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TEXAS MEDICAID

PROVIDER PROCEDURES MANUAL

Volume 2

PROVIDER HANDBOOKS

NURSING AND THERAPY 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.

NURSING AND THERAPY SERVICES HANDBOOK

TEXAS
Health and Human
Services Commission

NURSING AND THERAPY SERVICES HANDBOOK

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NURSING AND THERAPY SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for Nursing and Therapy Services. Nursing services include home health skilled nursing visits and home health aide services. Therapy services include occupational therapy (OT), physical therapy (PT), speech therapy (ST), and certified respiratory care practitioners (CRCP) services. The Handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

This section does not apply to Comprehensive Outpatient Rehabilitation Facilities or Outpatient Rehabilitation Facilities.

Refer to: Subsection 5.2.3, "Comprehensive Outpatient Rehabilitation Facilities (CORFs)/Outpatient Rehabilitation Facilities (ORFs)" in the Children's Services Handbook (Vol. 2, Provider Handbooks) for more 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.*

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

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

Subsection 3.10, "Therapy Services-CCP" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about providing OT, PT, and ST services to Medicaid clients.

2. CERTIFIED RESPIRATORY CARE PRACTITIONER (CRCP) SERVICES

2.1 Enrollment

To enroll in Texas Medicaid, a CRCP must be certified by the Department of State Health Services (DSHS) to practice under Texas Occupation Code, Chapter 604. For CRCPs, Medicare certification is not a prerequisite for Medicaid enrollment. A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted. CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.

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2.2 Services, Benefits, Limitations, and Prior Authorization

Respiratory therapy services provided by a Texas Medicaid provider enrolled as a CRCP may be reimbursed when services are reasonable, medically necessary, and prescribed by the client's physician. These services are for all age groups and do not require the client to be homebound.

Medicaid coverage of CRCP services is available to clients who meet the following criteria:

- Are ventilator-dependent for life support at least six hours per day
- Are ventilator-dependent for at least 30 consecutive days as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF)
- Require respiratory care as an inpatient in a hospital, SNF, or ICF and would be eligible to have payment made for such inpatient care
- Have adequate social support services available for care at home
- Prefer care at home

2.2.1 Prior Authorization

TMHP must prior authorize all in-home respiratory therapy services. CRCPs must request and receive prior authorization from TMHP for in-home respiratory therapy services. Prior authorization may be given for up to 12 months subject to renewal every year upon a supplemental report from the physician documenting the medical necessity for continued in-home respiratory therapy services.

2.3 Documentation Requirements

Prior authorization requests must include the physician's dated order, all pertinent medical records, and other information to justify the medical necessity/dependency of ventilator support and/or requested therapy services.

All supporting documentation must be included with the request for prior authorization. Providers should send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-A Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

CRCP services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

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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 6.5, "CMS-1500 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.

Electronic billers must submit the prior authorization number (PAN) on the electronic claim form. Providers should consult the software vendor for the location of this field in the software.

2.4.2 Procedure Code

Procedure code 99503 is allowable for CRCP services.

The recommended frequency for procedure code 99503 is as follows: one visit daily for the initial seven days of home ventilation therapy; one visit every fourth day through the initial 30 days of home ventilation therapy; and one visit every four weeks thereafter.

Procedure code 99503 includes, but is not limited to, the following:

- Respiratory therapy services and treatments prescribed by the client's physician
- Education of the client and/or appropriate family members/support people about the in-home respiratory care (must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation)

2.4.3 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider's billed charges or the rate calculated in accordance with 1 TAC §355.8089. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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

Procedure code 99503 may be reimbursed in the client's home, once per day, up to 24 visits per year. Disposable respiratory supplies and respiratory equipment rental or purchase are a benefit through Texas Medicaid Title XIX Home Health Services and are not reimbursed to the certified respiratory therapist.

3. HOME HEALTH SERVICES FOR NURSING AND THERAPY

3.1 Enrollment

To enroll in the Home Health Services Program, home health services and Home and Community Support Services (HCSSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and certified home health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier. PCS for clients 20 years of age or younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 3.8, "Personal Care Services (PCS) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

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To provide Comprehensive Care Program (CCP) services, HCSSA providers must follow the enrollment procedures in subsection 6.2, "Enrollment" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Providers may obtain the application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

For prior authorization requests on the Home Health Services contact:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

3.1.1 Change of Address/Telephone Number

A current physical and mailing address and telephone number must be on file for the agency/company to receive Remittance & Status (R&S) reports, reimbursement checks, Medicaid provider procedures manuals, the *Texas Medicaid Bulletin* (bimonthly update to the *Texas Medicaid Provider Procedures Manual*), and all other TMHP correspondence. Promptly send all address and telephone number changes to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

3.1.2 Pending Agency Certification

Home health agencies submitting claims before the enrollment process is complete or without prior authorization for services issued by TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Texas Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Texas Medicaid enrollment, the agency must contact the TMHP Home Health Services Prior Authorization Department before serving a Texas Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Texas Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

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

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3.2 Services, Benefits, Limitations, and Prior Authorization

3.2.1 Home Health Services

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). This extended prior authorization period begins on the date that clients receive their first prior authorized home health service. Texas Medicaid allows additional visits that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

3.2.1.1 Client Evaluation

When a home health agency receives a referral to provide home health services for a client who is eligible for Texas Medicaid, the agency-employed registered nurse (RN) should evaluate the client in the home before calling TMHP for prior authorization. A home evaluation by the agency-employed RN is required for skilled nursing (SN), home health aide (HHA), OT and PT services, durable medical equipment (DME), or supplies requested on a Home Health Services POC. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician to ensure the client's medical record is current.

This evaluation should include assessment of the following:

- Medical necessity for home health services, supplies, or DME
- Safety
- Appropriateness of care in the home setting
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition

Following the RN's assessment/evaluation of the client in the home setting for home health services needs, the agency-employed RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the start of care (SOC).

3.2.2 Benefits

Home health services include SN, HHA, OT and PT services, DME, and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 3.10, "Therapy Services-CCP" and subsection 3.9, "Private Duty Nursing (CCP)" in *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information on nursing and therapy benefits for clients who are 20 years of age or younger.

A SN and/or HHA visit may be provided up to a maximum of 2.5 hours per visit. A combined total of three SN and/or HHA visits may be reimbursed per day. When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support the services were delivered at distinct, separate time periods. Total home health services billed for all clients cannot exceed the individual provider's total number of hours spent at the place of service (POS).

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As needed (PRN), one SN visit may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been authorized for the particular client. For reimbursement purposes, home health SN and/or HHA services are always billed as POS 2 (home) regardless of the setting in which the services are actually provided. SN and/or HHA services provided in the day care or school setting will not be reimbursed unless delivered before or after school hours.

All unique procedure codes must be billed according to the description of the procedure code. The quantity billed must be identified and each procedure code must be listed as separate line items on the claim. SN, HHA, OT, and PT must be billed in 15 minute increments.

Procedural modifiers are required when billing SN, HHA, OT, and PT visits.

Modifier	Visit Service Category
U2	SN or HHA second visit per day
U3	SN or HHA third visit per day
GO	OT
GP	PT

Prior authorization must be obtained for all professional services, some supplies, and most DME from TMHP within three business days of SOC. Although providers may supply some DME and medical supplies to a client without prior authorization, they must still retain a copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that has Section B completed, signed, and dated by the client's attending physician.

3.2.3 Home Health Aide (HHA) Services

HHA visits (procedure code G0156) are a benefit of Home Health Services when a client requires nursing, OT, or PT services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. HHA visits are intended to provide personal care services under the supervision of an RN, OT, or PT employed by the home health agency to promote independence and support the client living at home.

An acute condition is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered a SN visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered a SN visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

HHA visits are considered medically necessary for clients who require general supervision of nursing care provided by an HHA over whom the RN, OT, or PT is administratively or professionally responsible in addition to the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death

When documentation does not support medical necessity for HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

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3.2.3.1 HHA Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (RN, OT, or PT) employed by the home health agency.

