CLAIMS FILING, THIRD-PARTY RESOURCES, AND REIMBURSEMENT

CSHCN SERVICES PROGRAM PROVIDER MANUAL

NOVEMBER 2026

TEXAS
Health and Human
Services

CLAIMS FILING, THIRD-PARTY RESOURCES, AND REIMBURSEMENT

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5.1 TMHP Claims Information

5.1.1 Claims Processed by TMHP

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

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

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)."

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

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

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

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

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

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

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

5.1.2 Claims Processed by the CSHCN Services Program

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

FSS includes, but is not limited to:

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

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

5.1.3 CPT and HCPCS Claims Auditing Guidelines

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

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

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

5.1.4 CMS NCCI and MUE Guidelines for All Claims

All claims must be filed in accordance with the Centers for Medicare & Medicaid Services (CMS)

National Correct Coding Initiative (NCCI) and Mutually Exclusive Edit (MUE) guidelines,

including claims for services that have been prior authorized or authorized with medical

necessity documentation.

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

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

5.1.5 TMHP Processing Procedures

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

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

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

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

Refer to: Chapter 6, "Remittance and Status (R&S) Reports."

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5.1.6 Claims Processed by Date of Service

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

The CSHCN Services Program may recoup claims that have been submitted and paid if a new claim with an earlier date of service is submitted, depending on the benefit limitations for the services rendered. Services that have been authorized for an extension of the benefit limitation will not be recouped.

Providers can submit an appeal with medical documentation if the claim has been denied. This rule also applies to NCCI/Medically Unlikely Edit (MUE) editing.

5.1.7 Inactive Provider Termination

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

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

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

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for additional information.

5.1.8 Claims Filing Deadlines

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

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

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

When a filing deadline falls on a weekend or holiday, the filing deadline is extended to the next business day following the weekend or holiday. Holidays that may extend the deadlines in 2026 are:

Date	Holiday
January 1, 2026	New Year's Day
January 19, 2026	Martin Luther King, Jr. Day
February 16, 2026	Presidents' Day
May 25, 2026	Memorial Day
June 19, 2026	Emancipation Day
July 4, 2026	Independence Day
September 7, 2026	Labor Day
October 12, 2026*	Columbus Day
November 11, 2026	Veterans Day
November 26, 2026	Thanksgiving Day
November 27, 2026	Day after Thanksgiving
December 24, 2026	Christmas Eve Day
December 25, 2026	Christmas Day
December 26, 2026	Day after Christmas
***Federal holiday, but not a state holiday. The claims filing deadline will be extended for providers because the Post Office will not be operating on this day.**	

Refer to: Filing Deadline Calendar for 2025

Filing Deadline Calendar for 2026

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

Electronic billers should notify TMHP about missing claims when:

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

5.1.9 Exception to Claim Filing Deadline

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

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

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- An affidavit or statement from a person with personal knowledge of the facts detailing the requested exception.
- The cause for the delay.
- Verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's current employee or agent.
- Any additional information requested by the CSHCN Services Program, including independent evidence of insurable loss; medical, accident or death records and a police or fire department report substantiating the damage or destruction.

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

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by the person making the repairs or installing the system concerning the relationship and impact of the computer problem or system implementation to delayed claims submission; and the reason alternative billing procedures were not initiated after the problems became known.

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

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

Send requests for exceptions to claim filing deadlines to:

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

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

5.1.10 Fiscal Agent Payment Deadline

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

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

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

5.2 Third-Party Resource (TPR)

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

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

- Private health insurance
- Dental insurance plan
- Health maintenance organization (HMO)
- Home, automobile, or other liability insurance
- Preferred provider organization (PPO)
- Cause of action (lawsuit)
- Medicare

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- Health-care plans of the U.S. Department of Defense or the U.S. Department of Veterans Affairs (also known as TRICARE)
- Employee welfare plan
- Union health plan
- Children's Health Insurance Program (CHIP)
- Prescription drug card
- Vision insurance plan

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

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

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

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

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

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

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

5.2.1 Health Maintenance Organization (HMO)

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

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

The CSHCN Services Program does not provide assistance for:

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

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

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5.2.2 CSHCN Services Program Notice of Eligibility

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

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

5.2.3 Claims Filing Involving a TPR

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

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

Claims must be submitted on paper with the EOB attached.

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

5.2.4 Verbal Denials by a TPR

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

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

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

When a provider is advised by a TPR that benefits were paid to the client, the provider must include that information on the claim with the date and amount of payment made to the client, if available. If a denial was sent to the client, refer to the information listed in this section. This information enables TMHP to consider the claim for payment.

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5.2.5 Filing Deadlines Involving a TPR

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

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

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

Claims involving a TPR have the following deadlines applied:

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

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

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

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

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

5.2.6 Blue Cross Blue Shield (BCBS) Nonparticipating Physicians

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

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

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

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

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

5.2.7 Refunds

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

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

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

Refund requests must be submitted to:

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

5.2.8 Refunds to TMHP Resulting From Other Insurance

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

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

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

Total billed	$300

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

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

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

5.2.9 Accident-Related Claims

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

If payment is available from a known third party, such as personal injury protection automobile insurance, that responsible party must be billed before the CSHCN Services Program. If the third-party payment is substantially delayed due to contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment. TMHP processes the liability-related claim and pursues reimbursement directly from the potentially liable party on a postpayment basis.

The following information must be included on these claims:

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

5.2.9.1 Accident Resources and Refunds Involving Claims for Accidents

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

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

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5.2.9.2 * Third-Party Liability for Claims Involving Accidents

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

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

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

Referrals should be submitted on the Tort Response Form to the following address:

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

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

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

The following information must be included:

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

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

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

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

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

5.3 Multipage Claim Forms

5.3.1 Professional (CMS-1500)

The approved electronic professional claim format is designed to list 50 line items.

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The total number of details allowed for a professional claim by the TMHP claims processing system (C21) is 28. If the services provided exceed 28 line items on an approved electronic claims format or 28 line items on paper claims, the provider must submit another claim for the additional line items.

The CMS-1500 paper claim form is designed to list six line items in Block 24. If more than six line items are billed, a provider may attach additional forms (pages) totaling no more than 28 line items. The first page of a multipage claim must contain all the required billing information. On subsequent pages of the multipage claim, the provider should identify the client's name, diagnosis, information required for services in Block 24, and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form and indicate "continued" in Block 28. The combined total charges for all pages should be listed on the last page in Block 28.

5.3.2 Institutional (UB-04 CMS-1450)

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

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

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

The total number of details allowed for an institutional claim by the TMHP claims processing system (C21) is 28. C21 merges like revenue codes together to reduce the lines to 28 or less. If the C21 merge function is unable to reduce the lines to 28 or less, the claim will be denied, and the provider will need to reduce the number of details and resubmit the claim.

