HOSPITAL

CSHCN SERVICES PROGRAM PROVIDER MANUAL

NOVEMBER 2026

TEXAS
Health and Human
Services

HOSPITAL

Table of Contents

24.1 Enrollment 4
24.1.1 Continuity of Hospital Eligibility Through Change of Ownership 4
24.1.2 Specialty Team or Center 5
24.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements 5
24.2.1 Chemotherapy 6
24.2.2 Cochlear Implants 6
24.2.3 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies) 6
24.2.4 Fluocinolone Acetonide Intravitreal Implant (*Retisert*) 6
24.2.5 Laboratory Services 6
24.2.6 Magnetoencephalography (MEG) Services 7
24.3 Inpatient Services 7
24.3.1 Benefits, Limitations, and Authorization Requirements 7
24.3.1.1 Initial Inpatient Prior Authorization Requests 7
24.3.1.2 Emergency Inpatient Hospital Admissions 8
24.3.1.3 Inpatient Behavioral Health 8
24.3.1.3.1 Inpatient Behavioral Health Prior Authorization Requirements 8
24.3.1.4 Inpatient Rehabilitation Services 9
24.3.1.4.1 Inpatient Rehabilitation Prior Authorization Requirements 10
24.3.1.4.2 Treatment for Acute Medical Episodes 10
24.3.1.5 Renal (Kidney) Transplants 10
24.3.1.5.1 Reimbursement for Renal Transplants 11
24.3.1.5.2 Renal Transplant Authorization Requirements 12
24.3.1.6 Transplants - Nonsolid Organ 12
24.3.1.6.1 Stem Cell Transplant Prior Authorization Requirements 13
24.3.1.7 Neonatal Level of Care Designation for Inpatient Services 13
24.3.1.7.1 Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation 13
24.3.1.7.2 Other Requirements 14
24.3.1.7.3 Transfers 14
24.3.2 Hospital Reimbursement 14
24.3.3 Prospective Payment Methodology 14
24.3.4 Client Transfers 15
24.3.4.1 Admission Dates 15
24.3.4.2 Continuous Stays - Client Transfers and Readmissions 15
24.3.5 Observation Status to Inpatient Admission 15
24.3.6 Outlier Ajustments 16
24.3.6.1 Day Outliers 16
24.3.7 Payment Window Reimbursement Guidelines 16
24.3.7.1 Exceptions 17
24.3.7.2 Professional and Outpatient Claims for Services Related to the Inpatient Admission 18
24.3.7.3 Professional and Outpatient Claims for Services Unrelated to the

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Inpatient Admission 18
24.4 Outpatient Services 18
24.4.1 Benefits, Limitations, and Authorization Requirements. 18
24.4.1.1 Hospital-Based Outpatient Behavioral Health Services 19
24.4.1.2 Hospital-Based Emergency Services Department 19
24.4.1.2.1 Hospital-Based Emergency Services Authorization. 19
24.4.1.3 Outpatient Observation. 20
24.4.1.3.1 Direct Outpatient Observation Admission 21
24.4.1.3.2 Observation Following Emergency Room 21
24.4.1.3.3 Observation Following Outpatient Day Surgery 21
24.4.1.3.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services. 21
24.4.1.3.5 Documentation Requirements for Outpatient Observation 22
24.4.1.3.6 Reporting Hours of Observation. 22
24.4.1.3.7 Client Status Change. 23
24.4.1.3.8 Outpatient Observation Authorization 24
24.4.1.3.9 Observation Services that are Not a Benefit. 24
24.4.1.3.10 Outpatient Observation Authorization 24
24.4.1.4 Sleep Studies 24
24.4.1.5 Hyperbaric Oxygen Therapy (HBOT) 25
24.4.2 Reimbursement Information 25
24.4.2.1 Hospital-Based Emergency Services Department 26
24.4.2.2 One-day Payment Window Reimbursement Guidelines 26
24.5 Ambulatory Surgical Centers 26
24.5.1 Benefits, Limitations, and Authorization Requirements. 26
24.5.1.1 Freestanding Surgical Centers. 26
24.5.2 Reimbursement Information 27
24.6 Claims Information. 27
24.6.1 Inpatient Claims 27
24.6.2 Outpatient Claims 28
24.6.2.1 Revenue Code and Procedure Code Requirements for All Outpatient Services 29
24.6.2.1.1 Revenue Codes That Require a Procedure Code 29
24.6.2.1.2 Clarification for Non-Hospital Facility Claims. 30
24.6.3 HASC Claims 31
24.6.4 Inpatient Stays Following Scheduled Day Surgeries. 31
24.6.5 Inpatient Stays Following Unscheduled (Emergency) Day Surgeries 32
24.7 TMHP-CSHCN Services Program Contact Center 32

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.1 Enrollment

To enroll in the CSHCN Services Program, a hospital must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the TMHP-CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state hospitals must meet all of these conditions and be located in New Mexico, Oklahoma, Arkansas, or Louisiana within 50 miles of the Texas state border. Hospital providers must be Medicare-certified.

Freestanding ambulatory surgical centers (ASCs) and hospital ambulatory surgical centers (HASCs) are subject to the same enrollment requirements as hospitals. HASCs must enroll separately from the hospitals in which they are based.

To be eligible for participation in the CSHCN Services Program, a psychiatric hospital or facility must be enrolled in Texas Medicaid as a freestanding inpatient psychiatric facility. Out-of-state psychiatric hospitals or facilities must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border.

All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA) of 1988.

Refer to: Section 25.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988" in Chapter 25, "Laboratory Services" for more information.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession or facility standards, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

24.1.1 Continuity of Hospital Eligibility Through Change of Ownership

When a hospital changes ownership, the new owner must take the following actions:

- Obtain recertification as a Medicare facility under the new ownership.
- Complete a Texas Medicaid Provider Enrollment Application. The provider must be enrolled with Texas Medicaid before applying for the CSHCN Services Program.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners in a language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership).
- Supply a listing of all the providers identified by the change of ownership.

24.1.2 Specialty Team or Center

In addition to requiring prior authorization, the following services require that the physicians or facilities be approved by the TMHP-CSHCN Services Program as specialty team or center providers:

- For kidney transplant services, the facility must be specialty center-approved.
- Stem cell transplant services must be provided in a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). The provider must attest to compliance with the required criteria when the prior authorization form is completed and submitted. TMHP maintains a current list of approved centers.

Refer to: Section 2.1.7, "Transplant Specialty Centers" in Chapter 2, "Provider Enrollment and Responsibilities" for more information about stem cell and kidney transplant facility designation.

24.2 Inpatient/Outpatient Benefits, Limitations, and Authorization Requirements

Facilities are responsible for knowing which services require authorization or prior authorization and whether they are a benefit in the inpatient or outpatient setting. The services listed below are not all-inclusive. Refer to the appropriate sections of the provider manual for specific benefit information.

The benefits, limitations, and authorization requirements in this section apply to both inpatient and outpatient services. Additional information specific to inpatient services can be found in Section 24.3, "Inpatient Services" in this chapter. Additional information specific to outpatient services can be found in Section 24.4, "Outpatient Services" in this chapter and information on ASCs can be found in Section 24.5, "Ambulatory Surgical Centers" in this chapter.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program.

Some procedures require prior authorization or specialty team or center approval. If prior authorization is not obtained as required, the procedures or hospital stay are denied. Authorization is a condition of reimbursement; it is not a guarantee of payment. Faxed transmittal confirmations are not accepted as proof of timely authorization submission.

Authorization or prior authorization is not given if the client is not eligible for the CSHCN Services Program benefits when the request is received by the TMHP-CSHCN Services Program. All claims for these services must meet the 95-day filing deadline.

Providers can fax or mail their written requests along with all other applicable documentation to the following address:

Texas Medicaid & Healthcare Partnership
TMHP-CSHCN Services Program Authorization Department
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4222

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information, including deadlines and appeal procedures.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.2.1 Chemotherapy

Inpatient and outpatient hospitals must use revenue code 636 for reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

Refer to: Section 31.2.11, "Chemotherapy" in Chapter 31, "Physician" for additional information.

