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TEXAS MEDICAID

PROVIDER PROCEDURES MANUAL

Volume 2

PROVIDER HANDBOOKS

HOSPITAL SERVICES HANDBOOK

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

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

HOSPITAL SERVICES HANDBOOK

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Note: *A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).*

HOSPITAL SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid hospital (medical and surgical acute care facility) providers and covers services that take place only in a hospital setting. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to acute care hospitals, including military hospitals. Services offered in settings such as rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), dialysis centers, and other similar facilities are detailed in the *Outpatient Services Handbook* (*Vol. 2, Provider Handbooks*).

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: Subsection 8.6, "PCCM" in Section 8, "Managed Care" (*Vol. 1, General Information*).

Important: *All providers are required to read and comply with Section 1, "Provider Enrollment and Responsibilities". In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

1.1 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

2. HOSPITAL (MEDICAL/SURGICAL ACUTE CARE FACILITY)

2.1 Introduction

While this section contains some claims filing information, hospitals should continue to refer to Section 6, "Claims Filing", and Section 7, "Appeals" in *Vol. 1, General Information*, for more comprehensive information about these subjects. Hospital providers are encouraged to review other handbooks for applicable information, prior authorization requirements, and for specific requirements for special programs such as the Texas Health Steps Comprehensive Care Program (THSteps CCP) in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2 Enrollment

2.2.1 Inpatient and Outpatient Enrollment

To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 1.1, "Provider Enrollment" in Section 1, Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about enrollment procedures.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology, Laboratory and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about CLIA.

Section 8, "Managed Care" (*Vol. 1, General Information*)

2.2.1.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

Note: *To obtain the Medicaid hospital participation agreement, call the TMHP Contact Center at 1-800-925-9126, Monday through Friday, 7 a.m. to 7 p.m., Central Time.*

Refer to: Subsection 1.3, "Provider Reenrollment" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.1.2 Hospital-Operated Ambulance

A hospital that provides ambulance services must enroll as a provider of ambulance services separately from the hospital. Claims must be submitted using the ambulance provider identifier, not the hospital provider identifier.

Refer to: Subsection 2.1, "Enrollment" in the *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*)

2.3 Services/Benefits, Limitations and Prior Authorization

2.3.1 Ambulance Services

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided by an ambulance provider for a Medicaid client to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the client's home after discharge from a hospital.

Nonemergency ambulance services are a benefit for the transport of a Texas Medicaid client whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (e.g., alternate means of transportation are medically contraindicated).

Refer to: Subsection 2.3.4.1, "Nonemergency Ambulance Transport Prior Authorization" in this handbook.

2.3.2 Inpatient 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. Texas Medicaid 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 Texas Medicaid's Utilization Review (UR) requirements. Services must also be billed to TMHP per Medicaid policy and procedures.

Inpatient hospital services include the following:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit including meals, special diets, and general nursing services; and an allowance for bed and board in private accommodations including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons as certified by the physician. Additionally, the hospital must document the medical necessity for a private room such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information should be included in Block 80 of the UB-04 CMS-1450 claim form or added as an attachment to the claim submission.
- Whole blood and packed red blood cells reasonable and necessary for treatment of illness or injury provided they are not available without cost.
- Maternity care (includes usual and customary care for all female clients).
- All medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology.
- Newborn care (includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems).

Circumstances requiring the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented. Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons and must be documented.

Take-home drugs, self-administered drugs, or personal comfort items are not separately reimbursable to hospitals. Take-home drugs and supplies are a benefit when supplied by prescription through the Vendor Drug Program (VDP).

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 as follows:

- 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 20 years of age or younger when a medically necessary condition exists.
- Some Medicaid Managed Care clients. Refer to Subsection 8.1, "Medicaid Managed Care" in Section 8, "Managed Care" (*Vol. 1, General Information*).

Medicaid reimbursement for acute care inpatient hospital 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 20 years of age or younger.*

2.3.2.1 Hysterectomy Services

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. The acknowledgment must be submitted to TMHP with the claim or to the client's health plan.

Each individual provider involved in the hysterectomy procedure is requested to submit a copy of a valid Hysterectomy Acknowledgment Form rather than relying on another provider. The provider is responsible for maintaining the original, signed copy of the Hysterectomy Acknowledgement Form in the client's medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

Refer to: Form MD.4, "Hysterectomy Acknowledgment Form" in Section 6, Forms, in this handbook.

2.3.2.2 Maternity Care/Children's Health Insurance Program (CHIP) Perinatal Coverage

CHIP perinatal services coverage includes hospital charges related to the delivery for a CHIP perinatal services client. Preterm labor that does not result in a birth and false labor are not covered benefits.

For women with a family income at or below 185 percent of the Federal Poverty Level (FPL), hospital facility charges are paid through Emergency Medicaid. A client must be determined eligible for Emergency Medicaid by HHSC for a claim to be paid to a Medicaid provider. Claims are sent to TMHP for processing.

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

TMHP processes CHIP perinatal newborn transfer hospital claims even if the claim from the initial hospital stay has not been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This applies only to CHIP perinatal newborns with a family income at or below 185 percent of the FPL.

Refer to: Subsection 6.17.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

2.3.2.3 Newborn Services

2.3.2.3.1 Eligibility Process

A child is deemed eligible for Texas 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 Form HS.1, "Hospital Report (Newborn Child or Children) (Form 7484)" in Section 6, Forms, in this handbook 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.* The form must be completed by the hospital no later than five days after the child's birth and should be sent to HHSC at the address identified on the form. The form should not be completed for stillbirths. Hospitals should duplicate the form as needed, because they are not supplied by HHSC, the Department of Aging and Disability Services (DADS) or TMHP.

Hospitals that submit the birth certificate information utilizing the Department of State Health Services (DSHS), Vital Statistics Unit (VSU) Texas Electronic Registrar for Birth 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 including pharmacies providing outpatient prescription benefits for medically-needy newborns. Additional information about electronic filing can be found on the HHSC website at www.hhsc.state.tx.us/medicaid/mc/proj/newid/applying.html#submit. Providers may also call 1-512-458-7368 for additional information or to comment about this process.

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 H3087).

Claims submitted for services provided to a newborn child eligible for Medicaid are filed using the newborn child's Medicaid client number.

Newborns who are from families with an income at or below 185 percent of the FPL and who receive CHIP perinatal benefits are assigned a client number for Texas Medicaid. This number is only assigned for reimbursement of the newborn's hospital facility charges (on a UB-04 CMS-1450 claim form) for the initial hospital stay after delivery. Claims for the newborn's hospital facility charges should be sent to TMHP.

TMHP will process CHIP perinatal newborn transfer hospital claims regardless if the claim from the initial hospital stay has been received. The hospital transfer must have occurred within 24 hours of the discharge date from the initial delivery hospital stay. This only applies to CHIP perinatal newborns with a family income at or below 185 percent of the federal poverty level. Transfer claims must be filed to TMHP using the admission type 1, 2, 3, or 5 in block 14; source of admission code 4 or 6 in block 15; and the actual date and time the client was admitted in block 12 of the UB-04 CMS-1450 claim form.

Note: *When billing for a Medicaid Managed Care client, providers must adhere to the Medicaid Managed Care health plans' guidelines for newborn billing.*

2.3.2.3.2 Newborn Hearing 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.

All newborns who have abnormal screening results should be referred to a Texas Medicaid provider who is a licensed audiologist or physician who provides audiology services. Clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services

For more information about newborn hearing screening, visit the Department of State Health Services website at www.dshs.state.tx.us/audio/default.shtm.

2.3.2.3.3 Newborn Hereditary/Metabolic Screening

The state of Texas requires newborn screening for genetic disorders within 24 to 48 hours of birth. Screening test cards are provided by DSHS at no charge for Medicaid-eligible or CHIP clients. Test cards can be ordered by calling 1-512-458-7661, or by faxing a request for a newborn screening kits and supplies order form to 1-512-458-7672. Mailing labels to return samples to DSHS for testing are included with the supplies. Additional information can be found at www.dshs.state.tx.us/lab/default.shtm.

Refer newborns with suspected genetic disorders or with a positive newborn screening test for a genetic work-up as appropriate.

Refer to: Section 4, "Genetic Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.2.3.4 Hepatitis B Immunizations

Newborns should be given the first dose of hepatitis B vaccine before discharge from the hospital. Hepatitis B vaccine for newborns is provided by the Texas Vaccines for Children (TVFC) Program. Hospitals may obtain vaccine at no cost by enrolling in the TVFC Program. For more information on enrolling in the TVFC Program, refer to subsection B.4, "Texas Vaccines for Children Program Packet" in Appendix B, Immunizations, in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) or call the DSHS Immunization Division 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 diagnosis related group (DRG). The reimbursement for the administration of hepatitis B vaccine to newborns is included in the DRG payment. Texas Medicaid 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.

Refer to: Subsection 6.3.1.8, "Newborn Examination" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.2.4 Linezolid

Linezolid, a new class of antibiotic, is a benefit of Texas Medicaid. Linezolid intravenous injection is covered only in the inpatient setting as part of the DRG payment.

The FDA recommended uses of linezolid include:

- The treatment of vancomycin resistant enterococcus faccium infections.
- Nosocomial pneumonia.
- Complicated and uncomplicated skin and skin structure infections.
- Community-acquired pneumonia.

2.3.2.5 Rehabilitation Services

Inpatient rehabilitation services are a benefit of Texas Medicaid 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.

Inpatient rehabilitation services in an acute care setting are included in the hospital DRG payment if the rehabilitation is incidental to the reason for admission.

If inpatient admission is to a freestanding rehabilitation facility, services are limited to clients 20 years of age or younger. Prior authorization is required.

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 CCP.

Refer to: Section 5, "Therapists, Independent Practitioners, and Physicians" in *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information.

Subsection 3.12, "Inpatient Rehabilitation Hospital (Freestanding) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.2.6 Nursing Facility Admission

The admission Minimum Data Set (MDS) must be used for admissions to a nursing facility. There are instances in which hospital social workers and/or discharge nurses might also complete the admission MDS, such as:

- If the client is in a long-term care acute center.
- If the potential receiving nursing facility (NF) desires a better clinical picture of the client, a paper copy of the admission MDS is completed by the hospital staff before the client is accepted for admission into the nursing facility.

Refer to: The Long Term Care Program's page on the TMHP website at www.tmhp.com for additional information, including instructions for all forms and assessments

2.3.2.7 Organ and Tissue Transplant Services

A facility wishing to perform organ transplants for Texas Medicaid clients must be a designated children's hospital or a facility in continuous compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Facilities whose status of "good standing" has been suspended for any reason by the national credentialing bodies will not be reimbursed by Texas Medicaid for transplant services until this status is restored.

2.3.2.7.1 Out-of-State Facilities

In order for Texas Medicaid to reimburse 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 Texas Medicaid.

Refer to: Subsection 6.3.42, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3 Outpatient 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 are not reimbursable.

Take-home drugs and supplies are a benefit in the outpatient setting for outpatients when supplied by prescription through the VDP.

Outpatient hospital services include those services performed in the emergency room (ER), day surgery, clinic, or observation room. In instances of sudden illness or injury, the client may receive treatment in the ER and be discharged, placed on observation status, or admitted as an inpatient. If a client 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 ER or clinic, the ER or clinic charges must be billed on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

Outpatient hospital services must be itemized by date of service. Procedures 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.

Texas 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: Subsection 1.7, "Texas Medicaid Limitations and Exclusions" in Section 1, Provider Enrollment and Responsibilities (*Vol. 1, General Information*) for more information about noncovered items/services.

