TELECOMMUNICATION SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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TEXAS
Health and Human
Services

TELECOMMUNICATION SERVICES

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38.1 Enrollment

To enroll in the CSHCN Services Program, telecommunication providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Home health agency and hospital providers who wish to provide telemonitoring services must notify TMHP as follows:

- Current providers must use the Provider Enrollment and Management System (PEMS) to indicate that they provide telemonitoring services.
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers will indicate whether they provide telemonitoring services during the enrollment process.

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, 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.

38.2 Benefits, Limitations, and Authorization Requirements

Prior authorization or authorization is not required for telemedicine or telehealth services, however prior authorization may be required for the individual procedure codes billed.

Health professionals that deliver telemedicine services must follow:

- All applicable Texas statutes, including, but not limited to, Title 3 Texas Occupations Code.
- The rules and standards of their respective licensing or certifying board, including all of the requirements for:
  - Obtaining and documenting informed consent for treatment, data collection, and data sharing.
  - Ensuring the privacy and security of patient data.
  - Record retention.

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Only those services that involve direct face-to-face interactive video communication between the client and the distant-site provider constitute a telemedicine or telehealth service. No separate reimbursement will be made for the cost of telemedicine and telehealth hardware or equipment, electronic documentation, and transmissions. Telephone conversations, chart reviews, electronic mail messages, and fax transmissions alone do not constitute a telemedicine or telehealth interactive video service and will not be reimbursed as telemedicine or telehealth services.

Emergency room care, critical care, home care, preventive care, newborn care, and care provided in a nursing home, skilled nursing facility, or client's home, are not approved telemedicine or telehealth services. Consultative, but not routine, inpatient care, is included as a telemedicine or telehealth service.

Documentation for a service provided via telemedicine or telehealth must be the same as for a comparable in-person service.

The audio and visual fidelity and clarity, and field of view of the telemedicine or telehealth service must be functionally equivalent to an evaluation performed on a client when the provider and client are both at the same physical location or the client is at an established medical site.

More than one medically necessary telemedicine or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties.

38.2.1 Patient Health Information Security

All video and data transmissions between the patient site provider and the distant site provider must comply with the Health Insurance Portability and Accountability Act (HIPAA) and the United States Health and Human Services (HHS) rules implementing HIPAA.

Distant and patient site providers should refer to the National Institute of Standards and Technology (NIST) for additional information about HIPAA-compliant health data storage and encryption technologies.

The software system used by both the distant and patient site providers must allow secure authentication of the distant site provider and the client.

The physical environments of the client and the distant site provider must ensure that the client's protected health information remains confidential. A parent or responsible adult may be physically located in the patient site or distant site environment during a telemedicine or telehealth visit with a child.

A parent or responsible adult must provide written or verbal consent to the distant site provider to allow any other individual, other than the distant site provider, the patient site presenter, or a representative of the distant site provider or patient site presenter, to be physically present in the distant or patient site environment during the visit with a child.

An adult client must also provide written or verbal consent to the distant site provider to allow any other individual, other than the distant site provider, the patient site presenter, or a representative of the distant site provider or patient site presenter, to be physically present in the distant or patient site environment during the visit.

Documentation of the written or verbal consent must be maintained in the client's medical record.

38.2.2 Telemedicine Services

Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following:

- Client assessment by a health professional
- Diagnosis, consultation, or treatment by a physician

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- Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health-care services or medical specialty expertise.

38.2.2.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site benefits include services that are performed by the following providers, who must be enrolled as a CSHCN Services Program provider:

- Physician
- Advanced Practice Registered Nurse (APRN)
- Physician assistant (PA)

Distant site providers that communicate with clients through email or other electronic methods must provide clients with written notification of their privacy practices prior to evaluation and treatment. A good faith effort must be made to obtain the client's written acknowledgment of the notice, which must be maintained in the client's medical record.

Before providing services, distant site providers who use telemedicine medical services must give their clients notice regarding telemedicine medical services, including the risks and benefits of being treated via telemedicine, how to receive follow-up care or assistance in the event of an emergency or adverse event, or in the event of a technology or equipment failure.

Procedure codes that indicate remote (telemedicine or telehealth) delivery in their description do not need to be billed with the 95 modifier. The following procedure codes, when billed with the 95 modifier, are a benefit for distant-site providers:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90951	90952
90954	90955	90957	90958	90960	90961	99202	99203	99204	99205
99211	99212	99213	99214	99215	99242	99243	99244	99245	99252
99253	99254	99255	99417	99418	G0406*	G0407*	G0408*	G0425	G0426
G0427	G0459								

The procedure codes in the table above are limited to one service per day.

