TX 75474
B	1234567890			
C				

67 PRIN. DIAG. CD.: 12345 | 68 CODE: V1234 | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78
79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE (A) | OTHER PROCEDURE CODE DATE (B) | OTHER PROCEDURE CODE DATE (C) | OTHER PROCEDURE CODE DATE (D) | OTHER PROCEDURE CODE DATE (E)
82 ATTENDING PHYS. ID: TXBA1234
83 OTHER PHYS. ID: TXBN1234 (A)
OTHER PHYS. ID (B)
84 REMARKS: Colostomy - After Surgery
85 PROVIDER REPRESENTATIVE: X *Dolores Jones*
86 DATE: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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D.29 Home Health Services Skilled Nursing Visit and Physical Therapy

APPROVED OMB NO. 0938-0279

Home Care Association
1200 Terrace Ct.
Webster, TX 77598

3 PATIENT CONTROL NO.: 123A45
4 TYPE OF BILL: 331

12 PATIENT NAME: Hernandez, Jorge C.
13 PATIENT ADDRESS: 6789 Ave. A Webster, TX 77598

14 BIRTHDATE: 05021948
15 SEX: M
17 ADMISSION DATE: 01012007
23 MEDICAL RECORD NO.: 123456

32 OCCURRENCE CODE / DATE: 27 01012007

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
550	SNV 68/69	C-G0154	01012007	1	50.00	
420	P.T. Treatment and Exercise 30 min. 67	C-97110 AT	01012007	1	88.20	
430	O.T. Application of a modality, to one or more areas, traction, mechanical	C-97012 AT	01012007	1	11.82	
		Total Charges			150.02	

50 PAYER: Medicaid
51 PROVIDER NO.: 9876543-21

DUE FROM PATIENT ▶

58 INSURED'S NAME: Hernandez, Jorge C.
60 CERT. - SSN - HIC. - ID NO.: 123456789

63 TREATMENT AUTHORIZATION CODES: 1234567890

67 PRIN. DIAG. CD.: 12345
68 CODE: 12345
69 CODE: 12345

82 ATTENDING PHYS. ID: TXBC1234
83 OTHER PHYS. ID: TXBC1234

84 REMARKS: Injury to neck of femur

85 PROVIDER REPRESENTATIVE: X *Dolores Jones*
86 DATE: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.30 Hospital-Based ASC

APPROVED OMB NO. 0938-0279

Greatland Hospital Center
4004 Elm Loop
Westville, TX
512-555-1234

3 PATIENT CONTROL NO.: 123456B
4 TYPE OF BILL: 131

12 PATIENT NAME: Lei, Wei Chu
13 PATIENT ADDRESS: 6789 Courtland Circle Westville TX 79065

14 BIRTHDATE: 12161963
15 SEX: M
17 ADMISSION DATE: 01012007
18 HR: 11
23 MEDICAL RECORD NO.: E123456

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
360	Typano W/ masto and chain reconstruct	F-69641	01012007	1	871.87	
		Total Charges			871.87	

50 PAYER: Medicaid
51 PROVIDER NO.: 9876543-21

DUE FROM PATIENT ▶

58 INSURED'S NAME: Lei, Wei Chu
60 CERT. - SSN - HIC. - ID NO.: 123456789

63 TREATMENT AUTHORIZATION CODES: 1234567890

67 PRIN. DIAG. CD.: 38903
68 CODE: 38421
69 CODE: 38900

82 ATTENDING PHYS. ID: TXBC1234

84 REMARKS: Hearing Loss, Left Ear

85 PROVIDER REPRESENTATIVE: X **Signature on File**
86 DATE: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.31 Hospital Inpatient

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

- Provider: Texas Hospital, 209 W. 45th, El Paso, Texas 77905, 915-555-1234
- 3 Patient Control No.: 12345
- 4 Type of Bill: 111
- 5 Fed. Tax No.:
- 6 Statement Covers Period: From 01012006 Through 01042006
- 7 Cov D.: 3
- 12 Patient Name: Skye, Amber L.
- 13 Patient Address: 1200 Whispering Pines, El Paso TX 77903
- 14 Birthdate: 03271974
- 15 Sex: F
- 16 MS: 14
- Admission: 17 Date: 01012007; 18 HR: 14; 19 Type: 2; 20 SRC: 1
- 21 D HR: 10
- 22 Stat: 01
- 23 Medical Record No.: 123456
- 32 Occurrence: Code 10, Date 04012004
- 33 Occurrence: Code 24, Date 02012004

42 Rev. CD.	43 Description	44 HCPCS / Rates	45 Serv. Date	46 Serv. Units	47 Total Charges	48 Non-Covered Charges
112	Room and Board - O.B.	Room 106.67 Rate	01012007		320.01	
250	Pharmacy		01012007		165.00	
258	Pharmacy - IV Solution		01012007		89.00	
270	Medical Surgical Supplies		01012007		712.43	
300	Laboratory		01012007		234.00	
720	Labor Room/Delivery		01012007		1100.00	
		Total Charges			2620.44	

- 50 Payer: A: Alm Insurance; B: Medicaid
- 51 Provider No.: 9876543-21
- DUE FROM PATIENT ►
- 58 Insured's Name: A: Skye, John; B: Skye, Amber
- 60 Cert. - SSN - HIC. - ID No.: A: 500-94-1998; B: 500-94-1998
- 61 Group Name: Alm Insurance
- 62 Insurance Group No.: 1998 AB
- 65 Employer Name: ABC Roofing
- 66 Employer Location: IH-35 S 7100, El Paso, TX
- 67 Prin. Diag. CD.: 650
- 68 Code: V270
- 76 Adm. Diag. CD.: V2700
- 79 P.C.: 9
- 80 Principal Procedure: Code 73.59, Date 010199
- 82 Attending Phys. ID: TXBE1234
- 83 Other Phys. ID: TXBE1234
- 84 Remarks: Pregnancy/Delivery. Alm Insurance, 11 Maple Dr., Boston, MA 11211 denied 02 01 2004 for pre-existing condition.
- 85 Provider Representative: X Signature on File
- 86 Date: 01 09 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.32 Hospital Outpatient

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

- Provider: Texas Hospital, 209 W. 45th, El Paso, Texas 77905, 915-555-1234
- 3 Patient Control No.: 12345
- 4 Type of Bill: 131
- 12 Patient Name: Baker, Ann C.
- 13 Patient Address: 6789 Ave. A, Austin, TX 78711
- 14 Birthdate: 03271964
- 15 Sex: F
- Admission: 17 Date: 01012007; 18 HR: 12
- 23 Medical Record No.: 123456
- 32 Occurrence: Code 05, Date 01012006

42 Rev. CD.	43 Description	44 HCPCS / Rates	45 Serv. Date	46 Serv. Units	47 Total Charges	48 Non-Covered Charges
450	Emergency Room		01012007	1	68.00	
272	Suture Kit		01012007	1	15.32	
258	Pharmacy - IV Solution		01012007	1		7.80
		Total Charges			91.12	

- 50 Payer: A: Medicaid
- 51 Provider No.: 9876543-21
- DUE FROM PATIENT ►
- 58 Insured's Name: A: Baker, Ann C.
- 60 Cert. - SSN - HIC. - ID No.: 500-01-1998
- 67 Prin. Diag. CD.: 8930
- 82 Attending Phys. ID: TXBE1234
- 84 Remarks: Lacerated toe, Rt.
- 85 Provider Representative: X *Sally Smith*
- 86 Date: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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D.33 In-Home Total Parenteral Hyperalimentation Supplier

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jefferson, Martha

3. PATIENT'S BIRTH DATE MM DD YY: 09 27 1956 SEX M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 5668 Marlin Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: San Antonio STATE: TX

8. PATIENT STATUS: Single [X] Married Other

CITY STATE

ZIP CODE: 77718 TELEPHONE (Include Area Code): ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dan Smith, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 579 2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24.	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	2	1	S9364	1	580 00	4				
2	01 05 2007	01 05 2007	2	1	S9368	1	145 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 725 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Carl Smith

SIGNED DATE 02 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Hyperalimentation Supply
2801 West Street
San Antonio, TX 77711
210-555-1234

PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.34 Independent Laboratory

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Platt, Sylvia J.

3. PATIENT'S BIRTH DATE MM DD YY: 08 03 1952 SEX M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 942 Hartford Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Comfort STATE: TX

8. PATIENT STATUS: Single [X] Married Other

CITY STATE

ZIP CODE: 78013 TELEPHONE (Include Area Code): (512) 555-1234

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Stan Levelson, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72 6
2. 583 89
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	6	5	80004	1	18 17					
2	01 01 2007	01 01 2007	6	5	88305	2	45 42					
3	01 01 2007	01 01 2007	6	5	88346	2	18 27					
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 81 86

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 01 09 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ABC Laboratory Services
1242 Medical Place
Comfort, TX 78013

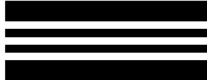
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.35 Licensed Clinical Social Worker (LCSW)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Escovedo, Doris M.
3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1994 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 4630 Liebe Cove
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)

CITY: Dale STATE: TX
8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY STATE

ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 296.20
2.
3.
4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2007	01 01 2007	1	1	90806	1	60 00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 60 00
29. AMOUNT PAID: $
30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Sophie Buschbaum, LCSW
SIGNED DATE 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Sophie Buschbaum, LCSW
1204 Mozart Street
Dale, TX 78216
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.36 Licensed Dietitians (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Marberry, Kayla M.
3. PATIENT'S BIRTH DATE MM DD YY: 10 26 1982 SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1544 Britanny Trail
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)

CITY: Austin STATE: TX
8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY STATE

ZIP CODE: 78727 TELEPHONE (Include Area Code): ( )
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jim Smith, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 250.00
2.
3.
4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2007	01 01 2007	1	1	S9470	1	30 00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 30 00
29. AMOUNT PAID: $
30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jill Brown
SIGNED DATE 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Jill Brown
2010 Main Street
Austin, TX 78728
512-555-1234
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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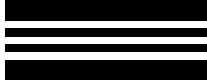
CPT only copyright 2005 American Medical Association. All rights reserved.

D.37 Licensed Marriage and Family Therapist (LMFT)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Thomas, Robin

3. PATIENT'S BIRTH DATE MM DD YY: 02 24 1992 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1544 Lansing Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Austin STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 78727 TELEPHONE (Include Area Code): (512) 555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **Signature on File**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 309 . 28
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	90806	1	60 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Daines, LMFT

SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

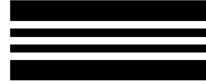
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Susan Daines, LMFT
4063 Lilling Road
Austin, TX 78728

PIN# GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.38 Licensed Professional Counselor (LPC)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Manning, Megan B.

3. PATIENT'S BIRTH DATE MM DD YY: 02 24 1992 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1544 Lansing Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Austin STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 75067 TELEPHONE (Include Area Code): (512) 555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **Signature on File**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 309 . 28
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	90806	1	60 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Daines, LPC

SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

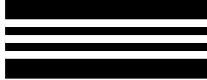
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Susan Daines, LPC
4063 Lilling Road
Austin, TX 75067

PIN# GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.39 Maternity Service Clinic

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID [X] / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cook, Irene M.
3. PATIENT'S BIRTH DATE: 12 20 1970 — SEX: F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 563 Malvern Ct.
6. PATIENT RELATIONSHIP TO INSURED: Self [X]
7. INSURED'S ADDRESS (No., Street):
CITY: Pharr — STATE: TX
8. PATIENT STATUS: Married [X]
ZIP CODE: 78576 — TELEPHONE (Include Area Code): (956) 555-1234
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS): NO [X]
b. AUTO ACCIDENT?: NO [X] — PLACE (State)
c. OTHER ACCIDENT?: NO [X]
10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: **Signature on File** — DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 01 01 2007
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V22 0
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From	To	B Place of Service	C Type of Service	D CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	2	99211	TH	1	22 80	1				

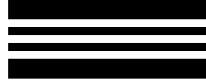
25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X]
28. TOTAL CHARGE: $ 22 80
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on File — DATE: 01 09 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:
Alvin Maternity Clinic
402 Chippendale Dr.
Pharr, TX 78577
PIN# — GRP# 9876543-21

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.40 Mental Health Case Management

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [X] / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Crew, Sarah J.
3. PATIENT'S BIRTH DATE: 06 11 1945 — SEX: F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 1200 Route 4
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Other [X]
7. INSURED'S ADDRESS (No., Street):
CITY: Bastrop — STATE: TX
8. PATIENT STATUS
ZIP CODE: 78602 — TELEPHONE (Include Area Code): (512) 555-1234
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS): NO [X]
b. AUTO ACCIDENT?: NO [X] — PLACE (State)
c. OTHER ACCIDENT?: NO [X]
10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: **Signature on File** — DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?: NO [X] — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 295 03
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From	To	B Place of Service	C Type of Service	D CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	1	G9012		1	63 89	1				

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X]
28. TOTAL CHARGE: $ 63 89
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Sally Smith — DATE: 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #:
TDMR Facility
411 Main Street
Bastrop, TX 78601
PIN# — GRP# 9876543-21

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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D.41 Military Hospital (Emergency Inpatient)

APPROVED OMB NO. 0938-0279

Field	Value
1 (Provider)	Clayham AFB, 123 Military Drive, Pampa, TX 79065, 512-555-1234
3 Patient Control No.	12345M2
4 Type of Bill	111
6 Statement Covers Period (From / Through)	01012007 / 01032007
7 Cov D.	2
12 Patient Name	Miller, Jason B.
13 Patient Address	6789 Courtland Circle, Pampa, TX 79065
14 Birthdate	07101971
15 Sex	M
17 Admission Date	01012007
18 HR	04
19 Type	1
20 SRC	7
21 D HR	08
22 STAT	05
23 Medical Record No.	A1234C1
32 Occurrence Code / Date	05 / 01012007
39 Value Codes Amount (a)	04.00

42 Rev. CD.	43 Description	44 HCPCS / Rates	45 Serv. Date	46 Serv. Units	47 Total Charges	48 Non-Covered Charges
120	Room	$5000 per day	01012007	2	10000.00	
001	Total Charges				10000.00	

Field	Value
50 Payer	Medicaid
51 Provider No.	9876543-21
57	DUE FROM PATIENT ▶
58 Insured's Name	Miller, Jason B.
60 Cert. - SSN - HIC. - ID No.	123456789
63 Treatment Authorization Codes	1234567890
67 Prin. Diag. CD.	9940
68 Code	9850
69 Code	94109
76 Adm. Diag. CD.	99400
82 Attending Phys. ID	TXBM1234
84 Remarks	Struck by lightning, pt. badly burned and in shock
85 Provider Representative	X Signature on File
86 Date	01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.42 Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

Family Planning 2017 Claim Form

Field	Value
1. Family Planning Program: V / XIX / XX	(none checked)
1a. Title X Only: Full Pay / Partial Pay / No Pay	(none checked)
2. Provider Number/TPI	1234567-89
3. Provider Name	Smith, Jenny
4. Eligibility Date (V or XX) (MM/DD/CCYY)	01/02/2007
5. Family Planning No. (Medicaid PCN if XIX)	
6. Patient's Name (Last Name, First Name, Middle Initial)	Pye, Sherrie
7. Address (Street, City, State)	341 Tosser Way, Houston, TX
7a. ZIP code	77485
8. County of Residence	Harris
9. Date of Birth (MM/DD/CCYY)	02/02/1970
10. Sex	F [X] M [ ]
11. Patient Status	New Patient [ ] Established Patient [X]
12. Patient's Social Security Number	123 - 456 - 7890
13. Race (Code #) White (1) Black (2) AmIndian/AlaskaNat (4) Asian (5) Unk/NotRep (6) NatHawaii/PacIsland (7) More than one race (8)	1
13a. Ethnicity Hispanic (5) Non-Hispanic (0)	0
14. Marital Status (1) Married (2) Never Married (3) Formerly Married	3
15. Family Income (All)	$1
15a. Family Size	2
16. Number Times Pregnant	1
17. Number Live Births	1
18. Number Living Children	1
19. Primary Birth Control Method Before Initial Visit	G
20. Primary Birth Control Method at End of This Visit	K