24.2.2 Cochlear Implants

Cochlear implant devices are payable to the facility where the cochlear implantation surgery takes place. Hospitals must submit procedure code L8614 when billing for cochlear implant devices. ASCs and HASCs must submit procedure code L8614 with modifier NU when billing for cochlear implant devices.

Refer to: Section 20.3.2, "Cochlear Implants" in Chapter 20, "Hearing Services" for additional information.

24.2.3 Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies)

Electromyography (EMG) and nerve conduction studies (NCS) are benefits of the CSHCN Services Program when medically indicated. EMG and NCS are diagnosis restricted and may require prior authorization.

Refer to: Section 31.2.18, "Evaluation and Management (E/M) Services" in Chapter 31, "Physician."

24.2.4 Fluocinolone Acetonide Intravitreal Implant (*Retisert*)

Fluocinolone acetonide intravitreal implant is a corticosteroid indicated for the treatment of chronic noninfectious uveitis affecting the posterior segment of the eye. The surgical implant is designed to release fluocinolone acetonide over approximately 30 months.

Procedure code J7311 is a benefit for the CSHCN Services Program for clients 12 years of age or older in a hospital, HASC, or ASC setting. Procedure code J7311 is only considered for reimbursement with a posterior uveitis diagnosis of more than 6 months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

24.2.5 Laboratory Services

Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient, but whose laboratory services are performed by the hospital.

All clinical laboratory services may be reimbursed at a percentage of the Medicare rate set by the Centers for Medicare and Medicaid Services (CMS), except for those hospitals that have been identified by Medicare as sole community hospitals. These hospitals may be reimbursed at 103.35 percent of the clinical lab rate.

Outpatient and nonpatient claims for laboratory services must only reflect tests actually performed by the hospital laboratory; however, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim.

Hospitals may bill a handling fee (procedure code 99001) for collecting and forwarding a specimen collected by venipuncture or catheterization and sent to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories. In order to bill a handling fee, the receiving laboratory's name and address and unique National Provider Identifier (NPI) number must be included on the claim in Blocks 17 and 17B.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

To be eligible for reimbursement by the CSHCN Services Program, all laboratories must be certified according to the Clinical Laboratory Improvement Amendments (CLIA) regulations.

Refer to: Section 25.1, "Enrollment" in Chapter 25, "Laboratory Services."

24.2.6 Magnetoencephalography (MEG) Services

Inpatient and outpatient hospitals must use revenue code 860 or 861 for reimbursement of magnetoencephalography (MEG) services. The appropriate MEG procedure code must be listed on the claim.

Note: *Reimbursement to an outpatient hospital will be based on the submitted procedure code.*

Refer to: Section 31.2.29, "Magnetoencephalography (MEG)" in Chapter 31, "Physician" for additional information.

24.3 Inpatient Services

24.3.1 Benefits, Limitations, and Authorization Requirements

Inpatient hospital services include medically necessary items and services ordinarily furnished by a CSHCN Services Program hospital or by an approved, enrolled, out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Hospital services must be medically necessary, prior authorized, and are subject to the utilization review requirements of the CSHCN Services Program.

Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year and may accrue intermittently or consecutively. Once 60 days of inpatient care are provided, reimbursement for additional inpatient care is not considered until the next calendar year, except as noted below.

Exception: *A benefit of up to 60 additional inpatient days may be granted to a client, to begin on the date of hospital admission, for an approved stem cell transplant.*

Inpatient hospital services include the following items and services:

- Room and board in semiprivate accommodations or in an intensive care or coronary care unit, including meals, special diets, and general nursing services. Room and board in private accommodations, including meals, special diets, and general nursing services may be reimbursed up to the hospital's charge for the most prevalent semiprivate accommodations. Private accommodations are not subject to the semiprivate rate if they are documented by the physician as medically necessary. The hospital must keep this documentation in the client's record and document the information on the claim.
- Whole blood and packed red blood cells that are reasonable and necessary for the treatment of illness or injury provided they are not available without cost.
- All medically necessary ancillary services and supplies ordered by a physician.
- Medically necessary emergency and non-emergency ambulance transportation of the client during the inpatient stay.

Note: *Items for personal comfort or convenience, such as a telephone or television, are not a benefit of the CSHCN Services Program and are not reimbursed, even if they are ordered by a physician.*

24.3.1.1 Initial Inpatient Prior Authorization Requests

All inpatient admissions must be prior authorized before the date of service or the entire hospital stay will be denied. Partial approvals for a hospital stay will not be approved. Friday and weekend admissions may be authorized when an emergency exists or when the required medical services will not be delayed due to the timing of the admission. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only must be completed and submitted to obtain authorization.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

All prior authorization request forms must be complete and must include either the surgeon's or the attending physician's name and NPI on the authorization request form. These physicians and the hospital must be actively enrolled in the CSHCN Services Program to obtain authorization.

If an initial request for prior authorization of an inpatient hospitalization is received for a CSHCN Services Program-enrolled client from a nonenrolled provider, the request is denied. If that provider subsequently enrolls as a CSHCN Services Program provider and submits a claim for these previously denied services within the 95-day claims filing deadline, then the claim may be considered for reimbursement based on the medical necessity of the services. If a provider does not complete the request, or if an initial request for prior authorization was not received from an enrolled provider, then the claim(s) cannot be considered for payment and are denied. All providers must be enrolled in order to receive reimbursement.

24.3.1.2 Emergency Inpatient Hospital Admissions

All inpatient admissions must be prior authorized. The CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admissions - For Use by Facilities Only Form must be submitted to the claims contractor for review and approval before the date of service, or the entire hospital stay will be denied. Partial approvals for a hospital stay will no longer be reimbursed.

Requests for emergency hospital admissions must be received within 48 hours of an admission or by the next business day for weekend admissions. Late submitted requests for emergency admissions will be denied for the entire hospital stay.

Note: *Partial approvals for a hospital stay will not be granted.*

If the initial prior authorization request meets the deadline requirements and is denied for incomplete or inaccurate information, the provider may correct and resubmit the prior authorization request. The corrected request is a one-time resubmission only and must be received within 5 business days following the denial of the initial request. If the corrected request still contains incomplete or inaccurate information, then the request will not be eligible for a second resubmission and will be denied for the entire hospital stay. Corrected requests received after 5 business days following the initial denial will be denied for the entire hospital stay.

All applicable information must accompany the request documenting the emergent conditions that necessitated the inpatient admission.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization and prior authorization requirements.

24.3.1.3 Inpatient Behavioral Health

The intent in providing inpatient services is to provide resources for behavioral health crisis stabilization while efforts are made to transfer the clients to a more appropriate outpatient program where they may receive the necessary psychiatric/psychological treatment required. Benefits are limited to inpatient assessment and crisis stabilization and must be followed by referral to the Texas Department of State Health Services (DSHS) or other appropriate behavioral health programs. Inpatient behavioral health services are limited to five days per calendar year, which count toward the inpatient hospital limitation of 60 days per calendar year.

Revenue code 124 may be a benefit of the CSHCN Services Program for inpatient behavioral health services.

24.3.1.3.1 Inpatient Behavioral Health Prior Authorization Requirements

Inpatient admissions for behavioral health crisis stabilization must be prior authorized. A completed CSHCN Services Program Prior Authorization Request for Inpatient Psychiatric Care Form must be submitted. Requests must be received by the TMHP-CSHCN Services Program before or on the day of the client's admission, unless the admission is after 5 p.m., or on a holiday, or a weekend. In these cases,

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

the TMHP-CSHCN Services Program must receive it by 5 p.m. on the next business day following admission. The TMHP-CSHCN Services Program will notify the provider of the decision in writing by fax. There may be no extensions to the 5-day limit.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

Chapter 29, "Outpatient Behavioral Health" for more information about behavioral health services.

Inpatient psychiatric hospitals may be reimbursed at 80 percent of the TEFRA rate for CSHCN services.