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The duties of an HHA during a visit include, but are not limited to the following:

- Ambulation
- Assistance with medication that is ordinarily self-administered
- Assisting with nutrition and fluid intake
- Completing appropriate documentation
- Exercise
- Household services essential to the client's health care at home
- Obtaining and recording the client's vital signs (temperature, pulse, respirations, and blood pressure)
- Observation, reporting and documentation of the client's status, and the care or service furnished
- Personal care (hygiene and grooming), including, but not limited to the following:
  - Sponge, tub or shower bath
  - Shampoo, sink, tub or bed bath
  - Nail and skin care
  - Oral hygiene
- Positioning
- Range of motion
- Reporting changes in the client's condition and needs
- Safe transfer
- Toileting and elimination care

3.2.3.2 Supervision of HHA

Supervision, as defined by the *Texas Nursing Practice Act,* is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity. An RN or therapist (OT/PT) must provide the HHA written instructions for all the tasks delegated to the HHA. A therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

The requirements for HHA supervision are as follows:

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- When only HHA visits are provided, an RN must make a supervisory visit to the client's residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.
- When SN, OT, or PT visits are provided in addition to a HHA visit, an RN must make a supervisory visit to the client's residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only OT or PT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

3.2.4 Home Health Skilled Nursing (SN) Services

Home health SN services are a benefit of the Home Health Services when a client requires nursing, OT, or PT services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. SN visits may be provided on consecutive days. SN visits are intended to provide SN care to promote independence and support the client living at home. Home Health Services must be provided by a licensed and certified home health agency enrolled in Texas Medicaid.

> ***Note:*** *Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.*

An acute condition is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered a SN visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered a SN visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

SN visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments/procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death

When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client's age and needs.

3.2.4.1 SN Visits

SN visits (procedure code G0154) are limited to SN procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the *Texas Nursing Practice Act* and include direct SN care, and parent or guardian, caregiver training, and education as well as SN observation, assessment, and evaluation by an RN, provided a physician specifically requests that a nurse visit the client for this purpose, and the physician's order reflects the medical necessity for the visit.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes

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- Independent living arrangements

3.2.4.1.1 SN Care

SN care consists of those services that must, under state law, be performed by an RN or LVN, and meet the criteria for SN services specified in the Title 42 *Code of Federal Regulations* (CFR) §§ 409.32, 409.33, and 409.44. In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

The fact that the SN service can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a SN service. If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as a SN service.

Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be covered on that basis. However, in some cases, the client's condition may cause a service that would ordinarily be considered unskilled to be considered a SN service. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

SN services must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled services are needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

SN care must be provided on a part-time or intermittent basis.

3.2.4.1.2 Professional Nursing

Professional nursing provided by an RN, as defined in the *Texas Nursing Practice Act*, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes
- The maintenance of health or prevention of illness

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- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist
- The supervision of delegated nursing tasks or teaching of nursing
- The administration, supervision, and evaluation of nursing practices, policies, and procedures
- The performance of an act delegated by a physician
- Development of the nursing care plan

Professional nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

3.2.4.1.3 Vocational Nursing

Vocational nursing, as defined in the *Texas Nursing Practice Act*, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual
- Participating in the planning of the nursing care needs of an individual
- Participating in the development and modification of the nursing care plan
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual

Vocational nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

3.2.5 Supplies Submitted with a POC

The cost of incidental supplies used during a SN or HHA visit may be added to the charge of the visit ($10 maximum for supplies and included in G0154 visit code). Medical supplies left at the home for the client to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

Refer to: Subsection 3.2.23, "Prior Authorization" in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME/medical supplies prior authorization information.

When the Home Health Services POC is utilized to submit a prior authorization of supplies/DME that will be used in conjunction with the professional services provided by the agency, such as SN, OT, or PT, the home health agency's DME provider identifier must be submitted on the POC, and all of the requested supplies must be listed in the supplies section of the POC. The POC does not require a physician's signature before prior authorization of professional services and supplies/DME is requested but does require the assessing RNs dated signature. The POC must be signed and dated by a physician familiar with the client prior to submitting a claim for services and no later than 30 days from the SOC date.

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If the home health agency utilizes the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, the agency must complete Section A. The physician must complete Section B, and sign prior to submission to TMHP for prior authorization of the requested supplies/DME.

The following information is required to consider these supplies for prior authorization:

- Item description
- Procedure code
- Quantity of each supply requested
- Manufacturer's suggested retail price (MSRP) for items that do not have a maximum fee assigned

3.2.6 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not Food and Drug Administration (FDA)-approved.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, and/or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

3.2.7 Occupational Therapy (OT) Services

As stated in the TAC, to be payable as a Home Health Services benefit, OT services must be:

- Provided by an occupational therapist or an occupational therapy assistant who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners
- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition
- For specific goal-directed activities to achieve a functional level of mobility and communication to prevent further dysfunction within a reasonable length of time based on the therapist's evaluation, physician's assessment, and POC

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive those services through CCP.*

Refer to: Subsection 3.10, "Therapy Services-CCP" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for occupational therapy benefits for clients who are 20 years of age or younger and to Section 5, "Therapists, Independent Practitioners, and Physicians" in this handbook for occupational therapy benefits provided by a physician.

3.2.8 Physical Therapy (PT) Services

As stated in the TAC, in order to be payable as a Home Health Services benefit, PT services must be:

- Provided by a physical therapist or physical therapist assistant who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners

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- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition
- Expected to improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential after any necessary consultation with the therapist
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not a benefit. Additionally, services related to activities for the general good and welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 3.10, "Therapy Services-CCP" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for physical therapy benefits for clients who are 20 years of age or younger and to Section 5, "Therapists, Independent Practitioners, and Physicians" in this handbook for physical therapy benefits provided by a physician.

3.2.9 Prior Authorization

Prior authorization of initial coverage of home health services SN, HHA, OT, and PT for an eligible client can be obtained by calling the TMHP Contact Center Home Health Services line at 1-800-925-8957, by fax to 1-512-514-4209, or on the TMHP website at www.tmhp.com.

The following prior authorization requests can be submitted on the TMHP website at www.tmhp.com:

- Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form
- Home Health Services POC

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

If a client's primary coverage is private insurance, and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will pay only the coinsurance and/or deductible. If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of the date of Medicare's final disposition. The medicare remittance advice notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the SOC date.

The provider is responsible for determining if eligibility is effective by using Automated Inquiry System (AIS) or an electronic eligibility inquiry through TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the SOC for professional services or the DOS for DME/medical supplies to obtain prior authorization following the registered nurse's (RN) assessment/evaluation of the client in the home setting. When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client's home must make this call to answer questions about the client's condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be requested to furnish additional documentation as required to make a decision on the request. Because it often must be obtained from the client's physician, providers have two weeks to submit the requested

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documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, prior authorization is not considered before the date the additional documentation is received. It is the DME/supplier/home health agency's responsibility to contact the physician to obtain the requested additional documentation.

TMHP Home Health Services toll-free number is 1-800-925-8957. The Home Health Services Prior Authorization Checklist is a useful resource for home health agency providers completing the prior authorization process. This optional form offers the nurse a detailed account of the client's needs when completed.

Refer to: Subsection 1.2.2, "Durable Medical Equipment (DME) and Supplies " in *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for DME/medical supplies prior authorization.

Subsection 3.4.2, "Medicaid Relationship to Medicare" of this handbook.

Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.

3.2.9.1 HHA and Home Health SN Services Prior Authorization Requirements

SN and HHA services require prior authorization. Requests must be submitted by fax or in writing by mail. Providers must obtain prior authorization within three business days of the SOC date for an initial prior authorization. For extension of the prior authorization providers must obtain prior authorization within seven business days of the new SOC date. During the prior authorization process, providers are required to deliver the requested services from the SOC date, which is the date agreed to by the physician, the RN, the home health agency, and the client, parent, guardian, or caregiver. The SOC date must be documented on the POC.

Prior authorization of SN or HHA visits requires that a client's primary care physician complete the following steps:

- Provide specific, written, dated orders for SN or home health agency visits or recertification that identifies that the prescribed visits are medically necessary as defined in subsection 3.2.4, "Home Health Skilled Nursing (SN) Services" and subsection 3.2.3, "Home Health Aide (HHA) Services" of this handbook.
- Maintain documentation in the client's medical record that supports the medical necessity of the prescribed visits.
- Maintain documentation in the client's medical record that demonstrates that the client's medical condition is sufficiently stable to permit safe delivery of the prescribed visits as described in the client's Home Health Services POC.
- Establish a medical plan of care that is maintained in the client's medical record.
- Provide continuing care and medical supervision.
- Review and approve the client's Home Health Services POC once every 60 days or more frequently as the physician determines necessary, including but not limited to a change in the client's condition.

