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Introduction

This edition of the *Children with Special Health Care Needs (CSHCN) Services Program Provider Manual* supersedes all manuals published previously. Read the manual carefully.

This manual is designed to supply sufficient information to help providers submit claims to the new *Compass21* claims and encounters processing system expeditiously and correctly the first time.

By focusing on accurate and complete claims submission, we expect to minimize the need for resubmissions and appeals, and help to conserve provider and CSHCN program resources.

This manual also provides program policy information to those providers who submit claims to NHIC for the following services:

- Ambulance
- Dental and Orthodontia
- Durable Medical Equipment
- Freestanding Surgical Centers
- Hemophilia Blood Factor Products (Pharmacies)
- Home Health (Skilled Nursing Only)
- Hospitals
- Independent Laboratories
- Medical Nutritional Services and Products and Total Parenteral Nutrition (TPN) Services
- Orthosis and Prosthesis
- Physicians
- Physical and Occupational Therapy
- Prescription Shoes
- Speech Language Pathology Services
- Transportation of Remains of Deceased Clients

This manual also will be used throughout the year to supplement provider workshops presented by the National Heritage Insurance Company (NHIC).

The first section, “General,” addresses issues of concern to all CSHCN providers. Following the General section, we present specific sections that detail the CSHCN policies affecting the various types of health care providers.

NHIC publishes the CSHCN Bulletin quarterly to advise you of changes in CSHCN policies due to the evolution of health care and/or new government programs and regulations. All bulletins should be retained for future reference, because not all bulletin information will be incorporated into subsequent revisions of the manual.

Providers must be thoroughly familiar with the contents of the manual and the CSHCN Bulletins. It is a violation of the CSHCN provider agreement to fail to comply with the following:

- CSHCN policies
- Published CSHCN Bulletins
- Policy notification letters
- Provider policy or procedure manuals
- Contracts
- Statutes
- Rules
- Regulations
- Interpretations previously sent to the provider of any of the items listed above

CSHCN and NHIC welcome provider comments and suggestions. These must be mailed to:

National Heritage Insurance Company
ATTN: CSHCN Department
12545 Riata Vista Circle
Austin TX 78727-6524

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1.1 Program History

The CSHCN Services Program is a medical services program designed to identify and medically assist children who might otherwise be unable to benefit from present or future educational or employment opportunities. To be determined eligible for CSHCN program services, applicants must meet the medical, financial, and other criteria as stated in the CSHCN program rules effective July 1, 2001.

CSHCN is the oldest continuous medical assistance program within the Texas state government. In 1933, state legislative action initiated funding two years in advance of the first federal initiative, Title V of the Social Security Act.

CSHCN exists to achieve the following program goals:

- Early identification of children with special health care needs
- Diagnosis and evaluation to determine appropriate treatment
- Direct medical care and related services

Services provided include, but are not limited to:

- Behavioral health
- Braces and prosthetic devices
- Dental evaluation and treatment
- Durable medical equipment
- Habilitation and rehabilitation services
- Hospice
- Limited skilled nursing services
- Medications
- Medical supplies
- Physical and occupational therapy
- Renal dialysis
- Screening exams for early identification, medical diagnosis, and treatment
- Speech-language pathology services
- Transportation, meals, and lodging (may be reimbursed when a child must travel from his or her hometown for medical services)
- Vision – examinations and eyewear

Case management services include the following:

- Coordination of medical services
- Marshaling of available resources
- Liaison among the child, family, and caregivers
- Management of institutional services, insurance carriers, and other services needed for improving the well-being of the child and family

A statewide network of regionally based Social Service Program Consultants facilitates these activities.

1.2 CSHCN Regional Offices

1.2.1 Region 1

Canyon Office Texas Department of Health/Public Health Region 1 P O Box 60968 W.T.A.M.U. Canyon TX 79016 Telephone: 806-655-7151, ext. 223 FAX: 806-655-0820	Director of Social Work Services: Kathy Thomas, ACSW, LMSW-ACP Social Service Program Consultant: Susan Stokes, LSW, M. Ed. Eligibility Worker: Dina Herrera LSW

Lubbock Regional Office 1109 Kemper Lubbock TX 79403 Telephone: 806-767-0433 FAX: 806-767-0403	Assistant Director: Carol Marchbanks, ACSW, LMSW Social Service Program Consultant: Judy Lara, LSW Rebecca Williams, LSW Eligibility Worker: Regina Luna
Pampa Office 600 W. Kentucky Pampa TX 79065 Phone: 806-655-0746 FAX: 806-669-0149	Social Service Program Consultant: Donna Stephenson, LSW