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

5.3.3 Revenue Codes

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

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

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

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

5.3.4 Type of Bill

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

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

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

5.4 Tips on Expediting Paper Claims

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

5.4.1 General requirements

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

5.4.2 Data Fields

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

5.4.3 Attachments

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

5.5 Correction and Resubmission (Appeal) Time Limits

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

Refer to: Filing Deadling Calendar for 2025

Filing Deadline Calendar for 2026

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5.5.1 Claims with Incomplete Information

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

5.5.2 Other Insurance Appeals

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

5.5.3 Resubmission of TMHP EDI Rejections

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

5.5.3.1 TMHP EDI Batch Numbers, Julian Dates

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

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

Refer to: Section 7.3.1.3, "Electronic Rejections" in Chapter 7, "Appeals and Administrative Review" for more information on electronic appeals.

5.6 Coding

5.6.1 Diagnosis Coding

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

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

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

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5.6.2 Procedure Coding

5.6.2.1 Healthcare Common Procedure Coding System (HCPCS)

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

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

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

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

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

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

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

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

Most added procedure codes that are not directly replacing a discontinued procedure code must go through the Texas Medicaid rate hearing process, as required by Chapter 32 of the Human Resources Code, §32.0282, and Title 1 of the Texas Administrative Code, §355.201, which require public hearings to receive comments on Texas Medicaid payment rates.

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

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

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

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

Refer to: The Centers for Medicare & Medicaid Services HCPCS web page.

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5.6.2.2 National Correct Coding Initiative (NCCI) Guidelines

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

NCCI consists of two types of edits:

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

Each NCCI code pair edit is associated with a policy as defined in the *National Correct Coding Initiative Policy Manual*. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on this effective date. Termination dates also apply to code pairs in NCCI. This date represents the date when CMS removed the code pair combination from the NCCI edits. Code combinations are refreshed quarterly.

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

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

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

NCCI Appeals

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

Refer to: Section 7.3, "Claim Appeals" in Chapter 7, "Appeals and Administrative Review" for additional information about appealing claims.

5.6.2.3 Determining Reimbursement Rates for New HCPCS Procedure Codes

The CSHCN Services Program adopts the new codes that are direct replacements of discontinued codes at the discontinued codes reimbursement rate. The new HCPCS procedure codes that are not directly replacing discontinued codes require a rate hearing to determine an appropriate Texas Medicaid reimbursement rate. The Health and Human Services Commission (HHSC) conducts public rate hearings to provide an opportunity for the provider community to comment on the Medicaid proposed payment rate. After the rate hearings are complete for each procedure code, the CSHCN Services Program makes the determination to adopt the Texas Medicaid rate established through the rate hearing process or to adopt the rate of a similar discontinued code.

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As indicated in the *HCPCS Special Bulletin* that is published at the beginning of each year, claims for procedure codes that require a rate hearing must be submitted within the initial 95 day filing deadline. The most appropriate procedure code for the service provided must be submitted. Services provided are denied as pending a rate hearing (EOB 02008) until the applicable reimbursement rate is adopted.

Once the Medicaid reimbursement rate has been determined through the rate hearing process, the CSHCN Services Program will evaluate the proposed rate to determine whether alignment with the Medicaid rate is fiscally feasible. Once reimbursement rates are established in the rate hearing, evaluated by the CSHCN Services Program, and applied, TMHP will reprocess the claim. No action on the part of the provider is necessary. Providers are notified of the implementation date and reprocessing efforts. The client cannot be billed for these services.

For those procedures that require authorization or prior authorization, providers must follow the processes detailed in Chapter 4, "Prior Authorizations and Authorizations" of the current *CSHCN Services Program Provider Manual*. Providers must not wait until new codes have completed the rate hearing process to request an authorization or prior authorization.

5.6.2.4 National Drug Codes (NDC)

All CSHCN Services Program providers must submit an NDC for professional or outpatient electronic and paper claims submitted with physician-administered prescription drug procedure codes.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

National Drug Unit of Measure: The submitted unit of measure should reflect the volume measurement administered. Refer to the NDC Package Measure column on the Texas NDC-to-HCPCS Crosswalk.

The valid units of measurement codes are:

- F2—International unit
- GR—Gram
- ME—Milligram
- ML—Milliliter
- UN—Unit

Note: *Unit quantities must be submitted, and are required.*

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5.6.2.4.1 Paper Claim Submissions

Depending on the claim type, the NDC information must be submitted as indicated below for paper claims, or the equivalent electronic field:

UB-04 CMS-1450

Block No.	Description	Guidelines
43	Revenue codes and description	This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231) • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN or ME. (e.g., GR) • The unit quantity with a floating decimal for fractional units (limited to 3 digits). (e.g., 0.025) **Example:** N400409231231GR0.025

CMS-1500

Block No.	Description	Guidelines
24A	Date(s) of service	In the shaded area, enter: • NDC qualifier N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medicaiton was administered. Do not enter spaces or hyphens within this number. (e.g., 00409231231) **Example:** N400409231231
24D	Procedures, services, or supplies	In the shaded area, enter NDC quantity of units administered (up to 12 digits including the decimal point). A decimal point must be used for fractions of a unit (e.g., 0.025).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code (e.g., GR). There are 5 allowed values: F2, GR, ML, UN or ME.

2017 Claim Form

Block No.	Description	Guidelines
32A	Date(s) of service	In the shaded area, enter : • NDC qualifier N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medicaiton was administered. Do not enter spaces or hyphens within this number. (e.g., 00409231231) **Example:** N400409231231

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Block No.	Description	Guidelines
32D	Procedures, services, or supplies Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Modifier	In the shaded area, enter the NDC quantity of units administered (up to 12 digits including the decimal point). A decimal point must be used for fractions of a unit (e.g., 0.025).
32F	Days or units	In the shaded area, enter the NDC unit of measurement code (e.g., GR). There are 5 allowed values: F2, GR, ML, UN or ME.

National Drug Unit: Claims will be edited for the value submitted in the NDC quantity field. In order to convert the HCPCS units submitted into the NDC quantity; use the Texas NDC-to-HCPCS Crosswalk to review the "HCPCS Description" and the "NDC Label" description to identify the quantity.

The Texas NDC-to-HCPCS Crosswalk identifies relationships between HCPCS codes and National Drug Codes (NDC). The Texas file is published at least quarterly. The Texas NDC-to-HCPCS Crosswalk can be found a www.txvendordrug.com/formulary/clinician-administered-drugs. Clinician-administered drugs that do not have an appropriate NDC to HCPCS combination for the procedure code that is submitted are not payable.

Texas Supplemental NDC File lists those physician-administered multiple-source drugs that the U.S. Secretary of Health and Human Services has determined to have the highest dollar volume of physician-administered drugs that are dispensed through Medicaid.

5.6.2.5 Drug Rebate Program

The CSHCN Services Program will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the CMS Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered.

CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website. TMHP will republish this list quarterly in a more accessible format. Providers will be notified when the first formatted file from TMHP is available.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code (NDC) of the administered drug as indicated on the drug packaging.

TMHP will deny claims for drug procedure codes under the following circumstances:

- The NDC submitted with the drug procedure code is not on the CMS drug rebate list that was current on the date of service.
- The NDC submitted with the drug procedure code has been terminated.
- The drug procedure code is submitted with a missing or invalid NDC.

To avoid claim denials, providers must speak with the pharmacy or wholesaler with whom they work to ensure the product purchased is on the current CMS list of participating manufacturers and their drugs.

