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CSHCN Provider Bulletin

The Children with Special Health Care Needs Program

ProtectTexas
Texas Department of Health

Covering the Bases: Transition

Transition for children, adolescents, and young adults from pediatric-based care to adult-based care

By Albert C. Hergenroeder, M.D.

Ninety percent of children with disabilities survive into adulthood. Through the 1960s and 1970s this was a result of diagnostic and therapeutic advances for previously life-threatening conditions with life expectancies limited to the first decade, such as leukemia and cystic fibrosis. Currently the definition of the broader term, special health care needs, is: "Those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health and related services of a type or amount beyond that required by children generally."[1] Thirty percent of children have chronic conditions. Eighteen percent meet the definition of special health care needs, and six percent have disabilities that affect activities of daily living. The reason the percentage of those with chronic conditions (30 percent) is so much higher than the percentage of those who meet the special health care needs definition (18 percent) is because the term *chronic conditions* includes conditions such as obesity, which do not necessarily get good medical care but clearly are chronic conditions. Special health care needs affect 1 in 5 children and adolescents, and when obesity is included the percentage is much higher.

[1] Maternal and Child Health Bureau, Division of Services for Children With Special Health Care Needs

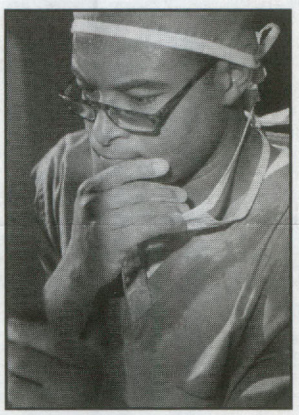
IN THIS EDITION

Transition Services – Definition

According to the Individuals with Disabilities Education Act (IDEA), transition services are "a coordinated set of activities that promote movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation."

Background

Transition is an important idea because the quality of life of those with special health care needs surviving into the third decade and beyond requires a broader look at transition to adult-based health care that includes other aspects of their lives beyond their medical conditions. In 1984, the U.S. Surgeon General convened a meeting describing a need for transition services in the United States, and in 2004, transition services still are uncommon. At the 2004 Annual Meeting of the Society for Adolescent Medicine, there was a consensus among the participants of the Chronic Illness Special Interest Group that it was hard to get transition services started for a variety of reasons. Certainly, the children and youth with special health care needs (CYSHCN) say that they are not receiving these services. Services currently provided follow the traditional medical model where services are disease or organ specific, the patient-physician encounter is the cornerstone of the visit to the medical center, and youth and families are seldom involved in planning and development.



Key elements to developing a transition program include the following:

- Professional support in which transition services are seen as desirable and necessary
- Family support for the transition
- Transitioning decision-making and consent for care gradually from the parent(s) to the teen or young adult as appropriate
- Professional sensitivity to psychosocial issues in transition

There is evidence of varying amounts of support of these four elements. For instance, some physicians are not supportive of transition because they are not comfortable with the medical services to which they are transitioning the patient. The adult health care systems may not be set up to take complicated medical and psychosocial problems of CYSHCN. Nevertheless, this represents an opportunity for building a bridge from pediatric-based to adult-based services, and the recognition that these services are not peripheral, but they are central to the care of the young adult. It is true that there are not enough adult specialists who can care for either the primary care or special needs of some of the CYSHCN. However, this speaks to the need for training of adult specialty and primary care providers for CYSHCN. Transition may not be desirable for every single adolescent or young adult with special health care needs, but for the majority it is an important active decision to be made.

One of the ways that families can assist the adolescent in preparing for transition is to establish responsibilities for the adolescent or young adult that facilitates transition from the school environment towards the work environment. For example, young adults should do household or other chores to the extent that they can and should be done. They also should maintain consistent school attendance as a norm, because this is a predictor of consistent job attendance. Working in a volunteer situation is another example of an opportunity to work outside the routine comfort zone in order to nurture an interest in a given area. A key to understanding transition and compliance with treatment in chronic illness is that, if the young person is able to stay healthy and active as a teenager and young adult, they will be more likely to stay healthy, and as a result, they will be more likely to be able to work. The ability to have a job and the quality of life that goes with having a job and an income requires that the young person stay healthy enough to go to work.

Professional Training

It is important that physicians become comfortable with many of the aspects of transition. Certainly, one

of the keys is that physicians need to be routinely addressing items as represented in the HEADDS acronym, which stands for Home, Education, Activity, Drugs, Depression, and Sex. Also important in transition is to have discussions about what issues will remain confidential between the physician or healthcare provider and the young adult, and what will be divulged with the parents.

Barriers to Transition

There are key barriers to transition from pediatric-based care to adult-based care, including that CYSHCN may lose insurance coverage when they transition beyond 18 years of age. There is also a lack of coordination of the multiple services needed for CYSHCN, including reimbursement for support and coordination functions. Managed care organizations often present restrictions to services such as mental health, skilled nursing, medications and equipment. Planning for transition should begin in childhood. Delaying this planning, in and of itself, is a barrier to transition. At times an adolescent's cognitive ability and personality may limit the transition, and the complexity of the condition may limit transition, with those being more complex and requiring greater support being less able to transition to adult-based health care.

Also intrinsic to adolescents is the drive for independence. This drive may manifest as noncompliance with medical and other treatment recommendations. However, in most cases, with appropriate services, most teens and young adults go through this resistance phase and emerge as compliant adults interested in keeping themselves healthy. Mental health services tend to be inadequate and fragmented, and the lack of a medical home makes the ability to receive comprehensive, family-centered, culturally competent, continuous care less likely.

Models of Care

There is no one model of transition care. Each center or clinic needs to develop its own method of transition services. This may be something that's developed within the pediatric hospital setting, may be a blend of pediatric and adult health services, or it may be fully in the adult health system. Unfortunately what happens for an important subgroup of adolescents or CYSHCN is that they go through transition and then drop out of all health care systems, leading to a greater deterioration in the medical condition.