1.2.2 Region 2

Abilene Office Commerce Plaza 1290 South Willis, #100 Abilene TX 79605 Telephone: 915-690-4420 FAX: 915-695-8363	Social Service Program Consultant: Debra Huffman-Harris, LMSW-ACP Eligibility Worker: Ann Simmons
Wichita Falls Office 4309 Jacksboro Highway, Suite 101 Wichita Falls TX 76302 Telephone: 817-767-8593 FAX: 940-767-2374	Social Service Program Consultants: Judy Keddy, LSW Mendy Alread, LSW Eligibility Worker: Anita Lancaster

1.2.3 Region 3

Regional Office (Arlington) Texas Department of Health/Public Health Region 2 & 3 1301 South Bowen Rd., Suite 200 Arlington TX 76013 Telephone: 817-264-4627 FAX: 817-264-4911	Director of Social Work Services: Crystal Womack, LMSW-AP Assistant Director of Social Work Services: Bea Hilton, LMSW-AP Social Service Program Consultants: Ardelia Evans, LSW Cynthia Morrison, LSW Kay Eller, LMSW Tom Sanders, SWA Carol Sorich, LMSW-ACP (Program Administrator II) Mary Hamilton (Contact/Secretary) Eligibility Workers: Tintian Padilla Ana Kumpf
Denton Office 3612-B East McKinney Denton TX 76209 Telephone: 940-591-6287 FAX: 940-382-6254	Social Service Program Consultant: Karen Long-DeSmit, LMSW-ACP
Granbury Office 1322 Palaxy Road, Ste. 1 Granbury TX 76048 Telephone: 817-579-0313	Social Service Program Consultant: Barbara Dubey, LSW

1.2.4 Region 4

Regional Office (Tyler) Texas Department of Health/Public Health Region 4 & 5, North 1517 West Front Street Tyler TX 75702 Telephone: 903-533-5231 FAX: 903-595-4706	Director of Social Work Services: Judy Porter, LMSW-ACP Assistant Directors: Lori Kelley, LSW Social Service Program Consultant: Jo Ann Cliver, LSW Felisa Hampton, LSW Eligibility Workers: Shirley Mayfield Cynthia Jones
Athens Office 708 East Corsicana Athens TX 75751 Telephone: 903-675-9107 FAX: 903-675-3622	Medical Social Worker Milinda D. Mezayek, LSW
Canton Office 555 W. Hwy 243 Canton TX 75103 Telephone: 903-567-5441 FAX: 903-567-2689	Social Service Program Consultant: Michelle Evans, LSW
Carthage Office 418 West Sabine Carthage TX 75633 Telephone: 903-693-9322 FAX: 903-693-2316	Social Service Program Consultant: Sherry Lynn Adams, LSW
Clarksville Office 1300 Highway 37N Clarksville TX 75426 Telephone: 903-427-2851 FAX: 903-427-5548	Social Service Program Consultant: Misty D. Ray, LSW
Daingerfield Office 205 Jefferson, PO Box 720 Daingerfield TX 75638 Telephone: 903-645-4037 FAX: 903-645-2864	Social Service Program Consultant: Lori Kelley, LSW
Gilmer Office 324 Yapaco Gilmer TX 75644 Telephone: 903-843-3039 FAX: 903-843-5200	Social Service Program Consultant: Jo Ann Cliver, LSW
Henderson Office 1229 Lone Star Henderson TX 75652 Telephone: 903-657-7578 FAX: 903-655-0104	Social Service Program Consultant: Sherry Lynn Adams, LSW
Jefferson Office 110 West Elizabeth Street Jefferson TX 75657 Telephone: 903-665-3924 FAX: 903-665-7690	Social Service Program Consultant: Sherry Lynn Adams, LSW
Linden Office 123 Kaufman PO Box 300 Linden TX 75563 Telephone: 903-756-7231 FAX: 903-756-5146	Social Service Program Consultant: Lori Kelley, LSW
Marshall Office 4105 Victory Drive Marshall TX 75670 Telephone: 903-938-6743 FAX: 903-927-0290	Social Service Program Consultant: Sherry Lynn Adams, LSW