Vitamins and minerals procedure codes will be listed on a separate tab of the supplemental file.

TMHP has created a Rebatable National Drug Codes web page to display the quarterly lists published by CMS. Every quarter, after CMS publishes an updated list of rebatable NDCs, TMHP will produce a formatted list with the unnecessary details removed and will add the new list to the web page.

Note: *CSHCN Services Program does not pay for drug wastage.*

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5.6.2.6 Modifiers

Modifiers further describe and qualify services provided. A modifier is placed after the five-digit procedure code. Refer to the service-specific sections for additional modifier requirements. Providers must maintain documentation in the client's medical record that supports the medical necessity of the services that are billed using a modifier. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records. On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed. Modifiers and their descriptions are available in current issues of CPT and HCPCS coding resources.

Note: *Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of a service and any modifier used to bill the claim.*

5.6.2.7 Modifier U8 and the Federal 340B Drug Pricing Program

All eligible organizations and covered entities that are enrolled in the federal 340B Drug Pricing Program to purchase 340B discounted drugs must use modifier U8 when submitting claims for 340B clinician-administered drugs.

Non-compliance with this new requirement to use modifier U8 on all claims submitted for 340B clinician-administered drugs may jeopardize a covered entity's 340B status with the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

Note: *Providers can refer to the HRSA website at www.hrsa.gov/opa/index.html for more information about the 340B Drug Pricing Program.*

5.6.2.8 Type of Services (TOS)

The TOS identifies the specific field or specialty of services provided. TOS codes are not required for billing, but they do appear on the provider's Remittance and Status (R&S) Reports.

For procedure codes that require a modifier to assign a TOS, providers can refer to the appropriate specific section for information on modifier requirements for claim submissions.

TOS	Description
0	Blood
1	Medical Services
2	Surgery
3	Consultations
4	Radiology (total component)
5	Laboratory (total component)
6	Radiation Therapy (total component)
7	Anesthesia
8	Assistant surgery
9	Other medical items or services
C	Home health services
E	Eyeglasses
F	Ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC)
G	Genetics
I	Professional component for radiology, laboratory, or radiation therapy
J	DME purchase new

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TOS	Description
L	DME rental
R	Hearing aid
T	Technical component for radiology, laboratory, or radiation therapy
W	Dental

Place of Service (POS) Coding

The POS identifies where services are performed. Indicate the POS by using the appropriate numeric code for each service listed on the claim. The following POS codes must be used:

Place of Service	Two-Digit Numeric Codes	One-Digit Numeric Codes
Office	02, 10, 11, 15, 17, 20, 49, 50, 60, 65, 71, 72	1
Home	12, 27	2
Inpatient hospital	21, 51, 52, 56, 61	3
Outpatient hospital	19, 22, 23, 24, 55, 56, 57, 62	5
Other location	01, 03, 04, 05, 06, 07, 08, 16, 18, 26, 34, 41, 42, 53, 99	9
Independent lab	81	6
Destination of ambulance	Indicate destination using above codes	Indicate destination using above codes

5.6.3 Benefit Code

A benefit code is an additional data element used to identify state programs. Providers participating in the CSHCN Services Program must use benefit code CSN and DM3 when submitting claims and authorizations to TMHP. Additional codes may be added as necessary.

Benefit Code	Program
CSN	CSHCN Services Program
DM3	CSHCN Services Program home health DME services

Important: *The appropriate benefit code must be included on each CSHCN Services Program claim that is submitted to TMHP. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions about TexMedConnect to the TMHP EDI Help Desk at 1-888-863-3638.*

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)"for more information about electronic billing.

5.7 Claims Filing Instructions

Providers must read the instructions in this section carefully and supply all the requested information on the claim form.

Claim forms must contain:

- The billing provider's:
  - Complete name.
  - Physical address.

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  - ZIP + 4 code.
  - NPI.
  - Taxonomy code.
  - Benefit code (if applicable).
- The signature of the provider or an authorized representative or a "signature on file" statement.

Claim forms prepared by computer billing services may have "Signature on File" printed in the signature block if the billing service retains a letter on file from the provider authorizing the service.

Claim forms must contain the following or the claim cannot be processed:

- The billing provider's:
  - Complete name.
  - Physical address.
  - ZIP + 4 code.
  - NPI.
  - Taxonomy code.
  - Benefit code (if applicable).
- The signature of the provider or an authorized representative or a "signature on file" statement.

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted to TMHP must be filed in accordance with NCCI guidelines. The guidelines can be found in the NCCI Policy and *Medicare Claims Processing Manuals*, which are available on the CMS website.

5.7.1 Claim Details

The maximum number of units on a claim detail can not exceed 9,999 units. Providers who submit a claim with more than 9,999 units must bill 9,999 units on the first detail of the claim and any additional units on separate details.

5.7.2 Provider Types and Selection of Claim Forms

5.7.2.1 Providers and Services Billable on CMS-1500

Claims for the following provider types or services must be billed on a CMS-1500 paper claim form or approved electronic format when requesting payment for medical services and supplies under the CSHCN Services Program:

- Advanced practice registered nurse (APRN), such as pediatric nurse practitioner (PNP), clinical nurse specialist (CNS), and family nurse practitioner (FNP)
- Ambulance
- Anesthesiologist assistants
- Augmentative communication devices (ACDs)
- Certified respiratory care practitioner (CRCP)
- Certified registered nurse anesthetists (CRNA)
- Durable medical equipment (DME)
- Freestanding ambulatory surgery center
- Gastrostomy devices

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- Genetic services
- Independent laboratory, radiology, and radiation therapy
- Medical foods
- Medical nutritional products and services
- Orthosis and prosthesis
- Outpatient behavioral health services
- Outpatient therapy (physical therapy [PT], occupational therapy [OT], and speech-language pathology [SLP])
- Pharmacy
- Physician (doctor of medicine [MD] and doctor of osteopathy [DO])
- Podiatry
- Total parenteral nutrition (TPN)
- Vision services
- Any other authorized provider of medical services and supplies not specifically required to use a different claim form when submitting claims to TMHP

Refer to: The Professional Paper Claim Form (CMS-1500) page of the CMS website at www.cms.gov for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

5.7.2.2 CMS-1500 Claim Form Provider Definitions

CMS-1500 Claim Form Provider Definitions

The following definitions apply to the provider terms used on the CMS-1500 Claim Form:

Referring Provider

The Referring Provider is the individual who directed the patient for care to the provider rendering the services being submitted on the claim form.

Examples include, but are not limited to, a primary care provider referring to a specialist; an orthodontist referring to an oral and maxillofacial surgeon; a physician referring to a physical therapist; and a provider referring to a home health agency.

Ordering Provider

The Ordering Provider is the individual who requested the services or items listed in Block D of the CMS-1500 claim form.

Examples include, but are not limited to, a provider ordering diagnostic tests and medical equipment or supplies.

Rendering Provider

The Rendering Provider is the individual who provided the care to the client. In the case where a substitute provider was used, that individual is considered the Rendering Provider.

An individual such as a lab technician or radiology technician who performs services in a support role is not considered a rendering provider.