24.3.1.4 Inpatient Rehabilitation Services

Inpatient rehabilitation programs must include medical management, two or more therapies (e.g., respiratory therapy, speech-language pathology [SLP] services, physical therapy [PT], occupational therapy [OT]), and rehabilitation nursing. The CSHCN Services Program may reimburse inpatient rehabilitation services if the client meets one of the following criteria:

- The client is 5 years of age or older, sufficiently alert to respond to interventions and to participate with the rehabilitation team in setting treatment goals, and is an active participant in therapeutic activities.
- The client is 4 years of age or younger, sufficiently alert to respond to interventions and to participate with the rehabilitation team, and the parent or caregiver can actively participate in setting treatment goals and learning therapeutic management.

In addition, at least one of the following criteria must be met for the client to be eligible for reimbursement of inpatient rehabilitation services:

- The client developed a recent onset of illness or trauma (within the last 12 months) without previous comprehensive rehabilitation efforts.
- There is no documentation of previous inpatient comprehensive rehabilitation effort.
- The client experienced a loss of previous level of functional independence through complications or recurrent illness, and the recovery of functional independence is feasible.

The following are examples of conditions that may be considered for coverage of inpatient rehabilitation:

- Spinal cord injuries
- Traumatic amputation of upper or lower extremities
- Rheumatoid arthritis and other inflammatory polyarthropathies
- Burns
- Postpolio syndrome
- Neoplasms
- Head or brain injuries
- Late effects of infections (i.e., Guillain-Barré syndrome)
- Cerebrovascular diseases
- Congenital conditions (e.g., spina bifida and cerebral palsy) may be considered when there is a recent change in medical and functional status, such as postspinal surgery

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.3.1.4.1 Inpatient Rehabilitation Prior Authorization Requirements

Prior authorization is required for inpatient rehabilitation services. An inpatient rehabilitation provider must be enrolled in the CSHCN Services Program as an inpatient hospital before a prior authorization may be approved.

Prior authorization may be approved in 14-day increments, not to exceed a maximum of 90 days per calendar year. Requests must be submitted in writing with documentation of medical necessity, including the diagnosis or condition of the client and progress toward goals (request for additional days) along with a copy of the treatment plan. The CSHCN Services Program Prior Authorization Request for Inpatient Rehabilitation Admission form must be submitted for the initial request and each extension. Providers must include all supporting documentation showing medical necessity for the extended inpatient stay.

A statement explaining the medical necessity of inpatient versus outpatient rehabilitation services must be included with the documentation submitted for prior authorization. The justification must state the client's current condition and why inpatient rehabilitation, as opposed to outpatient therapy, is required for optimal care. The client's need for daily, intense, focused, team-directed therapy must be substantiated by the circumstances of the case.

If the prior authorization request for additional days documents that the client has made progress toward treatment goals, an additional 14 days may be approved up to a maximum of 90 days per calendar year.

Requests for additional days must be received for prior authorization before the last inpatient rehabilitation day previously prior authorized.

Requests for extensions are *not* approved if one of the following conditions applies:

- The client has met treatment goals, as determined by the rehabilitation team or the CSHCN Services Program medical director or designee.
- The client has failed to make progress toward remaining treatment goals during the currently authorized period.
- The client no longer requires inpatient rehabilitation, and therapeutic goals can be met on an outpatient basis.
- The request was received after the last prior authorized inpatient day.
- The 90-day calendar maximum is exhausted.

24.3.1.4.2 Treatment for Acute Medical Episodes

If a client has been admitted for inpatient rehabilitation and develops an acute medical condition that prevents participation in rehabilitation program activities, then the CSHCN Services Program must not be billed for inpatient rehabilitation services. Acute care services (whether inpatient or outpatient) that are a benefit of the CSHCN Services Program may require authorization or prior authorization and must be billed as acute care services.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information on prior authorization requirements.

24.3.1.5 Renal (Kidney) Transplants

Renal transplants will only be approved for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant facility that is certified by the United Network of Organ Sharing (UNOS) by a Medicaid-approved, CSHCN-enrolled transplant team. All transplant facilities who wish to perform transplants for CSHCN Services Program clients must have current certification and be in continuous compliance with the criteria set forth by UNOS.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Renal transplants and post-transplant care will only be covered if the organ procurement is in alignment with the National Organ Transplant Act (NOTA). Only kidneys harvested voluntarily from within the United States under the oversight of the Health Resources and Services Administration (HRSA) and UNOS will be covered. Kidneys harvested for a fee or sponsorship and kidneys obtained from any country outside of the United States will not be covered for transplant or post-transplant care.

The CSHCN Services Program may reimburse renal transplants when the projected costs of the transplant and follow-up care is less than continuing dialysis treatments. The estimated cost of the renal transplant over a 1-year period versus the cost of renal dialysis for 1 year at the requesting facility must be both documented and reviewed. Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

For any client who is 18 years of age or older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for services through the CSHCN Services Program.

Renal transplants must be prior authorized, and approval is subject to the availability of funds. Only one initial and one subsequent renal transplant may be reimbursed per lifetime.

Some renal transplant procedure codes are subject to a global surgical period of 90 days, with postoperative care included in the reimbursement of the surgical fee.

Refer to: Section 31.2.39.6, "Global Fees" in Chapter 31, "Physician."

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6-week postoperative period will be denied for the surgeon, assistant surgeon, and facility. The anesthesiologist may be reimbursed.

24.3.1.5.1 Reimbursement for Renal Transplants

A maximum amount of $200,000 per client may be reimbursed for a renal transplant hospitalization. Hospitals may be reimbursed 80 percent of the All Patient Refined Diagnosis Related Groups (APR-DRG) payment rate, up to the maximum of $200,000. All hospital charges, including donor costs, are included in the $200,000 limit.

Reimbursement for renal transplants includes:

- The cost of the transplant services.
- One of the following:
    - The cost of the procurement of a cadaveric organ and services associated with the organ procurement, when the organ is obtained from an organ procurement organization designated by the U.S. Department of Health and Human Services. Documentation validating the organ's source must accompany the claim.
    - The cost associated with living donors. The donor costs must be included on the client's inpatient hospital claim and may be reimbursed only if another source of payment is not available. Donor costs for CSHCN Services Program clients who also have Medicaid benefits are not reimbursed.

The costs related to the donor-matching process will not be reimbursed.

If the cost related to a living donor will be paid by the client's other insurance carrier, the Other Insurance information must be completed on the claim form. If these costs will be paid by the donor's insurance carrier, the claim must be submitted using a paper claim form with attachments documenting the donor's insurance information.

Refer to: Section 5.7.2.7, "Instructions for Completing the UB-04 CMS-1450 Paper Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement."

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Renal transplant recipients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the renal transplant.

24.3.1.5.2 Renal Transplant Authorization Requirements

Prior authorization must be obtained by both the facility and the physician.

Documentation supporting the transplant prior authorization request must include:

- The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant form
- A recent and complete history and physical.
- A statement of the client's status, including why a transplant is being recommended at this time.
- Documentation of the cost effectiveness of the transplant vs. continued dialysis.

Nationally, stays for renal transplants in hospital are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program are authorized without an appeal documenting medical necessity.

24.3.1.6 Transplants - Nonsolid Organ

The CSHCN Services Program may cover only autologous and matched related and matched nonrelated allogenic transplants.

Stem cell transplants include the initial transplant and one subsequent retransplant. This allows a total of two transplants per lifetime regardless of payer. The subsequent transplant must be prior authorized separately from the initial transplant.

Indications for re-transplantation will include the following:

- Relapse of disease
- Failure to engraft or poor graft function
- Graft rejection

Services must be provided in a Texas facility that is a designated Children's Hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). TMHP maintains a current list of approved centers.

If a stem cell transplant has been prior authorized, a maximum of 60 days of inpatient hospital services may be a benefit beginning with the actual first day of the transplant. Any days remaining from the standard 60 inpatient day limit may be added to the 60 days for the transplant if the $200,000 limit for the transplant maximum amount has not been exceeded. This 60-day period is considered a separate inpatient hospital admission for reimbursement purposes.