2.3.3.1 Chemotherapy Administration

Hospitals must submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

For chemotherapy administration, outpatient facilities should submit charges using the appropriate revenue codes, such as the revenue codes listed below:

Revenue Code	Description
264	IV therapy, IV therapy/supplies
450 *or* 456 *or* 459	Emergency room *or* Emergency room, urgent care *or* Emergency room-other
510 *or* 511 *or* 512 *or* 514 *or* 515 *or* 516 *or* 517 *or* 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
761	Treatment room
762	Observation room

Revenue code 636 must be used to bill the technical component of chemotherapy administration. The appropriate chemotherapy procedure code must be listed on the claim.

Refer to: Subsection 6.3.15, "Chemotherapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.2 Cochlear Implants

A cochlear implant is a benefit of Texas Medicaid when medically indicated. Hospital ambulatory surgical centers may be reimbursed for the implantation procedure using procedure code 69930, and for the cochlear implant device using procedure code L8614.

Refer to: Subsection 6.3.17, "Cochlear Implants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.3 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week. Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

Emergency department room charges may be billed using the following revenue codes:

Revenue Code	Description
450 *or* 451 *or* 456 *or* 459	Emergency room *or* Emergency room-EMTALA emergency medical screening *or* Emergency room, urgent care *or* Emergency room-other
761	Treatment room
762	Observation room

Emergency department ancillary services include laboratory services, radiology services, respiratory therapy services, and diagnostic studies, such as ECGs, CT scans, and supplies. Ancillary services should be billed on a UB-04 CMS-1450 claim form using the appropriate procedure codes such as the Current Procedural Terminology (CPT) code or the Healthcare Common Procedure Coding System (HCPCS) code indicating the procedures or services performed.

According to the *Emergency Medical Treatment and Active Labor Act* (EMTALA) of 1986, if any individual presents at the hospital's emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

EMTALA medical screening code (451) may be considered for reimbursement when billed as a stand-alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement. Services beyond screening (451) can be billed with the appropriate corresponding emergency services code (450).

Medicaid claims administrators and Medicaid Managed Care Organizations (MCOs) are prohibited from requiring prior authorization or primary care provider notification for emergency services including those needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

Texas Medicaid provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not a benefit.

Texas Medicaid provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are also a benefit when the client's health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients with substance use disorders and those at risk of developing such disorders. Substance abuse includes, but is not limited to, the abuse of alcohol and the abuse of, improper use of, or dependency on illegal or legal drugs. SBIRT is used for intervention directed to individual clients and not for group intervention. SBIRT is targeted to clients who are from 14 years of age through 20 years of age and who present to the hospital emergency department for a traumatic injury, condition, or accident related to substance abuse. SBIRT may also be medically necessary for clients who are from 10 years of age through 13 years of age.

The first SBIRT session, including screening and brief intervention, must be billed by the hospital using an appropriate revenue code and procedure code H0050.

Screening to identify clients with problems related to substance use must be performed during the first session in the hospital emergency department or inpatient setting, but will not be separately reimbursed. Screening may be completed through interview and self-report, blood alcohol content, toxicology screen, or by using a standardized tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Brief intervention is performed during the first session following a positive screen or a finding of at least a moderate risk for substance or alcohol abuse. Brief intervention, directed to the client, involves motivational discussion focused on raising the client's awareness of their substance use and its consequences, and motivated them toward behavioral change. Successful brief intervention encompasses support of the client's empowerment to make behavioral changes. A client found to have a moderate risk for substance or alcohol abuse should be referred for brief treatment of up to 3 sessions. Upon determination that the client has a severe risk for substance or alcohol abuse, the client should also be referred for more extensive treatment to the appropriate chemical dependency treatment center or outpatient behavioral health provider. If the client is currently under the care of a behavioral health provider, the client must be referred back to that provider.

SIBERT documentation for the first session must include:

- The client has an alcohol or drug-related traumatic injury or condition.
- Positive screening by a standardized screening tool.
- Laboratory results such as blood alcohol content, toxicology screen, or other measures showing at least a moderate risk for alcohol or substance abuse.
- The name, address, and phone number of the provider to which the client is referred, if a referral is made.

The provider who performed the screening must document that a follow-up appointment was made for a subsequent session.

2.3.3.4 Fluocinolone Acetonide

The fluocinolone acetonide (*Retisert*) intravitreal implant will be considered for reimbursement to outpatient hospitals and HASCs for clients 12 years of age or older with prior authorization.

Refer to: Subsection 2.3.4.5, "Prior Authorization for Fluocinolone Acetonide " in this handbook.

2.3.3.5 Hospital Outpatient Observation Room Services

Outpatient means a client is in an organized medical facility and receives professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the client remains in the facility past midnight.

Some patients, while not requiring an inpatient hospital admission, may require an extended period of observation (less than 24 hours) in the hospital environment on an outpatient basis. The client is considered an outpatient if he or she remains in the hospital for less than 24 consecutive hours and is discharged to home from an outpatient observation status.

Observation services may be provided in any part of the hospital where a client can be assessed, examined, monitored, or treated. If a patient is being observed, it is not appropriate to bill additional services. For example, if a woman is under observation in a labor and delivery room to rule out labor, the hospital must bill for observation only, and not include labor/delivery room charges.

If a physician's order for outpatient observation is present in the patient's medical record, per 1 TAC §371.206(b), Texas Medicaid 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 Type of Bill (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 (762) is considered to be *hours*, claims submitted with observation room *units* exceeding 23 hours are denied with explanation of benefits (EOB) code 643, Claim indicates outpatient charges in excess of 23 hours. Facilities should resubmit these outpatient claims as appeals with charges for the initial 23 hours only.

Any service *ordered within* the initial 24 hour period may be included on the outpatient claim *if a physician's order for the service is within* the observation period time frame but hospital scheduling limitations prevent the service from being performed before 23 hours has expired. Any services ordered *after* the initial 24 hours must *not* be included on the outpatient claim nor billed to the client.

To receive reimbursement for physician-*ordered* services that are medically necessary and *exceed* the 24-hour period from the initial point of contact, the claim may be submitted as an inpatient stay. All observation room charges, outpatient charges (except ambulatory surgical procedure codes as listed in the current HASC fee schedule), and ER charges for an inpatient claim are included in the reimbursement methodology and are not reimbursed separately (charges for an observation room on an inpatient claim should be coded with revenue code 760).

It is important to realize that any inpatient stay billed to Texas Medicaid is subject to retrospective review by the HHSC UR Unit with the possibility for denial if the admission is determined not medically necessary. If the inpatient admission is denied as not medically necessary, HHSC UR may allow services rendered during the first 23 hours (less than 24 hours) to be rebilled to TMHP as an outpatient claim if a physician's order for outpatient observation is present in the hospital medical record (per 1 TAC §371.206[b]). The claim must be submitted to TMHP within 120 days from the date of the UR notification letter.

The following documentation must accompany the revised bill:

- Revised UB-04 CMS-1450 claim form containing the required data for outpatient billing for medically necessary outpatient services.

- Copy of the UR notification letter indicating services may be rebilled.

When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement. A hospital is not allowed to convert a client from observation status to inpatient admission status without a physician's order.

2.3.3.6 Fetal Nonstress Testing and Contraction Stress Test

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.

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.

Nonstress and contraction stress testing conducted in the outpatient setting should be billed with revenue code 729.

Procedure codes 59020 and 59025, when billed with revenue code 729 for outpatient facilities, may be reimbursed on the same day by a different provider without appeal. However, procedure codes 59020 and 59025, billed with revenue code 729 more than once per day by the same provider, will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

Revenue code 729 is payable for outpatient hospital stays. Services during an inpatient hospital stay are reimbursed under the hospital's DRG.

Refer to: Subsection 6.3.39.10, "Prenatal Surveillance" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.7 Day Surgery

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. Scheduled procedures performed in a HASC must be billed using the HASC provider identifier with TOB 131. Emergency or unscheduled procedures performed in a hospital when the client is an outpatient must be billed using the hospital provider identifier.

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 emergency or unscheduled hospital outpatient surgical procedures using the hospital's provider identifier and appropriate revenue code and/or HCPCS procedure code using TOB 131. File claims for scheduled outpatient surgical procedures using the hospital's HASC provider identifier and appropriate HCPCS procedure in Block 44 of the UB-04 CMS-1450 claim form, instead of the *International Classification of Diseases Ninth Revision Clinical Modification* (ICD-9-CM) procedure code in Block 74 of the claim form.

Reimbursement of HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. A complete list of approved HASC procedure codes with the assigned payment group can be found on the TMHP website at www.tmhp.com. Click on **Fee Schedules**. This list can also be obtained by calling the TMHP Contact Center at 1-800-925-9126.

2.3.3.7.1 HASC Global Services

The 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 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 HASC and implanted, inserted or otherwise applied during a covered surgical procedure.

Exception: *Certain pieces of equipment, such as cochlear implant and neurostimulator devices may be reimbursed separately from the HASC global rate.*

2.3.3.7.2 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.

2.3.3.7.3 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 appropriate hospital or 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.

2.3.3.7.4 Emergency/Unscheduled Day Surgeries

These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed.

If a client is first treated in the ER and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures should be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must bill unscheduled day surgery procedures and emergency services as outpatient procedures using the hospital 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. 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.

2.3.3.7.5 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.

2.3.3.7.6 American Society of Anesthesiologists (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 ASA Classification of Physical Status of III (P3), IV (P4), or V (P5) or Classification of Heart Disease IV (refer to Texas Medicaid Hospital Screening Criteria at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml#asa), 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 descriptions for ASA classes of physical status are as follows:

- *Class I.* A normal healthy patient, without organic, physiological, or psychiatric disturbance.

  Example: *Healthy patient with good exercise tolerance.*

- *Class II.* A patient with mild systemic disease, controlled medical conditions without significant systemic effects.

  Example: *Controlled hypertension or diabetes mellitus without system effects, cigarette smoking without evidence of COPD, anemia, mild obesity, age less than one or greater than 70 years, pregnancy.*

- *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 if 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.

2.3.3.7.7 Incomplete Day Surgeries

When HASC providers bill Texas Medicaid for an incomplete surgical procedure, one of the following *must* be included on the claim:

- Modifier 73 for a discontinued outpatient procedure after anesthesia administration or 74 for a discontinued outpatient procedure prior to anesthesia administration.
- At least one of the following diagnosis codes:

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 or modifier 73 or 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 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 HASC 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 HASC group payment schedule up to the administration of anesthesia.
- Reimburse at 67 percent of HASC group payment schedule after the administration of anesthesia but before incision.
- Reimburse at 100 percent of HASC group payment schedule after incision.

Surgeries canceled because of incomplete preoperative procedures are not reimbursed.

2.3.3.8 Lung Volume Reduction Surgery (LVRS)

An outpatient facility must bill using revenue code 469 and one of the pre-operative rehabilitation service procedure codes for preparation for LVRS (procedure codes G0302, G0303, and G0304) or for the post-discharge surgery services after LVRS (procedure code G0305). These services are restricted to diagnosis code 4928.

Procedure codes G0302, G0303, and G0304 are limited to once per rolling year per client for any provider. Post-discharge pulmonary surgery services after LVRS (procedure code G0305) are limited to once per rolling year per client for any provider and only if procedure code 32491 has been billed in the past 12 months. Procedure code G0305 may be considered on appeal with documentation of LVRS surgery performed in the previous 12 months.

2.3.3.9 Hyperbaric Oxygen Therapy (HBOT)

HBOT is a type of therapy that is intended to increase the environmental oxygen pressure to promote the movement of oxygen from the environment into the body tissues by means of pressurization that is greater than atmospheric pressure. Such treatment is performed in specially constructed hyperbaric chambers, which may hold one or several patients.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, etc., or applied topically is not considered hyperbaric treatment in itself.*

Authorization is not required. HBOT is diagnosis-restricted and is limited to one session per day.

Outpatient hospital clinics and free-standing facilities must use revenue code 413, Respiratory services, HBOT, (quantity of one) for reimbursement of the technical component. HBOT is not payable to psychiatric hospitals.