Supervising Provider

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The Supervising Provider is the individual who provided oversight of the Rendering Provider and the services listed on the CMS-1500 claim form.

An example would be the supervision of a resident physician.

Purchased Service Provider

A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis.

Examples of services include:

- Processing a laboratory specimen
- Grinding eyeglass lenses to the specifications of the Referring Provider
- Performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule.

In the case where a substitute provider is used, that individual is not considered a Purchased Service Provider.

5.7.2.3 CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500 claim forms with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837P 5010 format. Specifications are available to providers developing in-house systems, software developers, and vendors on the TMHP website at www.tmhp.com/topics/edi.

Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for more information about electronic billing. All CSHCN Services Program claims must be submitted with the appropriate benefit code.

Section 5.6.3, "Benefit Code" in this chapter for information about using the appropriate benefit code to file CSHCN Services Program electronic claims.

5.7.2.4 CMS-1500 Paper Claim Form Instructions

The following instructions describe the information that must be entered in each of the block numbers of the CMS-1500 paper claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

Refer to: The Professional Paper Claim Form (CMS-1500) page of the CMS website at www.cms.gov for more information about the CMS-1500 paper claim form. Providers can purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Block No.	Description	Guidelines
1a	Insured's ID No. (for program checked above, include all letters)	Enter the client's nine-digit CSHCN Services Program client number. For Other Property & Casualty Claims: Enter the Federal Tax ID or SSN of the insured person or entity.
2	Patient's name	Enter the client's last name, first name, and middle initial as printed on the CSHCN Services Program identification form. If the insured uses a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name.

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Block No.	Description	Guidelines
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's sex by checking the appropriate box. Only one box can be marked.
5	Patient's address	Enter the client's complete address as described (street, city, state, and ZIP+4 Code).
8	Benefit code	Enter the benefit code (if applicable) for the billing provider.
9	Other insured's name	For special situations, use this space to provide additional information such as: • If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	Is the patient's condition related to: a) Employment (current or previous)? b) Auto accident? c) Other accident?	Check the appropriate box. If other insurance is available, enter appropriate information in Blocks 11, 11a, and 11b.
11 11a 11b	Other health insurance coverage	• If another insurance resource has made payment or denied a claim, enter the name and information of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the Medicare Remittance Notice to the claim form. • For Workers' Compensation and Other Property & Casualty Claims: Required if known. Enter Workers' Compensation or Property & Casualty Claim Number assigned by the payer.
11c	Insurance plan or program name	Enter the benefit code, if applicable, for the billing or performing provider.
12	Patient's or authorized person's signature	Enter "Signature on File" or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the client.
14	Date of current	If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT.

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Block No.	Description	Guidelines
17 17b	Name of referring physician or other source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order: • Referring Provider • Ordering Provider • Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN = Referring Provider DK = Ordering Provider DQ = Supervising Provider The NPI must be entered in block 17b. **Supervising Physician for Referring Physicians:** If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.
19	Additional claim information	**Ambulance transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other client's complete name and CSHCN Services Program number, or indicate "Not a CSHCN Services Program client." **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility **Supervising Physician for Referring Physicians** If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.
20	Outside lab	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the name and address or provider identifier of the facility that performed the service in Block 32. ***Note:*** *The CSHCN Services Program regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.*

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Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
23	Prior authorization number	Enter the PAN issued by TMHP, if applicable. For Workers' Compensation and Other Property & Casualty Claims: Required when prior authorization, referral, concurrent review, or voluntary certification was received.
24	(Various)	General notes for Blocks 24a through 24j: • Unless otherwise specified, all required information should be entered in the unshaded portion. • If more than 6-line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multipage claim forms, indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the claim form.
24a	Date(s) of service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24g. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. National Drug Code (NDC) In the shaded area, enter: • NDC qualifier N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medicaiton was administered. Do not enter spaces or hyphens within this number (e.g., 00409231231) ***Example:*** *N400409231231* ***Refer to:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter.
24b	Place of service	Select the appropriate POS code for each service from the table under Section , "Place of Service (POS) Coding" in this chapter.

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Block No.	Description	Guidelines
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. ***Note:*** *ASC providers should enter only one CPT procedure code for the inclusive global fee.* In the shaded area, enter an NDC quantity of units administered, up to 12 digits including the decimal point (e.g., 0.025). ***Refer to:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter.
24e	Diagnosis pointer	In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 21 only. Do not enter diagnosis codes in Form Field 24E.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.
24g	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** *The maximum number of units per detail is 9,999.* In the shaded area, enter the NDC unit of measurement code (e.g., GR). There are 5 allowed values: F2, GR, ML, UN or ME. ***Refer to:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter. Enter the number of blood factor units provided.
24j	Rendering provider taxonomy code (performing)	Enter the taxonomy code of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Do not enter the performing identifier in Block 33. Enter the taxonomy code in the shaded area of the field. Enter the NPI in the unshaded area of the field.
26	Patient's account number	Optional Any alphanumeric characters (up to 15) in this block are referenced on the Remittance and Status (R&S) Report.
27	Accept assignment	Required All providers of the CSHCN Services Program Services must accept assignment to receive payment by checking Yes.

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Block No.	Description	Guidelines
28	Total charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. ***Note:*** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in Block 11. If the client makes a payment, the reason for the payment must be indicated in Block 11.
30	Balance due	If appropriate, subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	The physician, supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice. ***Refer to:*** Section 5.7, "Claims Filing Instructions" in this chapter
32	Service facility location information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP+4 Code of the facility where the service was provided.
32A	NPI	Enter the NPI of the service facility location.
33	Billing provider info & PH #	Enter the billing provider's name, physical address, city, state, ZIP+4 Code, and telephone number.
33A	NPI	Enter the NPI of the billing provider.
33B	Other ID #	Enter the taxonomy code of the billing provider.

5.7.2.5 UB-04 CMS-1450 Paper Claim Form Instructions

The following services must be billed using the UB-04 CMS-1450 paper claim form or electronic claim format when requesting payment:

- Hospital ambulatory surgical center (HASC)
- Home health (skilled nursing service)
- Hospice services
- Inpatient hospital
- Inpatient rehabilitation
- Outpatient hospital
- Renal dialysis facility

Refer to: The Institutional paper claim form (CMS-1450) CMS website at www.cms.gov for more information about the CMS-1450 paper claim form. Providers can purchase CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

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5.7.2.6 UB-04 CMS-1450 Electronic Billing

Electronic billers must submit UB-04 CMS-1450 claims with TexMedConnect or approved vendor software that uses the ANSI ASC X12 837I 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for more information about electronic billing.

5.7.2.7 Instructions for Completing the UB-04 CMS-1450 Paper Claim Form

These instructions describe the information that must be entered in each of the block numbers of the UB-04 CMS-1450 paper claim form. *Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.*

Block No.	Description	Guidelines
1	Unlabeled	Enter the hospital name, street, city, state, ZIP+4 Code, and benefit code (if applicable).
3a	Patient control number	Optional Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3b	Medical record number	Enter the client's medical record number (limited to ten digits) assigned by the hospital.