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN and/or HHA visits that will safely meet the client's needs. The amount and duration of SN and/or HHA visits requested will be evaluated by the claims administrator. The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician's orders.

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The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time.

As a client's problems are resolved and goals are met, a client's condition is expected to become more stable, and the client's needs for SN and HHA services may decrease.

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance. SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open prior authorization for home phototherapy. For clients receiving private duty nursing (PDN) services, instruction in the use of the phototherapy equipment must be part of the existing PDN authorized hours. SN visits will not be allowed on the same day as PDN services. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for parent or caregiver teaching, client monitoring, and obtaining customary and routine laboratory specimens.

SN visits to address total parenteral nutrition (TPN) must:

- Be provided by a RN appropriately trained in the administration of TPN
- Include education of the client or caregiver regarding the in-home administration of TPN before administration initially begins
- Include the use and maintenance of required supplies and equipment
- Occur at least once every month to monitor the client's status and to provide ongoing education to the client and/or caregivers regarding the administration of TPN

For clients receiving PDN who also require TPN administration education, intermittent SN visits may be considered for separate prior authorization when:

- The PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function
- There is documentation to support the medical need for an additional skilled nurse to perform TPN

The SN services may be prior authorized only for the client/caregiver training in TPN administration.

SN visits will not be approved for the sole purpose of instructing the client on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the prescribing physician.

The nurse providing the intermittent SN visit for TPN services will only be reimbursed for time spent delivering client/family instruction and for direct client TPN services. The services delivered must be documented in the client's record.

PDN and SN should not be routinely performed on the same date during the same time period. PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided, including, but not limited to the following:

- The start and stop time of each nursing provider's specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

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Up to a maximum combined total of three SN and HHA visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. SN and/or HHA visits may be provided on consecutive days.

When documentation does not support medical necessity for home health SN and/or HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

A prior authorization for SN and/or HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid.
- The client no longer meets the medical necessity criteria for SN and/or HHA services.
- The place of service cannot provide for the health and safety of the client.
- The client, parent, guardian, or caregiver refuses to comply with the attending physician's plan of treatment and compliance is necessary to ensure the health and safety of the client.
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

A SN/HHA may be prior authorized to provide services to more than one client over the span of the day as long as each client's care is based on an individualized POC and each client's needs and POC do not overlap with another client's needs and POC. Settings in which a SN/HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving home health services, foster homes, and independent living arrangements.

3.2.9.2 Canceling a Prior Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

3.2.9.3 Home Health SN Services and HHA Services That Will Not Be Prior Authorized

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care
- Child care
- Activities of daily living for the client
- Housekeeping services
- Routine post-operative disease, treatment, or medication teaching after a physician visit
- Routine disease, treatment, or medication teaching after a physician visit
- Individualized, comprehensive case management beyond the service coordination required by the *Texas Nursing Practice Act*

HHA visits requested primarily to provide the following will not be prior authorized:

- Housekeeping services
- Services provided to a client residing in a hospital, SN facility, or intermediate care facility

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Certain facilities are required by licensure to meet all the medical needs of the client. SN and/or HHA visits will not be prior authorized for clients receiving care in any of the following facilities:

- Hospitals
- SN facilities
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Special care facilities, including but not limited to, sub-acute units and facilities for the treatment of acquired immunodeficiency syndrome (AIDS)

3.2.9.4 OT and PT Prior Authorization Requirements

Prior authorization requests for occupational or physical therapy services, provided through a home health agency for an acute condition or an exacerbation of a chronic condition, must be obtained by contacting the TMHP Home Health Unit.

The date and time that therapy began and ended must be documented and maintained in the client's medical record.

The submitted POC must include all information as shown on the Texas Medicaid Home Health POC form. The Home Health POC form is recommended but not required. The Medicare POC (485/486) will not be accepted.

A nursing POC that addresses the physical or occupational therapy services must be completed, signed, and dated by the RN who performed the client's admission home assessment prior to the RN requesting authorization and must include:

- Diagnoses (including ICD-9-CM diagnosis codes)
- Treatment goals
- Duration of need
- Frequency
- Requested dates of service

To complete the prior authorization process by paper, the provider must complete the prior authorization requirements through fax or mail and must retain a copy of the POC signed and dated by the RN who completed the home assessment in the client's medical record at the provider's place of business.

To complete the prior authorization process electronically or telephonically, the provider must complete the prior authorization requirements through any approved electronic or telephonic methods and must retain a copy of the POC signed and dated by the RN who completed the home assessment in the client's medical record at the provider's place of business.

In addition to the nursing POC, home health agencies must provide the following information at the time each request for physical or occupational therapy is made:

- The requested therapy procedure codes with the appropriate GP or GO modifier
- Occupational and/or physical therapy evaluation or re-evaluation results
- An initial or subsequent therapy treatment plan to include occupational or physical goals and dates of service requested

As stated in the TAC, prior authorization may be given for a service period not to exceed 60 days on any given authorization. Specific authorizations may be limited to a time period less than the established maximum. When the need for home health services exceeds 60 days, or when there is a change in the service plan, prior authorization must be obtained.

Requests are neither accepted, nor authorization granted, directly to the therapist or therapy assistant.

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If a client discontinues therapy with a provider, and a new provider begins therapy during an existing authorization period, submission of a new POC and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.

Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist. Procedure code 97150 may be submitted for each member of the group.

3.2.10 Limitations, Exclusions

Payment cannot be made for any service, supply or equipment for which federal financial participation (FFP) is not available.

Refer to: Subsection 3.2, "CCP Overview" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) to find which of these items are a benefit for CCP clients who are 20 years of age or younger and who are eligible to receive THSteps services.

Home Health Services does not cover the following:

- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Allergy injections
- Any services, equipment, or supplies furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services or supplies furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services or supplies furnished without prior approval by TMHP, except as listed
- Application of a modality to one or more areas; hot or cold packs
- Blood products (the administration or the supplies and equipment used to administer blood products)
- Developmental therapy
- Inpatient rehabilitation
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B12, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis
- PDN services
- Respite care (caregiver relief)
- Services that are not medically necessary, including, but not limited to:
  - Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client's physical or occupational therapy program
  - Training in non-essential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling)

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- Maintenance therapy, including passive range of motion and exercises, which are not directed towards restoration of a specific loss of function
- Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment
- Therapy prescribed primarily as an adjunct to psychotherapy

- Speech therapy (ST) provided in the home
- Visits made primarily for performing housekeeping services are not considered a benefit of the Home Health Services Program. These requests should be referred to in-home and family support service at HHSC

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

3.3 Documentation Requirements

3.3.1 Written POC

A Home Health Services POC is required for SN, HHA, OT, and PT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be retained in the client's medical record with the provider and requesting physician. The client's attending physician must recommend, sign, and date a POC. The POC must be completed but does not need to be signed by the physician before contacting TMHP for prior authorization when orders for home care have been received from the physician. The POC shall be initiated by the RN in a clear and legible format.

The POC must contain the following information:

- Activities permitted
- All pertinent diagnoses
- Available caregiver
- Client Medicaid number
- Date the client was last seen by the physician. The client must be seen by a physician within 30 days of the initial SOC and at least once every six months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment. The physician visit may be waived when a diagnosis has already been established by the physician and the recipient is under the continuing care and medical supervision of the physician. Any waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the requesting physician and a copy must be maintained in the providing provider's files
- Equipment/supplies required
- Instructions for timely discharge or referral
- List of all community or state agency services the client receives in the home (e.g., PHC, PCS, community-based alternative [CBA], Medically Dependent Children's Program [MDCP])
- Medications including the dose, route, and frequency
- Mental status
- Nutritional requirements
- Physician's license number
- Prior and current functional limitations

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- Prognosis
- Provider Medicaid number
- Rehabilitation potential
- Safety measures to protect against injury
- SOC date for home health services
- Treatments, including amount, duration, and frequency
- Types of services including amount, duration, and frequency
- Wound care orders and measurements

Physician orders for OT or PT services must include the ICD-9-CM diagnosis codes for an acute or exacerbated event, when OT and PT is being requested and the following documentation is included with the request:

- Specific procedures and modalities to be used
- Amount, frequency, and duration of therapy needed
- Physical and/or occupational therapy and goals
- Name of therapist who participated in developing the POC

The physician and home health agency nursing, OT, and PT personnel must review the POC as often as the severity of the client's condition requires or at least once every 60 days. This signed and dated documentation must be maintained in the client's medical record and must include the ordering physician and requesting provider information. This applies to all written and verbal orders, and POCs.