Refer to: Subsection 6.3.27, "Hyperbaric Oxygen Therapy (HBOT)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*)

2.3.3.10 Implantable Infusion Pump

Implantable infusion pumps may be a benefit in an outpatient hospital or HASC setting if a medical necessity exists. Implantable infusion pumps may be medically necessary in the following circumstances:

- Intrathecal administration of anti-spasmodic drugs to treat chronic intractable spasticity
- Administration of opioid drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy on colorectal cancer with liver metastases
- Administration of intra-arterial chemotherapy in head and neck cancers

Programmable infusion pumps may be reimbursed with the appropriate procedure codes of E0782 or E0783.

Refer to: Subsection 6.3.32.26, "Implantable Infusion Pumps" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 2.3.4.8, "Prior Authorization for Implantable Infusion Pump " in this handbook.

2.3.3.11 Laboratory Services

2.3.3.11.1 Helicobacter Pylori (H. Pylori)

The following procedure codes are benefits of Texas Medicaid:

Procedure Codes						
78267	78268	83009	83013	83014	86677	87338

These codes are considered to be clinical lab services and must be billed as the total component. The interpretation/professional component is not separately reimbursed.

Refer to: Subsection 6.3.20.9, "Helicobacter Pylori (H. Pylori)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information.

2.3.3.11.2 Hospital Laboratory Services

Outpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

Exception: Hospital laboratories may bill for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 80 of the UB-04 CMS-1450 claim form and must enter the performing laboratory's provider identifier next to the service provided by the performing laboratory.

Hospitals may bill a handling fee (procedure code 99001) for collecting and forwarding a specimen to a referral laboratory if the specimen is collected by venipuncture or catheterization. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Laboratory tests generally performed as a panel (chemistries, complete blood counts) must be billed with the appropriate HCPCS panel code. The policy applies to laboratory tests performed by a hospital laboratory.

Modifier 91
Modifier 91 should be used for *repeat* clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the clinical diagnostic retest.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 91, the claim or detail is denied.
- If a clinical diagnostic retest is performed by the same provider on the same day and is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.

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 a nonclinical 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.

Certain procedure codes are not subject to 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, brucella, francisella, murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus). 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 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: Subsection 2.2.2, "Laboratory Paneling" in the *Radiology, Laboratory and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

2.3.3.11.3 Pap Smears (Cytopathology Studies)

Pap or estrogen smears are a benefit of Texas Medicaid for the early detection of cancer. 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.

Nongynecological cytopathology procedure codes 88160, 88161, and 88162 may be a benefit for an outpatient or inpatient hospital when billed as the total component.

Procedure codes 88160 and 88161 are denied if billed with procedure code 88161. Procedure code 88160 is denied if billed with procedure code 88161.

2.3.3.12 Neurostimulators

Neurostimulators may be a benefit in the outpatient hospital and HASC setting when medically necessary. All procedures require prior authorizations.

Refer to: Subsection 6.3.37, "Neurostimulators" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 2.3.4.9, "Prior Authorization for Neurostimulators " in this handbook.

2.3.3.13 Occupational and Physical Therapy Services

Refer to: The *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about therapy services.

2.3.3.14 Total Parenteral Nutrition

Outpatient total parenteral nutrition (TPN) is a benefit of Texas Medicaid for eligible clients who require long-term nutritional support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot absorb nutrition.

Covered services must be medically necessary and prescribed by the physician. This service is not payable when oral/enteral intake will maintain adequate nutrition. TPN and lipids must be prior authorized. Additional diagnoses may be considered for clients who are 20 years of age or younger and CCP eligible.

Outpatient hospital TPN should be billed using the appropriate revenue code. Reimbursement to hospital outpatient departments furnishing in-home TPN services may not exceed the maximum yearly fee established by HHSC or its designee. Claims for TPN therapy administered as a nutritional supplement are denied.

Refer to: Subsection 3.2.2, "Benefits" and subsection 3.2.10, "Limitations, Exclusions" in *Nursing and Therapy Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 2.3.4.10, "Prior Authorization for Outpatient Total Parenteral Nutrition " in this handbook.

2.3.3.15 Electrodiagnostic (EDX) Testing

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed to outpatient hospitals with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

Electromyography (EMG) and Nerve Conduction Studies (NCS)
The following EMG procedure codes are considered for reimbursement to outpatient hospitals:

Procedure Codes									
51784	51785	95860	95861	95863	95864	95865	95866	95867	95868
95869	95870	95872	95875						

Outpatient hospitals may be reimbursed only for the technical component for procedure codes 51784 and 51785.

Refer to: Subsection 6.3.20.7, "Electrodiagnostic (EDX) Testing" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

The following nerve conductions studies may be reimbursed to outpatient hospitals:

Procedure Codes								
95900	95903	95904	95905	95930	95933	95934	95936	95937

NCS and EMG studies are diagnosis restricted.

Refer to: Subsection 6.3.20.7, "Electrodiagnostic (EDX) Testing" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

2.3.3.16 Radiology and Imaging Services

2.3.3.16.1 Cardiac Blood Pool Imaging

Cardiac blood pool imaging is a benefit of Texas Medicaid. Use only the following procedure codes: 78472, 78473, 78481, 78483, 78494, or 78496. Only the total component may be reimbursed to hospitals in the outpatient setting.

Refer to: Subsection 6.3.55.1, "Cardiac Blood Pool Imaging" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.16.2 Colorectal Cancer Screening

Outpatient and inpatient hospitals may be reimbursed for the total or technical component of procedure code G0106. Procedure code G0104 may be reimbursed to an HASC. Procedure codes G0106 and G0104 are limited to diagnosis codes V1272, V7650, V7651, V7652, or V700.

Outpatient hospitals may also be reimbursed for the total component of procedure code G0120. An HASC may be reimbursed for procedure code G0105. Procedure codes G0105 and G0120 are limited to the following diagnosis codes:

Diagnosis Codes									
5550	5551	5552	5559	5560	5561	5562	5563	5568	5569
55841	55842	5589	V1005	V1006	V1272	V160	V1851		

Refer to: Subsection 6.3.11.3, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.16.3 Myocardial Perfusion Imaging

Myocardial perfusion imaging is a covered benefit of Texas Medicaid when it is medically indicated. Myocardial perfusing imaging studies may be reimbursed using procedure codes 78451, 78452, 78453, 78454, and 78761. Only the total component may be reimbursed to outpatient hospitals.

Refer to: Subsection 4.2.3.3, "Myocardial Perfusion Imaging" in *Radiology, Laboratory, and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.16.4 Stereotactic Radiosurgery

Procedure codes 61795 and S8030 are a benefit of Texas Medicaid for HASC facilities. Prior authorization is required.

Refer to: Subsection 6.3.54.3, "Stereotactic Radiosurgery" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 2.3.4.6, "Prior Authorization for Hospital Radiation Therapy Services " in this handbook.

2.3.3.16.5 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent (i.e., those that are scheduled) CT, computed tomography angiography (CTA), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) studies before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services.

Providers may request a prior authorization online through the TMHP website at www.tmhp.com. Providers may also request prior or retrospective authorization by calling the TMHP Radiology Services Prior Authorization Line at 1-800-572-2116, by fax to 1-800-572-2119, or by mail to:

Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd., Suite 800
Franklin, TN 37067

Refer to: Subsection 2.3.4.7.1, "Computed Tomography and Magnetic Resonance Imaging" in this handbook.

Subsection 4.2.3.2, "CT, CTA, MRI, and MRA" in the *Radiology, Laboratory, and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.17 Hospital Radiation Therapy Services

Take-home drugs given during the course of therapy can be reimbursed separately through the Vendor Drug Program.

Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 claim form when submitting charges for these services. Freestanding radiation treatment centers and outpatient hospitals are reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the services listed in the procedure code tables below.

Refer to: "Sterotactic Radiosurgery" under Subsection 2.3.4.6, "Prior Authorization for Hospital Radiation Therapy Services " in this handbook.

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

Contrast Materials/Radiopharmaceuticals
Reimbursement for radiological procedures, such as MRI or CT, with descriptions that specify "with contrast," include payment for high osmolar, low osmolar, LOCM, and paramagnetic contrast materials. Some diagnostic radiopharmaceuticals are benefits of Texas Medicaid. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for more information about the diagnostic radiopharmaceuticals that are reimbursed. Radiopharmaceuticals may be considered for separate reimbursement when used for therapeutic treatment.

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 a 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.

When appealing claims with modifier 76 for repeat non-clinical procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Refer to: Section 4, "Radiology, Physiological Laboratory, and Portable X-Ray Supplier" in *Radiology, Laboratory, and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*).

Clinical Treatment Planning

Procedure Codes					
77280	77285	77290	77295	77299	77301

Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services

Procedure Codes									
77300	77305	77310	77315	77326	77327	77328	77332	77333	77334
77371	77372	77373	77399						

Brachytherapy

Procedure codes 77785, 77786 and 77787 are payable to outpatient hospitals. The following procedure codes are payable to an HASC:

Procedure Codes									
19295	19296	19297	19298	31626	31643	32553	55860	55862	55865
55875	55876	57115	58346	92974					

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied on the same day that clinical brachytherapy services are billed.

Prior authorization is not required for brachytherapy.

Radiation Treatment Delivery/Port Films

Procedure Codes									
77401	77402	77403	77404	77406	77407	77408	77409	77411	77412
77413	77414	77416	77417	77418	77421	77422	77423		

2.3.3.17.1 Therapeutic Radiopharmaceuticals

Radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas Medicaid. The following procedure codes may be billed when used for therapeutic treatment:

Procedure Codes									
79403	A9500	A9542	A9543	A9545	A9563	A9564	A9600	A9605	A9699

Prior authorization is required for A9542, A9543, and A9545.

Procedure code A9542, A9543, or A9545 may only be considered once per lifetime, any provider. Only one of these procedure codes may be reimbursed per lifetime. Providers must use diagnosis code 20280 when submitting a claim for any of these procedure codes.

Strontium-89 chloride may be billed using procedure code A9600 and will be limited to a total of 10 mci intravenously injected every 90 days, any provider. Strontium-89 chloride and Samarium (procedure code A9605) must be billed with diagnosis code 1985. Chromic phosphate p-32 (procedure code A9564) may be reimbursed when billed with diagnosis code 1972 or 1769. Sodium phosphate p-32 suspension (procedure code A9563) will be considered when billed with one of the following diagnoses:

Diagnosis Codes									
20410	20412	20422	20492	20510	20512	20522	20582	20592	20812

Diagnosis Codes			
20822	20882	20892	2384

Chromium phosphate p-32 suspension will be considered when billed with diagnosis 1972 or 1976.

The following services are *not* benefits of Texas Medicaid:

Procedure Codes							
77321	77331	77336	77370	77470	77600	77620	77790

Radiation therapy services are allowed once per day, unless documentation submitted with an appeal supports the need for the service to be provided more than once.

Hospitals use revenue code 333, Radiation therapy, on the UB-04 CMS-1450 claim form when submitting charges for radiation therapy services.

Refer to: Subsection 6.3.54, "Radiation Therapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider handbooks*).

2.3.3.18 Respiratory Services

2.3.3.18.1 Aerosol Treatment

Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are a benefit of Texas Medicaid.

The following diagnosis codes are payable for aerosol treatments:

Diagnosis Codes									
1363	27700	27701	27702	27703	27709	46611	46619	4801	486
4880	4881	4910	4911	49120	49121	49122	4918	4919	4920
4928	49300	49301	49302	49310	49311	49312	49320	49321	49322
49381	49382	49390	49391	49392	4940	4941	4950	4951	4952
4953	4954	4955	4956	4957	4958	4959	496	5070	5071
5078	51911	51919	5533	7707	99527	99731	99739		

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 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 412 includes the inhalers listed below and is payable in the outpatient setting 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*)
- Bilateral (*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 412, Respiratory services–inhalation services, is billed on the same day for both aerosol therapy and inhalers, only one service is allowed, not both.