A maximum amount of $200,000 per client may be reimbursed for a stem cell transplant hospitalization. All hospital charges for patient care and donor costs (inpatient hospital only) during the time of the hospital stay are applied to the $200,000 limit. Donor costs must be included on the client's inpatient hospital claim for the transplant. Donor costs will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.

When a second stem cell transplant is prior authorized an additional maximum of $200,000 may be reimbursed for the second prior authorization period. All hospital charges for patient care and donor cost (inpatient hospital only) will be applied to the additional $200,000 limit. Donor cost must be included on the client's inpatient hospital claim for the transplant. Donor cost will not be considered by the CSHCN Services Program when another third-party resource is available to reimburse the transplant.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

If a second cell transplant has been prior authorized, a maximum of 60 days of inpatient hospital services may be a benefit beginning with the actual first day of the second transplant.

Claims are accumulated systematically and payments that exceed $200,000 are cut back, denied, or recouped.

Clients receiving a stem cell transplant are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the stem cell transplant event. This includes reimbursement for anti-rejection drugs.

24.3.1.6.1 Stem Cell Transplant Prior Authorization Requirements

Prior authorization is required for all stem cell transplants and must be obtained by both the facility and the physician.

Refer to: Section 31.2.42.2, "Transplants - Nonsolid Organ" in Chapter 31, "Physician" for additional benefit information.

24.3.1.7 Neonatal Level of Care Designation for Inpatient Services

Hospitals enrolled in Texas Medicaid and the CSHCN Services Program may be reimbursed for inpatient neonatal services only if the hospitals have received a neonatal level of care designation from DSHS in accordance with Title 25 Texas Administrative Code §§133.181-133.190.

A neonatal service is any inpatient hospital service rendered to a client who is 28 days of age and younger.

Refer to: The DSHS website for more information on Neonatal Level of Care Designation.

24.3.1.7.1 Hospitals that Do Not Meet Minimum Requirements for Neonatal Level of Care Designation

A hospital that does not meet the minimum requirements for any level of care designation for neonatal services will not be reimbursed for inpatient neonatal services rendered to Texas Medicaid and CSHCN Services Program clients. Hospitals without a neonatal level of care designation may be reimbursed for emergency services to stabilize an infant prior to transport to a facility capable of providing the appropriate level of care.

Claims for inpatient neonatal services submitted by hospitals that do not have a neonatal level of care designation on file will be denied. Providers can appeal claims by providing documentation that emergency services were required.

If neonatal inpatient services are rendered by a facility that has applied for (but not yet received) a neonatal designation, the facility must still adhere to existing claim filing deadlines (95 days from the date of discharge). While awaiting neonatal level of care designation the facility is responsible for maintaining active claims appeals to adhere to the 120-day claim appeal deadline.

Requirements to obtain a neonatal level of care designation only apply to facilities located in Texas. Those entities that are physically located outside of Texas and enrolled in Texas Medicaid (i.e., out-of-state or border state facilities) are exempt from requiring a neonatal level of care designation for inpatient services rendered to neonatal clients.

Note: *When submitting paper claims for inpatient neonatal services rendered at a facility with an address that is different from the provider's physical address, providers must enter the address of the facility where services were rendered in the remarks field.*

Refer to: Chapter 7, "Appeals and Administrative Review" for more information.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.3.1.7.2 Other Requirements

The submitted facility address on the claim must match the physical address of the location that has been issued a neonatal level of care designation. If the facility address is not included on the claim, the submitted billing address must match the physical address of the location that was issued a neonatal level of care designation by DSHS.

Important: *The hospital address on the health facilities license must match the address billed on the claim. Claims will be denied if the address submitted on the claim does not match the address on file. Providers should refer to the DSHS approval letter to verify the correct address.*

Refer to: The DSHS website for more information on address updates.

24.3.1.7.3 Transfers

When Texas Medicaid or CSHCN Services Program clients are 28 days of age or younger on the date of admission and are subsequently transferred to another facility, neonatal level of care designation requirements will apply to all facilities involved in that client's continuous inpatient stay.

24.3.2 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 Service Program.

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.*

24.3.3 Prospective Payment Methodology

The prospective payment methodology is based on a diagnosis related groups (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 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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 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. Hospital reimbursement is made in accordance with TAC §351.10 (6).

24.3.4 Client Transfers

24.3.4.1 Admission Dates

To ensure correct payor identification, providers that receive transfer patients from another hospital must enter the actual date on which the client was admitted into each facility in Block 12 on the UB-04 CMS-1450.

24.3.4.2 Continuous Stays - Client Transfers and Readmissions

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. The CSHCN Services Program does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the NPI. Readmissions to the same facility within 24 hours of a previous acute hospital or facility discharge are also considered one continuous stay and receive only one DRG payment.

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

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

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

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

24.3.5 Observation Status to Inpatient Admission

When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 48 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are submitted on the inpatient claim (TOB 111).

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.3.6 Outlier Ajustments

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients who are 21 years of age or younger as of the date of the inpatient admission. If a client's admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid.

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

24.3.6.1 Day Outliers

All of the following criteria must be met to qualify for a day outlier payment:

- Inpatient days must exceed the mean length of stay (MLOS) by more than two days; and
- Inpatient days must exceed the DRG day threshold for the specific DRG.

Once the outlier payment criteria are met:

- Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 60 percent of the per diem amount of a full DRG payment.
- The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

24.3.7 Payment Window Reimbursement Guidelines

The following payment window reimbursement guidelines apply to services that are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

CSHCN Services Program inpatient hospital providers must submit, as part of the client's inpatient hospital claim, all related professional and outpatient services that were rendered on the date of the client's inpatient admission or one of the following dates immediately before the client's inpatient admission:

- Within three calendar days before the client's inpatient admission for hospitals that receive DRG reimbursement
- Within one calendar day before the client's inpatient admission for hospitals that receive reimbursement other than DRG

Professional and outpatient services that must be submitted as part of the inpatient hospital claim include the following services if they are rendered by the hospital or an entity that is wholly owned or operated by the hospital:

- **Diagnostic services.** Diagnostic services include outpatient laboratory and radiology services that are related to the inpatient admission and submitted by physician and outpatient hospital providers. Affected services will include the total and technical components. The professional interpretation component will not be included in the payment windows identified above.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- **Non-diagnostic services.** Non-diagnostic services include surgeries and other non-diagnostic procedures and services that are related to the inpatient admission and submitted by physician, outpatient hospital, or other providers.

Important: *Related professional and outpatient services that were rendered within one day of the inpatient admission and related to the inpatient admission must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay.*

24.3.7.1 Exceptions

The following services are excluded from the payment window and may be submitted and reimbursed separately from the inpatient admission:

- Services rendered by federally qualified health center (FQHC) providers
- Services rendered by rural health center (RHC) providers
- Professional services that are rendered in the inpatient hospital setting (place of service 3)
- Non-emergency and emergency ambulance services

The outpatient emergency and maintenance renal dialysis procedure codes in the tables below are also exceptions to the one-day payment window reimbursement guidelines:

Emergency Renal Dialysis Services Procedure Codes
G0257

Maintenance Renal Dialysis Services Procedure Codes									
ESRD Physician Services									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970
Physician Services for Hemodialysis or Other Dialysis Procedures									
71010	71020	78300	78305	78306	80069	81050	82040	82310	82374
82435	82565	83615	83735	84075	84100	84132	84155	84295	84450
84520	85004	85007	85008	85014	85018	85025	85027	85041	85345
85347	85610	87340	90935	90937	90945	90947	93005		
Equipment and Supplies									
A4216	A4217	A4651	A4652	A4657	A4660	A4663	A4670	A4680	A4690
A4706	A4707	A4708	A4709	A4714	A4719	A4720	A4721	A4722	A4723
A4724	A4725	A4726	A4730	A4736	A4737	A4740	A4750	A4755	A4760
A4765	A4766	A4772	A4773	A4774	A4802	A4860	A4911	A4913	A4918
A4927	A4928	A4929	A4930	A4931	A4932	E0424	E0431	E0434	E0439
E0441	E0442	E0443	E0444	E1510	E1520	E1530	E1540	E1550	E1560
E1570	E1575	E1580	E1590	E1592	E1594	E1600	E1620	E1630	E1632
E1635	E1637	E1639	E1699	J0360	J1160	J1200	J1265	J1644	J1720
J1800	J1955	J2151	J2720	Q4081	36000	36430	36591	36593	49421
93040	93041								

Procedure code Q4081 is limited to three injections per calendar week (Sunday through Saturday).