Note: *Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health." Procedure codes 90833, 90836, 90838, 99417, and 99418 are add-on codes and must be billed with a primary procedure code on the same day, by the same provider in order to be reimbursed.*

Electronic documentation of the telemedicine consultation must be kept on file at the distant site location and must be available for review upon request by DSHS or its designee.

Refer to: Section 19.2.3, "Telecommunication Services" in Chapter 19, "Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)" for information about billing telemedicine services by FQHC providers.

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38.2.2.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site* - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.
- *Established health site* - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client's presenting complaint. A defined health provider-client relationship is required. A client's private home is not considered an established health site.

Telemedicine services provided at an established medical site require a defined physician-client relationship. The following communications do not meet the defined physician-client relationship requirement:

- An online questionnaire
- Questions and answers exchanged through email, electronic text, or chat
- Telephonic evaluation or consultation with a client

Patient-site providers enrolled in the CSHCN Services Program may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to advanced practice registered nurses, physician assistants, and physicians in the office and outpatient hospital settings and to hospitals in the outpatient hospital setting. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.

A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 *Texas Administrative Code* (TAC) 412.303

For new conditions, the patient site presenter must be readily available onsite at the established medical site to assist with care.

> ***Note:*** *Readily available means the patient site presenter is in the same room as the client or at the discretion of the licensed or certified professional providing the service, is not in the same room as the client but within the proximity determined by the licensed or certified professional providing the telemedicine service.*

A distant site provider delegating tasks to a patient site presenter must ensure that the patient site presenter is properly supervised when the tasks or activities are delegated.

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For follow-up evaluations or treatment of a previously diagnosed condition, the distant site physician will determine if a patient site presenter is necessary.

A client's home may be considered an established medical site when the services provided in the home are limited to mental health services.

If the only services provided are related to mental health services, a patient site presenter is not required, except in cases of behavioral emergencies.

For medical services other than mental health services to be provided in the client's home, the following requirements must be met:

- A patient site presenter is present
- There is a defined physician-client relationship
- The patient site presenter has sufficient communication and remote medical diagnostic technology to allow the physician to carry out an adequate physical examination for the client's presenting condition, while seeing and hearing the client in real time. The physical examination will be held to the same standard of acceptable medical practices as those in traditional clinical settings.

Procedure code Q3014 is not a benefit if the patient site is the client's home.

The patient-site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an electronic-health-record format.

In addition to the documentation requirements specified in this section, all of the outlined services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services that are provided.

38.2.2.3 Other Patient Site

For telemedicine medical services provided at a site other than an established medical site for a client's previously diagnosed condition, the following will apply:

- Patient-site presenters are not required for pre-existing conditions previously diagnosed by a physician through a face-to-face visit
- All clients must be seen by a physician for an in-person evaluation at least once a year
- Telemedicine medical services may not be used to treat chronic pain with scheduled drugs at a site other than a medical practice site
- A distant site provider may treat an established client's new symptoms that are unrelated to the client's pre-existing condition. The client must be advised to see a physician in a face-to-face visit within 72 hours. A distant site provider may not provide continuing telemedicine medical services for these new symptoms if the client has not seen a physician within 72 hours. If the client's symptoms are resolved within 72 hours, and continuing treatment for the acute symptoms is no longer necessary, then a follow-up face-to-face visit is not required.

A distant site provider who provides telemedicine services at a site other than an established medical site for a previously diagnosed condition must do one of the following:

- See the client one time in a face-to-face visit before providing telemedicine medical care
- See the client without a face-to-face visit, as long as the client has received an in-person evaluation by another physician who has referred the client for additional care and the referral is documented in the medical record

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38.2.3 Telehealth Services

Telehealth is defined as health services, other than telemedicine, that:

- Are delivered by licensed or certified health professionals who are acting within the scope of their license or certification.
- Require the use of advanced telecommunications technology, other than telephone or facsimile technology, including the following:
  - Compressed digital interactive video, audio, or data transmission.
  - Clinical data transmission using computer imaging by way of still-image capture and store-and-forward.
  - Other technology that facilitates access to health care services or medical specialty expertise.

Before receiving a telehealth service, the client must receive an in-person evaluation for the same diagnosis or condition. An in-person evaluation is a client evaluation that is conducted by a provider who is at the same physical location as the client.

Exception: *Clients who have a mental health diagnosis or condition may receive a telehealth service without an in-person evaluation if the purpose of the initial telehealth appointment is to screen and refer the client for additional services. The referral must be documented in the medical record.*

To continue receiving telehealth services, the client must have had an in-person evaluation by a person who is qualified to determine a continued need for services at least once in the 12 months before the telehealth service.