An example of a program in Texas that is drawing attention to the need for transition services is the Leadership Education in Adolescent Health (LEAH) Project at Baylor College of Medicine (BCM). The training program focuses on an interdisciplinary team approach to healthcare. The members of the team include faculty and fellows in medicine, nursing, nutrition, psychology, public health, and social work. The Adolescent Medicine and Sports Medicine Section, Department of Pediatrics, Baylor College of Medicine is based at Texas Children's Hospital. This program stresses excellence in adolescent health and finding ways to meet the healthcare needs of adolescents. The LEAH Project is funded by a grant from the Maternal Child Health Bureau (MHCB) under Title V. More information about the LEAH Project is available at the Baylor College of Medicine Department of Pediatrics website, http://public2.bcm.tmc.edu/pediatrics. To locate the LEAH program, click on Sections, Adolescent Medicine and Sports Medicine, and then Education and Training. LEAH sponsors an annual continuing medical education (CME) course for chronic illness and transition for health professionals, families, and CYSHCN. Details are located at the website listed previously. Follow the same instructions, and from the Education and Training page, click on Chronic Illness/Transition Conference. For more information, contact Tamara Greiner at the BCM CME Office at 1-713-798-8237.

A CME conference entitled *Chronic Illness: Transitioning from Child-oriented to Adult-oriented Care* is scheduled for November 4–5, 2004, at the Baylor College of Medicine in Houston, Texas. This event is sponsored by the Baylor College of Medicine, Office of CME. For additional information email cme@bcm.tmc.edu.

(Continued on page 4)

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Critical Steps for Establishing Transition Services

The following are some recommended guidelines or steps for establishing transition services:

- Promote care coordination, insuring that all providers participate in planning for transition.
- Identify and teach core health knowledge and skills to all health care providers involved in providing care in preparation for transition care.
- Address the important HEADDS topics with CYSHCN at least annually.
- Maintain a current up to date medical record. (One program in New Mexico gives transitioning CYSHCN their entire medical records electronically saved on CD-ROM.)
- Develop a written transition plan by age 14. This may not be the final and complete plan; however, it is an important starting point. Keep a copy of this in the medical record and with the patient and family.
- Follow primary care preventive guidelines for CYSHCN as should be done for all teens and young adults.
- Address issues such as exercise, nutrition, substance use, and sexuality at least annually.
- Affordable, continuous health insurance for transition planning and care coordination is essential.
- Vocational training to the extent possible is essential.

In summary, approximately 1 percent of those who are 21 years old in the United States are CYSHCN. At this time of their life, the shift that has occurred from survival to quality of life for the vast majority of CYSHCN is desirable and necessary. There are barriers and factors that affect this transition; however, those who are integral to providing health care services to CYSHCN need to address methods to overcome these barriers. ■

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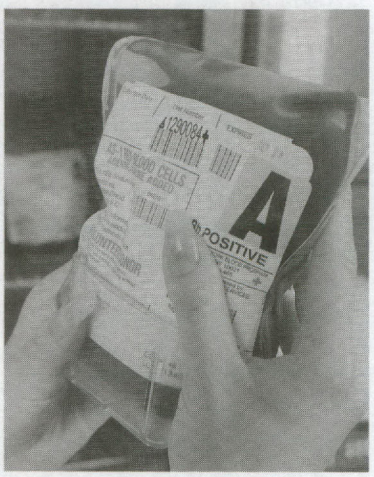
The Hemophilia Assistance Program

A Transition Service for Clients with Hemophilia



The Hemophilia Assistance Program (HAP) may offer help with obtaining blood factor products to transition CSHCN clients with hemophilia who are age 21 and are no longer eligible for CSHCN services.

HAP was created by the Texas Legislature to provide financial assistance for medically eligible adults to obtain blood, blood derivatives, and concentrates through approved providers for use in medical or dental facilities or in the home.

In order to be eligible for HAP, a person must:

- Be 21 years of age or older.
- Not be eligible for Medicaid or Medicare.
- Be a Texas resident.
- Be diagnosed as having hemophilia by a physician licensed to practice in Texas.
- Have an income level at or below 200 percent of federal poverty guidelines.

Eligibility must be established before any payment for services can be made, and annual limits may apply. All benefits are based on the availability of program funds. Changes in income or financial qualifications that would affect the applicant's eligibility must be reported to HAP.

Recipients who have a private or group health insurance plan that covers blood, blood derivatives, and concentrates used in the treatment of hemophilia are not eligible to receive HAP benefits. However, a client who has exhausted private/group health insurance coverage may be eligible to receive benefits from HAP.

For additional information or to obtain an application, contact the Hemophilia Assistance Program by telephone at 1-800-222-3986, visit the website at www.tdh.state.tx.us/hemophilia/default.htm, or write to the Texas Department of State Health Services at the following address:

Texas Department of State Health Services
Hemophilia Assistance Program - Mail Code Y-950
1100 West 49th Street
Austin, TX 78756 ■

Providers, the Medical Home, and Family-Centered Care

Providing a medical home for clients requires that physicians and other professionals team up with families. On a practical level, professionals and families care for children by working together to identify and access all the services needed to help a child reach his or her full potential. It is not surprising, then, that the approach known as "family-centered care" is often seen as a key part of any medical home.

As an approach to the planning, delivery, and evaluation of health care, family-centered care is often regarded as uniquely effective. Why? Because it acknowledges, respects, and supports the important roles that families play in their children's lives. The family-centered model of care emphasizes that most often, parents and other family members are a child's decision-makers, caregivers, teachers, and advocates.

Providers can practice family-centered care by recognizing and maximizing the role of parents and family in providing optimum care for children. A related tenet of family-centered care is that when it comes to children, parents are the experts. They know more about their children than anyone else, and this information can be invaluable in making the right decisions for each child.

Family-centered care revolves around the idea that each family's choices are based on their individual needs and strengths. For different families, even if they are in similar situations, the options may appear very different. Family-centered care supports the family's uniqueness in making decisions that are right for that family and that child. As a professional practicing family-centered care, each provider can help families make good decisions by sharing complete and unbiased information with them. Each provider possesses a unique professional perspective that will help them to identify many other ways to work together with the family on behalf of each child under their care.