Codes for 19/20: a=Oral Contraceptive; b=1-Month hormonal injection; c=3-Month hormonal injection; d=Cervical cap/diaphragm; e=Abstinence; f= Hormonal Implant; g=Male condom; h=Female condom; i=Hormonal/Contraceptive patch; j=Spermicide (used alone); k=Intrauterine device (IUD); l=Vaginal ring; m=Fertility awareness method (FAM); n=Sterilization; o=Contraceptive sponge; p=Other method; q=Method unknown; r=No method (if used for #20, must complete #21)

21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r): a=Refused; b=Pregnant; c=Inconclusive Preg Test; d=Seeking Preg; e=Infertile; f=Rely on Partner; g=Medical

Field	Value
22. Is There Other Insurance Available?	Y [ ] N [ ] If Y, Complete Items 23 – 25a
23. Other Insurance Name and Address	
24. Insured's Policy/Group No.	
25. Other Insurance Pd. Amt.	$
25a. Date of Notification	
26. Name of Referring Provider	
27. ID No. of Referring Provider	
28. Level of Practitioner	Physician [ ] Nurse [ ] Mid Level [ ] Other [ ]
29. Diagnosis Code (Relate Items 1,2,3,or 4 to Item 32D by Line # in 32E)	1. V25.1 2. V25.42 3. 4.
30. Authorization Number	
31. Date of Occurrence (MM / DD / CCYY)	

32. A Dates of Service From MM	DD	CCYY	To MM	DD	CCYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Dx. Ref. (29)	F Units or Days (Quantity) No. of Participants (Teen Counseling)	G $ Charges	H Performing Provider #
01	02	2007	01	02	2007	1	4	74000		1	1	$22 91	

Field	Value
33. Federal Tax ID Number/EIN	
34. Patient's Account No. (optional)	
35. Patient Co-Pay Assessed (V, X or XX)	$
36. Total Charges	$22.91
37. Signature of Physician or Supplier	Date: 01/02/2007 Signed: Joe Smith
38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	
39. Physician's, Supplier's Billing Name, Address, Zip Code & Phone No.	Joe Smith, 1234 Oak Drive, Houston, TX 77485

Form Revised: January 2005

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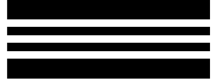
D.43 Occupational Therapists (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rodriguez, Maria L.

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 1984 — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 Glen Drive

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Webster — STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY — STATE

ZIP CODE: 78218 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: **Signature on File** — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: **Signature on File**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Phyllis Merrick, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 714 . 31
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24.

	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	97003	1	20 00	1				
2	01 01 2007	01 01 2007	1	1	97532	1	20 00	2				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 40 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Colin K. Smith, OT

SIGNED — DATE: 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Colin K. Smith, OT
406 Kings Hwy.
Webster, TX 78801
210-555-1234

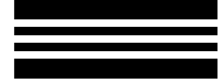
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.44 Office Visit with Lab and Radiology

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Murphy, Molly

3. PATIENT'S BIRTH DATE MM DD YY: 11 20 1962 — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 6702 Field St. #129

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Houston — STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY — STATE

ZIP CODE: 77093 — TELEPHONE (Include Area Code): (713) 555-1234

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Filed with Merchants on

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Merchants Inc. Co.

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 09/01/95 have not heard

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: 1313 Main St. Card, TX 75633

c. EMPLOYER'S NAME OR SCHOOL NAME: Back from OI.

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Policy #73721, Subscriber #3198

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: **Signature on File** — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 785 . 1
2. 427 . 9
3. 786 . 50
4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24.

	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1	01 05 2007	01 05 2007	1	1	99212	1	25 00					
2	01 05 2007	01 05 2007	1	T	93005 TC	3	50 00					
3	01 05 2007	01 05 2007	1	5	93224	2	350 00					
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 425 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Duane P. Olseen, DO

SIGNED — DATE: 01 09 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Duane P. Olseen, D.O.
1111 Pax Dr.
Houston, TX 77029
713-555-1234

PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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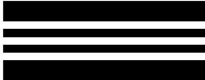
D.45 Orthotic and Prosthetic Suppliers (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jimenez, Jorge

3. PATIENT'S BIRTH DATE (MM DD YY): 11 23 1993 SEX: M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 563 Lake Ct.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Pharr STATE: TX

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY / STATE

ZIP CODE: 75235 TELEPHONE (Include Area Code): ( )

ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Joanne Wallace, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343 9 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2007	01 01 2007	1	9	L1960	1	887 35	2				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 887 35

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Nederland Orthotics
67 Medical Blvd.
Nederland, TX 77627
214-555-1234

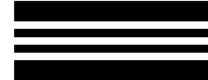
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.46 Pharmacy (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): May, Sharon P.

3. PATIENT'S BIRTH DATE (MM DD YY): 03 15 1993 SEX: M F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1500 Sansin Court

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Austin STATE: TX

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY / STATE

ZIP CODE: 75067 TELEPHONE (Include Area Code): (512) 555-1234

ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **Signature on File**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jim Smith, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 2. 3. 4.

No Diagnosis Codes Required

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567890

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2007	01 01 2007	2	9	B4150	1	22 20	12				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 22 20

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Super X Drugstore
104 South Main
Austin, TX 75067
512-555-1234

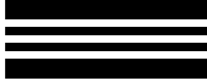
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.47 Physical Therapist

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gildon, Melinda
3. PATIENT'S BIRTH DATE MM DD YY: 06 14 1963 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 9901 Channing Cross
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)
CITY: Bryan — STATE: TX
8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY — STATE
ZIP CODE: 77081 — TELEPHONE (Include Area Code): (409) 555-1234
ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: John Martinez, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 767 6
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	97530	AT	1	30 00					
2	01 01 2007	01 01 2007	1	1	97520 neck	AT 76 area	1	13 45					
3	01 01 2007	01 01 2007	1	1	97520 left	AT 76 arm	1	13 45					
4													
5													
6													

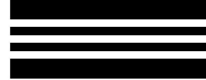
25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 56 90
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) *Patricia Brown, LPT* SIGNED — DATE 01 09 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Patricia Brown, LPT, 911 Medical Drive, Bryan, TX 77801
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.48 Physical Therapists (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Brown, Julie C.
3. PATIENT'S BIRTH DATE MM DD YY: 12 06 1994 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 1200 Baltic
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)
CITY: Conroe — STATE: TX
8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY — STATE
ZIP CODE: 77305 — TELEPHONE (Include Area Code): (409) 555-1234
ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 01 01 2007
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: David Jones, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 454 2
2. ___ . ___
3. ___ . ___
4. ___ . ___
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 02 2007	01 02 2007	1	1	97001		1	40 00	1				
2													
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 40 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) *Larry Jones* SIGNED — DATE 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Larry Jones, 1242 Rosewood, Conroe, TX 77307
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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D.49 Private Duty Nurses (THSteps-CCP Only)

APPROVED OMB NO. 0938-0279

ABC Homebound Care
123 Main Street
Austin, TX 78725

3 Patient Control No.: 12345678
4 Type of Bill: 331
6 Statement Covers Period: From 01212007 Through 01232007
12 Patient Name: Butler, Adele
13 Patient Address: 3201 Crow Road Austin TX 78729
14 Birthdate: 11062000
15 Sex: F
23 Medical Record No.: 123456

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
550	Home Heath Services LVN/RN, private duty nursing per hour	C-T1002	01212007	5	200 00	
		Total Charges			200.00	

50 Payer: Medicaid
51 Provider No.: 9876543-21
DUE FROM PATIENT ▶
58 Insured's Name: Butler, Adele
60 Cert. - SSN - HIC. - ID No.: 123456789
63 Treatment Authorization Codes: 9956619801
67 Prin. Diag. CD.: 7580
68 Code: 38903
82 Attending Phys. ID: TXBA1234
84 Remarks: Down's Syndrome
85 Provider Representative: X Sally Smith
86 Date: 02 25 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.50 Psychiatric Hospital/Facility (THSteps-CCP Only)

APPROVED OMB NO. 0938-0279

The First Hospital
123 Oak Street
Austin, TX 78701
512-555-1234

3 Patient Control No.: 123456
4 Type of Bill: 111
6 Statement Covers Period: From 01012007 Through 01062007
7 Cov D.: 5
12 Patient Name: Mador, Cory L.
13 Patient Address: 876 Avenue A Austin TX 78701
14 Birthdate: 01012000
15 Sex: F
16 MS: S
17 Admission Date: 01012007
18 HR: 14
19 Type: 3
20 SRC: 1
21 D HR: 15
22 STAT: 01
23 Medical Record No.: 123456

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
124	Room and Board	555.00		5	2775.00	
250	Pharmacy			1	102.00	
300	Laboratory			1	438.00	
915	Psychotherapy - Group			1	325.00	
		Total Charges			3640.00	

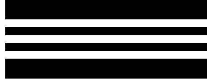
50 Payer: Medicaid
51 Provider No.: 987654321
DUE FROM PATIENT ▶
58 Insured's Name: Mador, Cory L.
60 Cert. - SSN - HIC. - ID No.: 123456789
63 Treatment Authorization Codes: 1234567890
67 Prin. Diag. CD.: 29500
76 Adm. Diag. CD.: 29500
82 Attending Phys. ID: TXBD1234 Dr. A. Smith
84 Remarks: Depressive Disorder
85 Provider Representative: X Sally Smith
86 Date: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.51 Psychologist

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [X] CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Mata, Joel L.

3. PATIENT'S BIRTH DATE MM DD YY: 05 19 2000 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 506 Medical Lane

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Terrell STATE: TX

8. PATIENT STATUS: Single Married Other

CITY STATE

ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jane Smith, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296 20
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	1	90801	1	78 47	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 78 47

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Carla Herrera, PhD

SIGNED DATE 01 10 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Carla Herrera, Ph.D.
463 Swan St.
Crane, TX 79731

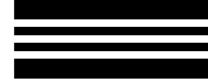
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.52 Radiation Therapy

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Garcia, Helmut E.

3. PATIENT'S BIRTH DATE MM DD YY: 08 08 1956 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 901 West Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: San Antonio STATE: TX

8. PATIENT STATUS: Single [X] Married Other

CITY STATE

ZIP CODE: 78218 TELEPHONE (Include Area Code): (210) 555-1234

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature on File

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY 10 13 2006 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V10 72
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 2007	01 01 2007	1	6	77420	1	105 00	1				
01 01 2007	01 01 2007	1	6	77420	1	105 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 210 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Jared Blanco, MD

SIGNED DATE 01 13 2007

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Jared Blanco, MD
1242 Garrick Way
Bryan, TX 77802

PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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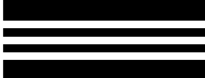
CPT only copyright 2005 American Medical Association. All rights reserved.

D.53 Radiological/Physiological Laboratory and Portable X-Ray Supplier

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Osgood, Paul T.

3. PATIENT'S BIRTH DATE MM DD YY: 01 04 1960 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 8001 Apt., Way #2

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other

7. INSURED'S ADDRESS (No., Street)

CITY: Del Rio STATE: TX

8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student

CITY STATE

ZIP CODE: 78841 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Blake Jones, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V72 5 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	T	70030	1	19 35	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO

28. TOTAL CHARGE: $ 19 35

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File 01 10 2007

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Portable X-Ray Services
1242 South Main
Del Rio, TX 78840
210-555-1234

PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.54 Rehabilitation Hospital (THSteps-CCP Only)

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Rehabilitation Hospital
999 West Blvd.
Tyler, TX 75702
903-555-1234

3 PATIENT CONTROL NO.: 12345678 | 4 TYPE OF BILL: 111

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM: 01012007 THROUGH: 01152007 | 7 COV D.: 14 | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Hearn, Jennifer K.

13 PATIENT ADDRESS: 4312 Branbury Cross Tyler, TX 75702

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24–30	31
04032000	F		01012007	10	2	1	13	06	1234K6		

32–35 OCCURRENCE CODE DATE; 36 OCCURRENCE SPAN CODE FROM THROUGH; 37 A B C

38

39–41 VALUE CODES CODE AMOUNT a b c d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	124	Semi Private Room	Room 400.00	14		5600 00		
2			Rate					
3	250	Pharmacy				298 63		
4								
5	270	Medical/Surgical Supplies				542 16		
6								
7	300	Laboratory				210 28		
8								
9	420	Physical Therapy				4878 00		
10								
11	430	Occupational Therapy				6878 00		
12								
13	910	Psychiatric Services - General				1794 00		
14								
15								
16								
17			Total Charges			20201.07		
18								
19								
20								
21								
22								
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	9876543-21					
B							
C							

57 **DUE FROM PATIENT ▶**

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Hearn, Jennifer K.		123456789		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	6116660000			
B				
C				

67 PRIN. DIAG. CD.: 34210 | 68–75 CODE | 76 ADM. DIAG. CD.: 34210 | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A, B, C, D, E

82 ATTENDING PHYS. ID: TXBE1234

83 OTHER PHYS. ID A / OTHER PHYS. ID B

84 REMARKS: Hemplegia, Spastic

85 PROVIDER REPRESENTATIVE: X *John Smith* | 86 DATE: 01 20 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D

D.55 Renal Dialysis Facility CAPD Training

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Renal Hospital
1113 Hospital Dr.
Victoria, TX 77123
1-495-555-1234

- 3 PATIENT CONTROL NO.: 12345678
- 4 TYPE OF BILL: 721
- 6 STATEMENT COVERS PERIOD: FROM 06042007 THROUGH 06302007
- 12 PATIENT NAME: Smith, Sue S.
- 13 PATIENT ADDRESS: 111 Broadway, Victoria, TX 77123
- 14 BIRTHDATE: 05191962
- 15 SEX: F
- 17 ADMISSION DATE: 06042007
- 18 HR: 10
- 23 MEDICAL RECORD NO.: 123456S

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
821	HEMODIALYSIS-IN CENTER		06042007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06072007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06092007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06112007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06142007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06162007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06212007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06232007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06252007	1	129.00		
821	HEMODIALYSIS-IN CENTER		06302007	1	129.00		
			TOTAL:	10	1,290.00		

- 50 PAYER: MEDICAID OF TX
- 51 PROVIDER NO.: 9876543-21
- 55 EST. AMOUNT DUE: 1,290.00
- DUE FROM PATIENT ▶
- 60 CERT. - SSN - HIC. - ID NO.: 123456789
- 67 PRIN. DIAG. CD.: 585
- 68 CODE: 2848
- 82 ATTENDING PHYS. ID: TXBL1234
- 84 REMARKS: Onset Date of Dialysis 010199
- 85 PROVIDER REPRESENTATIVE: X Signature on File
- 86 DATE: 02 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.56 Renal Dialysis Facility CAPD/CCPD

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Rural Community Clinic
1242 Medical Loop
Point West, Texas 77364

- 3 PATIENT CONTROL NO.: A64322
- 4 TYPE OF BILL: 721
- 12 PATIENT NAME: Johnson, Jack C.
- 13 PATIENT ADDRESS: 6789 Courtland Circle, New Caney, TX 79065
- 14 BIRTHDATE: 12161990
- 15 SEX: M
- 17 ADMISSION DATE: 01012007
- 18 HR: 10
- 23 MEDICAL RECORD NO.: A12345

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
845	Clinic Visit		01012007	1	75.00		
		Total Charges			75.00		

- 50 PAYER: Medicaid
- 51 PROVIDER NO.: 1234567-89
- DUE FROM PATIENT ▶
- 58 INSURED'S NAME: Johnson, Jack C.
- 60 CERT. - SSN - HIC. - ID NO.: 501361999
- 63 TREATMENT AUTHORIZATION CODES: 1234567890
- 67 PRIN. DIAG. CD.: 92310
- 82 ATTENDING PHYS. ID: TXBX4444
- 84 REMARKS: Pain in Arm
- 85 PROVIDER REPRESENTATIVE: X John Smith
- 86 DATE: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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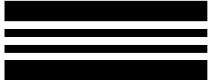
D.57 Renal Dialysis CMS-1500 Example