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Block No.	Description	Guidelines
4	Type of bill (TOB)	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient identifier	Optional Enter the client identification number if it is different than the Subscriber and insured's identification number.
8b	Patient name	Enter the client's last name, first name, and middle initial.
9a-9b	Patient address	Starting in 9a, enter the client's complete address as described (street, city, state, and ZIP+4 Code).
10	Birthdate	Enter the client's date of birth (MM/DD/YYYY).
11	Sex	Indicate the client's sex by entering an "M" or "F."
12	Admission date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims.
13	Admission hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.

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Block No.	Description	Guidelines
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 15.) 5 Trauma center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, 3, or 5: 1 Physician referral 2 Clinic referral 3 Health maintenance organization (HMO) referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (client status of "30"), leave the block blank.
17	Patient Status	For inpatient claims, enter the appropriate two-digit code to indicate the client's status as of the statement "through" date. ***Refer to:*** Section 5.7.2.8, "Client Status (for block 17)" in this chapter.
18-28	Condition codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a client.
29	ACDT state	Optional Accident state.
31-34	Occurrence codes and dates	Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61, 62, and 80 must also be completed as required. ***Refer to:*** Section 5.7.2.9, "Occurrence Codes (for blocks 31 through 34)" in this chapter.

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Block No.	Description	Guidelines
35-36	Occurrence span codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within 7 days of a previous stay. Enter the dates of the previous stay.
39-41	Value codes	Accident hour—For inpatient claims, if the client was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39-41 must equal the total days billed as reflected in Block 6.
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. National Drug Code Enter N4 Enter the 11-digit NDC number (number on package or container from which medication was administered). Do not enter hyphens or spaces within this number (e.g., 00409231231). The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) must also be submitted (e.g., 0.025). ***Example:*** *N400409231231GR0.025* ***Refer to:*** Section 5.6.2.4, "National Drug Codes (NDC)" in this chapter.

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Block No.	Description	Guidelines
44	HCPCS/rates	Inpatient Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. Outpatient Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. ***Note:*** *The UB-04 CMS-1450 claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e.* If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims. ***Note:*** *HASC providers should enter only one CPT procedure code for the inclusive global fee.*
45	Service date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation date	Enter the date the bill was submitted.
46	Serv. units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation. Enter the number of blood factor units provided.
47	Total charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. ***Note:*** *For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*

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Block No.	Description	Guidelines
48	Noncovered charges	Enter the amount of the total noncovered charges.
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan identification number.
54	Prior payments	Enter amounts paid by any TPR, and complete Blocks 31, 61, 62, and 80 as required.
56	NPI	Enter the NPI of the billing provider. HASC facilities should use the HASC provider identifier for scheduled outpatient day surgeries. Claims for emergency, unscheduled outpatient surgical procedures should be using the hospital's outpatient provider identifier.
57	Code Code (CC)	Optional Area to capture additional information necessary to adjudicate the claims. Required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.
58	Insured's name	If other health insurance is involved, enter the insured's name.
60	Insured's Unique ID	Enter the client's nine-digit CSHCN Services Program identification number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number if one was issued.
65	Employer name	Enter the name of the client's employer if health care might be provided.
66	Diagnosis/Procedure Code Qualifier	Enter the applicable ICD indicator to identify which version of ICD codes is being reported: 0 = ICD-10-CM
67	Principal diagnosis (DX) code and present on admission (POA) indicator	Enter the diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. Required POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. HASC providers are not required to enter a diagnosis code. ***Refer to:*** Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)" in this chapter.

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Block No.	Description	Guidelines
67A-67Q	Other DX codes and POA indicator	Enter the diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided for nonpatients (TOB "141"). ***Exception:*** *A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein.* ***Note:*** *Diagnosis codes entered in 67K-67Q are not required for systematic claims processing.* Required POA indicator-Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)" in this chapter.
69	Admit DX code	Enter the diagnosis code indicating the cause of admission or include a narrative. ***Note:*** *The admitting diagnosis is only for inpatient claims.*
70a-70c	Patient's reason DX	Optional New block indicating the client's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	Optional The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indicator	Required Enter the diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. ***Refer to:*** Section 5.7.2.10, "POA Indicators (for blocks 67 and 72)" in this chapter.
74	Principal procedure code and date	Enter the HCPCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed. ***Note:*** *HASC providers enter only one CPT procedure code for the inclusive global fee.*
74a-74e	Other procedure codes and dates	Enter the HCPCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.

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Block No.	Description	Guidelines
76	Attending provider	Enter the attending provider name and identifiers. NPI number of the attending provider. For inpatient claims enter the NPI of the provider who perform the service or procedure or is responsible for the treatment and plan of care (POC). For outpatient claims enter the NPI of the physician who referred the client to the hospital.
77	Operating	Enter name (last name and first name) and NPI number of the operating provider (the individual with the primary responsibility for performing the surgical procedures). Required when a surgical procedure codes is listed on the claim.
78-79	Other provider	Other provider's name (last name and first name) and NPI. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Designated physician—For a limited client when the physician performed or authorized nonemergency care. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure. ***Note:*** *If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.*

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Block No.	Description	Guidelines
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a client stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered.
81A-81D	Other identification (ID) number	Enter the CSHCN Services Program taxonomy code (non-NPI number) of the billing provider.

5.7.2.8 Client Status (for block 17)

Code	Description
1	Routine discharge
2	Discharged to another short-term general hospital
3	Discharged to SNF
4	Discharged to intermediate care facility (ICF)
5	Discharged to another type of institution
6	Discharged to care of home health service organization
7	Left against medical advice
8	Discharged or transferred to home under care of a Home IV provider
9	Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)
20	Expired
30	Still client (To be used only when the client has been in the facility for 30 consecutive days and payment is based on diagnosis-related group [DRG])
40	Expired at home (hospice use only)
41	Expired in a medical facility (hospice use only)
42	Expired - place unknown (hospice use only)

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Code	Description
43	Discharged or transferred to a federal hospital (such as a Veterans Administration [VA] hospital)
50	Hospice-Home
51	Hospice-Medical facility
61	Discharged or transferred within this institution to a hospital-based Medicare approved swing bed
62	Discharged or transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare-certified long-term care hospital (LTCH)
64	Discharged or transferred to a nursing facility certified under Medicaid, but not certified under Medicare
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged or transferred to a critical access hospital (CAH)
71	Discharged to another institution of outpatient (OP) services
72	Discharged to another institution

5.7.2.9 Occurrence Codes (for blocks 31 through 34)

Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of occurrence codes.

5.7.2.10 POA Indicators (for blocks 67 and 72)

Code	Description	Guidelines
Y	Yes	Diagnosis was present at the time of admission.
N	No	Diagnosis was not present at the time of admission.
U	Unknown	Documentation is insufficient to determine if condition is present at time of inpatient admission.
W	Clinically undetermined	Provider is unable to clinically determine whether condition was present at time of inpatient admission.
Blank	Unreported/Not used	Exempt from POA reporting.

5.7.2.11 Dental Claim Filing

Dental and orthodontia services must be billed using the American Dental Association (ADA) Dental Paper Claim Form or equivalent electronic format when requesting payment.