Mt. Pleasant Office 1014 North Jefferson Mt. Pleasant TX 75455 Telephone: 903-577-1929 FAX: 903-577-8957	Social Service Program Consultant: Lori Kelley, LSW
Palestine Office 100 West Brazos Palestine TX 75801 Telephone: 903-729-6164, 729-6165 FAX: 903-729-7034	Social Service Program Consultant: Marla Phillips, LSW
Paris Office 400 West Sherman Paris TX 75460 Telephone: 903-737-0236 FAX: 903-737-0385	Social Service Program Consultant: Misty D. Ray, LSW
Rusk Office 1209 North Main Rusk TX 75785 Telephone: 903-683-4688 FAX: 903-683-4899	Social Service Program Consultant: Terry Guinn, ACSW, LMSW-ACP (Texas Health Steps Contract)
Sulphur Springs Office 1400 College Sulphur Springs TX 75482 Telephone: 903-439-9336, 439-9331 FAX: 903-885-1166	Social Service Program Consultant: Betty Weir, LMSW-AP
Texarkana Office 410-B Baylor Texarkana TX 75501 Telephone: 903-838-2629, 838-3236 FAX: 903-838-2596	Social Service Program Consultant: Tangela Oliver, LSW

1.2.5 Region 5

Center Office 827 Nacogdoches Center TX 75935 Telephone: 936-591-0396, 591-0425 FAX: 936-591-0162	Social Service Program Consultant: Sandra Garrett, LSW
Crockett Office Southgate Shopping Center 1034 South Fourth Street Crockett TX 75835 Telephone: 936-544-4734, 936-544-8935 FAX: 936-544-0280	Social Service Program Consultant: Mable Thompson, LSW
Jasper Office 139 West Lamar Jasper TX 75951 Telephone: 409-384-6829 800-244-7909 FAX: 409-384-7861	Social Service Program Consultant: Jim Cashman, LMSW (CSHCN Contract)
Livingston Office 410 East Church, Suite B Livingston TX 77351 Telephone: 936-328-8242 FAX: 936-328-8249	Assistant Director: Peggy Wooten, ACSW, LMSW-ACP Social Service Program Consultant: Mona West, LSW
Longview Office 1750 North Eastman Road Longview TX 75601 Telephone: 903-232-3222 FAX: 903-232-3278	Social Service Program Consultant: Amy Norton, LSW

Lufkin Office 503 Hill Street Lufkin TX 75904 Telephone: 936-632-1250 FAX: 936-633-0613	Social Service Program Consultant: Carolyn Cantrell, LMSW-ACP
Nacogdoches Office 2027 North Stallings Drive Nacogdoches TX 75964 Telephone: 936-569-5422 FAX: 936-569-5454	Medical Social Worker: Regina Crain, LSW
Woodville Office 109 West Live Oak Woodville TX 75979 Telephone: 409-283-2735 FAX: 409-283-6071	Social Service Program Consultant: Mona West, LSW

1.2.6 Region 6

Regional Office (Houston) Texas Department of Health/Public Health Region 6 & 5 South 5425 Polk Avenue, Suite J Social Work/CSHCN Department Houston TX 77023-1497 Telephone: 713-767-3111 FAX: 713-767-3125	Director of Social Work Services: Raymond Turner, MA, LMSW-AP Social Service Program Consultants: Karen McDaniel, MA, LMSW Eligibility Workers: Nancy Benedick Claudia Salazar
Beaumont Office 3420 Fannin Street Beaumont TX 77701 Telephone: 409-833-0072 FAX: 409-839-8120	Social Service Program Consultants: Karen Ziegler, BA, SWA Judy Melling, BS, LSW Eligibility Worker: Martha Hardy
Conroe Office 108 Commercial Drive Conroe TX 77304 Telephone: 409-760-4704 FAX: 409-760-4840	Social Service Program Consultant: Cathie Richardson, MSW, LMSW
Texas City Office 714 Loop 197, North Texas City TX 77590 Telephone: 409-945-4712 FAX:409-945-4780	Social Service Program Consultant: Tamara Peoples, BSW, LSW
Wharton Office 2407 North Richmond Wharton TX 77488 Telephone: 979-532-8727 FAX: 979-532-2789	Social Service Program Consultant: Joan Clemons, MSW, LMSW-AP