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.3.7.2 Professional and Outpatient Claims for Services Related to the Inpatient Admission

Professional and outpatient services that are rendered on the date of admission or within one calendar day of the admission date by the hospital, or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Professional and outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.

When modifier PD is appended to a professional or outpatient service, the modifier indicates that the service is related to the inpatient admission. The total and technical components for professional and outpatient services that are related to the inpatient admission will be denied when submitted with modifier PD.

Note: *The professional interpretation component for professional and outpatient services that are related to the inpatient stay may be reimbursed separately even if accompanied by PD modifier.*

24.3.7.3 Professional and Outpatient Claims for Services Unrelated to the Inpatient Admission

Professional and outpatient services that are rendered within the specified timeframe by the hospital or an entity that is wholly owned or operated by the hospital may be reimbursed if they are identified as unrelated to the inpatient admission as follows:

- Professional and outpatient claims for diagnostic services that are unrelated to the inpatient admission must be submitted with modifier U4, which indicates the service is unrelated to the inpatient admission.
- Professional claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the professional claim to the principal inpatient diagnosis. Professional services must be submitted with modifier U4 if the services are unrelated and the referenced professional diagnosis is a three- to seven-digit match to the principal inpatient diagnosis.
- Outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with condition code 51 if the services are unrelated and the referenced outpatient diagnosis is a three- to seven-digit match to the principal inpatient diagnosis.

Unrelated services that are denied as part of the inpatient admission can be appealed with modifier U4 or condition code 51, which indicates that the service is unrelated to the inpatient admission.

Note: *Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission.*

These benefit changes do not impact services rendered by providers that are not wholly owned or operated by the hospital.

24.4 Outpatient Services

24.4.1 Benefits, Limitations, and Authorization Requirements

Outpatient services are ambulatory services provided to an individual who is in a hospital, but not admitted for inpatient care. Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services provided on an outpatient basis that are deemed medically necessary and are provided

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

by a CSHCN Services Program hospital or under the direction of a physician. Supplies provided by a hospital supply room for use in physician's offices in the treatment of clients are not reimbursable as outpatient services.

24.4.1.1 Hospital-Based Outpatient Behavioral Health Services

Outpatient behavioral health services are limited to no more than 30 encounters by all providers per eligible client per calendar year. Laboratory and radiological services do not count toward the 30 outpatient encounters. The CSHCN Services Program does not provide outpatient behavioral health benefits for clients who are also enrolled in the Texas Medicaid, the Medicaid Comprehensive Care Program (CCP), or Children's Health Insurance Program (CHIP).

Hospitals may be reimbursed for psychological testing (procedure codes 96130, 96131*, 96136, and 96137*) and neuropsychological testing (procedure codes 96132, 96133*, 96136, and 96137*) in the outpatient setting. Psychological and neuropsychological testing are limited to a total of 4 hours per day and 8 hours per calendar year, per client, by any provider. Time for interpretation and documentation, including time to document test results in the client's medical record, is included in procedure codes 96121*, 96130, 96131*, 96136, and 96137*and not reimbursed separately. Procedure codes 96130, 96131*, 96136, and 96137* will be denied if performed on the same day as procedure codes 96132, 96133*, 96136, and 96137*.

Note: *Add-on procedure codes indicated with asterisk must be billed with the appropriate primary procedure code*

Authorization is not required.

Refer to: Chapter 29, "Outpatient Behavioral Health."

24.4.1.2 Hospital-Based Emergency Services Department

The CSHCN Services Program may cover emergency room visits for program eligible clients when provided in a CSHCN-enrolled facility. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day, 7 days a week.

According to the federal *Emergency Medical Transportation and Labor Act* (EMTALA), if any individual presents at the hospital emergency department requesting an examination or treatment the hospital must provide for an appropriate medical screening examination and stabilization services within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in placing an individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The medical records must reflect continued monitoring according to the client's needs and must continue until the client is discharged, stabilized, or appropriately transferred.

EMTALA medical screening revenue code 451 may be considered for reimbursement when billed as a stand alone service and provided by a qualified medical professional as designated by the facility. Ancillary, professional, or facility services will not be considered for separate reimbursement when billed with revenue code 451. Services beyond screening can be billed with the appropriate corresponding emergency services revenue code 450, 456, 459, 761, or 762.

24.4.1.2.1 Hospital-Based Emergency Services Authorization

Authorization is not required for emergency medical services. Emergency department services are subject to retroactive review.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.4.1.3 Outpatient Observation

Outpatient observation services are a benefit of the CSHCN Services Program and do not require prior authorization. Observation care is defined by the Centers for Medicare & Medicaid Services (CMS) as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether clients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Outpatient observation services are usually ordered for clients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision about their admission or discharge. The admitting practitioner anticipates that the client will require observation care for a minimum of eight hours. The decision whether to discharge a client from the hospital following resolution of the reason for the observation care or to admit the client as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Outpatient observation services require the use of a hospital bed and periodic monitoring by the hospital's nursing or other ancillary staff to evaluate the client's condition and to determine the need for an inpatient admission. Outpatient observation services can be provided anywhere in the hospital. The level of care, not the physical location of the bed, dictates the observation status.

Outpatient observation services are a benefit only when medically necessary and when provided under a practitioner's order or under the order of another person who is authorized by state licensure law and hospital bylaws to admit clients to the hospital and to order outpatient services.

Outpatient observation services are considered medically necessary if the following conditions are met (this list is not all-inclusive):

- The client is clinically unstable for discharge and one of the following additional conditions apply:
    - Laboratory, radiology, or other testing is necessary to assess the client's need for an inpatient admission.
    - The treatment plan is not established or, based on the client's condition, is anticipated to be completed within a period not to exceed 48 hours.
    - The client had a significant adverse response to therapeutic services, invasive diagnostic testing, or outpatient surgery and requires short-term monitoring or evaluation.
    - The medical necessity for inpatient treatment is unclear, that is:
    - The client's medical condition requires monitoring and evaluation, or treatment to confirm or refute a diagnosis in order to determine whether an inpatient admission is necessary.
    - There is a delayed or slow progression of the client's signs and symptoms that makes diagnosis difficult and the monitoring or treatment does not meet the criteria for an inpatient level of care.
    - The client is undergoing treatment for a diagnosed condition, and continued monitoring of clinical response to therapy may prevent an inpatient admission.

Medically necessary services that do not meet the definition of observation care should be submitted separately or included as part of the emergency department or clinic visit, and are not reimbursed as observation care.

Outpatient observation services are not a substitute for a medically appropriate inpatient admission.

The determination of an inpatient or outpatient status for any given client is specifically reserved to the admitting practitioner. The decision must be based on the practitioner's expectation of the care that the client will require.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.4.1.3.1 Direct Outpatient Observation Admission

A client may be directly admitted to outpatient observation from the evaluating practitioner's office without being seen in the emergency room by a hospital-based practitioner. The practitioner's order should clearly specify that the practitioner wants the client to be admitted to outpatient observation status. An order for "direct admission" will be considered an inpatient admission unless otherwise specified by the practitioner's orders.

Brief observation periods following an office visit or at the direction of an off-site practitioner that involve a simple procedure (e.g., a breathing treatment) would be more appropriately coded as a treatment room visit.

24.4.1.3.2 Observation Following Emergency Room

A client may be admitted to outpatient observation through the emergency room if the client presents to the facility with an unstable medical condition and the evaluating practitioner determines that outpatient observation is medically necessary to determine a definitive treatment plan. An unstable medical condition is defined as one of the following:

- A variance in laboratory values from what is considered the generally accepted, safe values for the individual client.
- Clinical signs and symptoms that are above or below those of normal range and that require extended monitoring and further evaluation.
- Changes in the client's medical condition are anticipated, and further evaluation is necessary.