In addition to shared decision making, family-centered care has several other main elements. First, it sees the family as a constant in the child's life. While service systems and supports for any child may change over time, life for that child stills centers around the family. Family-centered care recognizes and honors that worldview. Another important tenet of family-centered care is the encouragement of family-to-family support and networking. Family-to-family support increases parents' confidence and problem-solving abilities, thus helping them to feel and *be* more positive and effective in caring for a child with special health care needs.

The family-centered health care model has proven to be effective for families and for patients of all ages. It can work in any health care setting, such as an office, a public health clinic, or a hospital. To find out more about family-centered care, visit the following websites:

- The National Center for Medical Home Initiatives for Children with Special Health Needs, www.medicalhomeinfo.org/resources/family.html
- Institute for Family-Centered Care, www.familycenteredcare.org
- Communities Can: Family-Centered Care, www.georgetown.edu/research/gucdc/commcan2.html

Additionally, the supplement to the May 2004 issue of *Pediatrics*, entitled *The Medical Home*, is available to subscribers at www.pediatrics.org. It includes the American Academy of Pediatrics' 2002 policy statement on the medical home and an additional list of helpful websites. ■

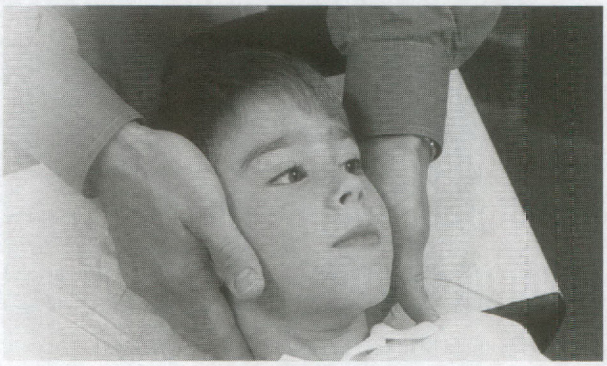
New Practice Guidelines for Mild Traumatic Brain Injury in Children

New practice guidelines for treating children with mild traumatic brain injury (MTBI) recently have been published. Entitled *Mild Traumatic Brain Injury in Children: Practice Guidelines for Emergency Department and Hospitalized Patients,* the guidelines were published in *Pediatric Emergency Care* (2003 Dec;19(6):431-40).

Brain injury is the leading cause of death and disability among children in the United States. Mild traumatic brain injury (concussion, with or without loss of consciousness) occurs frequently in children and often goes undiagnosed or is under-diagnosed. Wide variations in diagnosing, treating, discharge planning, and family preparation result in great disparities in outcomes for children This is exacerbated by the fact that the effects of the traumatic brain injury in children can be latent, emerging when brain development has caught up with the site of the injury and greater skills are required. Furthermore, if a diagnosis of traumatic brain injury is not recorded in a child's medical records, the child may experience significant challenges in getting the special education supports and services needed for the child to succeed in school.

Brain injury is the leading cause of death and disability among children in the United States.

A clinical pathway for children with MTBI will help identify patients at risk of underlying intracranial injury and provides best practice options for management of the injury to improve the quality and consistency of care. The clinical pathway was developed by an interdisciplinary team of experts from a level I trauma center. The guidelines are based on current literature and expert opinion. They provide direction in use of imaging technologies, whether to admit to a hospital or treat at home, discharge planning, parent/patient education, and when to return to play/sports activities following an MTBI (concussion).



The Mild Traumatic Brain Injury in Children: Practice Guidelines for Emergency Department and Hospitalized Patients is an excellent companion to *Guidelines for the Acute Medical Management of Severe Traumatic Brain Injury in Infants, Children, and Adolescents and Guidelines for the Pre-Hospital Management of Traumatic Brain Injury,* both published by the Brain Trauma Foundation (www.braintrauma.org). The Brain Trauma Foundation, in collaboration with the Texas Department of State Health Services Bureau of Emergency Management and the Texas Office of Rural Community Affairs (ORCA), is providing training throughout Texas in using the Guidelines for the Pre-Hospital Management of Traumatic Brain Injury. For additional information concerning the availability of the training, contact Al Lewis at ORCA Outreach and Development Services, 1-512-936-6733 or 1-800-544-2042.

For additional information concerning the practice guidelines for MTBI, contact Susan Kamerling, RN, MSN, CCRN, via e-mail at kamerling@email.chop.edu, or send a written request to the Trauma Program at the following address:

The Trauma Program: Department of Surgery
Children's Hospital of Philadelphia
University of Pennsylvania School of Medicine
Philadelphia, PA 19104

Other information sources include the Brain Injury Association of Texas, www.biatx.org, and the Brain Injury Association of America, www.biausa.org. ■

TDH Becomes TDSHS

Effective September 1, 2004, the Texas Department of Health (TDH) becomes the Texas Department of State Health Services (TDSHS). This change is occurring due to provisions of House Bill 2292, passed through the Texas Legislature in the 78th Regular Session (2003).

Twelve agencies are being combined to create four departments under the direction of the Health and Human Services Commission. The objectives of these new departments are to:

- Improve client services.
- Use public dollars efficiently.
- Focus on real results and accountability.

With this edition of the *CSHCN Provider Bulletin*, most mailing addresses and other references to the Texas Department of Health have been changed to the Texas Department of State Health Services. Though the department name and organizational structure are changing, CSHCN telephone numbers, mailing addresses, and physical locations remain the same.

Announcements of ongoing changes will be published in upcoming CSHCN provider bulletins and TMHP Remittance and Status report banner messages. ■

New Physician/Dentist Assessment Form Available

The revised Physician/Dentist Assessment Form (PAF) is now available. The new PAF is more streamlined, the urgent needs questions have been reworded for clarity, and directions for completing the form are now included on the back of the form. A copy of the revised form and instructions appeared in the May 2004 *CSHCN Provider Bulletin* (available for free download from the TMHP website, www.tmhp.com). The new form is also included as part of the revised client application packet that is now available.