PLEASE DO NOT STAPLE IN THIS AREA



MEDICAID OF TX
PO BOX 20055
AUSTIN, TX 78720-0555

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pye, Sherrie
3. PATIENT'S BIRTH DATE MM DD YY: 02 02 1970 — SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 341 Tosser Way
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):
CITY: Houston — STATE: TX
8. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY / STATE:
ZIP CODE: 12345 — TELEPHONE (Include Area Code): (123) 555-1234
ZIP CODE / TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED ______ DATE ______
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE: ONSET 05/13/05
20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 585 . __ 3. 280 . 9
2. 274 . 50 4. ___ . __
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24.	From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	20	2007	06	20	2007	5	1	J2501	KX	1,2	22 00	5				
2	06	21	2007	06	21	2007	5	1	J2501	KX	1,2	22 00	5				
3	06	22	2007	06	22	2007	5	1	J2916	KX	1,2	22 50	5				
4	06	23	2007	06	23	2007	5	1	J2916	KX	1,3	73 10	10				
5	06	24	2007	06	24	2007	5	1	J3370	KX	1,3	10 95	10				
6	06	25	2007	06	25	2007	5	1	J3370	KX	1,3	10 95	10				

25. FEDERAL TAX I.D. NUMBER: 55-5555555 — SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO.: 12345678
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 161 50
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on File — 07/10/2007
SIGNED / DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Renal Healthcare
3305 Bayshore Blvd.
Houston, TX 77777
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Renal Healthcare
3305 Bayshore Blvd.
Houston, TX 77777
PIN# — GRP# 7777777-77

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.58 Rural Health Clinic Freestanding

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

Rural Community Clinic
1242 Medical Loop
Point West, Texas 77364

2
3 PATIENT CONTROL NO.: A64322
4 TYPE OF BILL: 711
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D. 8 N-C D. 9 C-I D. 10 L-R D. 11
12 PATIENT NAME: Johnson, Jack C.
13 PATIENT ADDRESS: 6789 Courtland Circle, New Caney, TX 79065
14 BIRTHDATE: 12161990
15 SEX: M
16 MS
ADMISSION 17 DATE: 01012007; 18 HR: 10; 19 TYPE; 20 SRC
21 D HR 22 STAT
23 MEDICAL RECORD NO.: A12345
CONDITION CODES 24 25 26 27 28 29 30 31
32–35 OCCURRENCE CODE DATE; 36 OCCURRENCE SPAN CODE FROM THROUGH; 37
38
39 VALUE CODES CODE AMOUNT; 40 VALUE CODES CODE AMOUNT; 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	521	Clinic Visit	T1015 AM	01012007	1	75 00		
13			Total Charges			75 00		

50 PAYER: A Medicaid
51 PROVIDER NO.: 1234567-89
52 REL INFO 53 ASG BEN 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56
57 **DUE FROM PATIENT ▶**
58 INSURED'S NAME: A Johnson, Jack C.
59 P. REL
60 CERT. - SSN - HIC. - ID NO.: 501361999
61 GROUP NAME 62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES: A 1234567890
64 ESC 65 EMPLOYER NAME 66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.: 92310
68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE 76 ADM. DIAG. CD. 77 E-CODE 78
79 P.C. 80 PRINCIPAL PROCEDURE CODE DATE; 81 OTHER PROCEDURE CODE DATE (A, B, C, D, E)
82 ATTENDING PHYS. ID: TXBX4444
83 OTHER PHYS. ID
84 REMARKS: Pain in Arm
85 PROVIDER REPRESENTATIVE: X *John Smith*
86 DATE: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.59 Rural Health Clinic Freestanding (Immunization)

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Rural Community Clinic
1242 Medical Loop
Point West, Texas 77357

2

3 PATIENT CONTROL NO.: A64322

4 TYPE OF BILL: 711

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Johnson, Jack C.

13 PATIENT ADDRESS: 6789 Courtland Circle, New Caney, TX 79065

14 BIRTHDATE: 12161990 | 15 SEX: M | 16 MS | ADMISSION 17 DATE: 01012007 | 18 HR: 10 | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO.: A12345 | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
521	Clinic Visit	T1015 AM	01012007	1	75.00		
771	DTP #3	90471	01012007	1	5.00		
		90701	01012007				
		Total Charges			80.00		

50 PAYER: A Medicaid | 51 PROVIDER NO.: 1234567-89 | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME: A Johnson, Jack C. | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO.: 501361998 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: 37200 | 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE (A, B, C, D, E)

82 ATTENDING PHYS. ID: TXBX4444

83 OTHER PHYS. ID (A, B)

84 REMARKS: Conjunctivitis

85 PROVIDER REPRESENTATIVE: X *John Smith, MD* | 86 DATE: 01 10 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

D.60 Rural Health Clinic Hospital-Based

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Community Clinic
8008 Medical Drive
New Cany, Texas 77357

2

3 PATIENT CONTROL NO.: A12345

4 TYPE OF BILL: 711

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Johnson, Miguel F.

13 PATIENT ADDRESS: 6789 Courtland Circle, New Caney, TX 79065

14 BIRTHDATE: 10081963 | 15 SEX: M | 16 MS | ADMISSION 17 DATE: 01012007 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
521	Clinic Visit	1-T1015	01012007	1	36.00		
		Total Charges			36.00		

50 PAYER: A Medicaid | 51 PROVIDER NO.: 9876543-21 | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 DUE FROM PATIENT ▶

58 INSURED'S NAME: A Johnson, Miguel F. | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO.: 123456789 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: 4569 | 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE (A, B, C, D, E)

82 ATTENDING PHYS. ID: TXBF1234

83 OTHER PHYS. ID (A, B)

84 REMARKS

85 PROVIDER REPRESENTATIVE: X *John Smith, MD* | 86 DATE: 01 11 2007

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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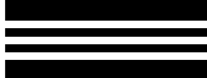
D.61 School Health and Related Services (SHARS)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [X] CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Blake, Pamela A.
3. PATIENT'S BIRTH DATE MM DD YY: 07 02 1998 SEX M F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 4420 Avenue C
6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY: El Paso STATE: TX
8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY STATE
ZIP CODE: 79985 TELEPHONE (Include Area Code): ( )
ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES [X] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Adam Gaite, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 359 1
2.
3.
4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24.

	A From MM DD YY	A To MM DD YY	B Place of Service	C Type of Service	D CPT/HCPCS	D MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	97001		1	12 00	4				
2	01 03 2007	01 03 2007	1	1	97110		1	6 00	2				
3	01 05 2007	01 05 2007	1	1	97110		1	3 00	1				
4													
5													
6													

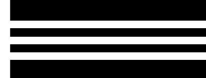
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO
28. TOTAL CHARGE: $ 21 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Sally Smith
SIGNED DATE: 01 15 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
El Paso I.S.D.
1223 Peacock Lane
El Paso, TX 79985
915-555-1234
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.62 Speech-Language Pathologists (THSteps-CCP Only)

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) [X] CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Hughes, Amanda J.
3. PATIENT'S BIRTH DATE MM DD YY: 06 15 1999 SEX M F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 506 Unterhalt Street
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY: Terrell STATE: TX
8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY STATE
ZIP CODE: 78218 TELEPHONE (Include Area Code): ( )
ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES [X] NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Karen Belman, M.D.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567-89
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 750 0
2.
3.
4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 1234567890

24.

	A From MM DD YY	A To MM DD YY	B Place of Service	C Type of Service	D CPT/HCPCS	D MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 2007	01 01 2007	1	1	97535			40 00	1				
2													
3													
4													
5													
6													

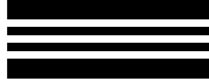
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES NO
28. TOTAL CHARGE: $ 40 00
29. AMOUNT PAID: $
30. BALANCE DUE: $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jay Masters
SIGNED DATE: 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Jay Masters
1402 Silver Blvd.
Terrell, TX 75160
210-555-1234
PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.63 Surgery

PLEASE
DO NOT
STAPLE
IN THIS
AREA



PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Baker, Ruth L.
3. PATIENT'S BIRTH DATE MM DD YY: 08 03 1980 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1523 Robinson Street
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):

CITY: Goliad — STATE: TX
8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY — STATE

ZIP CODE: 77963 — TELEPHONE (Include Area Code): (713) 555-1234
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File — DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE: Hysterectomy acknowledgement attached
20. OUTSIDE LAB? YES [ ] NO [X] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 218 9
2. 626 8
3. ___ . __
4. ___ . __
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 07 2007	01 07 2007	3	2	58260		1	970 00					1234567-89

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.: 12345
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 970 00
29. AMOUNT PAID: $
30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Jane Smith, MD
SIGNED — DATE: 01 10 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Unity Hospital
923 Medical Drive
Goliad, TX 77963
H01234567
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Woman's Health Center
921 Raite Place
Goliad, TX 77963
PIN# — GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.64 THSteps Example of a New Patient, Immunization, Physical Examination by a Nurse Practitioner, and FQHC Billing

PLEASE
DO NOT
STAPLE
IN THIS
AREA

MEDICAID OF TX

PO BOX 200555
AUSTIN, TX 78720-0555

PICA **HEALTH INSURANCE CLAIM FORM** PICA

CARRIER

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) [X] / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 727272727

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Child, Sally J.
3. PATIENT'S BIRTH DATE MM DD YY: 03 15 2004 — SEX M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 5432 West Main St.
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):

CITY: Star — STATE: TX
8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
CITY — STATE

ZIP CODE: 77787 — TELEPHONE (Include Area Code): ( )
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED — DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES [ ] NO [X] — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V202
2. ___ . __
3. ___ . __
4. ___ . __
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 05 2007	01 05 2007	1	S	99382	SA EP	1	88 00	1			NU	
01 05 2007	01 05 2007	1	S	90471	SA EP	1	5 00	1				
01 05 2007	01 05 2007	1	S	90700	SA EP	1	0 01	1				

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]
28. TOTAL CHARGE: $ 93 01
29. AMOUNT PAID: $
30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Signature on File — 01/20/07
SIGNED — DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Star Community Health Center
100 Main St.
Star, TX 77777
PIN# — GRP# 5454545-01

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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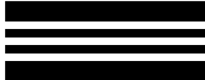
CPT only copyright 2005 American Medical Association. All rights reserved.

D.65 THSteps Example of an Established Patient and Referral, TB Skin Test, and Physical Examination by a Physician

PLEASE
DO NOT
STAPLE
IN THIS
AREA



MEDICAID OF TX

PO BOX 200555
AUSTIN, TX 78720-0555

CARRIER

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [X] CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (VA File #) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smiles, D.W

3. PATIENT'S BIRTH DATE MM DD YY: 02 01 1998 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 500 24th Place

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Lubbock STATE: TX

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 79488 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V202 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 02 2007	01 02 2007	1	S	99393	AM 32	1	120 00				ST	
2 01 02 2007	01 02 2007	1	S	86580	AM 32	1	0 01					
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 120 01

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File 01/20/07

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Carl Kidd, M.D., and Associates
3301 Hill Lane
Lubbock, TX 79488

PIN# GRP# 9876543-21

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.66 THSteps Dental

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Texas Medicaid & Healthcare Partnership
Claims
PO Box 200555
Austin, TX 78720-0555

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender [ ] M [ ] F 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Other Insured (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Hobday, Joey, G.
345 McFoster Drive
Pampa, TX 79063

13. Date of Birth (MM/DD/CCYY): 04/01/1991 14. Gender [X] M [ ] F 15. Subscriber Identifier (SSN or ID#): 123456789

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other

19. Student Status [X] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender [ ] M [ ] F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	01/10/2007					D0150	Comprehensive Evaluation	40 00
2	01/10/2007					D0210	Intraoral Film Series	58 00
3	01/10/2007					D1201	Fluoride Prophylaxis	42 00
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

	Permanent																Primary									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee 140 00

35. Remarks: Exam needed for Head Start.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Tyler Hitchens, D.D.S.
800 Braces Lane
Suite 302
Amarillo, TX 79016

49. Provider ID: 987654321 50. License Number 51. SSN or TIN

52. Phone Number (806) 575 – 4400

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X *Tyler Hichens, D.D.S.* 01/17/2007
Signed (Treating Dentist) Date

54. Provider ID: 987654321 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – 58. Treating Provider Specialty

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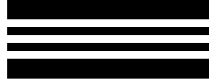
J515 (Same as ADA Dental Claim Form – J516, J517, J518, J519)

D.67 Tuberculosis (TB)



PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

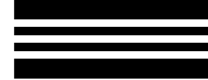
1. Medicaid: X
1a. INSURED'S I.D. NUMBER: 123456789
2. PATIENT'S NAME: Doe, Jane C.
3. PATIENT'S BIRTH DATE: 12 06 1964 — SEX: F X
5. PATIENT'S ADDRESS: 1200 Baltic Avenue
CITY: Conroe — STATE: TX
ZIP CODE: 77302 — TELEPHONE: (123) 555-1234
6. PATIENT RELATIONSHIP TO INSURED: Self X
8. PATIENT STATUS: Married X
10a. EMPLOYMENT? NO X
10b. AUTO ACCIDENT? NO X
10c. OTHER ACCIDENT? NO X
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: Signature on File
20. OUTSIDE LAB? NO X
21. DIAGNOSIS: 1. V01 1

24A From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units
01 01 2007	01 01 2007	1	1	99204	TF AM	1	75 70	1
01 01 2007	01 01 2007	1	4	71010		1	25 00	1

27. ACCEPT ASSIGNMENT? YES X
28. TOTAL CHARGE: $ 100 70
31. SIGNATURE OF PHYSICIAN OR SUPPLIER: Sally Green, ANP — DATE: 01 10 2007
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Sally Green, ANP, 1242 Rosewood, Conroe, TX 77307 — GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

D.68 Vision



PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. Medicaid: X
1a. INSURED'S I.D. NUMBER: 512345678
2. PATIENT'S NAME: Jones, Mary
3. PATIENT'S BIRTH DATE: 01 01 2000 — SEX: F X
5. PATIENT'S ADDRESS: 1234 N. Main Street
CITY: Anytown — STATE: TX
ZIP CODE: 77123 — TELEPHONE: (123) 555-1234
6. PATIENT RELATIONSHIP TO INSURED: Self X
9. OTHER INSURED'S NAME: Jones, Jim
9a. OTHER INSURED'S POLICY OR GROUP NUMBER: 123456789
9b. OTHER INSURED'S DATE OF BIRTH: 05 01 1965 — SEX: M X
9c. EMPLOYER'S NAME OR SCHOOL NAME: ABCD, Inc.
9d. INSURANCE PLAN NAME OR PROGRAM NAME: Prudential
10a. EMPLOYMENT? NO X
10b. AUTO ACCIDENT? NO X
10c. OTHER ACCIDENT? NO X
11. INSURED'S POLICY GROUP OR FECA NUMBER: 412345678A
11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO X
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: Signature on File
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: Signature on File
14. DATE OF CURRENT: 05 01 2007
17. NAME OF REFERRING PHYSICIAN: Dr. Dan Smith
17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8819004-02
21. DIAGNOSIS: 1. V99 99; 2. 367 9

24A From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units
05 01 2007	05 01 2007	1	E	V2020		1, 2	175 00	
				V2214				

26. PATIENT'S ACCOUNT NO.: 123456
27. ACCEPT ASSIGNMENT? YES X
28. TOTAL CHARGE: $ 175 00
29. AMOUNT PAID: $ 20 00
30. BALANCE DUE: $ 155 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER: Dr. Dan Smith, MD — DATE: 05 01 2007
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED: Eyecare Clinic, 124 S. First Street, Anytown, TX 77123
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Dr. Dan Smith, M.D., 1234 S. First Street, Anytown, TX 77123 — GRP# 111-222-3333

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

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Appendix

E

Vendor Drug Program

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E.2 Services Available for Children and Adolescents E-3
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E.3.1 Participating Synagis® Distribution Pharmacies E-3

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E.1 Vendor Drug Program

The Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs only to those pharmacy providers contracted with the VDP. In-state pharmacies licensed as Class A or C by the Texas State Board of Pharmacy are eligible for enrollment in the VDP. Out-of-state pharmacies and pharmacies holding any other class of pharmacy license are considered for inclusion in the program on a case-by-case basis, relative to the benefits made available to a client eligible for Medicaid. Contracts are not granted to applicants unless additional benefits to the recipient are established.