If a client is admitted to observation status from the emergency room, the hospital is reimbursed only for the observation room charges. The emergency room charges are not reimbursed separately, but must be submitted on a separate detail on the same claim as the observation room charges.

Brief observation periods following an emergency room evaluation will not be reimbursed if the service would normally have been provided within the time frames and facilities of an emergency room visit

24.4.1.3.3 Observation Following Outpatient Day Surgery

If a medical condition or complication of a scheduled day surgery requires additional care beyond the routine recovery period, the client may be placed in outpatient observation. The observation period should be submitted as an outpatient claim.

Reimbursement for outpatient observation after a scheduled day surgery is limited to situations in which the client exhibits an unusual reaction to the surgical procedure and requires monitoring or treatment beyond what is normally provided in the immediate post-operative period. Examples include, but are not limited to:

- Difficulty in awakening from anesthesia.
- A drug reaction.
- Other post-surgical complications.

24.4.1.3.4 Observation Following Outpatient Diagnostic Testing or Therapeutic Services

A client may be admitted to outpatient observation if the client develops a significant adverse reaction to a scheduled outpatient diagnostic test or to a therapeutic service, such as chemotherapy, that requires further monitoring. Observation services begin when the reaction occurred and end when the practitioner determines that the client is stable for discharge, or that an inpatient admission is appropriate.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.4.1.3.5 Documentation Requirements for Outpatient Observation

Documentation that supports the medical necessity of the outpatient observation services must be maintained by the facility in the client's medical record. Documentation must include:

- The order of the ordering practitioner for admission to observation care, which must be dated and timed.
- The practitioner's admission and progress notes, which must be dated and timed, confirm the need for observation care, and outline the client's condition, treatment, and response to treatment.
- Nurse's notes, which must be dated and timed, reflect the time at which the client was admitted to the observation bed, and the reason for the observation stay.
- All supporting diagnostic and ancillary testing reports, including orders for the testing or any pread-mission testing.
- Procedure notes and operative notes that address any complication that would support admission to observation status and must be dated and timed.
- Anesthesia and recovery room/post anesthesia care unit notes from the practitioner and the nurse, which must be dated and timed and detail orders and any complications that require admission to observation status.
- Documentation related to an outpatient clinic visit or critical care service that was provided on the same date of service as the observation service. The documentation must address any need for observation services and be dated and timed.
- All of the client education that was provided during the observation stay.
- The order for discharge from observation care, which must be signed, dated, and timed.
- The discharge notes, including nurse's notes that reflect the date and time at which the client was discharged from observation.

The client must be in the care of a practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are dated, timed, written, and signed by the practitioner.

Claims submitted for outpatient procedures in which the original intention was to keep the client for an extended period of time, such as overnight or for a 24-hour period, will be denied unless significant medical necessity is documented.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the outpatient observation services. Medical records will be evaluated to determine whether the practitioner's order (practitioner intent) and the services that were actually provided were consistent.

The medical records must clearly support the medical necessity of the outpatient observation services and must include a timed order for observation services that will support the number of hours that the client was under observation care and the hours that were submitted for payment.

24.4.1.3.6 Reporting Hours of Observation

Providers must submit the number of observation hours the client was under observation care.

Observation time begins at the clock time documented in the client's medical record. This time should coincide with the time that the client is placed in a bed for the purpose of initiating observation care in accordance with the practitioner's order.

Observation time ends when all medically necessary services related to observation care are completed. The end time of observation services may coincide with the time the client is actually discharged from the hospital or is admitted as an inpatient.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Hospitals should round clock times for the beginning and end of observation to the nearest hour and submit the total number of hours for the observation stay on the claim. For the purposes of submitting claims for observation services, one unit equals one hour. Partial units or hours should be rounded up or down to the nearest hour. Claims submitted with observation room units exceeding 48 hours will be denied.

Any service that was ordered within the observation period may be included on the outpatient claim if a practitioner's order for the service was made within the observation period time frame but hospital scheduling limitations prevented the service from being performed before the 48 hours expired. Any services ordered after 48 hours must not be included on the outpatient claim nor billed to the client. If a period of observation spans more than one calendar day (i.e., extends past midnight), all of the hours for the entire period of observation must be included on a single line, and the date of service for that line is the date on which the observation care began.

Observation time may include medically necessary services and follow-up care that is provided after the time the practitioner writes the discharge order, but before the client is discharged. Reported observation time does not include the time the client remains in the observation area after treatment is completed for reasons such as waiting for transportation home.

Observation services must not be submitted concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure. Time spent for the diagnostic or therapeutic procedure must not be included in the total amount of observation time submitted on the claim.

Recovery room hours that are associated with an outpatient procedure must not be submitted simultaneously with hours of observation time.

Revenue code 761 will be denied if it is submitted for the same date of service by the same provider as revenue code 760, 762, or 769.

24.4.1.3.7 Client Status Change

If a practitioner determines that a client in observation status meets criteria for an inpatient admission, the observation service becomes part of the inpatient stay and is not separately reimbursed.

Both the outpatient observation service (revenue code 760) and the inpatient admission must be submitted as separate details on the same inpatient claim. When a client's status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. The practitioner's order for a change in client status from outpatient observation to inpatient admission must be written, dated, and timed before the outpatient observation claim is submitted for reimbursement.

When a client is admitted to the hospital as an inpatient and a subsequent internal utilization review (UR) determines that the services did not meet inpatient criteria, the hospital may change the client's status from inpatient to outpatient observation. The order to change from an inpatient to outpatient observation admission is effective for the same date and time as the inpatient order. This practice is acceptable under the CSHCN Services Program if all of the following conditions are met:

- The change in client status is made before the claim is submitted.
- The hospital has not submitted a claim for the inpatient admission.
- The practitioner responsible for the care of the client concurs with the hospital UR determination to change to outpatient status.
- The practitioner's concurrence with the UR determination is documented in the client's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be submitted as an outpatient episode of care.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.4.1.3.8 Outpatient Observation Authorization

Authorization is not required for outpatient observation services. Prior authorization is required in the following situations:

- An outpatient observation stay is converted to an inpatient hospitalization.
- A completed CSHCN Services Program Authorization Request for Inpatient Hospital Admission - For Use by Facilities Only form must be completed and submitted to the CSHCN claims contractor.
- Documentation supporting the medical necessity of the outpatient observation services must be submitted with the request for the inpatient hospital admission and must include the beginning and end times of the outpatient observation services.
- For the practitioner's professional services related to a diagnostic, therapeutic, or surgical procedure performed during the time the client is in observation status.

24.4.1.3.9 Observation Services that are Not a Benefit

Outpatient observation services that are not medically necessary or appropriate are not benefits of the CSHCN Services Program, including, but not limited to, services provided under the following circumstances:

- As a substitute for an inpatient admission.
- Without a practitioner's order, including services ordered as inpatient services by the ordering practitioner, but submitted as outpatient by the billing office.
- For clients awaiting transfer to another facility.
- For clients with lack of or delay in transportation.
- As a convenience to the client, client's family, the practitioner, hospital, or hospital staff.
- For routine preparation before, or recovery after, outpatient diagnostic or surgical services.
- When an overnight stay is planned before diagnostic testing.
- To medically stable clients who need diagnostic testing or outpatient procedures that are routinely provided in an outpatient setting.
- Following an uncomplicated treatment or procedure.
- As standing orders for observation following outpatient surgery.
- For postoperative monitoring during a standard recovery period of four to six hours, which is considered part of the recovery room service.
- For outpatient blood or chemotherapy administration and concurrent services.
- For services that would normally require an inpatient admission.
- Beyond 48 hours from the time of the observation admission.

24.4.1.3.10 Outpatient Observation Authorization

Authorization is not required for outpatient observation services.