Verbal physician orders may only be given to people authorized to receive them under state and federal law. They must be reduced to writing, signed, and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service, and placed in the client's medical record. The physician must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. A copy of the written verbal order must be maintained in the client's medical record before and after being signed by the physician.

The type and frequency of visits, supplies, or DME must appear on the POC before the physician signs the POC, and may not be added after the physician has signed the orders. If any change in the POC occurs during a prior authorization period (additional visits, supplies, or DME), the home health agency must call TMHP Home Health Services Prior Authorization Department for prior authorization and maintain a completed revised POC signed and dated by the physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization. The agency must contact TMHP within three business days after the SOC date for prior authorization.

Refer to: Form NT.2, "Home Health Services Plan of Care (POC)" in Section 9 of this handbook.

Subsection 3.2.8, "Physical Therapy (PT) Services" of this handbook.

3.3.1.1 Physician Supervision-POC

For the Home Health Services POC to be valid, the treating physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in the client's condition.

Medicare Form 485 is not accepted as a POC. The Home Health Services POC is the only acceptable form for prior authorization through Texas Medicaid.

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3.3.2 Home Health SN and Home Health Aide (HHA) Services

A provider requesting prior authorization for SN and/or HHA services must submit the following documentation:

- A completed client assessment
- A completed Texas Medicaid Home Health Services POC that must:
  - Be signed and dated by the assessing RN
  - Signed and dated by the physician or submitted with the signed and dated physician's orders

All signatures and dates must be current, unaltered, original, and handwritten; computerized or stamped signatures or dates will not be accepted. All documentation, including all written and verbal orders, and all physician-signed POCs, must be maintained by the ordering physician. The home health agency must keep the original, signed copy of the POC in the client's medical record.

3.3.3 Home Health SN and HHA Services Assessments and Reassessments

When a provider has received a referral and has physician orders for SN and/or HHA services, the provider must have an RN perform an initial client assessment in the client's home. A client can be referred to a home health agency for SN and/or HHA services by the client, the client's physician, or the client's family.

The client assessment or reassessment should include, but is not limited to, the following:

- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client
- Comprehension level of client, parent, guardian, or caregiver
- Receptivity to training and ability level of the client, parent, guardian, or caregiver
- A nursing assessment of medical necessity for the requested visits which includes:
  - Complexity and intensity of the client's care
  - Stability and predictability of the client's condition
  - Frequency of the client's need for SN care
  - Identified medical needs and goals
  - Description of wounds, if present
  - Cardiac status

The initial assessment and any reassessments performed by an RN are required when changes in the client's condition occur during the course of the prior authorization period. If there is no change in the client's condition, the reassessment must document medical necessity to support continued and ongoing SN and/or HHA visits beyond the initial 60-day prior authorization period.

3.4 Other/Special Provisions

3.4.1 Home Health SN and HHA Services Provider Responsibilities

Providers must be a licensed home health agency enrolled in Texas Medicaid and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures. All providers must maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the primary caregiver that meet the standards of the *Texas Family Code,* Chapter 32, and obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

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Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the POS. The essential elements of safe and effective home health SN and/or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and back-up utility, communication, and fire safety systems must be available.

Note: *A parent or guardian, primary caregiver, or alternate caregiver may not provide SN and/or HHA services even if he or she is an enrolled provider or employed by an enrolled provider.*

3.4.2 Medicaid Relationship to Medicare

3.4.2.1 Possible Medicare Clients

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is entitled to receive.

Home health providers should follow these guidelines:

- Clients 64 years of age or younger without Medicare Part A or B:
  - If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of the Home Health Services Program.
- Clients 65 years of age or older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  - In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
  - If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

3.4.2.2 Benefits for Medicare/Medicaid Clients

For eligible Medicare/Medicaid clients, Medicare is the primary coinsurance and providers must contact Medicare first for prior authorization and reimbursement. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients. Home health service prior authorizations may be given for HHA services, certain medical supplies, equipment, or appliances suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) who does not qualify for home health services under Medicare because SN care, OT, or PT are not a part of the client's care.
- When the medical supplies, equipment, or appliances are not a benefit of Medicare Part B and are a benefit of Home Health Services.

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

Note: *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization. Texas Medicaid will only pay the coinsurance and deductible on the electronic crossover claim.*

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

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

3.4.2.3 Medicare and Medicaid Prior Authorization

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN.

Note: *For Medicaid qualified Medicare beneficiary (MQMB) clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Texas Medicaid is only responsible for premiums, coinsurance, and/or deductibles on these clients. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

To ensure Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients.

Contact TMHP for prior authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the MRAN. Fax a copy of the original MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

A MRAN is not required when a client is eligible for Medicare/Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day a HHA visit is made) thereafter as long as no skilled need exists. A SN supervisory visit is reimbursable, but a SN visit made for the primary purpose of assessing a client's nursing care is not. The SOC date will be the date of the first requested Medicare home health services visit as listed on the original MRAN.

Note: *Claims for STAR+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

When the client is 65 years of age or older or appears otherwise eligible for Medicare such as blind and disabled, but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.4, "Home Health Skilled Nursing (SN) Services" of this handbook.

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3.5 Claims Filing and Reimbursement

3.5.1 Claims Information

Providers must use only type of bill (TOB) 331 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and result in claim denial. Home Health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

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*).

Subsection 6.5, "CMS-1500 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the UB-04 CMS-1450 paper claim form in Block 63 and in Block 23 of the CMS-1500 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

3.5.2 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).

Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126. DME and expendable supplies other than nutritional products that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

For reimbursement, providers should note the following:

- The client's attending physician must request professional and/or HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of 1 month for supplies according to the billing requirements.

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- Nursing, HHA, OT, and PT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's provider identifier. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in the following locations: home of the client, home of the caregiver/guardian, client's day care facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) in POS 9.
- DME/supplies must be provided by either a Medicaid enrolled home health agency's Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

Note: *Medical social services and speech-language pathology services are available to clients 20 years of age or younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

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

3.5.3 Eligibility

To verify client Medicaid eligibility and retroactive eligibility, the home health agency or DME/medical supplier should contact the AIS at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Home health clients do not need to be homebound to qualify for services. The Medicaid client must be eligible on the date of service (DOS) and must meet all the following requirements to qualify for Home Health Services:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client's POC and considered a benefit under Home Health Services
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home
- Receive prior authorization from TMHP for most home health professional services, DME, or supplies

Certain DME/supplies may be obtained without prior authorization although providers must retain a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form reviewed, signed, and dated by the treating physician for these clients.

Refer to: "Automated Inquiry System (AIS)" in the TMHP Telephone and Address Guide (*Vol. 1, General Information*).

Note: *Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.*

Refer to: Subsection 5.3.3.4, "Durable Medical Equipment (DME) Supplier (CCP)" in *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information on DME benefits for clients who are 20 years of age or younger.

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3.5.3.1 Retroactive Eligibility

When a home health agency is providing services to a client who is pending Medicaid coverage, the agency is responsible for finding out the effective dates for eligibility, which can be done by contacting AIS at 1-800-925-9126 or the TMHP EDI Help Desk at 1-888-863-3638. TMHP must receive all documentation and claims for clients with retroactive eligibility within 95 days from the date eligibility was added to TMHP's eligibility file.

3.5.3.2 Prior Authorization of Retroactive Eligibility

After the client's eligibility is on TMHP's eligibility file, the agency has 95 days from the "add date" to obtain prior authorization for services already rendered. The agency must contact the TMHP Home Health Services Prior Authorization Department to obtain prior authorization for current services within three business days of the client's eligibility being added to TMHP's eligibility file. When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client's home must make this call.

3.5.4 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies home health services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for home health services care services and may not establish or review a plan of treatment."

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of 5 percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of 5 percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency's total operating expenses, whichever is less.