All other versions of the PAF and PAF addenda that providers may have on hand should be destroyed at this time.

The PAF must be updated at least annually by a physician (or dentist, if applicable) who has seen the client at least once within the past 12 months. However, it may be updated at any time that a client's medical condition changes.

The PAF is an official record documenting the client's medical need on the date submitted; therefore, an original form with an original signature of the physician or dentist must be used every time. The information on the PAF must be legible, with the physician or dentist data complete and clearly printed. Some providers have inappropriately submitted PAFs that are copies of originals that have been altered to include revised information. Often the dates on these revised documents are inaccurate. Copies of previously used forms are not acceptable.

For questions about completing or submitting the PAF, call the TDSHS-CSHCN Medical Policy staff at 1-800-252-8023. ■

Stale Date Check Process

In June 2004, Texas Medicaid implemented stale-dating (voiding) procedures for all checks issued. 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 180 days after the date of issue.

Provider checks that are stale-dated appear in the Financial Transactions/Void and Stop section of the Remittance and Status (R&S) report. Before stale-dating, checks may be applied to accounts receivable and/or IRS levies. Once a check has been voided, the associated claims may not be payable, and the transaction is considered final.

CSHCN providers are strongly encouraged to receive payment via Electronic Funds Transfer (EFT), which eliminates stale-dating issues for providers. EFT ensures that providers receive payments via direct deposit in a banking account of their designation. To enroll in EFT, call the TMHP Contact Center at 1-800-925-9126 and select Option 2. ■

Success in Removing CSHCN Clients from the Waiting List

Due to program efforts and cost control measures, the CSHCN Program has been able to remove eligible children from its waiting list on three occasions: February 2003, October 2003, and May 2004. In May, CSHCN was able to remove 997 clients. These clients were notified of their change in status and given access to program health care services effective May 1, 2004.

CSHCN appreciates the information that providers supplied to the program that assisted in this achievement. Some answers to questions about removing clients from the waiting list follow. For additional information, contact CSHCN at 1-800-252-8023.

How long does eligibility last for CSHCN clients?

CSHCN eligibility lasts for 6 months from the date the application is approved, *not* from the date a client moves off of the waiting list and begins receiving services. Clients need to reapply before the eligibility ending date that appears on the Eligibility Form.

How are clients chosen for removal from the waiting list?

A waiting list is imposed when it appears that current funding may be inadequate to pay for active CSHCN clients. The CSHCN rules specify the order in which clients may be removed from the waiting list when CSHCN determines that adequate funds are available. For example, clients who are younger than age 21 and who have an urgent need for health care benefits are removed first from the waiting list in order according to the date on which they first applied and were determined eligible. The total number of children removed at any time depends upon the estimated funds available and the estimated cost of care for program clients.

How does CSHCN decide if a client has an urgent need for health care benefits?

According to program rules, a client has an urgent need for health care benefits if he or she has an urgent medical need *and* no other source of health insurance. The client's physician provides information about the client's medical needs. The CSHCN medical director or assistant medical director reviews this medical information and confirms whether the medical need is urgent or not. When funds are available to remove clients from the waiting list, the medical determination is combined with the information about whether or not the client has any other source of health insurance. Those clients who meet both criteria at that point in time are said to have an urgent need for health care benefits.

Are any clients without urgent need ever released from the waiting list?

Yes. If the budget permits, and if all clients with urgent need have been released from the waiting list, then clients without urgent need may be released in the order defined in the program rules.

What happens when a patient or client is not removed from the waiting list?

Urge patients and clients to continue maintaining current CSHCN waiting list eligibility by reapplying in a timely manner. When CSHCN has the funding to remove more clients, the client may be eligible to be removed from the waiting list. Also, remember that all clients are eligible for case management through TDSHS regional offices. Contact the medical case manager to help explore other resources that may be available.

Which providers may be reimbursed for CSHCN services?

Only enrolled CSHCN providers may be reimbursed for services. If a provider is not yet enrolled, but desires to enroll in the CSHCN Program, there may be time to complete the enrollment process, provide the needed services, and obtain reimbursement. It is important to complete the provider enrollment process as quickly as possible. For inquiries concerning enrollment call 1-800-568-2413 or 1-512-514-3000. ■

Submit Claims For Payment Of Outstanding Bills Now

Because of careful management of funds, CSHCN has a limited amount of funding that allows the program to pay outstanding bills retroactively for clients removed from the waiting list.

Outstanding bills are defined as *unpaid* claims for covered health care benefits that:

- Have dates of service *only* within the time period that program funds are available.
- Were provided by an enrolled CSHCN provider.
- Occurred *only* during a client's period of eligibility.

In June 2004, each former waiting list client received a letter and an Outstanding Bills Form that described eligibility periods for payment of outstanding bills. The form indicates the dates that apply for each client. Providers may submit a claim if they provided services to a CSHCN client before they were removed from the waiting list and during their eligibility period for payment of outstanding bills. Due to limitations of program rules and funding, no period of eligibility for payment of outstanding bills extends before September 1, 2003.

It is important to act quickly because this is a limited offer. The funds available to pay these claims are limited. CSHCN will pay claims for covered health care benefits on a first-come, first-served basis only until available funds are exhausted. Since these are exceptional circumstances, the following special conditions apply:

- All claims must be submitted on paper and must be mailed to the following address:

  CSHCN Outstanding Bills
  Texas Department of State Health Services M-455
  1100 West 49th Street
  Austin, TX 78756
- The ordinary 95-day claim filing deadline does not apply; however, since funds are limited, submit your claims as soon as possible.
- Program requirements for *prior* authorization do not apply; however, if your service requires either authorization or prior authorization, all documentation required to process the claim must be submitted.
- CSHCN may pay for deductible and/or co-insurance up to the CSHCN allowed amount when another insurance is the primary payer.
- CSHCN may not pay for services covered by Medicaid.
- CSHCN may not pay for services covered by the Children's Health Insurance Program (CHIP).
- A claim *cannot* be paid more than 24 months past its date of service.