The only drugs eligible for VDP reimbursement are listed in the current *Texas Listing of National Drug Codes*. Additionally, the Texas Drug Code Index (TDCI) can be found on the HHSC website at www.hhsc.state.tx.us. The VDP does not reimburse claims for nutritional products (enteral or parenteral), medical supplies, or equipment.

For more information on the VDP, contact:

Vendor Drug Area	Telephone Number
Covered outpatient drugs and billing: The 800 number is for pharmacy use only and can be used to reach anyone in the VDP.	1-800-435-4165
Pharmacy contracts	1-512-491-1163
Policy	1-512-491-1340
Administration	1-512-491-1124
Drug formulary (Texas listing of national drug codes)	1-512-491-1157

Clients who are not locked-in to a specific pharmacy may obtain their drugs or supplies from any contracted Medicaid provider of pharmaceutical services.

Refer to: “Client Limited Program” on page 4-5 for more information about lock-in limitations.

Family planning services are excluded from lock-in limitation. Though TMHP reimburses family planning agencies and physicians for family planning drugs and supplies, the following family planning drugs and supplies are also available through the VDP Program:

- Diaphragms
- Oral contraceptives
- Jellies, creams, foams, suppositories, vaginal contraceptive film, and contraceptive sponge
- Condoms
- Medication for treatment of vaginal/cervical/genital infections (subject to the three prescription limit)

The VDP is limited to three prescriptions per month, per client, except for:

- Clients enrolled in waiver programs such as managed care, Class, Community-Based Alternatives (CBA)
- Texas Health Steps (THSteps)-eligible (clients younger than 21 years of age), unlimited but must be medically necessary and appropriate
- Residents in skilled nursing facilities, unlimited
- Clients enrolled in the State of Texas Access Reform (STAR) Program, and residing in a STAR Program service area, unlimited

  Refer to: “Service Areas” on page 7-14
- Prescriptions for family planning drugs and supplies are not subject to the three prescription limit

E.1.1 Lotions Available Through the Vendor Drug Program

The VDP offers Coats Aloe Vera products to Medicaid and Texas Health Steps (THSteps)-Comprehensive Care Program (CCP) clients with a physician’s prescription. Coats Aloe Vera products are available in cream, lotion, gel, liniment, and liquid form and they contain no alcohol or fragrances. The product information states that cetyl alcohol is a component. Cetyl alcohol, however, does not have alcohol as a base, does not act like alcohol, but is used as a thickener. The liniment form contains methylsalicylate (wintergreen). The following Coats Aloe Vera creme, lotion, gel, liniment, and liquid products are available from the VDP with a physician’s prescription:

TX Drug Code	Name and Strength	
58826070108	Coats Aloe Vera	Liquid, 100% (soaking)
58826070128	Coats Aloe Vera	Liquid, 100% (soaking)
58826070202	Coats Aloe Vera	85% Lotion
58826070208	Coats Aloe Vera	85% Lotion
58826070233	Coats Aloe Vera	85% Lotion
58826070304	Coats Aloe Vera	75% Creme
58826070316	Coats Aloe Vera	75% Creme
58826070408	Coats Aloe Vera	Liniment 85%, 11% methylsalicylate
58826070508	Coats Aloe Vera	90% Jelly
58826070533	Coats Aloe Vera	90% Jelly

If a physician does not wish to use these products, the physician is allowed to make a request to THSteps-CCP for another product, with specific documentation of the medical necessity for another product. THSteps-CCP does not provide nonlegend, cosmetic-type skin lotions and cremes.

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E.2 Services Available for Children and Adolescents

Medically necessary drugs and supplies that are not covered by the VDP Program may be available to children and adolescents (birth through 20 years of age) through the THSteps-CCP.

Contact the THSteps-CCP Customer Service at 1-800-846-7470.

The Prior Authorization Fax number is 1-512-514-4212.

For more information about pharmacy enrollment in THSteps-CCP, see "Pharmacies (THSteps-CCP Only)" on page 43-60.

E.3 Synagis® Available Through the Vendor Drug Program

Synagis® is available to physicians for administering to Medicaid clients through the VDP. This option enables physicians to have Synagis® shipped directly to their office from a network pharmacy. Physicians will not need to purchase the drug. Physicians that obtain Synagis® through the VDP may not bill Medicaid for the drug.

E.3.1 Participating Synagis® Distribution Pharmacies

Curascript
Telephone: 1-866-297-0933

Fax: 1-866-297-0934

Accredo/Nova Factor
Telephone: 1-877-482-5927

Fax: 1-877-369-3447

Refer to: "Obtaining Synagis® (palivizumab) Through the Vendor Drug Program" on page 36-123.

E

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Appendix

F

Acronym Dictionary

Term	Definition
A/EEG	Ambulatory Electroencephalogram
A/R	Accounts Receivable
AAC	Augmentative and Alternative Communication
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ABMG	American Board of Medical Geneticists
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetricians and Gynecologists
ACT	Assertive Community Treatment
AD	Home Health Aide
ADA	American Dental Association or Americans with Disabilities Act
AFP	Abdominal Flat Plates
AHI	Apnea/Hypopnea Index
AI	Auditory Impairment
AIDS	Acquired Immunodeficiency Syndrome
AIS	Automated Inquiry System
ALS	Advanced Life Support
ALS	Amyotrophic Lateral Sclerosis
AMA	American Medical Association
ANSI	American National Standards Institute
AP	Anterior-posterior
APN	Advanced Practice Nurse
ARD	Admission, Review, and Dismissal
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
ASHA	American Speech and Hearing Association
ASL	American Sign Language
AWP	Average Wholesale Price
BCG	Bacillus Calmette-Guérin
BCVDDP	Blind Children’s Vocational Discovery and Development Program
BHO	Behavioral Health Organization
BICROS	Bilateral Contralateral Routing of Offside Signal
BiPAP	Bilevel Positive Airway Pressure
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation

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Term	Definition
BNE	Board of Nurse Examiners
BPH	Benign Prostatic Hyperplasia
BRC	Bureau of Radiation Control
BUN	Blood Urea Nitrogen
BVS	Bureau of Vital Statistics
C21	Compass21
CAH	Critical Access Hospital
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARE	Client Assessment Review and Evaluation
CARTS	Case Action Request Tracking System
CAT	Computerized Axial Tomography
CBA	Community-Based Alternatives (Program)
CCIP	Comprehensive Care Inpatient, Psychiatric
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CDC	Centers for Disease Control and Prevention
CDT	Current Dental Terminology
CDTF	Chemical Dependency Treatment Facility
CFR	*Code of Federal Regulations*
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Comprehensive Health Centers
CHIP	Children's Health Insurance Program
CIHCP	County Indigent Health Care Program
CLASS	Community Living Assistance and Support Services
CLIA	Clinical Laboratory Improvement Amendments
CLPPP	Childhood Lead Poisoning Prevention Program
CMHC	Community Mental Health Centers
CMS	Centers for Medicare & Medicaid Services
CMV	Cytomegalovirus
CNM	Certified Nurse-Midwife
CNS	Clinical Nurse Specialist
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAP	Continuous Positive Airway Pressure
CPM	Continuous Passive Motion
CPR	Cardio Pulmonary Resuscitation
CPT	Current Procedural Terminology
CPW	Case Management for Children and Pregnant Women Program and Texas Health Steps Medical Case Management (THSteps MCM)
CRCP	Certified Respiratory Care Practitioner
CRD	Chronic Renal Disease
CRNA	Certified Registered Nurse Anesthetists
CSHCN	Children with Special Health Care Needs Services Program

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Term	Definition
CSI	Claim Status Inquiry
CT	Claim Type
CT	Computerized Tomography
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
dB	Decibel
DBS	Division for Blind Services
DC	Doctor of Chiropractic Medicine
DDS	Doctor of Dental Surgery
DDS	Disability Determination Services
DEA	Drug Enforcement Agency
DEFRA	*Deficit Reduction Act* of 1984
DFPS	Department of Family and Protective Services
DHHS	(United States) Department of Health and Human Services (cf. HHS)
DMARD	Disease-Modifying Anti-Rheumatic Drugs
DMD	Dental Medical Doctor
DME	Durable Medical Equipment
DMEH	Durable Medical Equipment–Home Health Services
DMERC	Durable Medical Equipment Regional Carriers
DNA	Deoxyribonucleic acid
DO	Doctor of Osteopathy
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty
DOPT	Directly Observed Preventive Therapy
DOS	Date of Service
DOT	Directly Observed Therapy
DPC	Diagnostic Procedure Code
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis-Related Group
DSHS	(Texas) Department of State Health Services
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
E/M	Evaluation and Management (Services)
ECC	Early Childhood Caries
ECF	Extended Care Facility
ECG	Electrocardiogram
ECI	Early Childhood Intervention
ECMO	Extracorporeal Membrane Oxygenation
EDC	Estimated Date of Confinement
EDD	Estimated Due Date
EDD	Expected Date of Delivery
EDI	Electronic Data Interchange
EDTA	Ethylenediaminetetraacetic Acid
EEG	Electroencephalogram
EFT	Electronic Funds Transfer

F

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Term	Definition
EGD	Esophagogastroduodenoscopy
EIA	Enzyme Immunoassay
EIN	Employer Identification Number
EKG	Electrocardiogram
EMG	Electromyography or Electromyogram
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ENT	Ear, Nose, and Throat
EOB	Explanation of Benefits
EOG	Electro-Oculogram
EOMB	Explanation of Medicare Benefits
EOPS	Explanation of Pending Status
EP	Erythrocyte Protoporphyrin
EPO	Erythropoietin Alfa
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ER&S	Electronic Remittance and Status Report
ERCP	Endoscopic Retrograde Cholangiopancreatography
eSP™	eScreener Plus
ESRD	End Stage Renal Disease
FDA	(United States) Food and Drug Administration
FFP	Federal Financial Participation
FIUT	Fetal Intrauterine Transfusion
FL	Form Locators
FMAP	Federal Medicaid Assistance Percentage
FNP	Family Nurse Practitioner
FP	Family Planning
FPL	Federal Poverty Limit
FQHC	Federally Qualified Health Center
FQS	Federally Qualified Satellite
FSR	Financial Status Reports
FTA	Fluorescent Treponemal Antibody Absorbed
FTS	Full Time Student
FY	Fiscal Year
FYE	Fiscal Year End
GAO	General Accounting Office
G-CSF	Granulocyte Colony Stimulating Factors
GIS	Geographic Information System
GM-CSF	Granulocyte-Macrophage Colony Stimulating Factor
GME	Graduate Medical Education
GYN	Gynecological
HA	Hearing Aid
HASC	Hospital-based Ambulatory Surgical Center

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Term	Definition
HB	House Bill
HBO	Hyperbaric Oxygen Therapy
HBP	Hospital-Based Physician
HBV	Hepatitis B Virus
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-Based Services
HCT	Hematocrit
HDL	High Density Lipoproteins
HEENT	Head, Eyes, Ears, Nose, and Throat
HepA	Hepatitis A
HepB	Hepatitis B
HFCWCS	High-Frequency Chest Wall Compression System
HHA	Home Health Aide or Home Health Agency
HHS	(United States Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HIC	Health Insurance Claim (Number)
HIPAA	*Health Insurance Portability and Accountability Act*
HIPPS	Health Insurance Premium Payments System
HIV	Human Immunodeficiency Virus
HLD	Handicapping Labio-Lingual Deviations
HMO	Health Maintenance Organization
HOTV	A type of eye test chart that uses the letters H, O, T, and V
HPRT	Hypoxanthine-guanine phosphoribosyltransferase
HRC	*Texas Human Resource Code*
HSC	*Texas Health and Safety Code*
HTLV	Human T-cell lymphotrophic virus
HUMR	Hospital Utilization Master Reporting (System)
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility (see also SNF and ECF)
ICF-MR	Intermediate Care Facility for the Mentally Retarded
ICN	Internal Control Number (in 24-digit Medicaid ICN)
ID	Identification
IDCU/TB	Infectious Disease Control Unit Tuberculosis Program
IDEA	*Individuals with Disabilities Education Act*
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IM	Intramuscular
IMD	Institution for Mental Diseases
ImmTrac	Texas immunization registry
IOL	Intraocular Lens
IPD	Intermittent Peritoneal Dialysis
IPPB	Intermittent Positive-Pressure Breathing
IPV	Intrapulmonary Percussive Ventilation

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Term	Definition
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
ISD	Independent School District
ITP	Idiopathic Thrombocytopenia
IUD	Intrauterine Device
IV	Intravenous
JCIH	Joint Committee on Infant Hearing
KUB	Kidneys, Ureters, Bladder
LASIK	Laser-In-Situ Keratomileusis
LCSW	Licensed Clinical Master Social Worker (formerly LMSW-ACP)
LDL	Low Density Lipoprotein
LEA	Local Education Agency
LEP	Limited English Proficiency
LLC	Limited Liability Company
LMFT	Licensed Marriage and Family Therapist
LMP	Last Menstrual Period
LOCM	Low Osmolar Contrast Material
LOS	Length of Stay
LPC	Licensed Professional Counselor
LPTA	Licensed Physical Therapist Assistant
LTC	Long Term Care
LTCH	Long Term Care Hospital
LVN/LPN	Licensed Vocational or Licensed Practical Nurse
MAO	Medical Assistance Only
MARS	Management and Administrative Reporting Subsystem
MCLS	Mucocutaneous Lymph Node Syndrome
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MD	Doctor of Medicine
MDCP	Medically Dependent Children's Program
MFADS	Medicaid Fraud and Abuse Detection System
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MIHIA	*Maternal and Infant Health Improvement Act*
MMPI	Minnesota Multiphasic Personality Inventory
MMWR	Morbidity and Mortality Weekly Report
MNC	Medically Needy Clearinghouse
MNP	Medically Needy Program
MPI	Medicaid Program Integrity
MQMB	Medicaid Qualified Medicare Beneficiary
MR	Mentally Retarded or Mental Retardation
MRA	Magnetic Resonance Angiography
MRAN	Medicare Remittance Advice Notice
MRDA	Mental Retardation Diagnosis and Assessment

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Term	Definition
MRI	Magnetic Resonance Imaging
MRLA	Mental Retardation Local Authority
MRT	Magnetic Resonance Technology
MSAFP	Maternal Serum Alfa-fetoprotein
MSC	Maternity Service Clinic
MSRP	Manufacturer's Suggested Retail Price
MTP	Medical Transportation Program
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NBS	Newborn Screen (Neonatal Screen)
NCQA	National Committee for Quality Assurance
NEC	Not Elsewhere Classified
NF	Nursing Facility
NICU	Neonatal Intensive Care Unit
NMDP	National Marrow Donor Program
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPI	National Provider Identifier
NPR	Notice of Amount of Program Reimbursement
OAE	Otoacoustic Emissions
OAG	Office of the Attorney General
OB	Obstetrics
OBRA	*Omnibus Budget Reconciliation Act*
OCR	Office for Civil Rights
OD	Doctor of Optometry
OI	Other Insurance
OIG	Office of the Inspector General
OMT	Osteopathic Manipulation Treatment
OPO	Organ Procurement Organization
OPT/SP	Outpatient Physical Therapy/Speech Pathology
OPTN	Organ Procurement and Transportation Network
ORF	Outpatient Rehabilitation Facilities
OSHA	Occupational Safety and Health Administration
PA	Physician Assistant
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAN	Prior Authorization Number
PASARR	Preadmission (MH/MR) Screening and Annual Resident Review
PC	Personal Computer
PCCM	Primary Care Case Management (Program)
PCN	Patient Control Number
PDA	Personal Digital Assistant
PDF	Portable Document Format
PDN	Private Duty Nursing
PE	Presumptive Eligibility