Demonstration and/or evaluation of client utilization of an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device will not be reimbursed separately.

IPPB treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

2.3.3.18.2 Pentamidine Aerosol

Aerosol pentamidine treatments are reimbursed using procedure code 94642.

Additionally, the provider may also be reimbursed for the medication using procedure code J2545.

Payment for aerosol pentamadine treatments is limited to the following diagnosis codes:

Diagnosis Codes						
042	07951	07952	07953	1363	48284	5186

Aerosol pentamidine treatments are limited to one treatment every 28 days.

Oral trimethoprim-sulfamethoxazole is available from pharmacies for self administration at home. The use of oral trimethoprim-sulfamethoxazole is not a payable benefit of the insured portion of Texas Medicaid.

2.3.3.18.3 Pulmonary Function Studies

Pulmonary function studies include, but are not limited to, the following procedures:

Procedure Codes									
94010	94014	94015	94016	94060	94070	94150	94200	94240	94250
94260	94350	94360	94370	94375	94400	94450	94620	94621	

When multiple procedure codes are billed, the most inclusive code of the related codes will be paid and all other related codes will be denied.

Procedure code 94010 billed with procedure code 94200 will be denied as part of 94200.

Procedure code 94010 billed with procedure code 94060 will be denied as part of 94060.

Procedure code 94150 billed with procedure code 94240 will be denied as part of 94240.

Procedure code 94200 billed with procedure code 94060 will be denied as part of 94060.

Procedure codes 94010, 94200, or 94060 billed with procedure code 94070 will be denied as part of 94070.

Procedure code 94015 billed with procedure code 94014 will be denied as part of 94014.

Procedure codes 94014, 94015, and 94016 will suspend for review if they are billed more than once per month.

Procedure code 94621 will suspend for review if it is billed more than once per day by the same provider.

When unrelated pulmonary function studies are billed together, each will be considered for reimbursement.

2.3.3.19 Sterilization Services

Texas Medicaid 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:

- 20 years of age or younger 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.

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.

Providers must use the consent form provided in this handbook and ensure all required fields are completed for timely processing.

An HASC may be reimbursed for procedure code 58600, 58615, 58670, 58671, 55200, 55250, or E1399 with modifier UD. An appropriate family planning diagnosis code must be billed when reporting facility fees related to tubal ligation.

Refer to: Subsection 3.3.8, "Sterilization and Sterilization-Related Procedures" in the *Gynecological and Reproductive Health, Obstetrics, and Family Planning Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 3.3.8, "Sterilization and Sterilization-Related Procedures" in *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*) for elective sterilization services requirements and instructions.

Form HS.7, "Sterilization Consent Form (English)" in this handbook.

Form GN.7, "Sterilization Consent Form (Spanish)" in *Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.3.20 Tetanus Injections, Acute Care

Tetanus toxoid absorbed and tetanus immune globulin, human, are benefits of Texas Medicaid.

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. Providers are expected to follow the Advisory Committee on Immunization practices (ACIP) recommendations for administration.

Tetanus toxoids are billed with procedure code 90703, 90714, 90715, or 90718, and tetanus immune globulin is billed with procedure code J1670.

2.3.4 Prior Authorization

Refer to: Form HS.5, "Radiology Prior Authorization Request Form" in this handbook.

2.3.4.1 Nonemergency Ambulance Transport Prior Authorization

Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services. 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.

TMHP responds to nonemergency transport prior authorization requests within two business days of receipt of the request. It is recommended that all requests for a prior authorization number (PAN) be submitted in sufficient time to allow TMHP to issue the PAN before the date of the requested transport. If the client's medical condition is not appropriate for transport by ambulance, nonemergency ambulance services are not a benefit. Prior authorization is a condition for reimbursement but is not a guarantee of payment. The client and provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

These prior authorization requirements also apply to Medicaid providers who participate in PCCM. Medicaid providers who participate in one of the Medicaid Managed Care Health Maintenance Organization (HMO) plans must follow the requirements of their plan.

The TMHP Ambulance Unit reviews the prior authorization request to determine whether the client's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be denied.

The following information assists TMHP in determining the appropriateness of the transport:

- An explanation of the client's physical condition that establishes the medical necessity for transport. The explanation must clearly state the client's condition(s) requiring transport by ambulance.
- The necessary equipment, treatment, or personnel used during the transport.
- The origination and destination points of the client's transport.

Prior authorization is required when an extra attendant is needed for any emergency transport. When a client's condition changes, such as a need for oxygen or an extra attendant for transport, the prior authorization request must be updated.

2.3.4.1.1 Prior Authorization Types, Definitions

One-Time, Nonrepeating
One-time, nonrepeating requests (1 day) for prior authorization must be submitted on the Nonemergency Ambulance Prior Authorization Request form. The physician's signature is not needed for one-time, nonrepeating requests.

Short Term
Short-term requests (2 to 60 days) for prior authorization are reserved for those clients whose transportation needs are short-term and are not anticipated to last longer than 60 days. Short-term requests must be submitted on the Nonemergency Ambulance Prior Authorization Request form. The request must include the physician's original signature and date signed. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form is considered incomplete.

Long Term

Long-term requests (61 to 180 days) are reserved for those clients whose transportation needs extend beyond 60 days. Long-term requests must be submitted on the Nonemergency Ambulance Prior Authorization Request form. The request must include the physician's original signature and date signed. Stamped or computerized signatures and dates are not accepted. Without a physician's signature and date, the form is considered incomplete.

Note: *Short-term and long-term prior authorization requests must be submitted on the Nonemergency Ambulance Prior Authorization Request form and must be signed. The request must include the physician's original signature and date signed. Stamped or computerized signatures and dates are not accepted. Without a physician's signature and date, the form is considered incomplete.*

2.3.4.2 Nonemergency Prior Authorization Process

Prior authorization is required for all nonemergency ambulance transport. The special evening and weekend hours for submitting prior authorization requests by telephone ended on September 1, 2009. Providers may submit prior authorization on the TMHP website at www. tmhp.com or may fax the new Nonemergency Ambulance Prior Authorization Request form to the TMHP Ambulance Unit at 1-512-514-4205. This form was created to replace the "Physician's Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program)" and the "Ambulance Fax Cover Sheet" which were end-dated as of November 1, 2009.

Medicaid providers may request prior authorization using one of the following methods:

- The client's physician, nursing facility, Intermediate Care Facility for Person's with Mental Retardation (ICF-MR), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at www.tmhp.com.
- Hospitals may call TMHP at 1-800-540-0694 to request prior authorization Monday through Friday, 7 a.m. to 7 p.m., Central Time. A request may be submitted up to 60 days before the date on which the nonemergency transport will occur. A request for a one-day transport may be submitted on the next business day following the transport in some circumstances; however, every attempt should be made to obtain prior authorization before the transport takes place.

Authorization requests for one day transports submitted beyond the next business day period will be denied. A request for a recurring transport must be submitted before the client is transported by ambulance.

Clients requiring hospital-to-hospital and hospital-to-outpatient medical facility transports are issued a PAN for that transport only.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted on the TMHP website at www.tmhp.com is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting provider. The client is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or that the client is not eligible for the dates of services requested. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406.

The requesting provider contacts the transporting ambulance provider and supplies the ambulance provider with the PAN and the dates of service that were approved.

Refer to: Subsection 5.3.1, "Prior Authorization Requests Through the TMHP Website" in Section 5, "Prior Authorization" (*Vol. 1, General Information*), for additional information, including mandatory documentation requirements and retention.

Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation.

Incomplete online or faxed request forms are not considered a valid authorization request and are returned as a denial.

A Nonemergency Ambulance Prior Authorization Request form that is completed and signed after the service is rendered is not considered documentation and should not be sent with a claim or appeal.

Emergency transports that use an extra attendant do not require prior authorization. Modifier ET must be billed with the extra attendant procedure code A0424.

2.3.4.3 Nonemergency Prior Authorization and Retroactive Eligibility

If a client's Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. This request will be initially denied for Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date that the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be reconsidered.

To inquire about Medicaid eligibility, providers can contact the Automated Inquiry System (AIS) at 1-800-925-9126.

Refer to: Form HS.3, "Nonemergency Ambulance Prior Authorization Request" in this handbook.

2.3.4.4 Prior Authorization for Organ/Transplant Services

All solid organ transplant services provided by facilities and professionals must be prior authorized. If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day preoperative and six-week postoperative period also will be denied, regardless of who provides the service, (e.g., 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 transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution's transplant protocol.

2.3.4.4.1 Program Limitations

If a transplant has been authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be a benefit, beginning with the actual first day of the transplant. This benefit is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay. Physician services that HHSC or its designee determines to be reasonable and medically necessary are also a benefit during the 30-day period. Day limitations do not apply for clients 20 years of age or younger.

Expenses for a single inpatient hospital admission for an authorized transplant are not included in the annual $200,000 inpatient expenditure cap. Dollar limitations do not apply for clients 20 years of age or younger.

All program coverage limits are applied.

The above guidelines also apply to one subsequent re-transplant, because of rejection, as a lifetime benefit. A subsequent transplant is not included in the prior authorization for the initial transplant; it must be prior authorized separately.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent re-transplant because of rejection. Expenses incurred by a living donor will not be reimbursed.

Transplants are also a benefit under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Texas 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. Texas 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 Texas Medicaid, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under Texas Medicaid. 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 Texas Medicaid. Services unrelated to the transplant surgery will be paid separately.

Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.

The DRG payment for the transplant includes procurement of the organ and services associated with the organ procurement. Texas 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.

Refer to: Subsection 2.2, "Reimbursement Methodology" in Section 2, Texas Medicaid Reimbursement (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 2.3.2.7, "Organ and Tissue Transplant Services" in this handbook.

Subsection 6.3.42, "Organ/Tissue Transplants" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.4.5 Prior Authorization for Fluocinolone Acetonide

Procedure code J7311 is only payable with a posterior uveitis diagnosis (36320) of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. To request prior authorization, providers must submit requests by fax or mail to the Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: Subsection 2.3.3.4, "Fluocinolone Acetonide" in this handbook.

2.3.4.6 Prior Authorization for Hospital Radiation Therapy Services

2.3.4.6.1 Sterotactic Radiosurgery

Prior authorization is required for sterotactic radiosurgery.

Refer to: Subsection 6.3.52.3, "Stereotactic Radiosurgery" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.3.4.6.2 Brachytherapy

Prior authorization is not required for brachytherapy.

2.3.4.6.3 Therapeutic Radiopharmaceuticals

Prior authorization is required for A9542, A9543, and A9545, which will be considered with documentation of all of the following:

- A diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy.
  - Marrow involvement is less than 26 percent.
  - Platelet count is 100,000 cell/mm3 or greater.
  - Neutrophil count is 1,500 cells/mm3 or greater.
  - Client has failed a trial of rituximab.

Prior authorization must be requested through the Special Medical Prior Authorization (SMPA) department with appropriate documentation. Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: Subsection 2.3.3.17, "Hospital Radiation Therapy Services " in this handbook.

2.3.4.7 Prior Authorization for Hospital Radiology Services

2.3.4.7.1 Computed Tomography and Magnetic Resonance Imaging

Prior authorization is required for all outpatient nonemergent CT, CTA, MRI, and MRA studies (i.e. those that are scheduled) before services are rendered. Authorization is not required for the emergency department or inpatient hospital radiology services. Intraoperative MRI does not require prior authorization.