Also, a provider *can* enroll retroactively to be paid for dates of service that are prior to enrollment. This requires completion of the provider enrollment application *before* submitting claims for processing. To receive an enrollment application, or for questions about a provider's status as an enrolled CSHCN provider, call 1-800-568-2413 or 1-512-514-3000 as soon as possible. Note that CSHCN providers must also be Medicaid providers.

More information is available on the CSHCN website at www.tdh.state.tx.us/cshcn/ or contact TDSHS-CSHCN at 1-800-252-8023 and select Option 5.

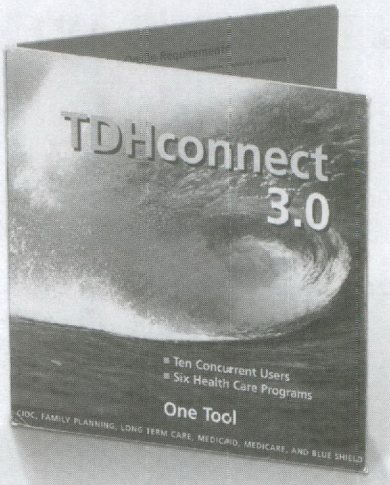
CSHCN appreciates each provider's participation in the program, and especially appreciates assistance with this special offer. Payment of claims for outstanding bills may require extra effort on the provider's part, and on behalf of the clients we all serve, we thank you. ■

CSHCN Provider Manual Available Online

The 2004 *CSHCN Provider Manual* is now available online. Providers can download an electronic copy of the manual by visiting the TMHP website at www.tmhp.com. Click on the *Find Publications/File Library* link on the right hand side of the page, choose *Provider Manuals*, then *CSHCN.*

Providers who have not received a copy of the manual by the end of May 2004, or those needing assistance downloading the manual from the website, should contact TMHP-CSHCN at 1-800-568-2413. ■

TDHconnect 3.0 Service Pack 4



TMHP will release the TDHconnect 3.0 Service Pack 4 on August 20, 2004. Providers who use TDHconnect 3.0 are encouraged to download and install this service pack. Service Pack 4 resolves many of the issues associated with the current version of TDHconnect.

Service Pack Download

To download the service pack, do the following:

1. Connect to TMHP at www.tmhp.com.
2. Click the **Find Software/Service Packs** link located in the *I would like to...* list on the right side of the page. The TMHP File Library main page opens.
3. Scroll down to locate the *File Library* links.
4. Click the **TDHconnect** link. The TMHP File Library/TDHconnect web page opens.
5. Scroll down to locate the *File Library* links.
6. Click the **TDHconnect Updates** link. The TMHP File Library/TDHconnect/TDHconnect Updates web page opens.
7. Scroll down to locate the *File Library* links.
8. Select the most recent Service Pack, such as **TDHconnect 3.0 Updates Service Pack 4.**

Service Pack Installation

To install the service pack, do the following:

1. Double-click the **TDHconnect 3.0 Updates Service Pack 4.zip** icon. This icon was added to the desktop during the file download.
   TIP: The file can be moved to a location on a LAN to share with other TDHconnect 3.0 users.
2. A dialog opens with the following message: *This will install TDHconnect 3.0 Service Pack 4. Do you want to continue?* Click **Yes** to install the TDHconnect 3.0 Service Pack.
3. After the TDHconnect Service Update Installation Utility window opens and the TDHconnect 3.0 Service Pack wizard opens, several informational messages will open. Read each message and click **Next** to advance to the next screen.
4. A dialog opens with the following message: *Do you wish to backup your databases? This will overwrite databases that are in the Backup folder.* Choose one of the following options:

   - Click **Yes** to backup your databases before installing any database updates (this is the recommended choice).
   - Click **No** to continue with the installation without making backups.

Note: Several additional informational messages open. This process may take several minutes as database updates are made.

5. Installation of the TDHconnect 3.0 Service Pack is complete. To view the readme file, check the **View readme** check box and click **Finish**. The readme document opens.
6. Read the document, close it, uncheck the **View readme** check box, and click **Finish**.
7. When prompted to restart the computer, select **Yes, I want to restart my computer now**, and then click **Finish**.

The next time TDHconnect is opened, the version of the Service Pack is listed along with the name TDHconnect 3.4.0. For problems with the download, contact the TMHP EDI Help Desk at 1-888-863-3638. ■

Omalizumab

Effective for dates of service on or after July 1, 2004, omalizumab is approved for the treatment of severe asthma in clients 12 years of age and older. Clients younger than 12 years of age will be considered on an exception basis.

Omalizumab must be prior authorized. When requesting prior authorization, the exact dosage must be indicated on the request using procedure code S0107, Inj, omalizumab, 25 mg. Doses and dosing frequency are determined by body weight and by serum IgE level (IU/mL) measured before the start of the treatment.

Contact TMHP-CSHCN at 1-800-568-2413 or 1-512-514-3000 to obtain additional information concerning prior authorization for omalizumab. ■

Augmentative Communication Devices

Effective for dates of service on or after July 1, 2004, the following augmentative communication devices (ACD) may be requested for authorization through TDSHS-CSHCN:

Procedure Code	Description
E2500	SGD digitized pre-rec <=8min
E2502	SGD prerec msg>8min<=20min
E2508	SGD spelling phys contact
E2510	SGD w multi methods msg/accs
E2510-TF	SGD w multi methods msg/accs (intermediate level of care)
E2510-TG	SGD w multi methods msg/accs (complex/high tech level of care)
E2512	SGD accessory, mounting sys
E2599	SGD accessory noc
SGD = Speech generating device	

To ensure that client needs are met, an ACD system will not be prior authorized for purchase until the client has completed a 30-day trial period that includes experience with the requested system. Prior authorization may be provided for rental of an ACD system during this trial period. All components, such as access devices, mounting devices, and necessary lap trays must be evaluated during this trial period.