Written policies and procedures must be maintained and evaluated at least annually by both the distant-site provider and the patient-site presenter and must address all of the following:

- Client privacy, to assure confidentiality and integrity of client telehealth services
- Archival and retrieval of client service records
- Quality oversight mechanisms

38.2.3.1 Distant Site

A distant site is the location of the provider rendering the service. Distant-site benefits include services that are performed by the following providers, who must be enrolled as a CSHCN Services Program provider:

- Licensed professional counselor
- Licensed marriage and family therapist
- Licensed clinical social worker
- Psychologist
- Licensed dietician

The following procedure codes, when billed with the 95 modifier, are a benefit for distant-site providers:

Procedure Codes						
90791	90832	90834	90837	97802	97803	S9470

The procedure codes in the table above are limited to one service per day.

Note: *Procedure codes for behavioral health services are subject to the benefits and limitations outlined in Chapter 29, "Outpatient Behavioral Health."*

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Procedure codes 90833, 90836, 90838, 99417, and 99418 are add-on codes and must be billed with a primary procedure code on the same day, by the same provider in order to be reimbursed.

Electronic documentation of the telehealth consultation must be kept on file at the distant site location and must be available for review upon request by DSHS or its designee.

38.2.3.2 Patient Site

A patient site is where the client is physically located while the service is rendered. The patient-site must be one of the following:

- *Established medical site* - A location where clients will present to seek medical care. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the client's presenting complaint. A defined physician-client relationship is required. A client's private home is not considered an established medical site.
- *Established health site* - A location where clients will present to seek a health service. There must be a patient-site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation or assessment, as appropriate for the client's presenting complaint. A defined health provider-client relationship is required. A client's private home is not considered an established health site.

Telehealth services provided at an established medical site require a defined physician-client relationship. The following communications do not meet the defined physician-client relationship requirement:

- An online questionnaire
- Questions and answers exchanged through email, electronic text, or chat
- Telephonic evaluation or consultation with a client

The facility fee (procedure code Q3014) is not a benefit for telehealth services. Charges for other services that are performed at the patient site may be submitted separately.

All patient sites must maintain documentation for each service, including:

- The date of the service.
- The name of the client.
- The name of the distant-site provider.
- The name of the patient-site presenter.

A patient-site presenter must introduce the client to the distant-site provider for examination and must perform any tasks and activities that are delegated by the distant-site provider. A patient-site provider must be one of the following:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual's licensure or certification
- A qualified mental health professional-community services (QMHP-CS) as defined in Title 25 *Texas Administrative Code* (TAC) 412.303

For telehealth services, the patient-site presenter must be readily available.

> ***Note:*** *Readily available means in the same room or (at the discretion of the licensed or certified professional that is providing the service) not in the same room as the client but within a proximity determined by the licensed or certified professional who is providing the telehealth service.*

If the telehealth services relate only to mental health, a patient-site presenter does not have to be readily available unless the client is a danger to the client or to others (e.g., behavioral health emergency).

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The patient-site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an electronic-health-record format.

In addition to the documentation requirements specified in this section, all of the outlined services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services that are provided.

38.2.4 Telemonitoring Services

Home telemonitoring services are a benefit of the CSHCN Services Program.

Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a client's health, and transmission of the data from the client's home to a licensed home health agency or a hospital. The data transmission must comply with standards set by the *Health Insurance Portability and Accountability Act* (HIPAA).

Data parameters are established as ordered by a physician's plan of care. Data must be reviewed by a registered nurse (RN), APRN, or PA, who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters.

Telemonitoring providers must be available 24 hours a day, 7 days a week. Although transmissions are generally at scheduled times, they can occur any time of the day or day of the week, according to the client's plan of care.

The physician who orders home telemonitoring services has a responsibility to ensure that the client has the right to discontinue home telemonitoring services at any time.

Although the CSHCN Services Program supports the use of home telemonitoring, clients are not required to use this service.

38.2.4.1 Collection and Interpretation of Client Data

The collection and interpretation of a client's data (procedure code 99091) for home telemonitoring services is a benefit and limited to reimbursement once per 30 days. Prior authorization is not required for procedure code 99091.

38.2.4.2 Facility Services

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency or the hospital. The initial setup and installation (procedure code S9110 with modifier U1) of the equipment in the client's home is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 with procedure code S9110 and one of the appropriate modifiers listed in the table within this section.

Procedure code S9110 (with modifier U1) is limited to once per episode of care even if monitoring parameters are added after initial setup and installation. A claim for a subsequent set up and installation will not be reimbursed unless there is a documented new episode of care or documentation of the occurrence of extenuating circumstances.

Home monitoring (procedure code S9110 with the appropriate modifier) is a benefit when services are provided by a home health agency or an outpatient hospital. Hospital providers must submit revenue code 780 with procedure code S9110 and the appropriate modifier for monthly home monitoring. Refer to table below for the appropriate modifier.