Retrospective authorization is required for outpatient emergent studies when the physician determines a medical emergency that imminently threatens life or limb exists, and the medical emergency requires advanced diagnostic imaging (CT, CTA, MRI, or MRA). Providers must submit a retrospective authorization request no later than seven calendar days beginning the day after the study is completed. Retroactive authorization is not required when a previously prior authorized procedure is changed by the ordering physician or radiologist to a lesser procedure of the same imaging technology (e.g., an MRI with contract is prior authorized and the actual procedure performed is an MRI without contract).

The addition of post 3-D reconstruction (76376 and 76377) CT, CTA, MRI, and MRA studies must be prior authorized. No additional payment will be made without prior authorization. Obstetrical 3-D reconstruction ultrasound is not a benefit of Texas Medicaid.

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.

Prior authorization of nonemergent and retrospective authorization of urgent or emergent CT, CTA, MRI, and MRA studies will be considered on an individual basis adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained by the ordering physician and the radiologist in the client's record. Nationally accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for both emergent and nonemergent studies. These include: American College of Radiology (specifically, their Appropriateness Criteria), American Academy of Neurology, American Academy of Orthopedic Surgeons, American College of Cardiology, the American Heart Association, and the National Comprehensive Cancer Care Network.

Refer to: Subsection 2.3.3.16, "Radiology and Imaging Services" in this handbook.

Form HS.5, "Radiology Prior Authorization Request Form" in this handbook.

2.3.4.8 Prior Authorization for Implantable Infusion Pump

Providers must request prior authorization for the implantable infusion pump through the SMPA department with the supporting documentation for medical necessity. Send authorization requests to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: Subsection 2.3.3.10, "Implantable Infusion Pump" in this handbook.

Subsection 6.3.32.26.1, "Prior Authorization for Implantable Infusion Pumps" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2 Provider Handbooks*).

2.3.4.9 Prior Authorization for Neurostimulators

All procedures require prior authorizations.

Refer to: Subsection 2.3.3.12, "Neurostimulators" in this handbook.

Subsection 6.3.37.1, "Prior Authorization for Neurostimulator" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2 Provider Handbooks*).

2.3.4.10 Prior Authorization for Outpatient Total Parenteral Nutrition

TPN and lipids must be prior authorized.

Refer to: Subsection 2.3.3.14, "Total Parenteral Nutrition" in this handbook.

2.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including hospital services. Hospital services are subject to retrospective review and recoupment if documentation does not support the service billed.

2.5 Utilization Review

UR activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982 are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to UR monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of Texas Medicaid.

2.5.1 Inpatient Utilization Review

The HHSC Office of Inspector General (OIG) UR Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits or on a mail-in basis.

2.5.1.1 Utilization Review Process

The inpatient UR process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- *Admission review.* Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP) and 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 diagnoses (complications or comorbidities), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care. The medical record must reflect that any services reimbursed by Texas Medicaid were ordered by a physician, certified nurse-midwife, or nurse practitioner.

Effective for dates of admission on or after September 1, 2006, the HHSC OIG UR Unit uses evidence-based guidelines to assist in performing retrospective UR of inpatient hospital claims for Medicaid clients. The evidence-based guidelines are Milliman Care Guidelines, which replace the physician-developed and physician-approved Medicaid hospital screening criteria addressed through a rule revision effective August 1, 2006. Reviews required by the TMRP, TEFRA, and the current LoneSTAR Select II contracting program are included.

All services, supplies, or items billed are medically necessary for the client's diagnosis or treatment as certified on claim submission.

Refer to: Subsection 1.4.8, "Provider Certification/Assignment" in Section 1, *Provider Enrollment and Responsibilities* (*Vol. 1, General Information*).

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 days of stay that are denied. When a DRG is reassigned as a result of UR, the payment to the hospital is adjusted.

If an inpatient admission is denied, but a physician's order is present documenting the client originally was placed in observation, the UR unit may authorize the rebilling of services rendered during the first 23 hours on an outpatient claim.

Admission Review

Effective for admissions on or after September 1, 2006, review personnel assess the medical necessity of an admission by comparing documentation present in the medical record using recognized evidence-based guidelines for inpatient screening criteria. Non-physician reviewers use the criteria as guidelines for the initial approval or for the referral of inpatient reviews for medical necessity decisions. Cases that do not meet initial approval are referred to a physician consultant to determine the medical necessity of the inpatient admission. If the criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

Review personnel assess the medical necessity of admissions prior to September 1, 2006 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 to determine 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.

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) or Sanctions Unit.

Readmission Review
If a hospital admission or readmission occurs within 30 days of a discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity.

Transfers from one facility to another and readmissions are also subject to review.

Hospital-Based Ambulatory (HASC) Surgical Procedures
Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

Quality Review
Each Medicaid case is evaluated for quality of client care, adequacy of discharge planning, and medical stability of the client at discharge. To accomplish this review, CMS Generic Quality Screens and discharge screens included in the TMRP Hospitalization Screening Criteria are used. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG MPI or Sanctions Unit.

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 co-morbidities), 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 condition must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect client care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, or have clinically significant implications for future health-care needs.

The coding of diagnoses that have clinically significant implications for future health-care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or co-morbidities for DRG assignment.

Refer to: Subsection 1.7, "Texas Medicaid Limitations and Exclusions" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; or have been omitted, codes may be deleted, changed, or added. All diagnosis/procedure coding changes potentially resulting in a DRG change are

referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly, the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

2.5.1.2 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. Texas Medicaid, through its hospital UR activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims. To enhance compliance with Texas Medicaid fee-for-service hospital billing and decrease the submission of inappropriate inpatient hospital claims, adhere to the following suggestions:

- Physicians and hospital personnel, primarily case managers, UR, and billing staff, should become familiar with the Hospital Inpatient Screening Criteria used by the HHSC staff in performing reviews of hospital medical records related to paid, inpatient hospital claims for admissions prior to September 1, 2006. The criteria provide guidelines for review staff to assist with the determination of medical necessity of inpatient stays. The Medicaid Hospital Inpatient Screening Criteria are available on the HHSC website at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml.
- Initially admit clients in observation status if the physician feels that it is reasonable to expect that the client may be able to be discharged within 24 hours. If the client is initially admitted in observation status (per physician order), the stay is more than 24 hours, and the hospital submits an inpatient claim, the hospital is given the opportunity to rebill the first 24 hours of services on an outpatient claim if the inpatient claim is subsequently denied per retrospective UR.
- When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable when the physician makes the changes to the admitting order before the hospital submits the claim for payment.
- This correction in admission status avoids errors in billing and the potential need for a more lengthy appeal process. If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

2.5.1.3 Hospitals Reimbursed Under TEFRA

For all Medicaid admissions identified for review, the TEFRA review process consists of the following major components:

- *Admission review.* Determination of the medical necessity of the admission. For purposes of the TMRP and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- *Continued stay review.* Determination of the medical necessity of each day of stay.
- *Quality of care review.* Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

TEFRA hospitals are required to submit all charges.

HHSC OIG UR Unit staff review the complete medical record to make decisions about the medical necessity of the admission, continued stay, and quality of care.

2.5.1.4 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. 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 in the format approved by HHSC 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: Subsection 1.4.3, "Retention of Records and Access to Records and Premises" in Section 1, *Provider Enrollment and Responsibilities* (*Vol. 1, General Information*).

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. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Hospital inpatient claim payments that have been recouped because of a technical denial may not be re-billed on an outpatient claim.

Note: *A notarized business record affidavit in the format approved by HHSC 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: Subsection 1.4.3, "Retention of Records and Access to Records and Premises" in Section 1, "Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.5.1.5 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

> **Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client's principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.

The acknowledgment of penalty notice must be specific to Texas Medicaid. Medicare penalty notices are not accepted.

2.5.1.6 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 or Sanctions Unit.

2.5.1.7 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC OIG UR Unit to the HHSC UR Medical Appeals Unit. A UR Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC OIG UR Unit nor TMHP are responsible for Medical UR appeals.

Refer to: Subsection 7.3.4, "Utilization Review Appeals" in Section 7, "Appeals" (*Vol. 1, General Information*).

2.5.2 Outpatient Utilization Review

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate billing patterns by outpatient hospitals and HASCs. All providers are subject to TMHP's UR monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid compliance. An analysis of UR data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider's practice and billing patterns are inconsistent with the federal requirements and Texas Medicaid'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.
- Indicated by the documentation in the medical record.
- Billed to Texas Medicaid only after other medical insurance resources have been exhausted.

Refer to: Subsection 4.11.1, "Medicaid Identification (Form H3087)" in Section 4, *Client Eligibility* (*Vol. 1, General Information*).

"The determination of TMHP's UR process may result in the following:

- Educational letters/visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, 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

2.6 Claims Filing and Reimbursement

2.6.1 Medicaid Relationship to Medicare

Texas Medicaid 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, the Health and Human Services Commission (HHSC) is not required to pay the Medicare Part A deductible/coinsurance/copay on a crossover claim.*

Texas Medicaid 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, Texas 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 (PT) services
  - Speech pathology services
  - Dialysis treatments
- Submit to TMHP the remaining Part A charges on a UB-04 CMS-1450 claim form (or its electronic equivalent) indicating in Block 80 that the client is eligible for Medicare Part B benefits only. The client's health insurance claim (HIC) number must appear on the Medicaid claim in Block 80. TMHP must receive these charges within 95 days of the last date of service on the claim.

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

2.6.2 Inpatient Claims Information

Claims for inpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form. Providers may purchase UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

In Block 44 of the UB-04 CMS-1450, enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals should use TOB 110 to file these claims:

- Inpatient 30-day spell of illness benefit is exhausted.
- Payment made by a third-party resource/other insurance exceeds the Medicaid allowed amount.

Additional claims information can be found within individual topic areas in this section.

Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.6.3 Outpatient Claims Information

Claims for outpatient hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon/referring physician name/number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do *not* use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. 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 (e.g., gait training).

Example:

- *Emergency Room.* Bill as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. Claims for emergency CT, CTA, MRI, or MRA studies provided in the emergency department must have the appropriate corresponding emergency services revenue code (450, 451, 456, or 459) to be considered for payment.
- *Observation Room.* Bill as "observation room." (Revenue code 762).
- *Operating Room.* Bill as "Operating Room." (Revenue code 360, 361, or 369).
- *Recovery Room.* Bill as "Recovery Room" or "Cast Room" as appropriate. (Revenue code 710 or 719).
- *Injections.* Must have "Inj.-name of drug; route of administration; the dosage and quantity" or the injection code.
- *Drugs and Supplies.* The drug description must include the name, strength, and quantity. Take-home drugs and supplies are not a benefit of Texas Medicaid:
  - Take-home drugs must be billed with revenue code 253.
  - Take-home supplies must be billed with revenue code 273.

- Self-administered drugs must be billed with revenue code 637.

- *Radiology.* The description should provide the location and the number of views. As an alternative, enter the HCPCS code. The physician must bill professional services by a physician separately. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Laboratory.* Provide a complete description or use the procedure codes for the laboratory procedures. The physician must bill professional services by a physician separately. Blocks 78–79 must have the license number of the ordering physician. If laboratory work is sent out, enter the name of the test and name and address or Medicaid number of the laboratory where the work was forwarded. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.
- *Nuclear Medicine.* Provide a complete description.
- *Day Surgery.* Day surgery should be billed as an inclusive charge using TOS F. Do not bill separately services that were provided in conjunction with the surgery (e.g., lab, radiology, and anesthesia). File claims for unscheduled emergency outpatient surgical procedures with separate charges (e.g., lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's provider identifier.

Additional claims information can be found within individual topic areas within this section.

Charges on claims must be itemized on the face of the UB-04 CMS-1450 claim form instead of submitting attachments or charge details. TMHP uses information attached to the claim for clarification purposes only.