If an ACD system is not available for rental, purchase will 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.

Providers must contact TDSHS-CSHCN at 1-800-252-8023 for information about how to request authorization or bill for this service. ■

Behavioral Health Services

Effective for dates of service on and after October 1, 2004, psychiatrists should bill outpatient behavioral health services directly to TMHP-CSHCN at the following address:

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

Other providers of behavioral health services should continue to bill those services to TDSHS-CSHCN at the following address:

TDSHS-CSHCN
1100 West 49th Street
Austin, TX 78756

Outpatient behavioral health procedure codes include: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90847, 90853, 90857, 90862, 90865, 96100, 96117, and M0064.

Reimbursement for procedure codes 90801 and 90802 will be limited to once every two years, any provider. Subsequent visits should be billed using psychotherapy procedure codes. Outpatient behavioral health services are limited to no more than 30 encounters by all providers, per eligible client, per calendar year. Coverage includes, but is not limited to, psychological and neuropsychological testing, psychotherapy, psychoanalysis, counseling, and narcosynthesis. ■

Filing Deadline Changes

On August 1, 2004, HHSC will implement new filing deadlines for appeals of denied claims and requests for adjustments on paid claims. These deadlines are intended to help ensure that all claims are finalized within 24 months from their dates of service. Providers must file all claims and appeals promptly. The Medicaid and CSHCN fiscal agent cannot pay claims or appeals beyond the 24-month payment deadline (refer to *Fiscal Agent Payment Deadlines*, below).

Appeal and Adjustment Filing Deadlines

Effective August 1, 2004, providers must file corrections, appeals, or adjustment requests within *120 days* from the date of disposition. This change applies to both paper and electronic submissions. The date of disposition refers to the date of the Remittance and Status (R&S) report on which the last action on the claim appears. As of July 31, 2004, HHSC or TMHP will no longer process appeal or adjustment requests received more than 120 days after the date of disposition. For example, a request for an appeal received on August 2, 2004, will be processed only if the date of disposition is between April 2, 2004, and August 2, 2004. If the date of disposition is more than 120 days old, or before April 2, 2004, the request will deny for late filing. ■

Fiscal Agent Payment Deadlines

As of January 1, 2004, TMHP, as the state's Medicaid and CSHCN fiscal agent, is required to finalize all claims, including appeals or adjustments, within 24 months. Following are the new payment deadlines:

- All Provider Claims (excluding Long Term Care) – CSHCN and Medicaid payments cannot be made after 24 months from the date of service or discharge date on inpatient claims.
- Refugee Claims – The payable period for all Refugee Medicaid payments is the federal fiscal year (October–September) in which each date of service (discharge date for inpatient claims) occurs plus one additional Federal Fiscal year.
- Retroactive SSI Eligibility Claims – The payment deadline is derived from the client's eligibility add date; to allow twenty-four (24) months from the add date for the retroactive SSI eligible client.
- County Indigent Retroactive Eligibility Claims – The payment deadline is derived from the client's eligibility add date; to allow twenty-four (24) months from the add date for the retroactive County Indigent eligible client.

Payment deadlines should not be confused with the claims filing deadlines that are in place for claim submissions and appeals (refer to *Filing Deadline Changes*, above). ■

HCPCS Update

Each year the Centers for Medicare & Medicaid Services (CMS) issues its changes to HCFA Common Procedure Coding System (HCPCS) procedure codes and modifiers. The codes below have been added, discontinued, or the description has been revised (the revised description is listed). TMHP will continue to accept discontinued HCPCS codes until October 1, 2004.

ADA/AMA Copyright Requirements

This article is intended to notify providers of CSHCN coding changes. In some instances, code descriptions have changed; however, due to American Medical Association (AMA) and American Dental Association (ADA) copyright requirements, the complete long descriptions may not be published. Contact the appropriate copyright holder in order to obtain full procedure code descriptions.

2004 CSHCN Additions Table

New procedure codes added for coverage through the CSHCN Program were published in detail in the Texas Medicaid 2004 *HCPCS Special Bulletin*, No. 180. Refer to that bulletin for the complete listing of updates. The procedure codes listed in the following table are corrections to the *HCPCS Special Bulletin*, No. 180.

Procedure Code/Modifier	Description	Allowable by Type of Service		
36558	Insert tunneled CV cath	2=7.91 RVUs	8=NC	
79403	Hematapoetic nuclear therapy	6=7.68 RVUs	T=3.25 RVUs	I=4.43 RVUs
A4216	Sterile water/saline, 10 ml	9=$0.46	J=NC	
A4217	Sterile water/saline, 500 ml	9=$3.27	J=NC	
E1030	W/c vent tray gimbaled	9=NC	J=$1165.27	
NC=Noncovered service, RVU=Relative value units				

Botulinum Toxin Type A and Type B

Revised procedure code 64680, Injection treatment of nerve, as reported on page 2 in the Texas Medicaid 2004 *HCPCS Special Bulletin*, No. 180, is not a payable procedure code for the injection of botulinum toxin type A or type B. The correct codes that are payable for the injection of botulinum toxin type A or type B are : 64600, 64605, 64610, 64612, 64613, 64614, 64620, 64626, 64630, 64640, and 67345, none of which were revised in 2004. Refer to the 2004 Current Procedural Terminology (CPT-4) for complete descriptions of these codes.

Chemotherapy

Effective for dates of service on or after July 1, 2004, procedure code 95991, Spin/brain pump refil & main, has been added as a covered benefit.

Doctor of Dentistry Services as a Limited Physician

Effective for dates of service on or after July 1, 2004, the following procedure code descriptions have been revised:

Procedure Code	Description
20240	Bone biopsy, excisional
70250	Xray exam of skull
70260	Xray exam of skull

Durable Medical Equipment (DME)

The CSHCN Program requires DME to be authorized except for custom, manual, or power wheelchairs, custom seating systems, and pediatric hospital cribs and their tops, which must be *prior* authorized.