When providing CCP services and general home health services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and should send them to the appropriate address. Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing services. Documentation should be sent to TMHP Provider Enrollment at the address indicated in "Written Communication With TMHP" in the TMHP Telephone and Address Guide (*Vol. 1, General Information*).

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3.5.5 Claims Filing for OT Services

Providers must use the codes listed under subsection 3.5.9, "OT Procedure Codes" of this handbook to submit claims for Title XIX OT services that are provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each OT procedure code. OT services should be billed on a UB-04 CMS-1450 claim form. Providers must use procedure code 97003 when requesting prior authorization and billing for wheelchair evaluations.

3.5.6 Claims Filing for PT Services

Providers must use the procedure codes listed in subsection 3.5.10, "PT Procedure Codes" of this handbook to submit claims for Title XIX PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code. PT services should be billed on a UB-04 CMS-1450 claim form. Providers must use procedure code 97001 when requesting prior authorization and billing for wheelchair evaluations.

Refer to: Subsection 3.10, "Therapy Services-CCP" in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for CCP OT and PT services.

Subsection 6.3.5, "Modifiers" in Section 6, "Claims Filing" (*Vol. 1, General Information*).

3.5.7 OT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate OT procedure codes identifying the therapy service provided. OT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GO modifier must also be billed with all occupational procedure codes except evaluation and reevaluation procedure codes 97003 and 97004.

Providers must use procedure code 97003 when billing for OT evaluations. OT evaluations are payable once every 180 days for any provider. Providers must use procedure code 97004 when billing for OT reevaluations. OT reevaluations are payable one time per month for any provider.

An evaluation or reevaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy type in one day when:

- Therapy is rendered at different times
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one reevaluation

If a therapy evaluation or reevaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or reevaluation will be denied. OT evaluations (procedure code 97003) or reevaluations (procedure code 97004) will be denied as part of the following OT procedure codes billed with modifier GO.

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97039	97110	97112	97116	97124	97139	97140	97150	97530
97535	97537	97542	97799						

3.5.8 PT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate PT procedure codes identifying the therapy service provided. PT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GP modifier must also be billed with all PT procedure codes except evaluation and reevaluation procedure codes 97001 and 97002.

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Providers must use procedure code 97001 when billing for PT evaluations. PT evaluations are payable once every 180 days for any provider. Providers must use procedure code 97002 when billing for PT reevaluations. PT reevaluations are payable one time per month for any provider.

An evaluation or reevaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy type in one day when:

- Therapy is rendered at different times
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one reevaluation

If a therapy evaluation or reevaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or reevaluation will be denied. PT evaluations (procedure code 97001) or reevaluations (procedure code 97002) will be denied as part of the following PT procedure codes billed with modifier GP.

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97039	97110	97112	97116	97124	97139	97140	97150	97530
97535	97537	97542	97799						

3.5.9 OT Procedure Codes

OT services may be reimbursed using the following procedure codes:

Procedure Codes									
97003	97004	97012	97014	97016	97018	97022	97024	97026	97028
97032	97033	97035	97039	97110	97112	97116	97124	97139	97140
97150	97530	97535	97537	97542	97799				

All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are identified in the following table:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes

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Units	Number of Minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

OT is limited to one visit per day per discipline. The following OT procedure codes are billed in 15 minute increments and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97039	97110	97112	97116	97124	97139	97140	97150	97530
97535	97537	97542	97799						

3.5.10 PT Procedure Codes

PT services may be reimbursed using the following procedure codes:

Procedure Codes									
97001	97002	97012	97014	97016	97018	97022	97024	97026	97028
97032	97033	97035	97039	97110	97112	97116	97124	97139	97140
97150	97530	97535	97537	97542	97799				

All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Refer to: Section 3.5.9, "OT Procedure Codes" in this handbook for an example of the 15-minute conversion table.

PT is limited to one visit per day per discipline. The following PT procedure codes are billed in 15 minute increments and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97035	97039	97110	97112	97116	97124	97139	97140	97150	97530
97535	97537	97542	97799						

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4. PERSONAL CARE SERVICES (PCS)

Refer to: Subsection 3.8, "Personal Care Services (PCS) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information regarding Personal Care Services.

5. THERAPISTS, INDEPENDENT PRACTITIONERS, AND PHYSICIANS

5.1 Enrollment

To enroll in Texas Medicaid, licensed therapists and physicians must be enrolled in Medicare. The Medicare enrollment requirement is waived for therapists that only provide services to Texas Health Steps (THSteps)-eligible clients who are 20 years of age or younger and who do not receive Medicare benefits. These therapists must enroll as individuals.

Refer to: Subsection 6.1.1, "Physicians and Doctors" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* for information regarding Physician enrollment requirements.

If providers are currently enrolled with Texas Medicaid or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in CCP is not necessary. All non-CCP therapy services must be billed with the current provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days of application. A current license must be submitted.

5.2 Services, Benefits, Limitations, and Prior Authorization

Occupational therapy (OT), physical therapy (PT), and speech therapy (ST) are benefits of Texas Medicaid for an acute condition or an exacerbation of a chronic condition when all of the following criteria are met:

- Treatments are expected to significantly improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential.
- Treatments are directed towards restoration of or compensation for lost function.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice, as defined by state law.

Therapy may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing therapist.

OT, PT, and ST that is not a benefit of traditional Medicaid may be covered:

- In the physician's office, or Medicaid-enrolled private therapist's office for a chronic condition
- Through the school health and related services (SHARS) program
- In an outpatient rehabilitation or free-standing rehabilitation facility
- In a licensed hospital

In addition, OT, PT, and ST services that are not benefits of traditional Medicaid may be benefits under CCP.

Refer to: Subsection 3.10, "Therapy Services-CCP" in *Children's Services Handbook* (*Vol.2, Provider Handbooks*) for therapy benefits for clients who are 20 years of age or younger.

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5.2.1 OT Services

Payment for OT is limited to the treatment of disease for individuals whose ability to function in life roles is impaired. OT can be provided by a physician or occupational therapist and may include physical agents such as massage, electricity, traction, or exercises as forms of therapy. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions

OT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy type on the same date of service when the therapy is rendered at different times.

An evaluation or reevaluation performed on the same date of service as a therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Claims for OT services must include modifier GO to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or reevaluations.

Reimbursement for OT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) should be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are identified in the following table:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

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The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of eight units (two hours) per day, per therapy type:

Procedure Codes									
97032	97033	97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97530	97750	97799				

Occupational group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist. When billing for occupational group therapy, procedure code 97150 must be used for each member of the group. Procedure code 97150 will be denied when billed on the same date of service by the same provider as procedure code 97750.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients birth through 20 years of age in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97003 is payable once per 180 days, any provider. Reevaluation procedure code 97004 is payable once per 30 days, any provider.

OT evaluations or reevaluations (procedure code 97003 or 97004) will be denied when any of the procedure codes in the following table are billed with modifier GO by any provider on the same date of service:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97750	97799					

5.2.2 PT Services

Payment for PT is limited to acute disorders of the musculoskeletal and neuromuscular systems. PT can be provided by a physician or physical therapist and may include physical agents such as massage, electricity, traction, or exercises in the treatment of disease. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions
- Interventions that result in a change in a client's condition, such as a newly implanted pump to administer an antispasmodic
- Botulinum toxin type A injections

PT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy type on the same date of service when the therapy is rendered at different times.

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An evaluation or reevaluation performed on the same date of service as a therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Claims for PT services must include modifier GP to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or reevaluations.

Reimbursement for PT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) should be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Refer to: Section 5.2.1, "OT Services" in this handbook for an example of the 15-minute conversion table.

The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of eight units (two hours) per day, per therapy type:

Procedure Codes									
97032	97033	97034	97035	97036	97039	97110	97112	97113	97116
97124	97139	97140	97530	97750	97799				

Physical group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist. When billing for physical group therapy, procedure code 97150 must be used for each member of the group. Procedure code 97150 will be denied when billed on the same date of service by the same provider as procedure code 97750.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients birth through 20 years of age in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97001 is payable once per 180 days, any provider. Reevaluation procedure code 97002 is payable once per 30 days, any provider.