Important: *All inpatient admissions require prior authorization. Providers must submit the prior authorization request immediately upon determining that the patient's status is changing from observation to inpatient.*

24.4.1.4 Sleep Studies

Polysomnography, multiple sleep latency tests, and pediatric pneumograms may be a benefit of the CSHCN Services Program.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Sleep facilities that perform services for CSHCN Services Program clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Documentation of accreditation must be maintained in the facility and be available for review. Sleep facilities must also follow current AASM practice parameters and clinical guidelines. Providers may refer to the AASM website at https://aasm.org/ for AASM facility certification requirements or to the JCAHO website at www.jointcommission.org for JCAHO facility accreditation information.

Sleep facility technicians and technologists must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

The sleep facility must have one or more supervision physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of the non-physician staff who use the equipment.

Refer to: Section 31.2.38, "Sleep Studies" in Chapter 31, "Physician."

24.4.1.5 Hyperbaric Oxygen Therapy (HBOT)

Hyperbaric oxygen therapy services may be a benefit of the CSHCN Services Program when reimbursed in the outpatient setting to hospital providers when using procedure code G0277. Procedure code G0277 requires prior authorization.

Claims for procedure code G0277 must be submitted with revenue code 413 on the same claim. Claims that are submitted without revenue code 413 will be denied.

The number of billable units that may be submitted for procedure code G0277 will be based on the length of time during which the patient receives treatment with hyperbaric oxygen.

The number of billable units of procedure code G0277 is based upon the time that the patient receives treatment with hyperbaric oxygen. In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbrakes and ascent, (in minutes), as follows:

- The first unit is for the time spent in the chamber receiving hyperbaric oxygen and must be for a minimum of 16 minutes.
- To bill for a second (or subsequent unit), all previous units of time must have been for the full 30 minutes, and the last unit must be for 16-30 minutes.

Refer to: Section 31.2.24, "Hyperbaric Oxygen Therapy (HBOT)" in Chapter 31, "Physician" for more information on benefit and prior authorization criteria.

24.4.2 Reimbursement Information

Outpatient hospital services may be reimbursed 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate. The CSHCN Services Program does not have a separate cost settlement process.

Nonemergent and nonurgent evaluation and management (E/M) services rendered in the emergency room may be reimbursed 125 percent of the adult, physician office visit fee for procedure code 99202.

Imaging services rendered by outpatient hospital providers are reimbursed at the flat fee that is based on the procedure code submitted on the same line item as the imaging revenue code. Rural hospitals are eligible for a different rate for outpatient imaging. The CSHCN Services Program Online Fee Lookup (OFL) will display imaging rates for rural outpatient hospitals with a note code of "RH."

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.4.2.1 Hospital-Based Emergency Services Department

Hospital-based emergency departments may be reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Texas Medicaid cost settlement report. The reasonable cost is reduced by a percentage determined by the state.

24.4.2.2 One-day Payment Window Reimbursement Guidelines

According to the one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within 1 day 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.

Refer to: Section 24.3.7, "Payment Window Reimbursement Guidelines" in this chapter for additional information about the one-day payment window reimbursement guidelines.

24.5 Ambulatory Surgical Centers

24.5.1 Benefits, Limitations, and Authorization Requirements

The ASC or HASC payment represents a global payment and includes room charges and supplies. Benefit services provided are billed as one inclusive charge. All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, and medical supplies) are considered part of the global payment and cannot be itemized or billed separately. All nonroutine laboratory and X-ray services should be billed separately using the hospital's full care NPI and taxonomy code.

Day surgery payment represents a global payment. Physician services must be billed separately.

Day surgery services include prosthetic devices, such as an intraocular lens (IOL), when supplied by the day surgery facility and implanted, inserted, or otherwise applied during a surgical procedure that is a benefit. Certain devices, such as cochlear implants and neurostimulator devices, may be reimbursed separately from the global rate.

24.5.1.1 Freestanding Surgical Centers

To be considered for payment, all surgeries performed in a freestanding surgical center must meet the following requirements:

- Child must be 24 months of age or older.
- The client's current state of health, using the American Society of Anesthesiologists (ASA) physical state classification, must be Level I or II:
  - ASA I or P1: a normal health patient.
  - ASA II or P2: a patient with mild systemic disease.

Services for a client with physical status P3, P4, P5, or P6 cannot be authorized in a freestanding surgical center.

ASA Designation	Physical Status Modifier
ASA I	P1
ASA II	P2
ASA III	P3
ASA IV	P4
ASA V	P5
ASA VI	P6

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Documentation of the client's physical status must be on the surgery authorization request form.

A CSHCN Services Program-enrolled provider must perform the surgical procedure.

24.5.2 Reimbursement Information

ASC and HASC procedure code group information can be obtained from the fee schedules on the TMHP website at www.tmhp.com. When two or more procedures are performed at the same surgical event, only the procedure with the highest reimbursement rate on the fee schedule will be reimbursed.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

24.6 Claims Information

Inpatient, outpatient, and HASC claims must be submitted to TMHP in an approved electronic format or on a UB-04-CMS-1450 paper claim form. Freestanding ASC claims must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase UB-04 CMS-1450 or CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

The total number of details allowed for a UB-04 CMS-1450 paper claim form is 28. The TMHP claims processing system accepts a total of 71 details, and merges like revenue codes together to reduce the lines to 28 or less. If the 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.

All claims that require prior authorization must include the prior authorization number.

When completing the claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for additional information about claims filing.

Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims filing.

Important: *All CSHCN Services Program paper hospital claims must include benefit code CSN.*

24.6.1 Inpatient Claims

Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays. The itemized charges must be retained by the facility for a period of at least 5 years from the date of service.

Medical or surgical supplies (e.g., infusion pumps, traction setups, and crutches only for inpatient use) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or NPI of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

The date of admission must reflect the date that the client was admitted to the hospital as an inpatient.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The from date of service must reflect the date that the client first presented at the hospital for services including but not limited to, emergency room, observation, labor and delivery, or inpatient services.

If services that are rendered before the inpatient admission must be submitted on the inpatient claim, the number of pre-admission days that are related to the inpatient admission cannot exceed the days allowed for the rendered services:

Services	Days Allowed	Units
Emergency Room (ER) services	One day (24 hours) before the inpatient admission	Submitted per day
Observation Services	Up to two days (48 hours) before the inpatient admission	Submitted in hours
Labor and Delivery	Up to three days before the inpatient admission	Submitted per day

Diagnosis-Related Group (DRG) hospital claims allow for a total of three days of pre-admit services. Non-DRG hospital claims are allowed one day of pre-admit services and a second day if additional observations hours occurred.

24.6.2 Outpatient Claims

Medical or surgical supplies (e.g., infusion pumps and traction setups) must be itemized on Block 42-43 of the UB-04 CMS-1450 paper claim form. If provided to all admitted clients, admission kits should be billed using revenue code 270. If laboratory work is sent out, the name and address or NPI of the laboratory where the work was forwarded must be entered in Block 80 of the UB-04 CMS-1450 paper claim form or in Block 32 of the CMS-1500 paper claim form.

Emergency department services by facilities for the room charges may be billed using the following revenue codes:

Revenue Code	Description
450	Emergency room
451	Emergency room - EMTALA
456	Emergency room, urgent care
459	Emergency room, other
761	Treatment or observation room, treatment room
762	Treatment or observation room, observation room

Emergency room ancillary services by facilities include laboratory services, radiology services, respiratory therapy services, and diagnostic studies such as electrocardiogram (EKG), computed tomography (CT) scans, and supplies. Facilities billing outpatient claims (claim type 023) bill for ancillary services must use the appropriate procedure code such as the CPT code or the HCPCS code that indicates the procedure or service performed.

If the client visits the emergency room more than once in a day, the time must be given for each visit. The time of the first visit must be identified in Block 18 of the UB-04 CMS-1450 paper claim form, using 00 to 23 hours military time (e.g., 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code.

Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity of the drug. Take home drugs and supplies are not a benefit of the CSHCN Services Program.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.6.2.1 Revenue Code and Procedure Code Requirements for All Outpatient Services

The *Health Insurance Portability and Accountability Act* (HIPAA) of 1996, requires that a revenue code be billed for outpatient services that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent. All revenue codes (except for those in the table below) must be billed with the most appropriate corresponding procedure code.