1.2.7 Region 7

Regional Office (Temple) Texas Department of Health/Public Health Region 7 2408 South 37th Street Temple TX 76504 Telephone: 254-778-6744 FAX: 254-778-4066	Director of Social Work Services: Leslie Anderson, LMSW-ACP Assistant Director of Social Work Services: Eileen Walker, MS, SWA Social Service Program Consultant: Lillian Lessenger, SWA Eligibility Worker: Alice Watkins
Austin Office 1101 Camino La Costa, Room 210 Austin TX 78752 Telephone: 512-467-9875 FAX: 512-451-1468	Social Service Program Consultants: Elaine Mittel, LSW David Ross, MSW Eligibility Workers: Wanda Bernhardt Maggie Chavez
Hearne Office 809 W. Davis #9 & #10 Hearne TX 77859 Telephone: 797-279-2477 FAX: 797-279-9281	Eligibility Worker: Vacant
Waco Office 801 Austin Avenue Waco TX 76701 Telephone: 254-757-0679 FAX: 254-753-0879	Social Service Program Consultants: Dixie Skeen, LSW Jan Lamar, LSW

1.2.8 Region 8

Regional Office (San Antonio) Texas Department of Health/Public Health Region 8 7430 Lewis Pasteur Dr. San Antonio TX 78229 Telephone: 210-949-2155 FAX: 210-949-2047	Director of Social Work Services: Vicky Contreras, LMSW-ACP Asst. Director of Social Work Services: John Garcia, LMSW Social Service Program Consultants: Jose Morales, BA Arnaldo Cardenas, LMSW Malachi Troup, MSW Eligibility Workers: Lydia Medina Julia S. Morquecho
Del Rio Office 1401 Las Vacas Del Rio TX 78840 Telephone: 830-768-2800 FAX: 830-774-6380	Social Service Program Consultant: Sharlene Perez, LSW, M.Ed.
Eagle Pass Office 490 S. Bibb Eagle Pass TX 78852 Telephone: 830-773-9438 FAX: 830-757-3244	Social Service Program Consultant: Linda Ruiz, BSW-LSW
Uvalde Office 1021 Garner Field Rd. Uvalde TX 78802 Telephone: 830-278-7173 FAX: 830-278-7170	Social Service Program Consultant: Rosie DeAnda, LSW
Victoria Office 1502 E. Airline, #39 Victoria TX 77901 Telephone: 361-574-7421 FAX: 361-574-7396	Social Service Program Consultant: Kay Roeh, LMSW-ACP