Providers are responsible for obtaining these forms from a supplier of their choice.

Refer to: The ADA website at www.ada.org for a sample of the ADA Dental Claim Form.

5.7.2.12 ADA Dental Claim Electronic Billing

Electronic billers must submit dental claims using TexMedConnect or an approved vendor software that uses the ANSI ASC X12 837D 5010 format. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, block locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for more information about electronic billing.

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5.7.2.13 Instructions for Completing the Paper ADA Dental Claim Form

The instructions describe the information that must be entered in each of the block numbers of the paper ADA Dental Claim Form. Thoroughly complete the dental claim form according to the instructions below to facilitate prompt and accurate reimbursement and reduce follow-up inquiries.

Block No.	ADA Description	Instructions
1	Type of Transaction (Mark all applicable boxes)	For the CSHCN Services Program, check Statement of Actual Services Box. The other two boxes are not applicable.
2	Predetermination/Preautho-rization Number	Enter PAN if assigned by the CSHCN Services Program.
3	Company/Plan Name, Address, City, State, ZIP Code	Enter name and address of CSHCN Services Program Contractor payer where the claim is to be sent.
4	Other Dental or Medical Coverage	Check applicable box If both Dental and Medical are marked, complete blocks 5-11 for dental only
5	Name of Policyholder/ Subscriber in #4	This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
6	Date of Birth (MM/DD/ CCYY)	Enter insureds eight-digit date of birth (MM/DD/CCYY). This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
7	Gender	Check insureds correct gender. This line refers to the insured and is not necessarily the client. May be parent or legal guardian of client receiving treatment.
8	Policyholder/Subscriber ID (SSN or ID#)	Enter insureds subscriber identifier. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
9	Plan/Group Number	Enter insureds plan/group number. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
10	Client's Relationship to Person Named in #5	Enter insureds relationship to primary subscriber. This line refers to the insured and is not necessarily the client. May be a parent or legal guardian of the client receiving treatment.
11	Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, ZIP Code	Information on other insurance carrier, if applicable.
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Enter client's last name, first name, and middle initial exactly as written on the CSHCN Services Program Eligibility Form.
13	Date of Birth (MM/DD/ CCYY)	Enter client's eight-digit date of birth (MM/DD/CCYY).
14	Gender	Check client's gender.
15	Policyholder/Subscriber ID (SSN or ID#)	Enter client's CSHCN Services Program number.
16	Plan/Group Number	Enter the benefit code, if applicable, of the billing provider.

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Block No.	ADA Description	Instructions
17	Employer Name	Not applicable for the CSHCN Services Program.
18	Relationship to Policy-holder/Subscriber in #12 Above	Not applicable for the CSHCN Services Program.
19	Reserved for Local Use	Leave blank and skip to Item 20. (Field was previously used to report "Student Status") Include the appropriate modifier.
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Must put client name information, same as in Block 12.
21	Date of Birth (MM/DD/CCYY)	Must put client's eight-digit date of birth information, same as in Block 13.
22	Gender	Must put client gender information, same as in Block 14.
23	Client ID/Account # (Assigned by Dentist)	**Optional**—Used by dental office to identify internal client account number. This block is not required to process the claim.
24	Procedure Date (MM/DD/CCYY)	Enter eight-digit date of service (MM/DD/CCYY).
25	Area of Oral Cavity	Not applicable for the CSHCN Services Program.
26	Tooth System	Not applicable for the CSHCN Services Program.
27	Tooth Number(s) or Letter(s)	Enter the Tooth ID as required for procedure code. Select the appropriate tooth number for permanent teeth (01–32 or the appropriate letter for primary teeth 0A through 0T).
28	Tooth Surface	Enter the Surface ID as required for procedure code using M (Mesial); F (Facial); B (Buccal or Labial); O (Occlusal); L (Lingual or Cingulum); D (Distal); and/or I (Incisal).
29	Procedure Code	Use appropriate *Current Dental Terminology* (CDT) procedure code.
29a	Diagnosis Code Pointer	Enter the letter(s) from Box 34 that identified the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b	Procedure Quantity	Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in item 24. The default value is "01."
30	Description	Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).
31	Fee	Enter usual and customary charges for each line of service used. Charges must not be higher than the fees charged to private pay clients.
31a	Other Fee(s)	When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies. Identify the source of each payment date in Block 11. If the client makes a payment, the reason for the payment must be identified in Block 11.

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Block No.	ADA Description	Instructions
32	Total Fee	Enter the sum of all fees in Block 31. For multipage claims, enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. **Note:** *Indicate the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.*
33	Missing Teeth Information	Mark an "X" on the number of the missing tooth. (For identifying missing permanent detention only.) Report missing teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant services procedures on a particular claim.
34	Diagnosis Code List Qualifier	Enter the appropriate code to identify the diagnosis code source: Enter "AB= ICD-10" to identify the diagnosis code source.
34a	Diagnosis Code(s)	Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".
35	Remarks	Use the Remarks space for local orthodontia codes, a narrative explanation for exception to periodicity (Block 19), a facility name, address, and NPI if the place of treatment (Block 38) is not a provider's office, an emergency narrative (Block 45), or additional information, such as reports for 999 codes or multiple supernumerary teeth, or remarks codes.
36	Client/Guardian signature	Not applicable for the CSHCN Services Program.
37	Subscriber signature	Not applicable for the CSHCN Services Program.
38	Place of Treatment	Enter the 2-digit place of service (POS) code for professional claims, which is a *Health Insurance Portability and Accountability Act* (HIPAA) standard. Frequently used POS codes include the following: • 11=Office • 12=Home • 21=Inpatient hospital • 22= Outpatient hospital • 31=Skilled nursing facility • 32= Nursing facility ***Note:*** *All current POS codes are available online from the Centers for Medicare & Medicaid Services (CMS).*
39	Enclosures	Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models). Field changed to report Yes/No instead of types and quantities of enclosures.
40	Is Treatment For Orthodontics?	Check **Yes** or **No** as appropriate.
41	Date Appliance Placed (MM/DD/CCYY)	Not applicable for the CSHCN Services Program.

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Block No.	ADA Description	Instructions
42	Months of Treatment Remaining	Not applicable for the CSHCN Services Program.
43	Replacement of Prosthesis?	Not applicable for the CSHCN Services Program.
44	Date Prior Placement (MM/DD/CCYY)	Not applicable for the CSHCN Services Program.
45	Treatment Resulting from	Providers are required to check Other Accident box for emergency claim reimbursement. If Other Accident box is checked, information about the emergency must be provided in Block 35.
46	Date of Accident (MM/DD/CCYY)	Not applicable for the CSHCN Services Program.
47	Auto Accident State	Not applicable for the CSHCN Services Program.
48	Name, Address, City, State, ZIP Code	Name and physical address of the billing group or individual provider (not the name and address of a provider employed within a group).
49	NPI	Enter required billing dentist's NPI for a group or an individual (not the NPI for a provider employed within a group).
50	License Number	Not applicable for the CSHCN Services Program.
51	SSN or TIN	Not applicable for the CSHCN Services Program.
52	Telephone Number	Enter area code and telephone number of billing group or individual (not the telephone number of a provider employed within a group).
52A	Additional Provider ID	Enter the taxonomy code assigned to the billing dentist or dental entity (not the CSHCN Services Program employed within a group).
53	Signed (Treating Dentist)	Required signature of treating dentist or authorized personnel.
54	NPI	Enter the performing dentist's (provider who treated the client).
55	License Number	Not applicable for the CSHCN Services Program.
56	Address, City, State, ZIP Code	Not applicable for the CSHCN Services Program.
56A	Provider Speciality Code	This block is optional.
57	Telephone Number	Not applicable for the CSHCN Services Program.
58	Additional Provider ID	Required information—must enter taxonomy code for the performing dentist (provider who treated the client).