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Term	Definition
PENS	Percutaneous Electrical Nerve Stimulator
PEP	Positive Expiratory Pressure
PHC	Primary Home Care
PIC	Provider Information Change
PIF	Provider Information Form
PIP	Personal Injury Protection
PKU	Phenylketonuria
PL	Public Law
PNP	Pediatric Nurse Practitioner
POC	Plan of Care
POS	Place of Service
PPD	Purified Protein Derivative
PPMP	Physician Performed Microscopy Procedure (CLIA-Certified)
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRK	Photorefractive Keratectomy
PRN	Pro Re Nata (As Needed)
PT	Physical Therapy, Physical Therapist, or Proficiency Test
PTA	Percutaneous Transluminal Angioplasty
QA	Quality Assurance
QC	Quality Control
QMB	Qualified Medicare Beneficiary
R&S	Remittance and Status report
RA	Remittance Advice
RAST	Radio Allergo Sorbent Test
RBRVS	Resource-Based Relative Value Scale
RDC	Renal Dialysis Center
RDI	Respiratory Disturbance Index
REM	Rapid Eye Movement
RFP	Request For Proposal
RGO	Reciprocating Gait Orthoses
RHC	Rural Health Clinic
RIMS	Referral Identification Monitoring System
RN	Registered Nurse
RN	Remittance Notice
RPR	Rapid Plasma Reagin
RSDI	Retirement Survivors Disability Insurance
RSV	Respiratory Syncytial Virus
RVU	Relative Value Unit
SA	Service Area
SADMERC	Statistical Analysis DME Regional Carrier
SARS	Severe Acute Respiratory Syndrome
SB	Senate Bill
SCID	Severe Combined Immunodeficiency

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Term	Definition
SDA	Standard Dollar Amount
SED	Serious Emotional Disturbance
SFY	State Fiscal Year (September 1 – August 31)
SHARS	School Health and Related Services
SID	Surface Identification
SIMV	Synchronized intermittent mandatory ventilation
SLIAG	State Legalization Impact Assistance Grant
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility (see also ICF and ECF)
SOC	Start of Care (concerning Home Health Services claims)
SPMI	Severe and Persistent Mental Illness
SQ/SC	Subcutaneous
SSA	Social Security Administration
SSI	Supplemental Security Income (Program)
SSL	Secure Socket Layer
SSN	Social Security Number
ST	Speech Therapy
STAR	State of Texas Access Reform (Program)
STD	Sexually Transmitted Diseases
SUR	Surveillance/Utilization Review
TAA	Texas Access Alliance
TAC	*Texas Administrative Code*
TANF	Temporary Assistance to Needy Families
TB	Tuberculosis
TCADA	Texas Commission on Alcohol and Drug Abuse
TCU	Temperature Control Unit
TDCI	Texas Drug Code Index
TDD	Telecommunications Device for the Deaf
TEA	Texas Education Agency
TEFRA	*Tax Equity and Fiscal Responsibility Act* (of 1982)
TEHDI	Texas Early Hearing Detection and Intervention
TENS	Transcutaneous Electrical Nerve Stimulator
TESS	Texas Eligibility Screening System
THKAO	Thoracic-Hip-Knee-Ankle Orthoses
THSteps	Texas Health Steps
THSteps-CCP	Texas Health Steps-Comprehensive Care Program
TID	Tooth Identification Number
TIERS	Texas Integrated Eligibility Redesign System
TIFB	Telecommunications Infrastructure Fund Board
TMHP	Texas Medicaid & Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedure Manual
TMRM	Texas Medicaid Reimbursement Methodology
TMRP	Texas Medical Review Program
TNA	Texas Nurses Association

F

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Term	Definition
TOB	Type of Bill
TORCH	Toxoplasmosis, Other agents, Rubella, Cytomegalo virus, Herpes simplex (congenital perinatal infection)
TOS	Type of Service
TP	Type Program
TPI	Texas Provider Identifier
TPN	Total Parenteral Hyperalimentation (in-home hyperalimentation)
TP-PA	Treponema pallidum Particle Agglutination
TPR	Third Party Resources
TRAM	Transverse Rectus Abdominis Myocutaneous
TSBDE	Texas State Board of Dental Examiners
TURP	Transurethral Resection of the Prostate
TVFC	Texas Vaccines for Children (Program)
TxDOT	Texas Department of Transportation
UB-92	Uniform Bill-92 (HCFA-1450)
UCB	University of California at Berkeley
UM	Utilization Management
UNOS	United Network for Organ Sharing
UPIN	Universal Provider Identification Number
UR	Utilization Review
USC	*United States Code*
USDA	United States Department of Agriculture
VA	Veteran’s Administration
VDP	Vendor Drug Program
VDRL	Venereal Disease Research Laboratory
VIS	Vaccine Information System
VLDL	Very Low Density Lipoproteins
VPN	Virtual Private Networking
WAIS-R	Wechsler Adult Intelligence Scale–Revised
WIC	Women, Infants, and Children

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Appendix

G

HIV/AIDS

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G.1 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

G.1.1 Purpose

The purpose of this policy is to protect the employment rights and privileges of individuals infected with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Texas Department of State Health Services (DSHS) encourages all employers to establish workplace policies concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients. However, the content and intent must remain consistent with this document and the *Texas Health and Safety Code*.

G.1.2 Authority

Governance for this policy is found in *Vernon's Texas Codes Annotated*, Health & Safety Code (HSC) §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines developed by the DSHS, HIV/ sexually transmitted disease (STD) Comprehensive Services Branch, as required by HSC §85.012, "Model Workplace Guidelines," and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of certain designated state agencies and organizations funded by those state agencies (HSC §85.113). "State Agencies Listed Under HSC §85.113" on page G-4 These guidelines are also the standard for health care facilities licensed by DSHS and the Department of Aging and Disability Services (DADS) as stated in HSC §85.010, "Educational Course for Employees and Clients of Health Care Facilities."

G.1.3 Who Must Use Workplace Guidelines

G.1.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should incorporate, at a minimum, the DSHS model workplace guidelines in this policy.

G.1.3.2 State Contractors

A program involving direct client contact, which contracts with or is funded by any of the state agencies listed on page G-4, will adopt and carry out workplace guidelines as stated in HSC §85.113.

G.1.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact.
- Provide workers with current information about HIV risk reduction for employees and their families.
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues.
- Prevent work disruption and rejection of the infected employee by coworkers.
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety.
- Provide specific and ongoing education and equipment to employees in health care settings who are at risk of exposure to HIV, and to assure that appropriate infection-control procedures are used.
- Reduce the financial impact, legal implications, and other possible effects of HIV/AIDS in the workplace.

G.1.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. We encourage use of the following statements in agency policy:

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV infected individuals is not acceptable. Employees who believe that they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may also be available.
- This policy is consistent with current information from public health authorities, such as the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service, and with state and federal laws and regulations.

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While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- *Discrimination.* The *Americans with Disabilities Act* (ADA) of 1990 prohibits discrimination against people with disabilities, which include HIV and AIDS, in employment, public accommodations, public transportation, and other situations.

  A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. Such a statement might be, "This agency complies with the ADA protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or conditions of employment." Managers may want to define ways in which they will deal with discriminatory actions.

- *Desire and Ability to Work.* A workplace policy should address the infected employee's desire and need to work and the infected employee's value to the workplace. Such a statement reassures employees that the employer supports them.

  The health status of someone with HIV may vary from healthy to critically ill. In the work setting, the ultimate concern is whether or not the employee can satisfy job expectations. A policy statement may say, for example, "Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform the essential functions of their job with or without reasonable accommodation."

- *Performance Standards.* The ADA provides protections for disabled persons "qualified" to perform their jobs. And although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant; employers may terminate employees and refuse to hire individuals who cannot perform the essential functions of the job, with or without the reasonable accommodation.

  One suggested statement is, "While the ADA does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."

- *Reasonable Accommodation.* The ADA requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the ADA.

  Such a policy statement might read, "The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules."

- *Confidentiality and Privacy.* Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds.

  Employees are not required to reveal their HIV status to employers. All medical information that an HIV infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty").

  A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."

- *Coworker Concerns.* Employers need to be aware of the concerns that coworkers may have about an HIV infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally important is a policy statement that clarifies the limits of an employer's response to coworker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."

- *Employee Education.* Any health care facility *licensed by* the DSHS or the DADS must require its employees to complete an educational course about HIV infection (HSC §85.010). A suggested policy statement may be: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC, §85.004, "Educational Programs," DSHS developed model education program guidelines. These are available from DSHS, HIV/STD Comprehensive Services Branch, 1100 W. 49th St., Austin, TX. 78756-3199, (512) 490-2505. Employers may also find the CDC's educational kit, *Business Responds to AIDS*, useful in developing educational courses. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers.

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Experience shows that educated coworkers usually respond to persons with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions.

Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids that are considered to be high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and individuals confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning will reflect a commitment to the health and well-being of the work force and the community being served.

- *Assistance.* Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services.
  - Provide HIV/AIDS workplace training for managerial staff.
  - Serve as a liaison between management and the employer's clinical and occupational health programs.
  - Provide counseling for employees who irrationally fear coworkers or clients.

Employers who have no employee assistance program may consider working with other organizations that provide assistance. Some of these groups include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

A suggested policy statement might be: "An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits."

G.1.6 Where to Go for Help

Refer employees to the Texas HIV/STD InfoLine at 1-800-299-AIDS or other appropriate resource. This is a toll-free HIV/AIDS and STD information and referral service sponsored by DSHS. It provides referrals to HIV/AIDS testing sites; prevention, case management and treatment providers; STD clinics; and other related service organizations. Information and referral is available for English and Spanish speaking callers, and for those who are hearing-impaired.

G.1.7 State Agencies Listed Under HSC §85.113

HSC §85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by…to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." H.B. 2292, 78th Leg., abolished 10 of the 12 existing health and human services agencies and transferred their powers and duties to three new state agencies and to HHSC; therefore rendering the state agency list found in HSC §85.113 obsolete. The list below reflects the state agency consolidation brought about by H.B. 2292 and identifies the state agencies to who HSC §85.113 applies.

- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)
- Department of State Health Services (DSHS)
- Health and Human Services Commission (HHSC)
- Texas Department of Criminal Justice
- Texas Juvenile Probation Commission
- Texas Youth Commission

G.2 THSteps Medical Checkups Periodicity Schedule Referral

Refer to: ."THSteps Medical Checkups Periodicity Schedule" on page 43-15

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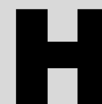

Immunizations

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H.1 Immunizations Overview

All providers must assess the immunization status of the client at every encounter and administer any medically indicated immunizations. (*Code of Federal Regulations* [CFR] and *Texas Administrative Code* [TAC]).

Children must be immunized according to the current Recommended Childhood Immunization Schedule for the United States. The checkup provider is responsible for the administration of immunizations and may not refer children to local health departments. The Department of State Health Services (DSHS) requires that medically necessary immunizations or immunizations routinely recommended by the Advisory Committee on Immunization Practices (ACIP) be administered during the Texas Health Steps (THSteps) medical checkup, unless they are medically contraindicated or excluded from immunization for reasons of conscience, including a religious belief.

A $5 administration fee per dose is paid for immunizations given during a THSteps medical checkup, a follow-up visit, or as part of an acute care visit. THSteps providers should bill for each vaccine separately. If administering a combined vaccine, such as DTaP (diphtheria, tetanus, and pertussis vaccine), providers should not bill separately for each antigen.

Providers, in both public and private sectors, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a child for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current VISs and other immunization forms or literature may call the DSHS Immunization Branch at 1-512-458-7284 or 1-800-252-9152. VISs may also be downloaded from the DSHS Immunization Branch's website at www.immunizetexas.com.

H.1.1 Exemption from Immunization for School and Child-care Facilities

Parents may choose not to vaccinate their children. Immunization requirements for school and childcare entry offer an exemption from these requirements for reasons of conscience or religious beliefs. An exemption is also available for children who are medically contraindicated from receiving a vaccine. For more information on exemptions call 1-512-458-7284, or visit www.immunizetexas.com.

Refer to: "Texas Health Steps (THSteps)" on page 43-1

H.2 Recommended Childhood Immunization Schedule

The Recommended Childhood and Adolescent Immunization Schedule for the United States indicates the recommended age for routine administration of currently licensed childhood vaccines. This schedule is approved by ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The Recommended Childhood and Adolescent Immunization Schedule for the United States is updated annually. The most current version of the schedule is available at www.cdc.gov/nip/recs/child-schedule.htm.

Some combination vaccines are available and may be used whenever any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturers package insert for detailed recommendations.

Vaccines should be administered at the recommended ages. Any dose not given at the recommended age should be given as a *catch-up* immunization on any subsequent visit when indicated and feasible.

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H.2.1 Recommended Childhood and Adolescent Immunization Schedule, 2006

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2006

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–14 years	15 years	16–18 years
Hepatitis B[1]	HepB	HepB		*HepB[1]*		HepB					HepB Series			
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP		DTaP			DTaP	Tdap		Tdap	
Haemophilus influenzae type b[3]			Hib	Hib	*Hib[3]*	Hib								
Inactivated Poliovirus			IPV	IPV		IPV				IPV				
Measles, Mumps, Rubella[4]						MMR				MMR		MMR		
Varicella[5]							Varicella				Varicella			
Meningococcal[6]							Vaccines within broken line are for selected populations		MPSV4		MCV4		MCV4 MCV4	
Pneumococcal[7]			PCV	PCV	PCV	PCV			PCV		PPV			
Influenza[8]						Influenza (Yearly)					Influenza (Yearly)			
Hepatitis A[9]										HepA Series				

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. ▬ Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **www.vaers.hhs.gov** or by telephone, **800-822-7967**.

Range of recommended ages | Catch-up immunization | 11–12 year old assessment

1. **Hepatitis B vaccine (HepB).** ***AT BIRTH:*** **All newborns** should receive monovalent HepB soon after birth and before hospital discharge. **Infants born to mothers who are HBsAg-positive** should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. **Infants born to mothers whose HBsAg status is unknown** should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **For infants born to HBsAg-negative mothers,** the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. ***FOLLOWING THE BIRTHDOSE:*** The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. It is permissible to administer 4 doses of HepB (e.g., when combination vaccines are given after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. **Infants born to HBsAg-positive mothers** should be tested for HBsAg and antibody to HBsAg after completion of the HepB series, at age 9–18 months (generally at the next well-child visit after completion of the vaccine series).
2. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years.
   Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap – adolescent preparation) is recommended at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13–18 years who missed the 11–12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent **tetanus and diphtheria toxoids (Td)** are recommended every 10 years.
3. ***Haemophilus influenzae*** **type b conjugate vaccine (Hib).** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.
4. **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11–12 years.
5. **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.
6. **Meningococcal vaccine (MCV4).** Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11–12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although **meningococcal polysaccharide vaccine (MPSV4)** is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see *MMWR* 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2–10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.
7. **Pneumococcal vaccine.** The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children aged 2–23 months and for certain children aged 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000; 49(RR-9):1-35.
8. **Influenza vaccine.** Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2005;54[RR-8]:1-55). In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2005;54(RR-8):1-55. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).
9. **Hepatitis A vaccine (HepA).** HepA is recommended for all children at 1 year of age (i.e., 12–23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children 2–18 years of age are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of 1-year-old children should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups (see *MMWR* 1999; 48[RR-12]1-37).