Note: *The UB-04 CMS-1450 claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.*

If a claim contains more than 28 details, continue the claim on additional UB-04 CMS-1450 claim forms. Total each claim form as a stand-alone claim. If you do not total each page, your claim may be denied for being over the limitation, and must be resubmitted with 28 or less details.

Providers may purchase UB-04 CMS-1400 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.6, "UB-04 CMS-1450 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.6.4 Inpatient Reimbursement

2.6.4.1 Prospective Payment Methodology

Inpatient hospital stays except in children's hospitals, state-owned teaching hospitals, and psychiatric facilities (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 Texas Medicaid's UR requirements.

The DRG reimbursement includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Texas Medicaid clients.

Texas Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all 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, Texas 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 UB-04 CMS-1450 claim form, to be considered for payment.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

In accordance with legislative direction included in the 2006–2007 *General Appropriations Act* (Article II, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), a rate reduction will be applied to inpatient hospital services rendered to non-Medicare Supplemental Security Income (SSI) and SSI-related Medicaid clients. The rate reduction will affect hospital providers within the Bexar, Dallas, El Paso, Lubbock, Tarrant, Nueces, Harris, and Travis service areas that are reimbursed by DRG.

Effective September 1, 2007, a hospital that is either located in a county with 50,000 or fewer persons, is a Medicare-designated rural referral center (RRC) or sole community hospital (SCH) that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or is a Medicare-designated critical access hospital (CAH), will be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by the *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA) using the most recent data.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital's payment division indicator times the relative weight associated with the DRG assigned by Grouper.

Refer to: Subsection 2.6.4.5, "Children's Hospitals " in this handbook.

Subsection 3.11, "Inpatient Psychiatric Hospital/Facility (Freestanding) (CCP)" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for enrollment and other program information.

2.6.4.2 Client Transfers

2.6.4.2.1 Admission Dates

The Texas Medicaid claims processing system automatically identifies whether a client's claim should be paid under Texas Medicaid fee-for-service, PCCM, or through the client's HMO based on the client's program eligibility at the time of admission. HMO claims are denied by TMHP and should be submitted by the provider to the appropriate HMO. To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

2.6.4.2.2 Continuous Stays

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas 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. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions billed inappropriately are identified and denied during the UR process and may result in intensified review.

When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of either the mean length of stay for the DRG or the eligible days in the facility. The DRG modifier, PT, on the R&S report indicated per diem pricing related to a client transfer. Services must be medically necessary and are subject to Texas Medicaid's UR requirements.

HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date that the client was admitted into each facility in Block 12 on the UB-04 CMS-1450. Inpatient authorization requirements are based on the requirements that are specified by the program in which the client is enrolled on the date of the original admission. Providers must adhere to the authorization requirements for claims to be considered for reimbursement. Providers are reimbursed at the rate in effect on the date of admission.

2.6.4.3 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).

2.6.4.4 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 20 years of age or younger as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

To ensure that day and cost outliers are reimbursed appropriately, if the client's length of stay and/or services rendered are different or more complex than the ones that were authorized, providers should contact the PCCM Inpatient Prior Authorization Department to update the authorization before the claim is submitted.

Providers can view their day and cost outlier payment information for inpatient hospital claims on the Electronic Remittance and Status (ER&S) Report. The R&S Report reflects the outlier reimbursement payment and defines the type of outlier paid. To view the day and cost outlier payment information, providers, facilities, and third-party vendors may need to update their 835 electronic file format. For information about how to update the 835 electronic file format, refer to the revised electronic data interchange (EDI) companion guide (ANSI ASC X12N 835 Healthcare Claim Payment/Advice-Acute Care Companion Guide) on the TMHP website at www.tmhp.com.

2.6.4.4.1 Day Outliers

The following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the DRG day threshold for the specific DRG.
- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

Hospitals should use the following formula to calculate the day outliers. To calculate the day outlier payment amount, the number of outlier days must first be determined:

Number of Days Allowed-DRGs Threshold = Outlier Days

SDA x DRG relative weight (Divided by) Mean length of stay x Outlier Days x 0.70 = Day outlier amount

2.6.4.4.2 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 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 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 x 0.70 = cost outlier amount.

2.6.4.5 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.*

2.6.4.6 State-owned Teaching Hospitals

Inpatient hospital stays in designated state-owned teaching hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated state-owned teaching 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.

State-owned teaching hospitals are defined specifically in 1 TAC §355.8052 as the following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital. A designated children's hospital is excluded from the Medicaid prospective payment system.

Note: *State-owned teaching 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.*

2.6.5 Outpatient Reimbursement

Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital's most recent tentative Medicaid cost report settlement.

Reimbursement for outpatient hospital services for high-volume providers is 84.48 percent of allowable cost. For the remaining providers, reimbursement for outpatient hospital services is 80.3 percent of allowable cost. High-volume providers are eligible for additional payments on Texas Medicaid fee-for-service and PCCM claims. A high-volume outpatient hospital provider is defined as one that was paid at least $200,000 during calendar year 2004.

All clinical laboratory services are reimbursed at 60 percent of the prevailing charge except for those hospitals identified by Medicare as sole community hospitals. These hospitals are reimbursed at 62 percent of the prevailing charges for services provided to clients in the outpatient setting and 60 percent to clients in the inpatient setting. Clinical pathology consultations continue to be allowed for reimbursement.

Refer to: Subsection 2.6.6, "Provider Cost and Reporting" in this handbook for more information about the calculation of the interim rate.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in *Radiology, Laboratory and Physiological Lab Services Handbook* (*Vol. 2, Provider Handbooks*) for important information.

2.6.6 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 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" in TMHP Telephone and Address Guide (*Vol. 1, General Information*). 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 Texas Medicaid.
- 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 Texas Medicaid 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. The provider must send TMHP a copy of one of the following:
  - Audited or settled without audit Medicare Cost Report
  - Medicare Notice of Amount of Program Reimbursement
  - Medicare Audit Adjustment Report, if applicable

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested through the provider's administrator account on the TMHP website at www.tmhp.com. Medicaid logs can also be requested by calling 1-512-506-6117 or by sending a written request to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

2.6.7 Revenue Codes (Outpatient Hospital)

UB-04 CMS-1450 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		
250	General classification	
251	Generic drugs	

Revenue Code	Description	Comments
252	Nongeneric drugs	
253	Take-home drugs	Not a benefit
254	Drugs incident to other diagnostic services	
255	Drugs incident to radiology	
256	Experimental drugs	Not a benefit
257	Nonprescription drugs	
258	IV solutions	
259	Other pharmacy	
630	Drugs requiring specific identification	HCPCS and NDC code required
631	Single source drug	HCPCS and NDC code required
632	Multiple source drug	HCPCS and NDC code required
633	Restrictive prescription	HCPCS and NDC code required
634	Erythropoietin (EPO) less than 10,000 units	HCPCS and NDC code required
635	Erythropoietin (EPO) 10,000 or more units	HCPCS and NDC code required
636	Drugs requiring detailed coding	HCPCS and NDC code required
637	Self-administrable drugs	Not a benefit
Intravenous (IV) Therapy		
260	General classification	
261	Infusion pump	
262	IV therapy/pharmacy services	
263	IV therapy/drug/supply delivery	
264	IV therapy/supplies	
269	Other IV therapy	
Medical/Surgical Supplies and Devices		
270	General classification	
271	Nonsterile supply	
272	Sterile supply	
273	Take-home supplies	Not a benefit
274	Prosthetic/orthotic devices	HCPCS code required
275	Pacemaker	
276	Intraocular lens	
277	Oxygen–take-home	
278	Other implants	HCPCS code required
279	Other supplies/devices	HCPCS code required
620	Medical/surgical supplies	HCPCS code required
621	Supplies incident to radiology	
622	Supplies incident to other diagnostic services	
623	Surgical dressings	
624	Food and Drug Administration (FDA) investigational devices	Not a benefit

Revenue Code	Description	Comments
Oncology		
280	General classification	
289	Other oncology	
Laboratory		
300	General classification	HCPCS code required
301	Chemistry	HCPCS code required
302	Immunology	HCPCS code required
303	Renal client (home)	HCPCS code required
304	Nonroutine dialysis	HCPCS code required
305	Hematology	HCPCS code required
306	Bacteriology and microbiology	HCPCS code required
307	Urology	HCPCS code required
309	Other laboratory	HCPCS code required
Laboratory–Pathological		
310	General classification	HCPCS code required
311	Cytology	HCPCS code required
312	Histology	HCPCS code required
314	Biopsy	HCPCS code required
319	Other pathology	HCPCS code required
Radiology–Diagnostic		
320	General classification	HCPCS code required
321	Angiocardiography	HCPCS code required
322	Arthrography	HCPCS code required
323	Arteriography	HCPCS code required
324	Chest X-ray	HCPCS code required
329	Other diagnostic radiology	HCPCS code required
Radiology–Therapeutic		
330	General classification	HCPCS code required
331	Chemotherapy–injected	HCPCS code required
332	Chemotherapy–oral	HCPCS code required
333	Chemotherapy–radiation therapy	HCPCS code required
335	Chemotherapy–IV	HCPCS code required
339	Other therapeutic radiology	HCPCS code required
Nuclear Medicine		
340	General classification	HCPCS code required
341	Diagnostic	HCPCS code required
342	Therapeutic	HCPCS code required
349	Other nuclear medicine	HCPCS code required

Revenue Code	Description	Comments
Computed Tomography (CT) Scan		
350	General classification	HCPCS code required
351	Head scan	HCPCS code required
352	Body scan	HCPCS code required
359	Other CT scans	HCPCS code required
Operating Room Services		
360	General classification	
361	Minor surgery	
369	Other operating room services	
Anesthesia		
370	General classification	
371	Anesthesia incident to radiology	
372	Anesthesia incident to other diagnostic services	
374	Acupuncture	Not a benefit
379	Other anesthesia	
Blood		
380	General classification	HCPCS code required
381	Packed red cells	HCPCS code required
382	Whole blood	HCPCS code required
383	Plasma	HCPCS code required
384	Platelets	HCPCS code required
385	Leucocytes	HCPCS code required
386	Other components	HCPCS code required
387	Other derivatives (cryoprecipitates)	HCPCS code required
389	Other blood	HCPCS code required
Blood Storage and Processing		
390	General classification	
391	Blood administration	Not a benefit
399	Other blood storage and processing	Not a benefit
Other Imaging Services		
400	General classification	HCPCS code required
401	Diagnostic mammography	HCPCS code required
402	Ultrasound	HCPCS code required
403	Screening mammography	HCPCS code required
404	Positron emission tomography	HCPCS code required
409	Other imaging services	HCPCS code required
Respiratory Services		
410	General classification	
412	Inhalation services	

Revenue Code	Description	Comments
413	Hyperbaric oxygen therapy	
419	Other respiratory services	HCPCS code required
Physical Therapy (PT)		
420	General classification	HCPCS code required
421	Visit charge	HCPCS code required
422	Hourly charge	HCPCS code required
423	Group rate	HCPCS code required
424*	Evaluation or re-evaluation	HCPCS code required
429	Other PT	HCPCS code required
Occupational Therapy (OT)		
430	General classification	HCPCS code required
431	Visit charge	HCPCS code required
432	Hourly charge	HCPCS code required
433	Group rate	HCPCS code required
434	Evaluation or re-evaluation	HCPCS code required
439	Other OT	HCPCS code required
Speech-Language Pathology		
440	General classification	HCPCS code required
441	Visit charge	HCPCS code required
442	Hourly charge	HCPCS code required
443	Group rate	HCPCS code required
444*	Evaluation or re-evaluation	HCPCS code required
449	Other speech-language pathology	HCPCS code required
Emergency Room		
450	General classification	
451	Emergency room - EMTALA screening	
456	Urgent care	
459	Other emergency room	
Pulmonary Function		
460	General classification	HCPCS code required
469	Other pulmonary function	HCPCS code required
Audiology		
470	General classification	HCPCS code required
471	Diagnostic	HCPCS code required
472	Treatment	HCPCS code required
479	Other Audiology	HCPCS code required
Cardiology		
480	General classification	HCPCS code required
481	Cardiac cath lab	HCPCS code required