PT evaluations or reevaluations (procedure code 97001 or 97002) will be denied when any of the procedure codes in the following table are billed with modifier GP by any provider on the same date of service:

Procedure Codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97530	97750	97799					

5.2.3 ST and Aural Rehabilitation Services

ST is limited to treatment of conditions of the head or neck which affect speech production. ST may be provided by a physician or speech-language pathologist (SLP). Examples of what may be considered acute are as follows:

- Stroke or Cerebral Vascular Accident (CVA)
- Neoplasms of the head or neck

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- Open or closed head trauma

ST is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy type on the same date of service when the therapy is rendered at different times.

ST evaluations are performed before the initiation of speech therapy. The therapy may be performed by a SLP if he or she is on staff at the hospital or under the personal supervision of a physician.

Aural rehabilitation is ST used to treat hearing-impaired clients to improve their speech and communication, including but not limited to speech-reading and auditory training with use of hearing devices. An example of what may be "acute" includes but is not limited to placement of a new hearing device. For clients 21 years of age or older, aural rehabilitation is limited to a maximum of 12 visits within a 6-month period when provided for a client with a new implantable hearing device.

Claims for ST services must include modifier GN to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or reevaluations.

Reimbursement for ST procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) should be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Refer to: Section 5.2.1, "OT Services" in this handbook for an example of the 15-minute conversion table.

Procedure codes 92526 and 92610 may be reimbursed for the evaluation and treatment of swallowing dysfunctions and oral functions for feeding.

Procedure codes 92507, 92508, and 92526 may be reimbursed in 15-minute increments, and are limited to four units (one hour) per day. Procedure codes 92630 and 92633 are limited to a total of 2 services per day, for different procedures, billed by the same provider.

Evaluation procedure code 92506 is payable once per 180 days, any provider. Reevaluation procedure code S9152 is payable once per 30 days, any provider. Evaluations and re-evaluations exceeding these limitations may be considered on appeal with supporting medical documentation that a comprehensive evaluation and assessment was provided by a different provider.

ST evaluations or reevaluations (procedure code 92506 or S9152) will be denied when billed on the same date of service, any provider as procedure codes 92507 and 92508 with modifier GN.

5.2.4 Therapy in a Nursing Facility

Separate payment cannot be made to a physician who provides physical medicine to a resident of a nursing facility. These services must be made available to nursing facility residents as needed and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources as part of the daily care. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

5.2.5 Prior Authorization

Authorization is not required for acute therapy.

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5.2.6 Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Therapy that exceeds 180 days for clients who are 21 years of age or older
- Application of a modality to one or more areas; hot or cold packs
- Services that are not considered medically necessary. Examples include, but are not limited to the following:
  - Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client's OT, PT, and ST program
  - Separate reimbursement for VitalStim therapy for dysphagia
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, and scheduling)
  - Maintenance therapy, including passive range of motion and exercises that are not directed towards restoration of a specific loss of function
  - Emotional support, adjustment to extended hospitalization, or disability behavioral readjustment
  - Therapy prescribed primary as an adjunct to psychotherapy

Note: *Therapy that exceeds 180 days may be considered for prior authorization for clients who are birth through 20 years of age through CCP.*

5.2.7 Rehabilitative Services

Rehabilitative Services is a program administered by TMHP to nursing facility clients who need rehabilitation. These services must be prior authorized through TMHP before the therapy is provided and paid by TMHP. Covered services include OT, PT, and ST to clients who are eligible for Texas Medicaid, with an acute onset of an illness or injury, with the expectation that function will be improved measurably. For all rehabilitative services inquiries, call Rehabilitative Services at 1-800-792-1109.

5.3 Documentation Requirements

Therapy must be provided by the current written orders of a physician and based on medical necessity. A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy.

The physician must maintain documentation of medical necessity including the treatment plan and therapy evaluation or re-evaluation in the client's medical record. The date, time, and length of services provided must be documented and maintained in the client's medical record. The physician's original dated signature copy must be kept in the physician medical record for the client.

If a client discontinues therapy with a provider and a new provider begins therapy, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.

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5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

The Medicaid rates for therapists, independent practitioners, and physicians are calculated in accordance with 1 TAC §355.8081 and §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

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

Therapy services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.

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

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

Subsection 6.5, "CMS-1500 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.

6. PRIVATE DUTY NURSING

Refer to: *Subsection 3.9, "Private Duty Nursing (CCP)"* in *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information regarding Private Duty Nursing.

7. CLAIMS RESOURCES

Providers may refer to the following sections 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*)
Certified Respiratory Care Practitioner (CRCP) Claim Form Example	Form NT.6, Section 10 of this handbook
CMS-1500 Claim Filing Instructions	Subsection 5.5 (*Vol. 1, General Information*)
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)	Form DM.4, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*)
Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form	Form DM.5, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*)
Home Health Services DME/Medical Supplies Claim Form Example	Form DM.19, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*)

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Resource	Location
Home Health Services Plan of Care (POC)	Form DM.8, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*)
Home Health Services Plan of Care (POC) Instructions	Form DM.7, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*)
Home Health Services Prior Authorization Checklist	Form DM.9, *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*)
Home Health Services Skilled Nursing Visit and Physical Therapy Claim Form Example	Form NT.8, Section 10 of this handbook
Home Health Services Skilled Nursing Visit Claim Form Example	Form NT.7, Section 10 of this handbook
Physical Therapist	Form NT.9, Section 10 of this handbook
Physical Therapists (CCP Only) Claim Form Example	Form CH.28, *Children's Services Handbook* (*Vol. 2, Provider Handbooks*)
State and Federal Offices Communication Guide	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 5.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Claim Filing Instructions	Subsection 5.6 (*Vol. 1, General Information*)

8. CONTACT TMHP

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

9. FORMS

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NT.1 Home Health Services Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form.	
Client Information	
Client's name	Last name, first name, middle initial
Date of birth	Date of birth given by month, day and year
Date last seen by doctor	Client must be seen by a physician within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment
Medicaid number:	Nine-digit number from client's current Medicaid identification card.
Home Health Agency Information	
Name	Name of Home Health agency
License number	Medical license number issued by the state of Texas
Address	Agency address given by street, city, state and ZIP code
Telephone	Area code and telephone number of agency
TPI	Texas Provider Identifier number (10-digit) of agency
NPI	National Provider Identifier number (10-digit) of agency
Taxonomy	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
DME TPI	Texas Provider Identifier number (10-digit) of agency DME
Benefit Code	Code identifying state program for the service provided
Physician Information	
Name	Name of Physician
License number	Physician's medical license number issued by the state of Texas
Telephone	Area code and telephone number of physician
TPI	Texas Provider Identifier number (10-digit) of physician
NPI	National Provider Identifier number (10-digit) of physician
Plan of Care Information	
Status	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request
Original SOC date	First date of service in this 365 day benefit period
Revised request effective date	Date revised services, supplies or DME became effective
Services client receives from other agencies	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnoses	Diagnosis related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered (Include ICD-9 code if PT/OT is ordered)
Functional Limitations/ Permitted Activities	Include on revised request only if pertinent
Prescribed medications	List medications, dosages, routes, and frequency of dosages (Include on revised request if applicable)
Diet Ordered	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (Include on revised request if applicable)
Mental Status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment. For PT, list specific modalities and treatments to be used.
SNV, HHA, PT, OT visits requested:	State the number of visits requested for each type of service authorized
Supplies	List all supplies authorized
DME	List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed
RN signature	The signature and date this form was filled out and completed by the RN
From and To dates	Dates (up to 60 days) of authorization period for ordered home health services
Conflict of Interest Statement	Relevant to the physician signing this form; physician should check box if exception applies.
Physician signature, Date signed, Printed physician name	The physician's signature and the date the form was signed by the physician ordering home health services, and the physician's printed name

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NT.2 Home Health Services Plan of Care (POC)

Write legibly or type. Claims will be denied if POC is illegible or incomplete.