5.7.2.14 Electronic Claims Submission

TMHP uses the HIPAA-compliant ANSI ASC X12 5010 file format through secure socket layer (SSL) and virtual private networking (VPN) connections for maximum security.

Claims may be submitted electronically to TMHP through TexMedConnect on the TMHP website at www.tmhp.com or through billing agents who interface directly with the TMHP Electronic Data Interchange (EDI) Gateway. Files that are submitted using EDI version 5010 are limited to a maximum of 5,000 transactions per file. Files that have more than 5,000 transactions will be rejected.

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Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for more information about electronic claims submission.

5.7.2.15 Taxonomy Codes

Billing providers that are not associated with a group are required to submit a taxonomy code on all electronic claims. TMHP will reject claims for non-group billing providers (individuals and facilities) that are submitted without a taxonomy code.

Group billing providers are no longer required to submit the taxonomy code on electronic claims. Group billing providers can submit the taxonomy code to assist with the NPI crosswalk.

5.7.2.16 Dates on Claims

All dates (such as date of birth and date of service) entered on the claim (electronic and paper) must be eight digits in MMDDYYYY format.

Example: *August 6, 2019, is entered as 08062019.*

5.7.2.17 Span Dates

Providers currently submitting paper claims and that have provided services on consecutive days may bill multiple consecutive days per claim detail as long as the dates are in the same month and year. Providers must indicate (in the quantity billed) the number of dates they are billing.

Example: *Services were provided each day from August 6, 2019, to August 16, 2019. When submitting the paper claim, enter the from date of service as 08062019 and the to date of service as 08162019. The quantity is 11.*

Note: *Claims submitted with a quantity billed not equal to the number of days indicated in the date of service blocks are denied. When the claim is processed, the system creates multiple details consisting of four consecutive days each so that the claim appears on the provider's R&S Report with one detail for each 4 days billed. Using the example above, there are three details as illustrated below.*
If the number of details created during this process is greater than 28, the claim is denied for exceeding the maximum details per claim, and the provider must resubmit the claim, dividing the dates of service into multiple claims, to convey complete billing information.

Detail	From DOS	To DOS	Qty Billed
1	08062019	08092019	4
2	08102019	08132019	4
3	08142019	08162019	3

5.7.2.18 Hospital Billing

Hospitals submitting inpatient claims on paper may submit up to 61 service lines per claim. When the claim is submitted, the system performs a merge function that combines like revenue codes to reduce the number of service lines to 28 or less. Because of the merge function, it is important to understand that when the claim appears on the R&S Report the provider does not see the 61 service lines submitted, but rather the results of merged details. If the merge function is unable to merge the number of service lines to 28, the claim is denied for exceeding the maximum details per claim, and the claim needs to be subdivided and resubmitted as multiple claims.

For more information on electronic claim submission, contact the TMHP EDI Help Desk at 1-888-863-3638, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

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5.7.2.19 Group Billing

Providers billing as a group must give the NPI and taxonomy code of the individual rendering the services on their claims as well as the group provider NPI. To be eligible for reimbursement, both the group and the performing provider must be enrolled in the CSHCN Services Program.

5.7.3 Supervising Physician Provider Number Required on Some Claims

The supervising physician provider number will be required on some claims for services that are ordered or referred by one provider at the direction of or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the client.

If a referral or order for services is based on a client evaluation that was performed by the supervised provider, the claim from the performing provider must include the names and National Provider Identifiers (NPIs) of both the ordering provider and the supervising provider for Children with Special Health Care Needs (CSHCN) Services Program clients. The performing provider will need to obtain all of the required information from the ordering or referring provider before submitting the claim to TMHP.

Note: *Pharmacy claims are currently excluded from this requirement.*

5.7.4 Ordering/Referring Provider NPI

All CSHCN Services Program claims for services that require a physician order or referral must include the ordering or referring provider's NPI:

- If the ordering or referring provider is enrolled in the CSHCN Services Program as a billing or performing provider, the billing or performing provider NPI can be used.
- If the ordering or referring provider is not currently enrolled in the CSHCN Services Program as a billing or performing provider, the provider can enroll to receive an ordering or referring-only NPI. The provider will receive one NPI that can be used for orders and referrals for both Texas Medicaid clients and CSHCN Services Program clients.

  Note: *The billing provider will be responsible for confirming that the ordering or referring provider is enrolled as an ordering or referring-only provider.*

Claims that are submitted without the ordering or referring provider's NPI may be subject to retrospective review and denial if the NPI is not included on the claim.

5.8 Reimbursement

CSHCN Services Program reimbursements are available to all actively enrolled providers either by check or electronic funds transfer (EFT). Through EFT, TMHP deposits reimbursements directly into a provider's bank account. Active providers do not have any type of payment holds on their enrollment status.

The CSHCN Services Program reimburses hospitals, physicians, and other suppliers of service. Each section of this manual gives more detail concerning the methods used to reimburse each provider specialty for claims processed by TMHP. The following information is provided as an overview of the CSHCN Services Program reimbursement methodology.

The CSHCN Services Program implemented rate reductions for certain services. The Online Fee Lookup (OFL) includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

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5.8.1 Electronic Funds Transfer (EFT)

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

5.8.1.1 Advantages of EFT

The advantages of EFT are:

- Stop payments are no longer necessary because no paper is involved in the transaction process.
- Payment theft is less likely to occur because the process is handled electronically rather than by paper.
- Deposited funds are available for withdrawal within a few days after completion of the TMHP financial cycle.
- Upon deposit, the bank considers the transaction immediately collected. No float is attached to EFT deposits for CSHCN Services Program funds.
- TMHP includes provider and R&S Report numbers with each transaction submitted. If the banks processing software captures and displays the information, both numbers would appear on the banking statement.

5.8.1.2 Enrollment Procedures

Providers are strongly encouraged to participate in EFT. EFT does not require special software, and providers can enroll immediately. To enroll in EFT, complete the Electronic Funds Transfer (EFT) Maintenance Request through the TMHP Provider Enrollment and Management System (PEMS).

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

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

If the provider changes bank accounts, the provider must submit a new EFT Agreement to the TMHP Provider Enrollment department. The prenotification process is repeated and, once completed, the EFT transaction is deposited to the new bank account.

5.8.1.3 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

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Refer to: Section 24.3.7, "Payment Window Reimbursement Guidelines" in Chapter 24, "Hospital" for additional information about the payment window reimbursement guidelines for inpatient admission.