Revenue Code	Description	Comments
482	Stress test	HCPCS code required
489	Other cardiology	HCPCS code required
Clinic		
510	General classification	
511	Chronic pain center	
512	Dental clinic	
513	Psychiatric clinic	
514	Obstetrics-Gynecology (OB/GYN) clinic	
515	Pediatric clinic	
516	Urgent Care clinic	
517	Family Practice clinic	
519	Other clinic	
Freestanding Clinic		
520	General classification	
523	Family practice clinic	
526	Urgent care clinic	
529	Other freestanding clinic	
Magnetic Resonance Technology (MRT)		
610	General classification	HCPCS code required
611	Magnetic resonance imaging (MRI) brain (including brainstem)	HCPCS code required
612	MRI spinal cord (including spine)	HCPCS code required
619	Other MRT	HCPCS code required
Cast Room		
700	General classification	
709	Other cast room	
Recovery Room		
710	General classification	
719	Other recovery room	
Labor Room/Delivery		
720	General classification	
721	Labor	
722	Delivery	
723	Circumcision	
724	Birthing center	
729	Other labor room/delivery	
Electrocardiogram (EKG/ECG)		
730	General classification	HCPCS code required
731	Holter monitor	HCPCS code required
732	Telemetry	HCPCS code required

Revenue Code	Description	Comments
739	Other EKG/ECG	HCPCS code required
Electroencephalogram (EEG)		
740	General classification	HCPCS code required
749	Other EEG	HCPCS code required
Gastrointestinal Services		
750	General classification	
759	Other gastrointestinal	
Treatment or Observation Room		
760	General classification	
761	Treatment room	
762	Observation room	
769	Other treatment/observation room	
Preventive Care Services		
770	General classification	HCPCS code required
771	Vaccine administration	HCPCS code required
779	Other preventive care services	HCPCS code required
Lithotripsy		
790	General classification	HCPCS code required
799	Other lithotripsy	HCPCS code required
Other Diagnostic Services		
920	General classification	HCPCS code required
921	Peripheral vascular lab	HCPCS code required
922	Electromyelogram	HCPCS code required
923	Pap smear	HCPCS code required
924	Allergy test	HCPCS code required
925	Pregnancy test	HCPCS code required
929	Other diagnostic service	HCPCS code required

2.6.8 Third-Party Liability Reporting

Hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third-party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers should mail or fax the Tort Response Form for accidents and Other Insurance Form for Health Insurance to the following address:

Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third-Party Resources Unit PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-490-4666

Refer to: Subsection 4.11, "Third Party Resources (TPR)" in Section 4, Client Eligibility (*Vol. 1, General Information*) for more information.

Form B.31, "Tort Response Form" in Appendix B, Forms (*Vol. 1, General Information*).

Form B.12, "Other Insurance Form" in Appendix B, Forms (*Vol. 1, General Information*).

3. MILITARY HOSPITALS

3.1 Military Hospital Enrollment

To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veterans Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Military hospital providers must comply with the rules and regulations of the CLIA rules and regulations. Providers who do not comply with CLIA will not be reimbursed for laboratory services.

3.2 Services/Benefits, Limitations and Prior Authorization

3.2.1 Military Hospital 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:

- 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: Section 8, "Managed Care" (*Vol. 1, General Information*)

Hospitals may submit *information only* claims to TMHP when one of the following situations exists:

- The inpatient 30-day spell of illness benefit is exhausted.
- Payment that was made by a third-party resource/other insurance exceeds the Medicaid allowed amount.

For clients 21 years of age and older who are not enrolled in Medicaid Managed Care, there is an inpatient expenditure cap of $200,000 per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 will be recouped.

It is appropriate to submit *information only* claims using TOB 110.

The following hospital services must be medically necessary and are subject to the utilization review requirements of Texas Medicaid. Medicaid reimbursement for services cannot exceed the limitations of Texas Medicaid.

Inpatient hospital services include the following items and services:

- Bed and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services; or an allowance for bed and board in private accommodations, including meals, special diets, and general nursing services up to the hospital's charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons, as certified by the physician. Additionally, the hospital must document the medical necessity for a private room, such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information is included in Block 80 or attached to the claim.
- Whole blood and packed red cells that are reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary services or supplies ordered by a physician.

Medicaid benefits are not available for take-home or self-administered drugs or personal comfort items except when received by prescription through the VDP.

Only inpatient claims that have an emergency diagnosis on the claim are considered for reimbursement.

3.2.2 Military Hospital 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.

3.2.3 Prior Authorization

Prior authorization is not required for services rendered in military hospitals.

3.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including military hospital services. Military hospital services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Military Hospital Claims Information

If TOB 110 is used to submit a claim, all charges must be noncovered and the claim will finalize with EOB 217, "Payment reduced through hospital action."

It is appropriate to submit *information only* claims using TOB 110.

Military hospitals may submit total charges in one line with appropriate accommodation revenue codes. Emergency hospital services must be submitted to TMHP in an approved electronic format or on the UB-04 CMS-1450 claim form. Providers may purchase claim forms from the vendor of their choice. TMHP does not supply the forms.

Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

When completing a UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claims supplements.

Refer to: Subsection 6.6, "UB-04 CMS-1450 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Form HS.11, "Military Hospital (Emergency Inpatient)" in Section 7, Claim Form Examples, in this handbook.

3.4.2 Military Hospital 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 DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Texas Medicaid 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 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 20 years of age or younger and covered by the CCP, or to services for certain clients enrolled in Medicaid Managed Care.

Military hospitals should keep a Medicaid client as an inpatient for only the length of time necessary to stabilize the 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.

Client transfers within the same facility or readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are considered one continuous stay. These readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be billed as one submission under the provider identifier. Admissions that were billed inappropriately are identified and denied during the utilization review process and may result in an 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: Subsection 2.2, "Reimbursement Methodology" in Section 2, Texas Medicaid Reimbursement (*Vol. 1, General Information*) for more information about reimbursement.

4. CLAIMS RESOURCES

Refer to the following sections and/or forms when filing claims:

Resource	Location
Acronym Dictionary	Appendix F (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Address Guide (*Vol. 1, General Information*)
CMS-1500 Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Hospital Inpatient Claim Form Example	Form HS.8, Section 7 of this handbook
Hospital Outpatient Claim Form Example	Form OP.6, *Outpatient Services Handbook* (*Vol. 2, Provider Handbooks*)
Hospital Report (Newborn Child or Children) (Form 7484)	Form HS.2, Section 6 of this handbook
Hospital-Based ASC Claim Form Example	Form HS.7, Section 7 of this handbook
Military Hospital (Emergency Inpatient) Claim Form Example	Form HS.9, Section 7 of this handbook
Sterilization Consent Form (English)	Form HS.4, Section 6 of this handbook
Sterilization Consent Form (Spanish)	Form HS.5, Section 6 of this handbook
Sterilization Consent Form Instructions (2 Pages)	Form HS.3, Section 6 of this handbook
State and Federal Offices Communication Guide	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
UB-04 CMS-1450 Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

5. CONTACT TMHP

Note: *The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.*

6. FORMS

HS.1 Hospital 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 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. T|X|B|	TPI
Completed By (please type or print)	
Hospital Telephone No. ( )	Date Form Mailed

HS.2 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

HS.3 Nonemergency Ambulance Prior Authorization Request

TMHP

Nonemergency Ambulance Prior Authorization Request
Texas Medicaid Program

1.) **Is an ambulance the only appropriate means of transport?** ☐ Yes ☐ No
2.) **If no**, this client does not qualify for nonemergency ambulance transport.
3.) **If yes**, please complete the remainder of the form.

In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the client's medical condition is such that the use of an ambulance is the only appropriate means of transport, and other alternate means of transport are medically contraindicated. Alternate means of transport include services provided through Medicaid's Medical Transportation Program or services included in the rate for Long Term Care - Nursing Facilities.

This form is to be completed by the provider requesting nonemergency ambulance transportation. [Reference: Chapter 32.024(t) Texas Human Resources Code]

Date Request Submitted: _____

Submit by Fax : 1-512-514-4205

Requesting Provider

Name: _____

Provider TPI: _____ **NPI:** _____ **Taxonomy:** _____

Contact Name: _____ **Phone:** _____ **Fax:** _____

Ambulance Provider Name: _____

Ambulance Provider Identifier: _____

Client Information

Last Name: _____ First Name: _____ MI: ____

DOB: __ __/__ __/__ __ __ __ Client Medicaid Number: _____

Client's Current Condition Affecting Transport

Diagnoses affecting transport: _____

(**Check** each applicable condition)

☐ Client requires monitoring by trained staff because
- ☐ Oxygen ☐ Airway ☐ Suction
- ☐ Cardiac ☐ Comatose ☐ Life support

☐ Ventilator dependent
☐ Poses immediate danger to self or others
☐ Continuous IV therapy or parenteral feedings **
☐ Physical restraint or chemical sedation **
☐ Decreased level of consciousness **
☐ Isolation precautions (VRE, MRSA, etc.) **
☐ Wound precautions **
☐ Advanced decubitus ulcers **
☐ Contractures limiting mobility **
☐ Must remain immobile (i.e., fracture, etc.) **
☐ Decreased sitting tolerance time or balance **
☐ Active Seizures **

** Provide additional detail (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition), or provide detail of the client's other conditions requiring transport by ambulance.

_____

_____

☐ **Extra Attendant** Reason: _____

Reason for Transport Hospital discharge? ☐ Yes ☐ No **If yes,** expected transport time: _____

Other purpose: _____

Origin: _____ Destination: _____

Method of Transport: ☐ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized Vehicle

Request Type:

☐ One Time, Non-repeating Medicaid or Medicare
☐ Short Term (2 - 60 days) Medicaid or Medicare *
☐ Long Term (61 - 180 days) Medicaid Only *
* Physician signature required for Short Term and Long Term

Begin Date: __ __/__ __/__ __ __ __
End Date: __ __/__ __/__ __ __ __

Certification: I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

*** Name:** _____ **Title:** _____ **Provider Identifier:** _____

*** Signature:** _____ **Date Signed:** __ __/__ __/__ __ __ __

Effective Date 11012009/Revised Date 11022009

HS.4 Provider Instructions for Nonemergency Ambulance Prior Authorization Request Form

Provider Instructions for Nonemergency Ambulance Prior Authorization Request Form

All nonemergency ambulance transportation must be medically necessary. Texas Medicaid and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate both programs' requirements. The criteria for determining medical necessity include: the client is bed-confined and other methods of transportation are contraindicated, or the client's condition is such that transportation by ambulance is medically required. For additional information and changes to this policy and process refer to the respective program information: Texas Medicaid's Provider Procedures Manual, bulletins and Banner Messages; and to Medicare's manuals, newsletters and other publications.