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip • American Academy of Pediatrics www.aap.org • American Academy of Family Physicians www.aafp.org

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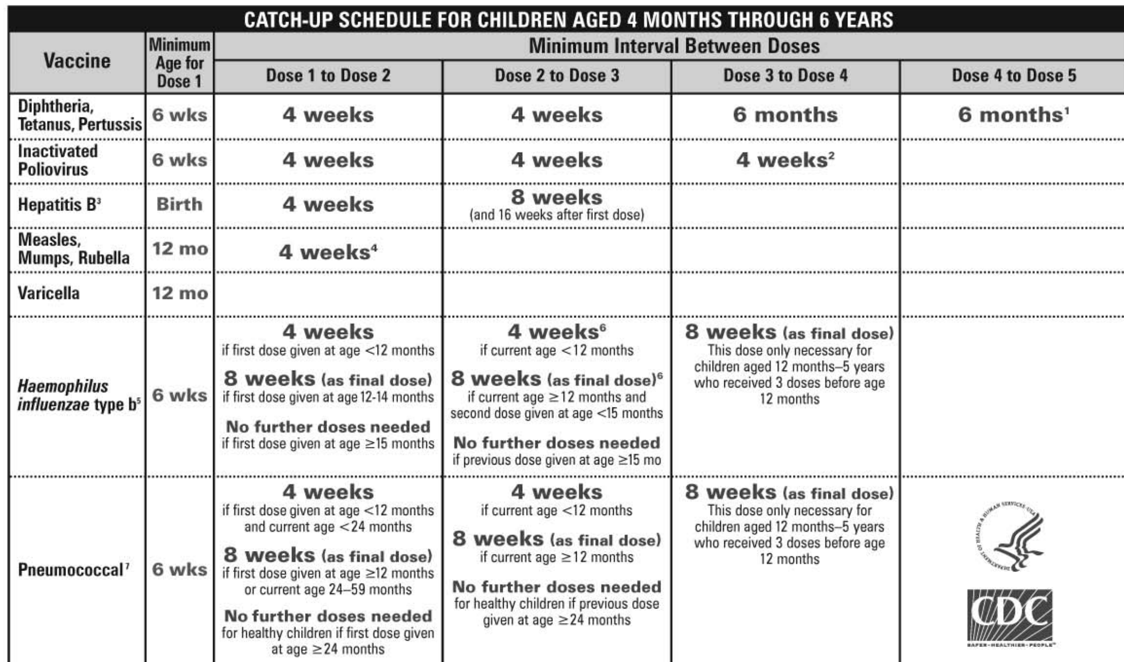
Recommended Immunization Schedule for Children and Adolescents Who Start Late or Who Are More Than 1 Month Behind

UNITED STATES • 2006

The tables below give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.



CATCH-UP SCHEDULE FOR CHILDREN AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 wks	4 weeks	4 weeks	6 months	6 months[1]
Inactivated Poliovirus	6 wks	4 weeks	4 weeks	4 weeks[2]	
Hepatitis B[3]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 mo	4 weeks[4]			
Varicella	12 mo				
Haemophilus influenzae type b[5]	6 wks	**4 weeks** if first dose given at age <12 months **8 weeks (as final dose)** if first dose given at age 12-14 months **No further doses needed** if first dose given at age ≥15 months	**4 weeks**[6] if current age <12 months **8 weeks (as final dose)**[6] if current age ≥12 months and second dose given at age <15 months **No further doses needed** if previous dose given at age ≥15 mo	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 wks	**4 weeks** if first dose given at age <12 months and current age <24 months **8 weeks (as final dose)** if first dose given at age ≥12 months or current age 24–59 months **No further doses needed** for healthy children if first dose given at age ≥24 months	**4 weeks** if current age <12 months **8 weeks (as final dose)** if current age ≥12 months **No further doses needed** for healthy children if previous dose given at age ≥24 months	**8 weeks (as final dose)** This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	CDC

CATCH-UP SCHEDULE FOR CHILDREN AGED 7 YEARS THROUGH 18 YEARS

Vaccine	Minimum Interval Between Doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria[8]	4 weeks	6 months	**6 months** if first dose given at age <12 months and current age <11 years; otherwise **5 years**
Inactivated Poliovirus[9]	4 weeks	4 weeks	IPV[2,9]
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps, Rubella	4 weeks		
Varicella[10]	4 weeks		

1. **DTaP.** The fifth dose is not necessary if the fourth dose was administered after the fourth birthday.
2. **IPV.** For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.
3. **HepB.** Administer the 3-dose series to all children and adolescents <19 years of age if they were not previously vaccinated.
4. **MMR.** The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
5. **Hib.** Vaccine is not generally recommended for children aged ≥5 years.
6. **Hib.** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
7. **PCV.** Vaccine is not generally recommended for children aged ≥5 years.
8. **Td.** Adolescent tetanus, diphtheria, and pertussis vaccine (Tdap) may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A five-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. See ACIP recommendations for further information.
9. **IPV.** Vaccine is not generally recommended for persons aged ≥18 years.
10. **Varicella.** Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following immunization, please visit www.vaers.hhs.gov or call the 24-hour national toll-free information line 800-822-7967. Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or contact 800-CDC-INFO (800-232-4636) (In English, En Español — 24/7)

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H.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the February 8, 2002, issue of the *Morbidity and Mortality Weekly Report* (MMWR), *General Recommendations on Immunization, Recommendations of the Advisory Committee on Immunization Practices* (ACIP). For copies of the *General Recommendations on Immunization* or the MMWR, contact the Immunization Branch at 1-512-458-7284.

H.3.1 How to Obtain Free Vaccines

Texas Vaccines for Children (TVFC) provides routinely recommended ACIP vaccines for immunization of THSteps and other Medicaid-eligible patients free of charge to providers who are enrolled in TVFC. The local health department/district or DSHS regional office provides information on how to order, account for, and inventory vaccines. Monthly reports are required in order to receive state-purchased vaccines. Physicians who request and accept state-supplied vaccines must complete and sign the provider enrollment and profile forms annually.

Additional information can be found at www.immunizetexas.com.

H.3.2 Provider Administration Reimbursement Fee

THSteps and other qualified providers may be reimbursed $5 for each dose of vaccine administered during a THSteps medical checkup or a follow-up visit. Combined antigen vaccines (DTaP-Hib, MMR) are reimbursed as one dose.

H.3.3 Requirements for TVFC Providers

By enrolling, public and private providers agree to:

1) Determine TVFC eligibility before administering vaccines obtained through TVFC. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.
2) Maintain records of the parent, guardian, or authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If requested, the provider will make such records available to DSHS, the local health department authority, or the U.S. Department of Health and Human Services (DHHS).
3) Comply with the appropriate vaccination schedule, dosage, and contraindications, as established by ACIP, unless (a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas law, including laws relating to religious and medical exemptions.
4) Provide VISs to the responsible adult, parent, or guardian and maintain records in accordance with the *National Childhood Vaccine Injury Act*. Signatures are not required for the VISs but are recommended.
5) Not charge for vaccines supplied by DSHS and administered to a child who is eligible for TVFC.
6) Charge a vaccine administration fee to the Medicaid program, but not impose a charge for the administration of the vaccine in any amount higher than the maximum administration fee established by DSHS (providers may charge a vaccine administration fee to Medicaid, but not a fee for the vaccine). Medicaid patients cannot be charged any out-of-pocket expense for the vaccine, administration of the vaccine, or an office visit associated with Medicaid services.
7) Not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
8) Comply with the state's requirements for ordering vaccines and other requirements as described by DSHS.
9) Allow DSHS (or its contractors) to conduct onsite visits as required by TVFC regulations.

The provider or the state may terminate the agreement at any time for personal reasons or failure to comply with the requirements listed above.

H.3.4 How to Report Immunization Records to ImmTrac, the Texas Immunization Registry

Texas law requires all medical providers and payors to report *all immunizations* administered to children under 18 of years of age to ImmTrac, the Texas immunization registry operated by DSHS (*Texas Health and Safety Code,* §§161.007-161.009). Providers must report all immunization information within 30 days of administration of the vaccine, and payors must report within 30 days of receipt of data elements from a provider. Prior to reporting immunizations to ImmTrac, providers must first register for registry participation and access.

ImmTrac is a centralized repository of immunization histories for children younger than 18 years of age and is a free service and benefit available to all Texans. Registry information is confidential and, by law, may be released only to:

- The child's parent, legal guardian, or managing conservator
- The child's physician, school, or licensed childcare facility in which the child is enrolled
- Public health districts or local health departments
- The insurance company, health maintenance organization, or other organization that pays for the provision of the child's health care benefits

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- A health care provider authorized to administer a vaccine
- A state agency that has legal custody of the child

ImmTrac offers three methods to report immunizations to DSHS: Direct Internet Entry, Electronic Data Transfer (Import), and Paper Reporting Form.

H.3.4.1 Direct Internet Entry

This method allows providers to access and review clients' immunization histories prior to administering vaccines. Providers then update their client's immunization record directly into the ImmTrac web application after administering vaccines to the patient.

H.3.4.2 Electronic Data Transfer (Import)

This method allows providers to report immunizations from an electronic medical record (EMR) software application via extract file for import into ImmTrac. Providers may still have access to the ImmTrac web application to access and review their clients' immunization histories.

H.3.4.3 Paper Reporting Form

This method of reporting is available to providers without Internet or computer access. Providers report immunizations to the registry via the ImmTrac Paper Reporting Form. In this case, providers are not able to access and view their clients' immunization histories in ImmTrac.

Before including a child's immunization information in ImmTrac, DSHS must verify that written consent for registry participation has been granted by the child's parent, legal guardian, or managing conservator. Most parents grant consent for ImmTrac participation during the birth certificate application process. Written parental consent for ImmTrac participation applies to all past, present, and future immunizations. Texas law also permits a parent, managing conservator, or guardian to withdraw consent for ImmTrac participation at any time.

Before January 1, 2005, medical providers were responsible for obtaining, maintaining, and reporting parental consent for ImmTrac registry participation to TMHP by including the U6 modifier next to each immunization listed on claim forms. *The U6 modifier is no longer required* because Texas law currently requires providers and payors to report *all* immunizations to ImmTrac, and ImmTrac, rather than the provider, verifies parental consent for participation in the registry. There is no need for providers to include the U6 modifier on the claim forms.

Medical providers may report directly to ImmTrac by entering immunizations online for patients currently participating in the registry. The online (Direct Internet Entry) and Electronic Data Transfer (Import) reporting options allow providers to access, review, and update a patient's immunization history at any time. Before reporting immunizations to ImmTrac via any of these options, providers must complete an ImmTrac Registration Packet (for providers and schools) and receive login credentials from ImmTrac Customer Support. A copy of this packet may be obtained from www.ImmTrac.com or requested from ImmTrac Customer Support by calling 1-800-348-9158.

H.4 Texas Vaccines for Children Program Packet

Refer to: "TVFC Patient Eligibility Screening Record" on page C-96

"TVFC Provider Enrollment (3 Pages)" on page C-97

"TVFC Questions and Answers (3 Pages)" on page C-100

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Medical Transportation

I.1 Medical Transportation I-2
I.1.1 MTP Eligibility I-2
I.1.2 MTP Requirements. I-2
I.1.3 Contacting MTP I-2
I.1.4 MTP Program Limitations I-2

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I.1 Medical Transportation

The Medical Transportation Program (MTP) is funded with federal and state funds to provide nonemergency transportation to medical or dental appointments for eligible clients and their attendants. When eligible clients and their attendants have no other means of transportation, the Texas Department of Transportation (TxDOT) arranges the most cost-effective mode of transportation to and from a medically necessary health care facility that can meet the client's medical needs, including dental services for clients younger than 21 years of age.

I.1.1 MTP Eligibility

People who are currently eligible for Medicaid, Medicaid Managed Care, and Children with Special Health Care Needs (CSHCN) Services Program benefits and their attendants are eligible to receive services. The client's attending physician must certify the need for an attendant unless the client is a CSHCN client or a minor, or a language or other barrier to communication or mobility exists that requires the assistance of an attendant. For Medicaid and CSHCN clients younger than 21 years of age, MTP provides advance funds for travel. Additionally, when health care services require an eligible client to remain overnight, MTP provides for meals and lodging for the eligible child and attendant. CSHCN clients older than 21 years of age diagnosed with cystic fibrosis may also qualify for these services.

I.1.2 MTP Requirements

To receive MTP services, eligible clients and their attendants must have no other means of transportation. In some cases, the client's attending provider is asked to complete Form 3113, Health Care Provider Statement of Need. Form 3113 is required to determine if a particular health care service is a Medicaid-covered benefit for which federal financial participation (FFP) is available, the service is medically necessary, and the health care provider is *reasonably close*.

I.1.3 Contacting MTP

Clients or their advocates may call the statewide MTP toll-free number (1-877-633-8747) to request transportation services. For transportation services within the county, or a county adjacent to the resident county, clients or their advocates should call the MTP office at least two business days before the scheduled appointment. For clients who need to travel beyond an adjacent county, clients or their advocates should call the MTP office at least five business days before the scheduled appointment. The following client information must be provided to the intake operator at the time of the call:

- Medicaid number, CSHCN number, or Social Security number (SSN)
- Name, address, and telephone number, if available
- Name, address, and telephone number of the health care provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special needs, wheelchair lift, or attendant need

I.1.4 MTP Program Limitations

Clients and their attendants are *not* eligible to receive medical transportation services under the following circumstances (this list is not all-inclusive):

- Emergency transportation or nonemergency ambulance services
- Transportation for children who are younger than 18 years of age and not accompanied by a parent or legal guardian, unless one of the following conditions exists:
  - The client is 15 through 17 years of age and presents the parent's or legal guardian's signed, written consent for the transportation services to the regional MTP office or the transportation contractor
  - The treatment to which the minor is being transported is such that the law extends confidentiality to the minor for this treatment
- Transportation to or from a day activity health services facility, personal care home, state institution, nursing facility (unless the client requires dialysis treatment), or facility participating in another Title XIX Program for which the reimbursement rate structure includes transportation funds
- Transportation when the client or another person or entity providing care for the client receives direct payment of worker's compensation benefits, U.S. Department of Veterans Affairs benefits, or other third-party resources for transportation to health care services on the client's behalf
- Transportation when the client is an inpatient in a health care facility
- Transportation of deceased clients
- Transportation passenger assistance beyond that which is necessary to ensure that clients enter and leave vehicles safely unless the contractor's contract states that door-to-door service is provided

Refer to: Title 1, Part 15, Chapter 380 of the *Texas Administrative Code* (TAC) for more information.

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Appendix

J

Lead Screening

J.1 Blood Lead Screening Procedures and Follow-up Testing J-2
J.2 Physician Reference on Follow-up Testing and Case Management J-3
J.3 Lead Poisoning Prevention Educational Materials and Forms J-4

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J.1 Blood Lead Screening Procedures and Follow-up Testing

Blood analysis for lead testing measures micrograms of lead per deciliter of whole blood. A lead concentration of 10 μg/dL or higher meets the Centers for Disease Control and Prevention (CDC)-defined “level of concern” and requires follow-up.

Providers are responsible for confirming capillary blood lead results of 10 μg/dL or above.

A confirmed lead test result is:

- An initial venous test
- A venous test used to confirm a capillary result
- A second capillary test performed within 12 weeks

Note: *The (capillary) blood lead test is subject to a false-elevated result from skin lead contamination during collection. A soap and water wash of the patient’s hands/feet and the collector’s hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.*

If the initial blood lead test is 10 μg/dL or above, recalling a client for an office visit to take a venous blood sample may be billed as a Texas Health Steps (THSteps) follow-up visit. The specimen may be submitted, using the appropriate Department of State Health Services (DSHS) laboratory form to the DSHS Clinical Chemistry Laboratory the same way as for all other THSteps laboratory blood specimens. An initial blood lead test collected as part of a THSteps medical checkup must be submitted to the DSHS laboratory; subsequent screens for the same client may be sent to a private laboratory.

Refer to: “Follow-Up Care Guidelines Summary Table” on page 43-31.

Form Pb-109 “Physician Reference on Follow-up Testing and Case Management” on page J-3 for interpretation of laboratory test results and guidelines for follow-up for clients with elevated blood lead levels.