Client's name:			Date of birth: / /	
Date last seen by doctor: / /			Medicaid number:	
Home Health Agency Information				
Name:	Fax number:		Telephone:	
Address:				
TPI:	NPI:		Taxonomy:	
DME TPI:		Benefit Code:		
Physician Information				
Name:			Telephone:	
TPI:	NPI:		License number:	
Status (check one):	New client ☐	Extension ☐	Revised Request ☐	
Original SOC date: / /		Revised request effective date: / /		
Services client receives from other agencies:				
Diagnoses (include ICD-9 codes if PT/OT is ordered):				
Function Limitations/Permitted Activities/Homebound Status:				
Prescribed medications:				
Diet ordered:		Mental status:		
Prognosis:		Rehabilitation potential:		
Safety Precautions:				
Medical Necessity, clinical condition, treatment plan (Brief narrative of the medical indication for the requested services and instructions for discharge, etc., include musculoskeletal/neuromuscular condition if PT/OT requested):				
SNV visits requested:				
HHA visits requested:				
PT visits requested:				
OT visits requested:				
Supplies:				

DME Item No. 1	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 2	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 3	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?
DME Item No. 4	Own ☐	Repair ☐	Buy ☐	Rent ☐	How long is this DME item needed?

RN signature:	Date signed: / /	
I anticipate home care will be required:	From: / /	To: / /

Conflict of Interest Statement

By signing this form, I certify that I do not have a significant ownership interest in, or a significant financial or contractual relationship with, the billing Home Health Services agency if Home Health Services for the above client are to be covered by the Texas Medicaid Program.
Check if this exception applies.

☐ Exception for governmental entities (Home Health Services agency operated by a federal, state or local governmental authority) or exception for sole community Home Health Services agency as defined by 42CFR 424.22.

Physician signature:	Date signed: / /

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NT.3 Home Health Services Prior Authorization Checklist

Contact Medicaid Home Health Services at 1-800-925-8957

To facilitate the authorization process, the home health agency nurse should have completed the following tasks before contacting TMHP for prior authorization of home health services:

- Completion of this optional form
- Evaluation of the client in the home (preferably by the same nurse requesting services)

PLEASE DO NOT SUBMIT THIS FORM TO TMHP.

Date:_____ Agency Nurse Name:_____
Client Medicaid Number:_____ Client Name: _____
Client Medicare Number:_____ Date Last Seen by Physician: _____
Start of Care Date: _____ Date of Last Hospitalization:_____
Date of Home Evaluation: _____
Diagnoses:_____
_____
(If PT/OT is requested, please provide ICD-9-CM diagnosis codes)
Skilled Nursing functions to be provided: _____
_____
_____
_____
Pertinent Nursing Observations (prior teaching, size and descriptions of wounds, functional limitations, etc.): _____
_____
_____
Observations of home setting that may effect care (i.e., cleanliness, availability of running water, electricity and refrigeration, etc.): _____
_____
_____
Availability and capability of caregiver(s): _____
_____
Services client receives from other sources (i.e., Primary Home Care): _____
_____
Services Requested: ___ Skilled Nursing Frequency _____
___ Home Health Services Aide Frequency _____
___ Physical Therapy Frequency _____
___ Occupational Therapy Frequency _____
___ DME_____ Repair _____Rent _____ Purchase
_____Bid #1
_____Bid #2
___ Supplies: _____
TMHP Nurse: _____ PAN: _____

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NT.4 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 pages)

General Instructions

This form must be completed and signed as outlined in the instructions below before DME/medical supplies providers contact TMHP Home Health Services for prior authorization.

Either the DME supplier/Medicaid provider or the prescribing physician may initiate the form. This completed form must be retained in the records of both the DME supplier/medical provider and the prescribing physician, and is subject to retrospective review. This form becomes a prescription when the physician has signed section B.

***Note:** This form cannot be accepted beyond 90 days from the date of the prescribing physician's signature.*

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

All fields must be filled out completely. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Section A: Requested Durable Medical Equipment and Supplies

The supplier or prescribing physician can complete Section A. Include the most appropriate procedure code description using the Healthcare Common Procedure Coding System (HCPCS). In addition, include the appropriate quantity and the manufacturer's suggested retail price (MSRP) if the item requires manual pricing. A price is not required for those items with a maximum fee listed in the Texas Medicaid Fee Schedule. The appropriate box must be completed to indicate whether this section was completed by the physician or the supplier. If the item requested is beyond the quantity limit or a custom item, additional documentation must be provided to support determination of medical necessity.

Requested Durable Medical Equipment and Supplies

Item number	HCPCS Code	Description of DME/medical supplies	Quantity	Price
1	J-E1399	Appropriate HCPCS code description	1	$50.00
2	J-E1220	Appropriate HCPCS code description	1	$2500.00
3				
4				
5				

Examples of Supplies

Item number	HCPCS Code	Description of DME/medical supplies	Quantity	Price
1	9-A4253	Appropriate HCPCS code description	2 boxes	N/A
2	9-A4259	Appropriate HCPCS code description	1 box	N/A
3	9-A4245	Appropriate HCPCS code description	1 box	N/A
4				
5				

Physicians must indicate their professional license number. If the prescribing physician is out of state, the physician must provide the license number and state of professional licensure. Texas Medicaid TPI and UPIN numbers are not acceptable as licensure. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must be used when prescribing more than 5 items. The *Addendum to the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* must accompany *the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.*

***Note:** Addendums received without this form will not be accepted.*

***Reminder:** Home health services are not a benefit for clients residing in a nursing facility, hospital, or intermediate care facility.*

***Note for DME:** The DME company must also complete the DME Certification and Receipt Form. All equipment is to be assembled, installed, and used pursuant to the manufacturer's instructions and warning.*

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Section B: Diagnosis and Medical Information

Section B is a prescription for DME/supplies and must be filled out by the prescribing physician.

The prescribing physician must indicate the corresponding item number requested from Section A, an ICD-9 code with a brief description, and complete justification for determination of medical necessity for the requested item(s). If applicable, include height/weight, wound stage/dimensions and functional/mobility.

The physician is not required to repeat the procedure code or description of the requested DME or supplies in this section.

Note: *The date last seen must be within the past 12 months.*

The prescribing physician must indicate the duration of need for the prescribed supplies/DME. The estimated duration of need should specify the amount of time the supplies/DME will be needed, such as six weeks, three months, lifetime, etc. The prescribing physician's TPI (if a Texas Medicaid provider), NPI, and license number must be indicated.

Note: *Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*

Diagnosis and Medical Need Information

Item No. [2] (From Section A)	ICD-9	Brief Diagnosis Description	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
1,2	438	Appropriate diagnosis description	Unable to get in and out of the tub or shower.
2	27801	Appropriate diagnosis description	Need swing-away arms and legs for transfer secondary to hemiparesis and need oversize chair for clients weighing 400 lbs.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

Examples of Supplies

Item No. [2] (From Section A)	ICD-9	Brief Diagnosis Description	Complete justification for determination of medical necessity for requested item(s). Refer to Section A: Requested Durable Medical Equipment and Supplies.[1,2]
1,2,3	25001	Appropriate diagnosis description	Client has frequent variation of blood glucose levels and needs monitoring several times a day.

1. Refer to Footnote 1 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
2. Refer to Footnote 2 of the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

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NT.5 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature. Fax completed form to 1-512-514-4209.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Supplier

Client name:		Client date of birth: / /
Client Medicaid number:		Is client under 21 years of age? YES □ NO □
Supplier name:	Supplier address:	
Supplier telephone:	Supplier Fax:	Supplier TPI:
Supplier NPI:	Supplier Taxonomy:	Supplier Benefit Code:
Physician name:	Physician telephone:	Physician Fax:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1					□ Y □ N	□ Y □ N	□ Y □ N
2					□ Y □ N	□ Y □ N	□ Y □ N
3					□ Y □ N	□ Y □ N	□ Y □ N
4					□ Y □ N	□ Y □ N	□ Y □ N
5					□ Y □ N	□ Y □ N	□ Y □ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

□ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES □ NO □	If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	ICD-9	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification. Enter all *Item numbers* from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

Note:** The "Date last seen" and "Duration of need" items below **must be filled in.