1. **Request Date**—Enter the date the form is submitted.
2. **Requesting Provider Information**—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
3. **Requesting Provider Identifiers**—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. **Ambulance Provider Identifier**— Enter the TPI or NPI number of the requested ambulance provider. If the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-925-9126, Option 3) or fax (1-512-514-4205).
5. **Client's Current Condition**—This section must be filled out to indicate the client's *current condition* and not to list all historical diagnoses. Do not submit a list of the client's diagnoses unless the diagnoses are relevant to transport (i.e., if client has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to TMHP when reviewing the request form, exactly why the client requires transport by ambulance and cannot be safely transported by any other means.
6. **Isolation Precautions**—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.
7. **Details for Checked Boxes**—For each checked answer, a detailed explanation is required (i.e., if contractures is checked, please give the location and degree of contracture[s]). If a client has a decreased tolerance for sitting time, please indicate why the client has a decreased tolerance as well as the maximum length of time the client is able to sit upright. Additional documentation can be submitted with this request form if needed.
8. **Request Type**—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Short Term request is for a period of 2-60 days when repeated transports are expected to occur; both Medicaid and Medicare permit short-term requests. A Long Term request is for a period of 61-180 days when repeated transports are expected to occur; Medicare does not permit a Long Term request. Medicaid requires a physician signature for Short Term and Long Term requests. Enter the begin and end dates of the authorization period for short and long-term requests.
9. **Transport Time**—This field must be filled out for all hospital discharge requests. The anticipated time of transport must be entered in order to ensure the request was initiated prior to the actual time of transport.
10. **Name of Person Signing the Request**—All request forms require a signature, date, and title of the person signing the form. A One Time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition. A request of a Short Term or Long Term authorization period must be signed and dated by the physician. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
11. **Signing Provider Identifier**—This field is for the TPI or NPI number of the requesting facility or provider signing the form. The signature must be dated no earlier than 60 days prior to the transport.

HS.5 Radiology Prior Authorization Request Form

Radiology Prior Authorization Request Form

This form is used to obtain prior authorization for elective outpatient services or update an existing outpatient authorization. All fields marked with an asterisk (*) are required. The information in Section 2 is only required for updated or retroactive authorizations. Forms that are submitted without all of the required information will be returned for correction.

Telephone number: 1-800-572-2116			Fax number: 1-800-572-2119			*Date of Request: / /
Please check the appropriate action requested:						
☐ CT Scan	☐ CTA Scan	☐ MRI Scan	☐ MRA Scan	☐ PET Scan	☐ Cardiac Nuclear Scan	☐ Update/change codes from original PA request

Client Information

*Name:	*Medicaid number:	*Date of Birth: / /

Facility Information

*Name:	Reference number:
*Address:	
TPI:	*NPI:
Taxonomy:	Benefit Code:

Requesting/Referring Physician Information

*Name:	License number:
*Address:	
*Telephone:	*Fax number:
TPI:	*NPI:
Taxonomy:	Benefit Code:

Section 1

Service Types	*Outpatient Service(s) ☐	Emergent/Urgent Procedure ☐
Date of Service: / /		*Procedures Requested:
Diagnosis Codes	*Primary:	Secondary:

*Clinical documentation supporting medical necessity for a radiology procedure includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (Signature Required):

*Print Name:	*Date: / /

Section 2—Updated Information (when necessary)

*Date of Service: / /		*Procedures Requested:
Diagnosis Codes	*Primary:	Secondary:

*Clinical documentation supporting medical necessity for a procedure code change includes treatment history, treatment plan, medications, and previous imaging results:

*Requesting/Referring Physician (signature required):

*Print Name:	*Date: / /
Physician must complete and sign this form prior to requesting authorization.	Requesting/Referring Physician License No.:
*Requesting/Referring Physician NPI:	Requesting/Referring Physician TPI:

Effective Date_02012010/Revised Date_10012009

HS.6 Sterilization Consent Form Instructions (2 Pages)

Sterilization Consent Form Instructions

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.

Clients must be *at least 21 years of age* when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery -There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of *all* sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Date of Birth (month, day, year).
- Client's Name (first and last names are required).
- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client's Signature.
- Date of Client Signature - *Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.*

Effective Date_07302007/Revised Date_03102010

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).
- The following provider identifcation numbers will be required to expedite the processing of the consent form:
  - TPI
  - NPI
  - Taxonomy
  - Benefit Code
- Provider/Clinic Phone Number.
- Provider/Clinic Fax Number (If available).
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.

Effective Date_07302007/Revised Date_03102010

HS.7 Sterilization Consent Form (English)

Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

Notice: *Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.*

Consent to Sterilization

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible. **I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.** I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____ (month), ____(day), ____ (year). I, _____, hereby consent of my own free will to be sterilized by _____(doctor or clinic) by a method called _____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

Client's Signature:	Date of Signature: / / (month/day/year)

Notice: *You are requested to supply the following information, but it is not required.*

Race and Ethnicity Designation

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race (mark one or more) ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

Interpreter Signature:	Date of Signature: / / (month/day/year)

Statement of Person Obtaining Consent

Before _____ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation known as a _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent:	Date of Signature: / / (month/day/year)

Facility name:	Facility address:

Physician's Statement

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on_____/_____/_____ at (date of sterilization), I explained to him/her the nature of the sterilization operation _____(specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.) (1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed. (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery - Individual's expected date of delivery:_____/_____/_____ (month, day, year)

☐ Emergency abdominal surgery (describe circumstances): _____

Physician's Signature:	Date of Signature: / / (month/day/year)

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:

Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX

Effective Date_01152008/Revised Date_03112010

HS.8 Sterilization Consent Form (Spanish)

Sterilization Consent Form (Spanish)

(Fax Consent Form to 1-512-514-4229)

Client Medicaid or family planning number:	Date Client Signed / / (month/day/year)

Nota: *La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causará el retiro o la retención de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.*

Consentimiento para Esterilización

Yo he solicitado y he recibido información de _____(médico o clínica) sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible. **Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedar embarazada, no quiero tener hijos o no quiero procrear hijos.** Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o. Entiendo que seré esterilizada/o por medio de una operación conocida como _____. Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el ____ (mes), ____(día), ____ (año). Yo, _____, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por _____ (médico o clínica) por el método llamado _____.

Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales. He recibido una copia de esta Forma.

Firma:	Fecha: / / (mes, día , año)

Nota: *Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo:*

Definición de Raza y Origen Étnico

Origen étnico ☐ No hispano o latino ☐ Hispano o latino

Raza (marque según aplique) ☐ Natural de Hawaii u otras islas del Pacífico ☐ Indígena americano o indígena de Alaska ☐ Negro o afroamericano ☐ Blanco ☐ Asiático

Declaración Del Intérprete

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de Consentimiento en idioma _____ y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

Firma:	Fecha: / / (mes, día , año)

Declaración De La Persona Que Obtiene Consentimiento

Antes de que _____(nombre de persona) firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación _____, para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias..

Firma de la persona que obtiene el consentimiento:	Fecha: /: /: (mes, día , año)
Lugar:	Dirección:

Declaración Del Médico

Previamente a realizar la operación para la esterilización a _____ (nombre de persona esterilizada/o), en _____/_____/_____ (fecha de esterilización: día, mes, año), le expliqué a él/ella los detalles de esta operación para la esterilización _____(especifique tipo de operación), del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación. Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento. (Instrucciones para uso alternativo de párrafos finales: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique). (1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización. (2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

☐ Parto prematuro - Fecha prevista de parto _____/_____/_____(mes, día , año)

☐ Cirugía abdominal de urgencia (Describa las circunstancias): _____

Firma del médico:	Fecha: / / (mes, día , año)

Declaración Sobre Ley De Reducción De Trámites

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

All Fields in This Box Required for Processing

TPI:	NPI:	Taxonomy:
Benefit Code:	Provider/clinic telephone:	Provider/Clinic fax number:

Titled Billed (check one): ☐ V ☐ X ☐ XIX ☐ (Medicaid) ☐ XX

Effective Date_01152008/Revised Date_031120107

7. CLAIM FORM EXAMPLES

HS.9 Hospital-Based ASC

Field	Value
1	Greatland Hospital Center 4004 Elm Loop Westville, TX 512-555-1234
2	
3a PAT. CNTL #	123456B
b. MED. REC. #	E123456
4 TYPE OF BILL	0131
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	
7	
8 PATIENT NAME a	Doe, John
8 b	
9 PATIENT ADDRESS a	6789 Courtland Circle Westville TX 79065
9 b / c / d / e	
10 BIRTHDATE	12161964
11 SEX	M
ADMISSION 12 DATE	01012009
13 HR	11
14 TYPE	
15 SRC	
16 DHR	
17 STAT	
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT (a–d)	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
360	Typano W/ masto and chain reconstruct	F-69641	01012009	1	871 87		
		Total Charges			871 87		
	PAGE ____ OF ____		**CREATION DATE**	**TOTALS**			

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A Medicaid						1324658709
B						57 OTHER PRV ID 9876543-21
C						

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, John		123456789		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 1234567890		
B		
C		

Field	Value
66 DX	38903
67 A–Q	
68	38900
69 ADMIT DX	38421
70 PATIENT REASON DX a / b / c	
71 PPS CODE	
72 ECI a / b / c	
73	
74 PRINCIPAL PROCEDURE CODE / DATE	
a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI / QUAL / LAST / FIRST	
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	Hearing Loss, Left Ear
81CC a / b / c / d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

HS.10 Hospital Inpatient

1	2	3a PAT. CNTL. #	12345	4 TYPE OF BILL
Texas Hospital 209 W. 45th El Paso, Texas 77905 915-555-1234		b. MED. REC. #	123456	0111
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 01012009 THROUGH 01042009	7

8 PATIENT NAME	9 PATIENT ADDRESS
b Doe, Jane	b 1200 Whispering Pines El Paso TX 77903

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
03271975	F	01012009	14	2	1	10	01			

	31 OCCURRENCE CODE	31 DATE	32 CODE	32 DATE	33 CODE	33 DATE	34 CODE	34 DATE	35 CODE	35 SPAN FROM	35 SPAN THROUGH	36 CODE	36 SPAN FROM	36 SPAN THROUGH	37
a	10	04012005	24	02012005											a
b															b

38		39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	112	Room and Board - O.B.	Room 106.67	01012009		320.01		1
2			Rate					2
3	250	Pharmacy		01012009		165.00		3
4								4
5	258	Pharmacy - IV Solution		01012009		89.00		5
6								6
7	270	Medical Surgical Supplies		01012009		712.43		7
8								8
9	300	Laboratory		01012009		234.00		9
10								10
11	720	Labor Room/Delivery		01012009		1100.00		11
12								12
13			Total Charges			2620.44		13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	1324658709
A	Alm Insurance						57	
B	Medicaid						OTHER PRV ID	9876543-21
C								

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, John		123456789	Alm Insurance	1998 AB
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			ABC Roofing
B			IH-25 S 7100, El Paso, TX
C			

66 DX	67	A	B	C	D	E	F	G	H	68
650		I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
650										

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
73.59	010199					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC
Pregnancy/Delivery.	a
Alm Insurance, 11 Maple Dr.,	b
Boston, MA 11211 denied 02 01 2004	c
for pre-existing condition.	d

76 ATTENDING	NPI	QUAL
LAST		FIRST
77 OPERATING	NPI	QUAL
LAST		FIRST
78 OTHER	NPI	QUAL
LAST		FIRST
79 OTHER	NPI	QUAL
LAST		FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

HS.11 Military Hospital (Emergency Inpatient)

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
Clayham AFB 123 Military Drive Pampa, TX 79065 512-555-1234		12345M2 b. MED. REC. # AC1234C1	111
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 01012009 THROUGH 01032009

8 PATIENT NAME	9 PATIENT ADDRESS
a Doe, John	a 6789 Courtland Circle Pampa, TX 79065
b	b c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
07101972	M	01012009	04	1	7	08	05													

31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a 05	01012009													a
b														b

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a	04:00				
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	Room	$5000 per day	01012009	2	10000.00		1
2								2
3	001	Total Charges				10000.00		3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____	CREATION DATE		TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A Medicaid						1342658079	A
B						57 OTHER PRV ID 9876543-21	B
C							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, John		123456789		A
B				B
C				C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 1234567890		A
B		B
C		C

66 DX	A	B	C	D	E	F	G	H	68
9940									
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
99400										

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
Struck by lightning,	a		
pt. badly burned and in shock	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
12357 - B RIATA TRACE PARKWAY STE 150
AUSTIN, TX 78727
A STATE MEDICAID CONTRACTOR