Use one of the following modifiers with monthly home monitoring services procedure code S9110 to indicate the number of transmission days per month:

Modifier	Number of Days Per Month
U2	1 through 5 days per month
U3	6 through 10 days per month

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Modifier	Number of Days Per Month
U4	11 through 15 days per month
U7	16 through 20 days per month
U8	21 through 25 days per month
U9	26 through 30 days per month

The unit of reimbursement for procedure code S9110 and the appropriate modifier is a rolling month.

Providers must bill the appropriate modifier to indicate the number of days that transmissions of data were received and reviewed for the client within a rolling month.

Monthly home monitoring for transmission of client data will not be prior authorized more than once per rolling month for the length of the prior authorization period.

Providers are not required to submit modifiers U2, U3, U4, U7, U8, or U9 for telemonitoring on the prior authorization request, but are required to submit the appropriate modifier on the claim for reimbursement based on the number of days as outlined in the table.

Claims for procedure code S9110 with any modifier should not be submitted to Medicare. Procedure code S9110 is not reimbursed by Medicare.

38.2.4.3 Prior Authorization Guidelines

Procedure code S9110 with or without modifier U1 requires prior authorization. Telemonitoring services may be requested and approved for up to 90 days per prior authorization request. The initial setup and installation (procedure code S9110 with modifier U1) may be prior authorized once per episode of care, unless the provider submits documentation of extenuating circumstances that require another installation of telemonitoring equipment. If additional home telemonitoring services are needed, the home health agency or hospital must request prior authorization before the current prior authorization period ends.

Home telemonitoring services are available to clients only after the home health agency or hospital has received prior authorization. Dates of service requested before the prior authorization request is received will be denied.

The Home Telemonitoring Services Prior Authorization Request form must be signed and dated by the prescribing provider within 30 days before the start of care. If the form is signed after the start of care, all dates of services before the prescribing provider's signature date will be denied.

An RN, APRN, or PA may sign the prior authorization request form on behalf of the client's physician when the physician delegates this authority to the RN, APRN, or PA. The RN, APRN, or PA must complete Section D, then sign and date the form.

To avoid unnecessary denials, the prescribing physician must provide correct and complete information, including documentation of medical necessity for the equipment and supplies requested.

Home telemonitoring services are a benefit only for clients who are diagnosed with one or more of the following conditions:

- Diabetes
- Hypertension
- Congestive heart failure
- End-stage solid organ disease
- Organ transplant recipient
- Requiring mechanical ventilation

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Clients with diabetes or hypertension must exhibit two or more of the following risk factors for approval of telemonitoring services:

- Two or more hospitalizations in the previous 12-month period
- Frequent or recurrent emergency department visits
- A documented history of poor adherence to ordered medication regimens
- Documented history of falls in the previous six-month period
- Limited or absent informal support systems
- Living alone or being home alone for extended periods of time
- A documented history of care access challenges

Documentation that supports the prior authorization request must be maintained in the client's medical record.

The home health agency or hospital must maintain documentation of all the following information:

- The telemonitoring equipment meets all the following requirements:
  - The equipment is capable of monitoring any data parameters included in the plan of care
  - The equipment is classified as a Food and Drug Administration Class II hospital-grade medical device
  - The equipment is capable of measuring and transmitting client weight, oxygen levels in blood, glucose levels in blood, or blood pressure data
- The client's medical record, which must include data transmission information that demonstrates the use of monitoring equipment, such as the following:
  - Date of transmission
  - Frequency of transmission
  - Clinical data provided to the client's primary care physician, or his or her designee
- The provider's staff is qualified to install the telemonitoring equipment and to monitor the client data transmitted according to the client's care plan.
- Monitoring of the client's clinical data is not duplicated by any other provider.
- The client's ability to operate the equipment or has a willing and able person to assist in completing electronic transmission of data, unless the equipment does not require active participation from the recipient.
- Written protocols, policies and procedures on the provision of home telemonitoring services are available to the Department of State Health Services (DSHS) or its designee upon request. Written protocols must address all of the following:
  - Authentication and authorization of users
  - Authentication of the origin of client data transmitted
  - Prevention of unauthorized access to the system or information
  - System security, including the integrity of information that is collected, program integrity, and system integrity
  - Maintenance of documentation about system and information usage
  - Information storage, maintenance, and transmission
  - Synchronization and verification of patient profile data

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

Home Telemonitoring Services Prior Authorization Request Form

38.3 Claims Information

Telecommunication services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper 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 Centers for Medicare & Medicaid Services (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 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" and 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" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

38.4 Reimbursement

Telecommunication services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

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

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

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

38.5 TMHP-CSHCN Services Program Contact Center

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

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