Effective for dates of service on or after July 1, 2004, the following DME procedure codes have been added as a covered benefit:

Procedure Code	Description
A9999	DME supply or accessory, nos
E0247	Trans bench w/wo comm open
E0248	HDtrans bench w/wo comm open
E0300	Enclosed ped crib hosp grade
E0301	HD hosp bed, 350-600 lbs
E0302	Ex hd hosp bed > 600 lbs
E0303	Hosp bed hvy dty xtra wide
E0304	Hosp bed xtra hvy dty x wide
E0638	Standing frame sys
E0955	Cushioned headrest
E0956	W/c lateral trunk/hip suppor
E0957	W/c medial thigh support
E0960	W/c shoulder harness/straps
E0981	Seat upholstery, replacement
E0982	Back upholstery, replacement
E0983	Add pwr joystick
E0984	Add pwr tiller
E0985	W/c seat lift mechanism
E0986	Man w/c push-rim pow assist
E1002	Pwr seat tilt
E1003	Pwr seat recline
E1004	Pwr seat recline mech
E1005	Pwr seat recline pwr
E1006	Pwr seat combo w/o shear
E1007	Pwr seat combo w/shear
E1008	Pwr seat combo pwr shear
E1009	Add mech leg elevation
E1010	Add pwr leg elevation
E1019	HD feature power seat
E1021	Ex hd feature power seat
E1028	W/c manual swingaway
E1029	W/c vent tray fixed
E1030	W/c vent tray gimbaled
E2201	Manual w/ch acc seat w>=20"<24"
E2202	Seat width 24-27 in
E2203	Frame depth less than 22 in
E2204	Frame depth 22 to 25 in
E2300	Pwr seat elevation sys
E2301	Pwr standing
E2310	Electro connect btw control
E2311	Electro connect btw 2 sys
E2320	Hand chin control
E2321	Hand interface joystick
E2322	Mult mech switches
E2323	Special joystick handle
E2324	Chin cup interface
E2325	Sip and puff interface
E2326	Breath tube kit
E2327	Head control interface mech
E2328	Head/extremity control inter
E2329	Head control nonproportional
E2330	Head control proximity switc
E2331	Attendant control
E2340	W/c wdth 20-23 in seat frame
E2341	W/c wdth 24-27 in seat frame
E2342	W/c dpth 20-21 in seat frame
E2343	W/c dpth 22-25 in seat frame
E2351	Electronic SGD interface
E2360	22nf nonsealed leadacid
E2361	22nf sealed leadacid battery
E2362	Gr24 nonsealed leadacid
E2363	Gr24 sealed leadacid battery
E2364	U1nonsealed leadacid battery
E2365	U1 sealed leadacid battery
E2366	Battery charger, single mode
E2367	Battery charger, dual mode
E2399	Noc interface

Home Health Nursing Services

Effective for dates of service on or after July 1, 2004, the description was revised for procedure code S9123, Nursing care in home RN.

Hospital-Based Emergency Department

Effective for dates of service on or after July 1, 2004, descriptions for the following procedure codes have been revised:

Procedure Code	Current Description
36410	Nonroutine bl draw > 3 yrs
99050	Medical services after hrs

Injection - Omalizumab

Effective for dates of service on or after July 1, 2004, the procedure code S0107, Inj, omalizumab 25 mg, has been added as a covered benefit. Prior authorization is required.

Inpatient Professional Services

Effective for dates of service on or after July 1, 2004, coverage for the following procedure codes has been discontinued:

Procedure Code	Description
36488	Insertion of catheter, vein
36489	Insertion of catheter, vein

Effective for dates of service on or after July 1, 2004, the following procedure codes have been added as covered benefits:

Procedure Code	Description
36555	Insert nontunnel CV cath
36556	Insert nontunnel CV cath
36568	Insert tunneled CV cath
36569	Insert tunneled CV cath
36580	Replace tunneled CV cath
36584	Replace tunneled CV cath

Effective for dates of service on or after July 1, 2004, the following procedure code descriptions have been revised:

Procedure Code	Description
36400	Bl draw < 3 yrs fem/jugular
36410	Non-routine bl draw > 3 yrs
43752	Nasal/orogastric w/stent
99295	Neonate crit care, initial
99296	Neonate critical care subseq

Laboratory Services

Effective for dates of service on or after July 1, 2004, the description was revised for procedure code 84155, Assay of protein, serum.

Orthotics

Effective for dates of service on or after July 1, 2004, procedure code L3031, Foot lamin/prepreg composite, has been added as a covered benefit.

Outpatient Professional Evaluation and Management Services

Effective for dates of service on or after July 1, 2004, the description was revised for procedure code 99050, Medical services after hrs.

Radiology, Xrays, and Ultrasound

Effective for dates of service on or after July 1, 2004, the following procedure code descriptions have been revised:

Procedure Code	Description
20240	Bone biopsy, excisional
70250	Xray examination of skull
70260	Xray examination of skull

Renal Dialysis

Effective for dates of service on or after July 1, 2004, the description was revised for procedure code 84155, Assay of protein, serum.

Effective for dates of service on or after July 1, 2004, the following procedure codes have been added as covered benefits:

Procedure Code	Description
Q4054	Darbepoetin alfa, esrd use
Q4055	Epoetin alfa, esrd use

Providers must request authorization through and submit claims for renal dialysis to TDSHS-CSHCN.

Services Incidental to Surgery, Assistant Surgery, and Anesthesia

Effective for dates of service on or after July 1, 2004, coverage for the following procedure codes has been discontinued:

Procedure Code	Description
36488	Insertion of catheter, vein
36489	Insertion of catheter, vein
36490	Insertion of catheter, vein
36491	Insertion of catheter, vein

Effective for dates of service on or after July 1, 2004, coverage for the following procedure codes has been added:

Procedure Code	Description
36555	Insert nontunnel CV cath
36556	Insert nontunnel CV cath
36568	Insert tunneled CV cath
36569	Insert tunneled CV cath
36580	Replace tunneled CV cath
36584	Replace tunneled CV cath

Surgery – Ambulatory or Day Surgery

Effective for dates of service on or after July 1, 2004, descriptions for the following procedure codes have been revised:

Procedure Code	Current Description
36400	Bl draw < 3 yrs fem/jugular
36410	Non-routine bl draw > 3 yrs

Transportation - Ambulance

New procedure code A0800, Amb trans 7pm-7am, is not a benefit because only emergency transports are available at those times.