Date last seen by physician: / /

Duration of need for DME: _____ month (s)	Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:	
Prescribing physician's TPI:	Prescribing physician's NPI:

□ Check if all of the information in Section A was complete at the time of the prescribing provider signature

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10. CLAIM FORM EXAMPLES

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NT.6 Certified Respiratory Care Practitioner (CRCP)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare #) [X] (Medicaid #) [ ] (Sponsor's SSN) [ ] (Member ID#) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)	123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane A.	3. PATIENT'S BIRTH DATE MM DD YY: 05 27 1964 SEX M [ ] F [X]
5. PATIENT'S ADDRESS (No., Street): 422 Pine Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: Laredo STATE: TX	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]
ZIP CODE: 12345 TELEPHONE (Include Area Code): (210) 555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)	CARRIER
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED **Signature on File** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY: 12 29 99 (ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP))	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: B.J. Higgins, M.D.	17a. 17b. NPI 1234567089	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 518.5 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: 123456789

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	2009	01	07	2009	2		99503		1	466.76	7		NPI	
2	01	12	2009	01	12	2009	2		99503		1	1111.26	1		NPI	
3	01	16	2009	01	16	2009	2		99503		1	66.68	1		NPI	
4	01	20	2009	01	20	2009	2		99503		1	66.68	1		NPI	
5	01	21	2009	01	21	2009	2		99503		1	854.15	1		NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO. 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 2565.53	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) *Julie Harris, RCP* 01 24 2009 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) Julie Harris, RCP 1204 East Ave. Laredo, TX 78041 a. 9876543021 b. 1234567-01		

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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NT.7 Home Health Services Skilled Nursing Visit

1 Home Nursing Services 2214 Health Care Dallas, Texas 75235	2	3a PAT. CNTL # 12345678 b. MED. REC. # 123456	4 TYPE OF BILL 0331
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME	9 PATIENT ADDRESS
a Doe, John	a 2200 Trape Lane Harlingen, TX 78550

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	29 ACDT STATE
02141949	M	01012009						

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

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
550	Skilled Nursing Visit	C-G0154	01012009	1	50.00	
550	Skilled Nursing Visit (PRN)	C-G0154	01012009	1	50.00	
570	Home Health Aide	C-G0156	01012009	1	40.00	
		Total Charges			140.00	
	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	57 OTHER PRV ID
A All Health Insurance						1324658709	
B Medicaid							9876543-21
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, Jane	S	123456789	All Mart Corp.	G1234
B				
C Doe, John		123456789		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 1234567890		All Mart Corp. 25000 Hwy. 6, Dallas, TX 75474
B		
C		

66 DX	68
25000	

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73
V443				

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
2500 Colostomy - After Surgery	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.

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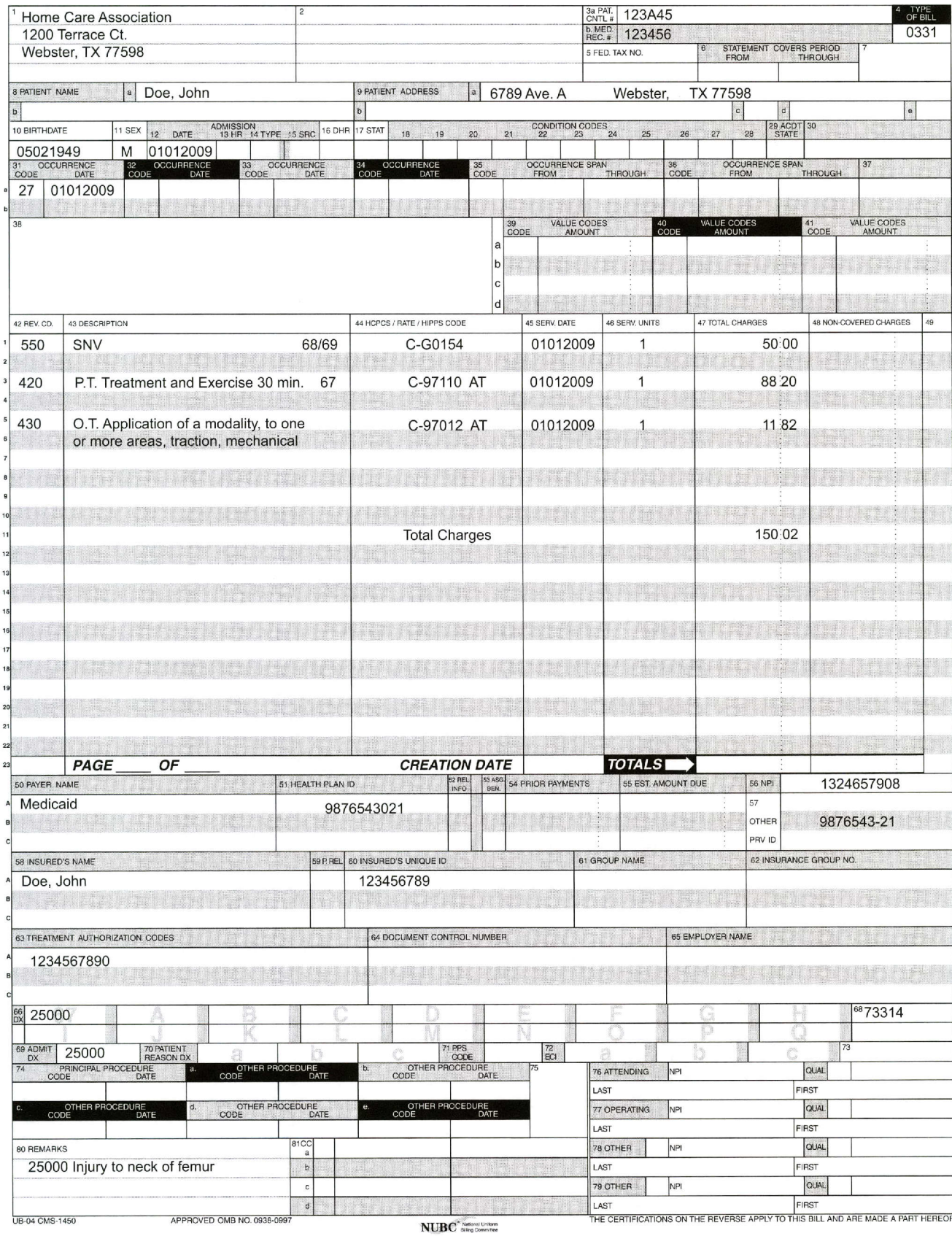
NT.8 Home Health Services Skilled Nursing Visit and Physical Therapy



1 Home Care Association 1200 Terrace Ct. Webster, TX 77598	2	3a PAT. CNTL # 123A45 b. MED REC. # 123456	4 TYPE OF BILL 0331
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
8 PATIENT NAME a Doe, John		9 PATIENT ADDRESS a 6789 Ave. A Webster, TX 77598	
10 BIRTHDATE 05021949	11 SEX M	12 ADMISSION DATE 01012009	13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES 29 ACDT STATE 30
31 OCCURRENCE CODE DATE a 27 01012009	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE 35 OCCURRENCE SPAN CODE FROM THROUGH 36 OCCURRENCE SPAN CODE FROM THROUGH 37
38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	550	SNV 68/69	C-G0154	01012009	1	50 00		
3	420	P.T. Treatment and Exercise 30 min. 67	C-97110 AT	01012009	1	88 20		
5	430	O.T. Application of a modality, to one or more areas, traction, mechanical	C-97012 AT	01012009	1	11 82		
11			Total Charges			150 02		
23		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	57
A	Medicaid	9876543021					1324657908	OTHER PRV ID 9876543-21

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

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

66 DX	25000	A	B	C	D	E	F	G	H	68 73314
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	25000	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

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
25000 Injury to neck of femur	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.

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NT.9 Physical Therapist

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]		1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane	3. PATIENT'S BIRTH DATE MM DD YY: 06 14 1964 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 9901 Channing Cross	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: Bryan STATE: TX	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]	CITY STATE
ZIP CODE: 77081 TELEPHONE (Include Area Code): (409)555-1234	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: John Martinez, M.D.	17a. 17b. NPI 1234567089	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 767.6 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2009	01 01 2009	1		97761	AT	1	30.00			NPI	
2	01 01 2009	01 01 2009	1		97761	AT 76	1	13.45			NPI	
	neck area											
3	01 01 2009	01 01 2009	1		97761	AT 76	1	13.45			NPI	
	left arm											
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 12345	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE: $ 56.90
29. AMOUNT PAID: $	30. BALANCE DUE: $		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) *Patricia Brown, LPT* 01 09 2009 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) Patricia Brown, LPT 911 Medical Drive Bryan, TX 77801 a. 9876543021 b. 1234567-01	

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AUSTIN, TX 78727
A STATE MEDICAID CONTRACTOR