Providers may obtain more information about the medical and environmental management of lead-poisoned children from the DSHS Childhood Lead Poisoning Prevention Program (CLPPP) by visiting the website at www.dshs.state.tx.us/lead/ or by calling 1-800-588-1248.

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J.2 Physician Reference on Follow-up Testing and Case Management

Form Pb-109 – Physician Reference on Follow-up Testing and Case Management

(keep for your records)

If you need a referral to an expert on medical treatment of child lead poisoning, call the Texas CLPPP Follow-Up Coordinator at 1-800-588-1248.

Table 1:
Recommended Schedule for Obtaining a Confirmatory Venous Specimen

Screening test results (μg/dL):	Perform a venous confirmation test within:
10-19	3 months
20-44	1 week - 1 month*
45-59	48 hours
60-69	24 hours
70 and up	Immediately as an emergency lab test

**The higher the Blood Lead Level (BLL) on the screening test, the more urgent the need for confirmatory testing.*

Table 2:
Schedule for Follow-Up Blood Lead Testing

Venous blood lead level (μg/dL)	Early follow-up (first 2-4 tests after identification)	Late follow-up (after BLL begins to decline)
10-14	3 months	6-9 months
15-19	1-3 months	3-6 months
20-24	1-3 months	1-3 months
25-44	2 weeks-1 month	1 month
45 and up	As soon as possible	Chelation w/subsequent follow-up*

Table 3:
Time Frame for Environmental Investigation and Other Case Management Activities

Venous Blood Lead Level (μg/dL)	Activity	Timeframe for Beginning Activity
10-14	Provide caregiver lead education. Provide follow-up testing. Refer the child for social services if necessary.	Within 30 days
15-19	Above actions, plus: If BLLs persist (i.e., 2 venous BLLs in this range at least 3 months apart) or increase, proceed according to actions for BLLs 20-44.	Within 2 weeks
20-44	Above actions, plus: Provide coordination of care (case management). Provide clinical evaluation and care. Provide environmental investigation and control current lead hazards.	Within 1 week
45-70	Above actions, plus hospitalize child for chelation therapy.*	Within 48 hours
70 or higher	Above actions, plus hospitalize child for chelation therapy immediately.*	Within 24 hours

*** Primary care providers should consult with an expert in the management of lead chemotherapy prior to using chelating agents. Contact your local Poison Control Center or contact Texas CLPPP at 1-800-588-1248 for a referral.**

Chelation therapy should never be administered before a venous confirmation is obtained.

Tables adapted from *Managing Elevated Blood Lead Levels Among Young Children:* CDC; March 2002.

Texas Childhood Lead Poisoning Prevention Program • http://www.dshs.state.tx.us/lead

Epidemiology & Surveillance Unit • Department of State Health Services
1100 West 49th St. • Austin, TX 78756-3199

Form #Pb-109 05-06

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J.3 Lead Poisoning Prevention Educational Materials and Forms

Providers may order lead poisoning prevention educational materials and forms by writing or faxing the DSHS warehouse or by contacting the warehouse online at dbs.dshs.state.tx.us/mamd/litcat/default.asp. Other materials are available for download from the Texas CLPPP website at www.dshs.state.tx.us/lead/default.shtm.

Written requests for warehoused materials can be faxed to 1-512-458-7707 or sent to the DSHS warehouse at:

DSHS Literature and Forms
Attn: Warehouse Manager
1100 West 49th Street
Austin, TX 78756-3199

Include the catalog number, title of item, quantity needed, and your mailing address.

The following table lists materials available to providers at no cost.

Free Lead Poisoning Prevention Materials Available Online and from the DSHS Warehouse	
1-26*	Protect Your Children From Lead Poisoning
1-26a*	Protect Your Children From Lead Poisoning (Spanish)
1-307**	Lead Around the Home (English/Spanish, front and back)
1-308**	Lead in Your Food and Remedies (English/Spanish, front and back)
1-309**	Lead in the Workplace and at Home (English/Spanish, front and back)
1-310**	My Child Has a High Lead Level (English/Spanish, front and back)
1-311**	How Lead Affects Your Child's Health (English/Spanish, front and back)
1-312**	Educator's Brochure
1-313**	Getting a Good Specimen (Poster)
Pb-100***	Lead Assessment Interview Tool
Pb-101***	Request for Environmental Investigation
Pb-102***	Provider Follow-up Questionnaire
Pb-104***	Physician Checklist for Parent Education Topics
Pb-109***	Physician Reference on Follow-up Testing and Case Management
Pb-110***	Risk Assessment for Lead Exposure Questionnaire
13-32*	Get the Lead Out With Good Nutrition

*** Available only from the warehouse**

**** Available from the warehouse or online (PDF format) from the Texas CLPPP website at www.dshs.state.tx.us/lead/default.shtm**

***** Available only online (PDF format)**

*** Available only from the warehouse**

**** Available from the warehouse or online (PDF format) from the Texas CLPPP website at www.dshs.state.tx.us/lead/default.shtm**

***** Available only online (PDF format)**

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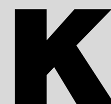
Appendix



Texas Health Steps Statutory State Requirements

K.1 Legislative Requirements K-2
K.2 Communicable Disease Reporting K-2
K.3 Early Childhood Intervention (ECI) Referrals K-2
K.4 Parental Accompaniment K-2
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K.1 Legislative Requirements

Several specific legislative requirements affect Texas Health Steps (THSteps) and the provider's participation in the Medicaid program. The legislation includes, but is not limited to, those included in this appendix.

K.2 Communicable Disease Reporting

Diagnosis of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are reportable conditions under Title 25 *Texas Administrative Code* (TAC), Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §§97.132–134.

K.3 Early Childhood Intervention (ECI) Referrals

ECI is a coordinated system of services available in every Texas county for children from birth to 3 years of age with disabilities or delays. ECI is federally and state funded through the Title 20 *Individuals with Disabilities Education Act (IDEA),* Chapter 33, and *Texas Human Resources Code* (HRC), Chapter 73. ECI supports families to help their children reach their potential through developmental services.

Texas families who have children younger than 3 years of age with a disability or suspected delays in development must be referred to ECI. A medical diagnosis or a confirmed developmental delay is not needed for referral. A referral can be based on professional judgment or a family's concern.

All primary referral sources must refer a child younger than 3 years of age who may be in need of, and/or qualify for, comprehensive early intervention services. Referrals must be within two work days of identification and must be made to a contracted provider for evaluation and assessment of the child. Primary referral sources include the following:

- Hospitals, including prenatal and postnatal care facilities
- Physicians
- Parents
- Day care programs
- Local educational agencies
- Public health facilities
- Other social service agencies
- Other health care providers

Refer to: 34 *Code of Federal Regulations* (CFR), §303.321
40 TAC §108.61.

For more information and referral to services, visit the Department of Assistive and Rehabilitative Services (DARS) website at www.dars.state.tx.us/ecis, or call the toll-free DARS Inquiries Line at 1-800-628-5115 or the ECI state office at 1-512-424-6745.

K.4 Parental Accompaniment

HRC §§32.024(s)–(s-1) requires the Texas Department of State Health Services (DSHS) to require, as a condition for provider reimbursement, that a child younger than 15 years of age be accompanied by the child's parent, guardian, or other authorized adult during medical and dental checkups or screenings and dental treatment. DSHS has implemented this requirement through rules found in 25 TAC §33.134 (THSteps medical) and 25 TAC §33.318 (THSteps dental) as well as the definitions found in 25 TAC §33.15 for medical and 25 TAC §33.301 for dental.

The DSHS rules require that the parent, guardian, or authorized adult come with the child to the checkup or screening, and that the parent, guardian, or authorized adult must continue to wait for the child while the checkup, treatment, or service takes place.

Providers will not be required to submit documentation to TMHP to verify compliance with this policy in order for TMHP to process claims. *By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.*

Exception: *School health clinics, Head Start programs, and childcare facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement in the health care of the child and obtains written consent for the services. The consent from the child's parent or guardian must have been received within the one-year period before the date the services are provided and must not have been revoked.*

Refer to: *HRC* §§32.024(s)–(s-1)
25 TAC §33.15, §33.134, §33.301, and §33.318.

K.5 Newborn Blood Screening

The *Health and Safety Code,* Chapter 33, Subchapter B, requires testing for phenylketonuria (PKU), galactosemia, hypothyroidism, sickle hemoglobin, and congenital adrenal hyperplasia on all newborns. This testing is the responsibility of any provider attending the birth of a baby. All infants *must* be tested a second time at 1 to 2 weeks of age. If there is any doubt that a child younger than 12 months of age was properly tested, the provider should submit the blood sample on the appropriate DSHS Form NBS-3 to the DSHS Newborn Screening Laboratory.

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K.6 Abuse and Neglect

K.6.1 Requirements for Reporting Abuse or Neglect

Providers are required to comply with requirements for reporting abuse or neglect as outlined in “Provider Responsibilities” on page 1-4.

Additionally, the *General Appropriations Act*, Article II, Rider 33 under DSHS, and Rider 13 under HHSC, of Senate Bill 1, 79th Legislative Regular Session, 2005, require that DSHS and HHSC distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse and reporting requirements set forth in the *Texas Family Code*, Chapter 261, relating to investigations of reports of child abuse and neglect.

K.6.1.1 Procedures for Reporting Abuse or Neglect

Professionals, as defined in the law, *Texas Family Code*, §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

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

A report must be made regardless of whether the provider staff suspects that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

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

The law requires that the report include the following:

- Name and address of the minor, if known
- Name and address of the minor’s parent or the person responsible for the care, custody, or welfare of the child if not the parent, if known
- Any other pertinent information concerning the alleged or suspected abuse, if known

Reports can be made anonymously.

You can also report nonemergency abuse online at www.txabusehotline.org

A provider may not reveal whether the child has been tested or diagnosed with HIV or AIDS. If the minor’s identity is unknown (e.g., the minor is at the provider’s office to receive testing for HIV or an STD anonymously), no report is required.

K.6.1.2 Staff Training on Reporting Abuse and Neglect

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

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Appendix

Hearing Screening Information

L.1 Newborn Hearing L-2
L.2 Texas Early Hearing Detection and Intervention (TEHDI) Process L-3
L.3 JCIH Year 2000 Position Statement. L-4

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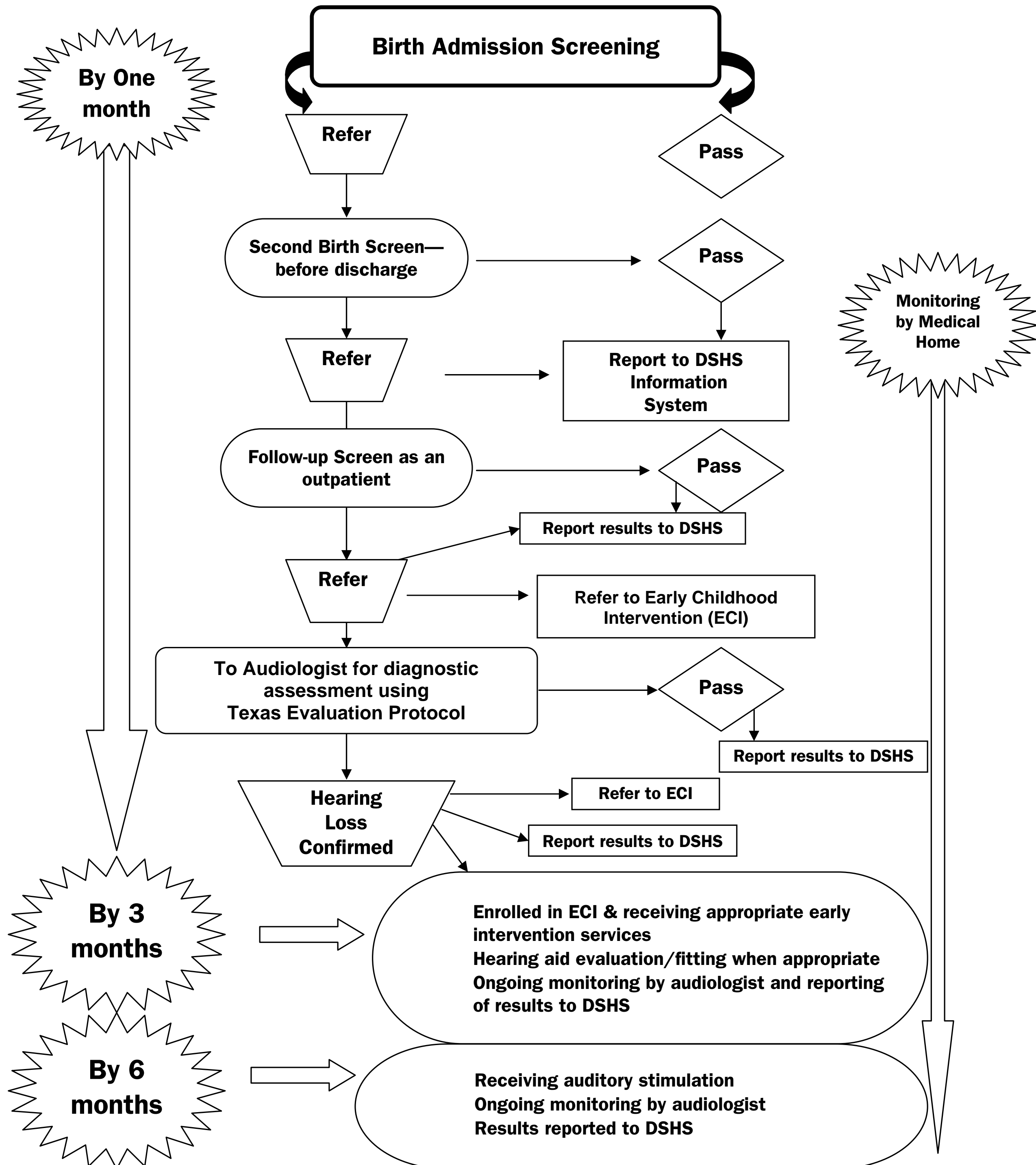
L.1 Newborn Hearing



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L.2 Texas Early Hearing Detection and Intervention (TEHDI) Process

The following is a list of processes for early hearing detection and intervention:

- *Birth Screen*: will be either screening Auditory Brainstem Response (ABR), or Transient or Distortion Product Otoacoustic Emissions (OAE):
    - A newborn's hearing is screened at the birth facility. If a newborn does not pass the screen, hearing is re-screened before discharge.
    - The birth facility reports results to the Department of State Health Services (DSHS) using the web-based eScreener Plus (eSP™) system.
    - The newborn's family and physician/medical home receive a written report of the hearing screen outcome.
    - If a newborn passes the screen, the physician monitors hearing as part of well child visits.
    - If a newborn does not pass the second screen, a referral is made to a local resource for outpatient re-screen. See the following steps.
- *Outpatient Rescreen*: will be either screening by ABR or OAE:
    - The physician/medical home receives the written report of results from the birth facility.
    - The screener/physician reports results to the DSHS contractor, OZ Systems, using the web-based eSP system, by calling 1-866-427-5768, or faxing 1-214-631-4231.
    - If the newborn passes the outpatient re-screen, the physician monitors hearing as part of well child visits.
    - If a newborn does not pass (refers) the outpatient re-screen, a referral is made to an audiologist for evaluation using the Texas Pediatric Protocol for Evaluation. Visit www.dshs.state.tx.us/audio/assumpt.shtm for more information.
    - For children whose families need financial assistance for testing, make an application to the DSHS Program for Amplification for Children of Texas (PACT). Consult the provider list at www.dshs.state.tx.us/audio/pactpro.shtm. Click on the area of the state and then on the city, or call 1-800-252-8023.
- *Evaluation using Texas Pediatric Protocol for Audiology:* will be diagnostic ABR and, if not previously done, OAE to verify cochlear involvement:
    - Audiologists use equipment norms for newborns, preferably ones that they have collected on their equipment.
    - Protocols include air and bone conduction results using tone burst ABR, as well as click ABR, so the amplification may be appropriately fit.
    - The physician/medical home receives results and makes the referral to Early Childhood Intervention (ECI) using the web-based eSP system or by calling 1-800-250-2246.
    - The physician/medical home monitors the child. See the *American Academy of Pediatrics Position Statement* at www.aap.org/policy/re9846.html.
    - The audiologist reports results to the DSHS contractor as noted above and makes the referral to ECI.
    - Includes the fitting of hearing aids by an audiologist when appropriate.
    - Continue audiological assessment and/or monitoring as needed (usually monitor each three months for the first year of hearing aid use).
- *Referral to an ECI program:* will be performed by an audiologist or physician within two working days of identification of hearing loss as required by law:
    - Service coordination provided by ECI.
    - ECI will refer to the Local Education Agency (LEA) for Auditory Impairment (AI) services as outlined in the *Memorandum of Understanding between TEA and DARS ECI.*
    - An evaluation and Individual Family Service Plan (IFSP) will occur within 45 days of referral to ECI.
    - ECI and LEA services are available up to age three when determined by an IFSP.
    - ECI and LEA will coordinate transition services upon the child's third birthday.
- *The physician/medical home continues to monitor periodically:* see the Joint Committee on Infant Hearing (JCIH) 2000 for suggested monitoring protocols at www.aap.org/policy/jcihyr2000.pdf.
- Deaf education and/or other special education services available from 3 to 21 years of age when determined by an individualized education program.
- Regional specialists from Deaf and Hard of Hearing Services at the Department of Assistive and Rehabilitative Services (DARS) will provide technical assistance to birth facilities, audiologists, and ear, nose and throat (ENT) physicians to ensure reporting of screening and evaluation results. Call 1-512-407-3250 for assistance.