Vaccines/Toxoids

Effective for dates of service on or after July 1, 2004, coverage for procedure code 90659, Influenza virus vaccine, whole virus, has been discontinued.

Effective for dates of service on or after July 1, 2004, descriptions for the following procedure codes have been revised:

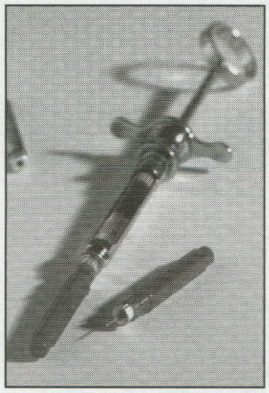
Procedure Code	Description
90657	Flu vaccine, 6-35 mo, IM
90658	Flu vaccine, 3 yrs, IM
90703	Tetanus vaccine, IM
90704	Mumps vaccine, SC
90705	Measles vaccine, SC
90706	Rubella vaccine, SC
90707	MMR vaccine, SC
90708	Measles-Rubella vaccine, SC
90718	TD vaccine > 7, IM

Effective for dates of service on or after July 1, 2004, coverage for the following procedure codes has been added:

Procedure Code	Description
90655	Flu vaccine, 6-35 mo, IM
90734	Meningococcal vaccine, IM

Refer to the Texas Medicaid 2004 *HCPCS Special Bulletin*, No. 180 for a complete listing of all HCPCS updates. ■

Reimbursement for Vaccines/Toxoids



CSHCN encourages providers to appropriately immunize CSHCN clients. CSHCN reimburses providers for vaccines/toxoids and their administration. All routine childhood immunizations, pneumococcal vaccines, influenza vaccines, and selected other vaccines/toxoids are covered by the CSHCN Program.

Providers who administer vaccines/toxoids can enroll in the Texas Vaccines for Children (TVFC) Program to obtain vaccines/toxoids at no charge. When providers obtain vaccines/toxoids from TVFC, no authorization is required, and CSHCN reimburses only the administration fee. Providers interested in obtaining current immunization information or enrollment information for TVFC may call the Texas Department of State Health Services, Bureau of Immunizations at 1-800-252-9152.

For providers who purchase vaccines/toxoids, CSHCN reimburses the lower of the billed amount, the amount allowed by the Texas Medicaid Program, or the maximum fee established by the CSHCN Program for the vaccine or toxoid product. When submitting claims, use the appropriate Current Procedural Terminology (CPT) code to identify the vaccine/toxoid being administered and use codes 90471, 90472, 90473, or 90474, as appropriate, for reimbursement of an administration fee. Effective with claims for dates of services beginning September 1, 2004, CSHCN has increased its reimbursement for the administration fee from $3.00 to $5.00.

Authorization is required for vaccines/toxoids administered by providers who have purchased the vaccine and are not enrolled in the TVFC, or if the client does not meet the TVFC criteria.

If the requested vaccine/toxoid is not currently covered by CSHCN, providers must submit a prior authorization request and documentation of medical necessity to be considered for payment.

Send authorization or prior authorization requests by fax to 1-512-514-4222 or by mail to:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Authorizations, MC-A11
12357-B Riata Trace Parkway
Austin, TX 78727 ■

Payment Change for Influenza Vaccine

Effective for dates of service on or after May 3, 2004, reimbursement rates for procedure codes 1-90657 and 1-90658 have decreased to mirror Medicaid's current rate of $4.01. Effective for dates of service on or after September 1, 2004, CSHCN has increased its reimbursement for the administration fee (1-90471 or 1-90472, as appropriate) from $3.00 to $5.00. ■

Medical Food Reimbursement

Effective for dates of service on or after July 1, 2004, procedure code 1-S9434, Mod solid food suppl, is a benefit of the CSHCN Program when medically necessary and appropriate.

Medical foods are defined as:

- Foods that are lacking the compounds that cause complications of the metabolic disorder
- Foods that are not generally available in grocery stores, health food stores, or pharmacies
- Products that are not used as food by the general population
- Items that are not foods covered under the Food Stamps program
- Approved products listed in enrolled provider's catalogs

Note: Foods with minimal nutritional value such as candy and gum, are not reimbursable.

To qualify, clients must have one of the following diagnoses:

Diagnosis Code	Description
2700	Disturbance of amino-acid transport (includes cystinosis)
2701	Phenylketonuria (PKU)
2702	Other disturbances of aromatic amino-acid metabolism (includes Oasthouse urine disease)
2703	Disturbance of branched-chain amino acid metabolism, includes maple syrup urine disease (MSUD)
2704	Disturbances of sulphur-bearing amino-acid metabolism, includes homocystinuria
2706	Disorder of urea cycle metabolism, includes citrullinemia
2707	Other disturbances of straight-chain amino-acid metabolism, includes hyperlysinemia

If billed with the previously mentioned diagnoses, authorization is not required. All other diagnoses must be prior authorized and must include documentation of medical necessity.

Providers of medical foods must bill directly to TDSHS-CSHCN to request payment from an invoice. Medical foods are only payable for home use. A maximum of $200.00 per month per client may be reimbursed for medical foods. A maximum of 3 months' food supply may be reimbursed at any one time.

Mail inquiries regarding provider enrollment and requests for reimbursement to the following address or call 1-800-252-8023 for more information:

Texas Department of State Health Services
Attn: Sandra Nink
CSHCN M-442
1100 West 49th Street
Austin, TX 78756-3179 ■

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CSHCN Provider Bulletin

The Children with Special Health Care Needs Program

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