5.8.2 Texas Medicaid Reimbursement Methodology (TMRM)

The CSHCN Services Program reimburses physicians based on the TMRM. This methodology is used to reimburse the following services and tests:

- Physician services
- Services incidental to physician's services
- Diagnostic tests (other than clinical laboratory)
- Radiology services

TMRM is based on Medicare's resource-based relative value scale (RBRVS) with Medicaid modifications.

Refer to individual provider chapters for specific information about reimbursement.

5.8.3 Maximum Allowable Fee Schedule

Physicians/supplier services that are not reimbursed according to TMRM or reasonable charge may be reimbursed according to a maximum fee schedule. Maximum fee schedules are determined by state and federal regulations.

5.8.4 Manual Pricing

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

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

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

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

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

5.8.5 Physician Services in Hospital Outpatient Setting

Section 104 of the *Tax Equity and Fiscal Responsibility Act* of 1982 (TEFRA) requires the CSHCN Services Program to limit reimbursement of physician services furnished in a hospital outpatient setting that are also ordinarily furnished in a physician's office. The limit for each service is determined by establishing a charge base for each professional service and multiplying the charge base by 0.60. The charge base for a service is the TMRM fee for similar services furnished in the office.

This provision applies to those procedures performed in the outpatient department of the hospital, such as in clinics and emergency departments. When the eligible client is seen in the outpatient department of the hospital in an emergency situation, the condition that created the emergency must be documented on the claim form.

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The following services are excluded from this limitation:

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

5.8.6 Inpatient Hospital Reimbursement

The reimbursement methodology for many CSHCN Services Program facilities that are reimbursed based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) has changed to the prospective payment methodology based on All Patient Refined Diagnosis Related Groups (APR-DRG) payment system.

Hospitals that are enrolled in the CSHCN Services program must first be enrolled in Texas Medicaid. The CSHCN Services Program reimbursement methodology has changed from TEFRA to APR-DRG. The reimbursement methodology for hospitals that are reimbursed by Texas Medicaid using APR-DRG also applies for the CSHCN Services Program. This reimbursement methodology applies to all hospitals except for state-owned teaching hospitals and inpatient psychiatric facilities.

The reimbursement method will not affect inpatient benefits and limitations. Inpatient admissions will continue to require prior authorization.

Note: *The 20-percent payment reduction that is currently applied to inpatient claims by the CSHCN Services Program will remain in effect.*

Refer to: Section 24.3.2, "Hospital Reimbursement" in Chapter 24, "Hospital" for more information about hospital reimbursement.

5.8.6.1 Prospective Payment Methodology

The prospective payment methodology is based on a DRG payment system. Reimbursement based on DRG includes all facility charges (e.g., laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. Claims may not be submitted for technical services.

The CSHCN Services Program does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (e.g., psychiatric or rehabilitation). Because all inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, providers may submit only one claim for each inpatient stay. The claim must include appropriate diagnosis and procedure code sequencing. The discharge and admission hours (military time) are required on the UB-04 CMS-1450 paper claim form or electronic equivalent, to be considered for payment.

The number of days of care charged for a client for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to- midnight method is to be used in counting days of care for reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

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A part of a day, including the day of admission and day on which a client returns from leave of absence, counts as a full day. However, the day of discharge, death, or a day on which a client begins a leave of absence is not counted as a day unless discharge or death occur on the day of admission.

If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (January 1 through December 31) for clients who are 21 years of age and older. Claims may be subject to retrospective review, which may result in recoupment.

5.8.7 Fees

Providers can now access the online fee lookup (OFL) function on the TMHP website at www.tmhp.com and do the following:

- Retrieve fee schedule information in real time
- Search for procedure code reimbursement rates individually, in a list, or in a range
- Search and review their contracted rates
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period
- Perform an online, interactive search of benefit information that has been published within the past 18 months for up to ten procedure codes.

5.8.7.1 Provider-Specific Rates for Procedure Codes with Modifiers and Age-Range Criteria

Providers with contracted rates may also use the OFL on the TMHP website to view provider-specific rates for procedure codes that have modifiers and age range criteria.

Providers may view their provider-specific rates for procedure codes with modifiers and age range criteria by completing the following steps:

1) Access the secure portion of the TMHP website at www.tmhp.com
2) Click **Resources**
3) Click **Online Fee Lookup**
4) Click **Fee Search**
5) Select or Enter the following:
    a) NPA/API/Taxonomy/Address/ZIP+4/ Benefit Code
    b) Program Code
    c) Procedure Code
    d) Date of Service
    e) Modifier 1 (if applicable)
    f) Modifier 2 (if applicable)
    g) Modifier 3 (if applicable)
    h) Modifier 4 (if applicable)
    i) From Age, in years (if applicable)
    j) To Age, in years (if applicable)
6) Click **Submit**

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The Contracted Rate Search results page features a display of contracted rate search criteria and additional columns and rows to display search results. The Contracted Rate Search results page displays the following:

- Rate Type
- Rate
- Start Date
- End Date (if end-dated)
- Modifiers (if applicable)
- Client From and To Age (if applicable)

5.8.8 CSHCN Services Program Reimbursement Information for Clients

The CSHCN Services Program may reimburse clients for drug copays and transportation of remains when there is an accompanying parent or other responsible person.

Clients may call TMHP at 1-877-888-2350, Monday through Friday, from 7 a.m. to 7 p.m., Central Time, for additional information.

Clients may also receive reimbursement for insurance premiums through the Insurance Premium Payment Assistance (IPPA) program. For additional information, clients may call the TMHP-IPPA toll-free client help line at 1-800-440-0493, Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

5.9 CSHCN Services Program Accounts Receivables (Using Medicaid Funds to Satisfy the AR)

A service that is rendered to a CSHCN Services Program client who receives retroactive Medicaid eligibility may be reimbursed by the CSHCN Services Program or by Medicaid, but not by both.

The CSHCN Services Program is the payer of last resort. The CSHCN Services Program does not supplement a client's Medicaid benefits. However, services that are not a benefit of Medicaid may be covered by the CSHCN Services Program. If dual Medicaid and CSHCN Services Program eligibility is determined, claims that have already been paid by the CSHCN Services Program will be reprocessed under the appropriate program.

An accounts receivable (AR) is created for each CSHCN Services Program claim that is reprocessed and subsequently reimbursed under Medicaid so that the amount the CSHCN Services Program originally reimbursed can be returned to the CSHCN Services Program.

If the CSHCN Services Program payout during the week's financial cycle in which the claim was reprocessed is not sufficient to satisfy the AR, the provider's Medicaid claim payouts will be used to satisfy the CSHCN Services Program AR.

> ***Note:*** *The deduction from Medicaid claim payouts will not exceed the amount Medicaid reimbursed the provider when the CSHCN Services Program claim was reprocessed.*

If the CSHCN Services Program AR is not satisfied within 45 days, TMHP will send the provider a notice that requests repayment to the CSHCN Services Program for the remaining AR balance.

5.10 TMHP-CSHCN Services Program Contact Center

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

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