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L.3 JCIH Year 2000 Position Statement

The JCIH 2000 recommends the following indicators for use with neonates or infants (age 29 days through 2 years). These indicators place an infant at risk for progressive or delayed-onset sensorineural hearing loss and/or conductive hearing loss. Any infant with these risk indicators for progressive or delayed-onset hearing loss who has passed the birth screen should, nonetheless, receive audiologic monitoring every 6 months until 3 years of age.

These indicators are:

- Parental or caregiver concern about hearing, speech, language, and developmental delay
- Family history of permanent childhood hearing loss*
- Stigmata or other findings associated with a syndrome known to include a sensorineural or conductive hearing loss or Eustachian tube dysfunction
- Postnatal infections associated with sensorineural hearing loss including bacterial meningitis*
- In-utero infections such as cytomegalovirus, herpes, rubella, syphilis, and toxoplasmosis
- Neonatal indicators specifically hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation, and conditions requiring the use of extracorporeal membrane oxygenation (ECMO)*
- Syndromes associated with progressive hearing loss, such as neurofibromatosis, osteopetrosis, and Usher's syndrome
- Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich's ataxia and Charcot-Marie-Tooth syndrome
- Head trauma
- Recurrent or persistent otitis media with effusion for at least three months*

Because some important indicators, such as family history of hearing loss, may not be determined during the course of universal newborn hearing screening programs, the presence of all late-onset risk indicators should be determined in the medical home during early well-baby visits. Those infants with significant late-onset risk factors should be carefully monitored for normal communication developmental milestones during routine medical care.

* See the original document for citations at www.jcih.org/jcih2000.pdf

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Appendix

M

THSteps Quick Reference Guide

M.1 Texas Health Steps Quick Reference Guide M-2

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M.1 Texas Health Steps Quick Reference Guide

Texas Health Steps Quick Reference Guide

*** Use THSteps Provider Identifier** **• Diagnosis Code V202** **• Type of service S**

THSteps Medical Checkup Billing Codes

THSteps Medical Checkups

99381	99382	99383	99384	99385
99391	99392	99393	99394	99395

THSteps Follow-up Visit

Use procedure code 99211 for a THSteps follow-up visit.

Immunizations Administered

Each immunization must have a corresponding vaccine code.

- If only one immunization is administered during a checkup, providers should bill procedure code 90471/90473 or 90465/90467 with a quantity of 1.
- If two or more immunizations are administered, providers should bill procedure code 90471/90473 or 90466/90468 with a quantity of 1, procedure code 90472/90474 with a quantity of 1 or more (depending on the number of vaccines administered), and the appropriate national procedure codes that describe each immunization administered.

Procedure Codes	Vaccine
90632* or 90633 with (90471/90472 or 90465/90466)	Hep A
90645, 90646, 90647, or 90648 with (90471/90472 or 90465/90466)	Hib
90655*, 90656*, 90657*, or 90658* with (90471/90472 or 90465/90466)	Flu
90669 with (90471/90472 or 90465/90466)	PCV7
90680 with (90471/90472 or 90465/90466)	Rotavirus
90700 with (90471/90472 or 90465/90466)	DTaP
90702 with (90471/90472 or 90465/90466)	DT
90707 with (90471/90472 or 90465/90466)	MMR
90710 with (90471/90472 or 90465/90466)	MMRV
90713 with (90471/90472 or 90465/90466)	IPV
90714 or 90718 with (90471/90472 or 90465/90466)	Td
90715 with (90471/90472 or 90465/90466)	Tdap
90716 with (90471/90472 or 90465/90466)	Varicella
90723 with (90471/90472 or 90465/90466)	DTap-Hep B-IPV
90732 * with (90471/90472 or 90465/90466)	Pneumococcal
90734 with (90471/90472 or 90465/90466)	Meningococcal
90744 or 90746 with (90471/90472 or 90465/90466)	Hep B
90748 with (90471/90472 or 90465/90466)	Hib-Hep B

* Vaccine maybe indicated for high-risk individuals only

Modifiers

Performing Provider
Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

AM	SA	TD	U7

Exception to Periodicity
Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

23	32	SC	

Immunization Tracking
Use to indicate parental consent to participate in ImmTrac Immunization Registry

FQHC
Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkup.

Condition Indicator Codes

Use one of the indicators below if a referral was made.

Condition Indicator	Condition Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

TB Skin Test

Be sure to include a charge of at least $.01 for procedure code 86580, even though this code is not reimbursed separately.

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Case Management for Children and Pregnant Women (CPW)

1-512-458-7111 x 2168
www.dshs.state.tx.us/caseman/default.shtm

Child Health Record Forms

May be downloaded from the THSteps website or camera-ready copies may be ordered from:

THSteps Program
1100 West 49th Street
Austin, TX 78756-3179
www.thstepsproducts.com

Early Childhood Intervention (ECI)

www.dars.state.tx.us/ecis/index.shtml

Hearing Evaluation/Hearing Aid

For recipients needing these services, refer to the Program for Amplification for Children of Texas (PACT). For THSteps Medicaid clients under 21 years of age, Form H3087 will have a “P” in the column under “Hearing Aid,” which indicates that prior approval must be obtained from PACT for hearing aid services.

Physicians, health department employees, school nurses, teachers, education service center employees, public officials, and other state agency employees may refer recipients to PACT. In addition, parents of recipients may apply for these services at the following address:

Program for Amplification for Children of Texas
Department of State Health Services
1100 West 49th Street
Austin, TX 78756-3199
1-800-252-8023
www.dshs.state.tx.us/audio

Laboratory

Requests for THSteps supplies from the Department of State Health Services (DSHS) should be made on Form G399 and submitted to:

Specimen Acquisition, Container Preparation & Supplies
Laboratory Services
Department of State Health Services
1100 West 49th Street
Austin, TX 78756-3199

Supplies: 1-512-458-7661
Fax: 1-512-458-7672
Technical Questions: 1-512-458-7680
Test Results: 1-512-458-7578

A written request for Newborn Screening (NBS) specimen collection form (NBS-3) and NBS supplies is required. To obtain an order form for written requests, call: **1-512-458-7661**

To obtain Newborn Screening test results, call the Newborn Screening Automated Voice Response System (personal identification number required): **1-512-458-7300**

PAP Smear supplies may be ordered from:
Texas Center for Infectious Disease
2303 Southeast Military Drive
San Antonio, TX 78223
Attn: Customer Service
1-210-531-4596

Obtain guidelines for collecting and handling specific types of specimens at: **www.dshs.state.tx.us/lab/default.shtm**

Medical Transportation Program (MTP) - Texas Department of Transportation

1-877-633-8747
www.dot.state.tx.us/PTN/mtp/mtphome.htm

Medicaid Fraud:

To report potential Medicaid fraud, contact one of the following hotlines, or visit the website:

HHSC Client Fraud Investigations: 1-800-252-8011

HHSC Provider Fraud/Abuse Investigations: 1-800-436-6184

www.hhs.state.tx.us/OIG/Fraud_Report_Home.shtml

Texas Nurses Association Assessment Training

1-800-862-2022
www.texasnurses.org/thsteps/thsteps.htm

Texas Immunization Registry (ImmTrac)

1-800-348-9158
www.dshs.state.tx.us/immunize/immtrac/default.shtm

Texas Medicaid & Healthcare Partnership (TMHP)

www.tmhp.com

THSteps-Comprehensive Care Program (THSteps-CCP)

Telephone: 1-800-846-7470
Fax: 1-512-514-4212

THSteps Medical Checkup Claims Inquiries

Call the following number to obtain answers to questions or determine the status of claims:

1-800-757-5691

THSteps Outreach & Informing Service, Missed Appointment & Referral Services

1-877-THSteps (847-8377)

THSteps Website

www.dshs.state.tx.us/thsteps/default.htm

Texas Vaccines for Children Program (TVFC)

1-800-252-9152
www.dshs.state.tx.us/immunize/tvfc/default.shtm

The Newborn Screen is the only test performed by the DSHS Laboratory for Children’s Health Insurance Program (CHIP) recipients.

M

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Appendix

N

THSteps Dental Guidelines

N.1 American Academy of Pediatric Dentistry Periodicity Guidelines N-2
N.2 American Dental Association Guidelines for Prescribing Dental Radiographs. N-5

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N.1 American Academy of Pediatric Dentistry Periodicity Guidelines

Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children

Originating Committee
Clinical Affairs Committee

Review Council
Council on Clinical Affairs

Adopted
1991

Revised
1992, 1996, 2000, 2003

Purpose

The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health care for infants, children, and adolescents. Because each child is unique, these recommendations are designed for the care of children who have no contributory medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from the normal.

Methods

This guideline is a compilation of pediatric oral health literature and national reports and recommendations, in addition to related policies and guidelines published in the AAPD Reference Manual.[1-24] The related policies and guidelines provide references for individual recommendations. Some recommendations are evidence-based, while others represent best clinical practice and expert opinion.

Background

The AAPD emphasizes the importance of professional oral health intervention very early in childhood. Caries-risk assessment[11] is an essential element of contemporary clinical care for infants, children, and adolescents. Continuity of care is based on the assessed needs of the individual patient. Although evidenced-based research supporting the benefits of an infant dental intervention is limited, there is sufficient evidence that certain groups of children are at greater risk for development of early childhood caries (ECC) and would benefit from infant oral health care. ECC can be a costly, devastating disease with a lasting detrimental impact on the dentition and systemic health issues.[7] The characteristics of ECC and the availability of preventive methods support anticipatory guidance as an important strategy in addressing this significant pediatric health problem. Major benefits of early intervention, in addition to assessment of risk status, include analysis of fluoride exposure and feeding practices, as well as oral hygiene counseling. The early dental visit should be seen as the foundation upon which a lifetime of preventive education and oral health care can be built. Clinicians must consider each infant's, child's, and adolescent's individual needs and risk indicators to determine the appropriate interval and frequency of dental visits.

Recommendations

Birth to 12 months

1. Complete the clinical oral examination with appropriate diagnostic tests to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance for parent/guardian/caregiver.
11. Consult with the child's physician as needed.
12. Based on evaluation and history, assess the patient's risk for oral disease.
13. Determine the interval for periodic re-evaluation.

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12 to 24 months

1. Repeat birth to 12-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices, including bottle, breast-feeding, and no-spill training cups, and provide counseling as indicated.
3. Review patient's fluoride status–including any childcare arrangements, which may impact systemic fluoride intake–and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

2 to 6 years

1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
3. Scale and clean the teeth every 6 months or as indicated by individual patient's needs.
4. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
5. Provide counseling and services (athletic mouthguards) as needed for orofacial trauma prevention.
6. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
7. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
8. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's risk status /susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral and perioral piercing.

12 years and older

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. At an age determined by patient, parent/guardian, and pediatric dentist, refer the patient to a general dentist for continuing oral care.

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10. American Academy of Pediatric Dentistry. Clinical guideline on the role of prophylaxis in pediatric dentistry. Pediatr Dent 2003;25(suppl):64-66.
11. American Academy of Pediatric Dentistry. Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents. Pediatr Dent 2003;25(suppl):18-20.
12. American Academy of Pediatric Dentistry. Clinical guideline on fluoride therapy. Pediatr Dent 2003;25(suppl):67-68.
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18. American Academy of Pediatric Dentistry. Clinical guideline on management of acute dental trauma. Pediatr Dent 2003;25(suppl):92-97.
19. American Academy of Pediatric Dentistry. Clinical guideline on management of the developing dentition in pediatric dentistry. Pediatr Dent 2003;25(suppl):98-101.
20. American Academy of Pediatric Dentistry. Clinical guideline on acquired temporomandibular disorders in infants, children, and adolescents. Pediatr Dent 2003; 25(suppl):102-103.
21. American Academy of Pediatric Dentistry. Policy on tobacco use. Pediatr Dent 2003;25(suppl):33-34.
22. American Academy of Pediatric Dentistry. Clinical guideline on adolescent oral health care. Pediatr Dent 2003;25(suppl):55-60.
23. American Academy of Pediatric Dentistry. Policy on intraoral and perioral piercing. Pediatr Dent 2003; 25(suppl):35.
24. American Academy of Pediatric Dentistry. Policy on oral and maxillofacial surgery for infants, children, and adolescents. Pediatr Dent 2003;25(suppl):116.

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Recommendations for Pediatric Oral Health Care

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of *very* early professional intervention and the continuity of care based on the individualized needs of the child.

Age	6–12 months	12–24 months	2–6 years	6–12 years	12 years and older
Clinical oral examination[1]	•	•	•	•	•
Assess oral growth and development[2]	•	•	•	•	•
Caries-risk assessment[3]	•	•	•	•	•
Prophylaxis and topical fluoride treatment[4]		•	•	•	•
Fluoride supplementation[5,6]	•	•	•	•	•
Anticipatory guidance[7]	•	•	•	•	•
Oral hygiene counseling[8]	Parents/guardians/ caregivers	Parents/guardians/ caregivers	Patient/parents/ guardians/caregivers	Patient/parents/ guardians/caregivers	Patient
Dietary counseling[9]	•	•	•	•	•
Injury prevention counseling[10]	•	•	•	•	•
Counseling for nonnutritive habits[11]	•	•	•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/ perioral piercing				•	•
Radiographic assessment[12]			•	•	•
Treatment of dental disease/injury	•	•	•	•	•
Assessment and treatment of developing malocclusion			•	•	•
Pit and fissure sealants[13]			•	•	•
Assessment and/or removal of third molars					•
Referral for regular and periodic dental care					•

1. First examination at the eruption of the first tooth and no later than 12 months.
2. By clinical examination.
3. As per AAPD "Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents."
4. Especially for children at high risk for caries and periodontal disease.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.
9. At every appointment discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
12. As per AAPD "Clinical guideline on prescribing dental radiographs."
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.

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N.2 American Dental Association Guidelines for Prescribing Dental Radiographs

GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS

The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women.

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New patient* being evaluated for dental diseases and dental development	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable

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GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS, cont'd.

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult Dentate and Partially Edentulous**	**Adult Edentulous**
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable
Patient for monitoring of growth and development	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars	Usually not indicated	
Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.				

***Clinical situations for which radiographs may be indicated include but are not limited to:**

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing

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5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical erosion

****Factors increasing risk for caries may include but are not limited to:**

1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titers of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects

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11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multisurface restorations
15. Chemo/radiation therapy
16. Eating disorders
17. Drug/alcohol abuse
18. Irregular dental care

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