Claims must be submitted with the revenue code in Block 42 and the corresponding procedure code in Block 44 for each line item submitted. The revenue code and corresponding procedure code must be on the same line for the claim to process correctly. The procedure code and revenue code combination that is submitted on the claim must reflect the services that were provided to the client. All claims are subject to retrospective review.

24.6.2.1.1 Revenue Codes That Require a Procedure Code

The following revenue codes must be billed with an applicable procedure code:

Revenue Codes That Require Procedure Code									
220	278	279	300	301	302	303	304	305	306
307	309	310	311	312	314	319	320	321	322
323	324	329	330	331	332	333	335	339	340
341	342	349	350	351	352	359	380	381	382
383	384	385	386	387	389	400	401	402	403
404	409	413	419	420	421	422	423	424	429
430	431	432	433	434	439	440	441	442	443
444	449	450*	452*	456*	459*	460	469	470	471
472	479	480	481	482	483	489	540	550	551
552	559	560	561	562	569	570	571	572	579
580	581	582	589	610	611	612	619	620	630
631	632	633	634	635	636	730	731	732	739
740	749	770	771	779	780	789	860	861	880
920	921	922	923	924	925	929	943		

*** For revenue codes 450, 452, 456, and 459, refer to Section 5.8.5, "Physician Services in Hospital Outpatient Setting" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for additional information about the 40-percent reduction for non-emergent and non-urgent services rendered in the emergency room.**

Claims that are submitted with a revenue code in the above table will be priced based on the procedure code pricing methodology. All limitations, guidelines, and pricing that apply to the procedure code will be applied to the line item. If the procedure code is not a benefit when rendered by outpatient hospital providers, the line item will be denied. The procedure code must be a benefit when rendered by outpatient hospital providers, and the provider must follow the benefit guidelines and restrictions for the procedure code in order to be reimbursed.

The following list provides examples of claim submissions and appropriate processing:

- Example 1: If the provider bills a revenue code from the above table and chooses a procedure code that requires a modifier, the appropriate modifier must be billed with the revenue code/procedure code combination.
- Example 2: If the provider bills a revenue code from the above table and chooses a procedure code that is not a benefit when rendered by outpatient hospital providers, the line item will be denied.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- Example 3: If the provider bills a revenue code from the above table and chooses a procedure code that must be submitted to the client's other insurance, the line item will be denied with an indication that the other insurance must be billed first.
- Example 4: If the provider bills a revenue code from the above table and chooses a procedure code with a CMS MUE limitation, the line item will be processed to determine whether the limitation for the procedure code has been exceeded.

The following revenue codes are the only codes that providers can submit without a corresponding procedure code:

Revenue Codes Exceptions List									
250	251	252	254	255	257	258	259	260	261
262	263	264	269	270	271	272	275	276	280
289	360	361	369	370	371	372	374	379	390
410	412	413	451	510	511	512	513	514	515
516	517	519	520	523	526	529	621	622	623
650	651	652	655	656	657	659	700	709	710
719	720	721	722	723	724	729	750	759	760
761	762	769	881						

24.6.2.1.2 Clarification for Non-Hospital Facility Claims

Claims that are submitted on the CMS-1450 UB-04 paper claim form or electronic equivalent by non-hospital facility or other non-hospital providers must be submitted with a revenue code for correct processing. The following guidelines apply to determine reimbursement based on the information submitted on the claim.

Claims submitted with one of the following revenue codes on the same detail line as the procedure code will be reimbursed based on the submitted procedure code:

Revenue Codes that Require a Procedure Code									
278	279	300	301	302	303	304	305	306	307
309	310	311	312	314	319	320	321	322	323
324	329	330	331	332	333	335	339	340	341
342	349	350	351	352	359	380	381	382	383
403	404	409	419	420	421	422	423	424	429
430	431	432	433	434	439	440	441	442	443
444	449	460	469	470	471	472	479	480	481
482	483	489	550	551	552	559	560	561	562
569	570	571	572	579	580	581	582	589	610
611	612	619	620	630	631	632	633	634	635
636	730	731	732	739	740	749	770	771	779
920	921	922	923	924	925	929	943		

Claims that are submitted with a revenue code in the above table will be processed and priced based on the procedure code processing guidelines and pricing methodology. The reimbursement for the line item will not reflect the submitted revenue code even though the revenue code is required for correct claims processing. All limitations, guidelines, and pricing that apply to the procedure code will be applied to the line item.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

For all revenue codes that are not in the above table, the following reimbursement guidelines will apply:

- If the revenue code is submitted without a procedure code, the claim will process using the limitations, guidelines, and pricing for the submitted revenue code.
- If the revenue code is submitted with a procedure code (i.e., on the same line item as the revenue code), the claim will process using the limitations, guidelines, and pricing for the submitted procedure code.

Note: *If the submitted procedure code is not a benefit when rendered by the provider that submits the claim, the line item will be denied. The procedure code must be a benefit when rendered by the provider that submits the claim, and the provider must following the benefit guidelines and restrictions for the procedure code in order to be reimbursed.*

Refer to: The Online Fee Lookup (OFL) on this website to determine whether a procedure code is a benefit when rendered by the provider that submits the claim.

24.6.3 HASC Claims

All surgical procedures performed in an ASC or HASC must be billed using the appropriate national procedure code. Day surgery payment represents a global payment. Physician services must be billed separately.

Claims for scheduled outpatient day surgeries performed in an HASC must be filed using the HASC NPI and type of bill (TOB) 131 for outpatient hospitals in Block 4 of the UB-04 CMS-1450 paper claim form. Surgical procedures performed in the hospital's outpatient departments (emergency room, treatment rooms) are to be billed under the hospital's NPI and taxonomy code and not under the ASC NPI.

Claims for emergency, unscheduled outpatient surgical procedures should be filed with separate charges for all services using TOB 131 and the hospital's outpatient NPI and taxonomy code. If a client is admitted for a day surgery procedure, whether scheduled or emergency, and has either an ASA Classification of Physical Status of III, IV, or V or Classification of Heart Disease IV, the surgical procedure must be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the full care NPI and taxonomy code. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the surgical procedure must be included on one inpatient claim.

Refer to: Section 24.6.2.1, "Revenue Code and Procedure Code Requirements for All Outpatient Services" in this chapter for more information about the revenue code and procedure code claim requirements for outpatient services.

24.6.4 Inpatient Stays Following Scheduled Day Surgeries

If a client suffers a complication following an elective day surgery procedure and requires an inpatient admission, the surgery must be billed as an outpatient service. All inpatient charges must be submitted on a second claim as inpatient services. The diagnosis on the inpatient claim must be the complication that resulted in the admission. The ambulatory surgical procedure must not be listed on the inpatient claim. All inpatient admissions require prior authorization.

Providers must bill the scheduled day surgery using the ASC or HASC NPI and taxonomy code. If a condition of the scheduled day surgery requires additional care beyond the recovery period, the patient may be placed in outpatient observation (stay less than 24 hours). This outpatient observation stay must be billed using the hospital NPI and taxonomy code. Care required beyond the outpatient observation period (stay of 24 hours or more) must be billed as an inpatient stay. The admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement must be included on the claim. The principal diagnosis to be used is the complication of surgery that necessitated the extended stay.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

24.6.5 Inpatient Stays Following Unscheduled (Emergency) Day Surgeries

Providers must bill the unscheduled day surgery as an outpatient claim using the hospital's NPI and taxonomy code. If a complication occurs, the same guidelines presented in Section 24.6.4, "Inpatient Stays Following Scheduled Day Surgeries" in this chapter must be followed with the following exception: the date of admission on the outpatient claim must reflect the date of first contact with the client.

Take-home drugs and supplies are not a benefit of the CSHCN Services Program. Drugs administered in the outpatient setting must be billed with modifier SH. The drug description must include the name, strength, and quantity.

24.7 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.