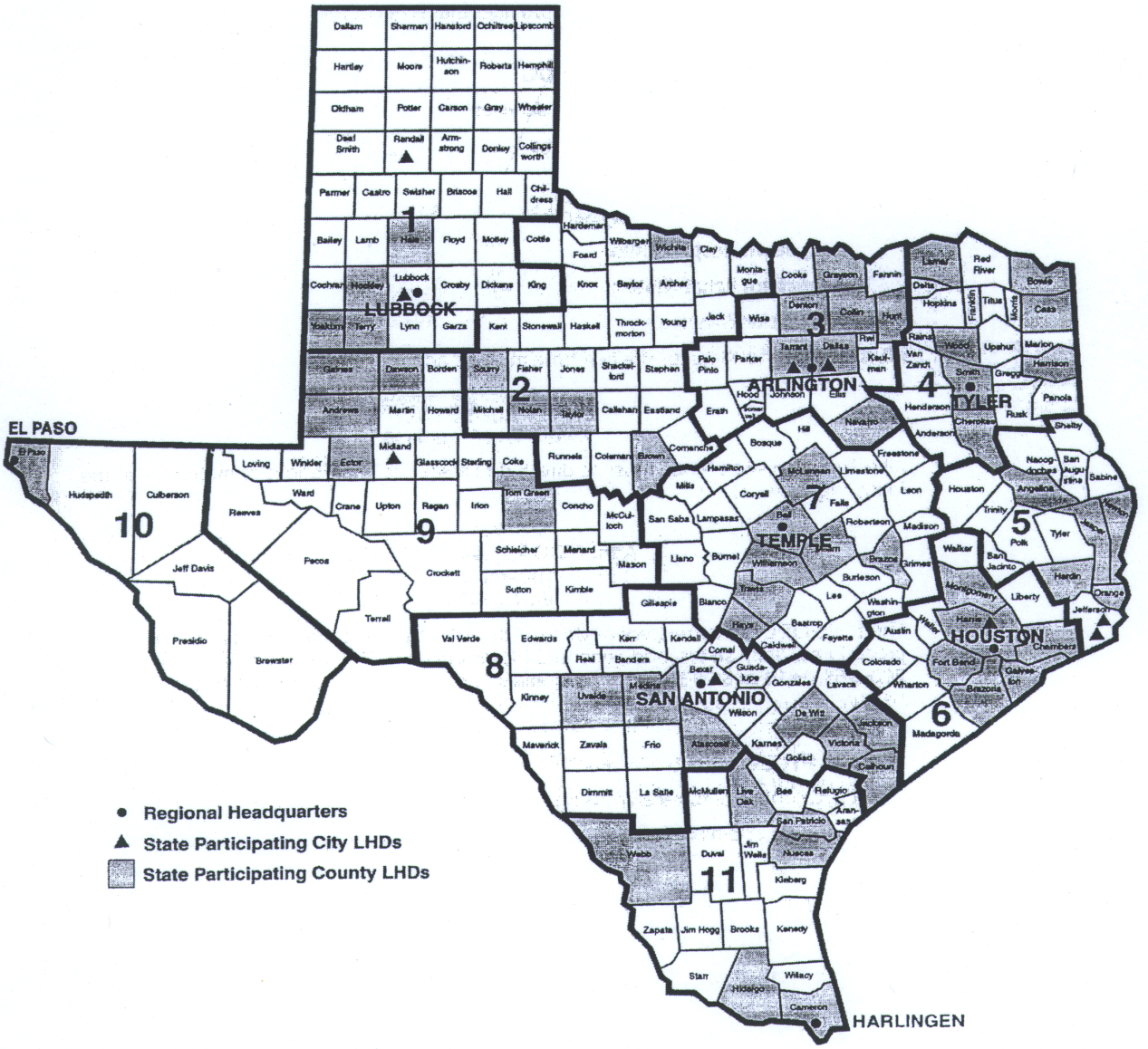
1.2.9 Region 9 & 10

Regional Office (El Paso) Texas Department of Health/Public Health Region 9 & 10 401 E. Franklin, Suite 200 PO Box 9428 El Paso TX 79995-9428 Telephone: 915-834-7695 FAX: 915-834-7804	Director of Social Work Services: Lois Marion Flynn, ACSW, LMSW-ACP Social Service Program Consultants: Agustin Lopez, LSW Armando Rodriguez, LSW Program Administrators: Frank Encinas, LSW Dianne Beltran, SWA Eligibility Workers: Bea Leyva Maryanne Villalobos
Midland Office 2301 N. Big Spring Rd., Ste. 300 Midland TX 79705 Telephone: 915-683-9492 FAX: 915-684-3932	Program Administrator: Joanne Mundy, LSW Social Service Program Consultants: Arline Leyva-Olazaba, LVN, SWA Beatrix Ho Guin, SWA
San Angelo Office 1702 West Avenue "N" San Angelo TX 76901 Telephone: 915-659-8830 FAX: 915-655-6798	Program Administrator II William Paul Buckingham, LMSW-ACP

1.2.10 Region 11

Regional Office (Harlingen) Texas Department of Health/Public Health Region 11 601 W. Sesame Dr. Harlingen TX 78550 Telephone: 956-423-0130 FAX: 956-444-3294	Director of Social Work Services: R. Scott Horney, LMSW, ACP Social Service Program Consultants: Rosalie Iris Cavazos, LSW Michael Garcia, LSW Richard T. Grant, LMSW-ACP Eligibility Worker: Ebelia Chairez
Corpus Christi Office 1233 Agnes St. Corpus Christi TX 78401 Telephone: 361-888-7762 FAX: 361-888-7766	Assistant Director of Social Work Services: Patricia H. Briggs, LMSW-ACP Social Service Program Consultants: Imelda Salinas-Garcia, LMSW-ACP Woodrow Mac Sanders, LSWA Eligibility Worker: Rosie Tagle
Edinburg Office 302-B West University Dr. Edinburg TX 78539 Telephone: 956-316-3636 FAX: 956-316-1148	Assistant Director of Social Work Services: Rodrigo Ramon, Jr, LMSW, AP Social Service Program Consultant: Martha Partida, LSW
Laredo Office 5601 I.H. 35, Ste. 3-A Laredo TX 78041 Telephone: 956-723-6889 FAX: 956-712-8019	Social Service Program Consultant: Ramiro Luna, Jr., SWA, LCCA, CI Clerical Support: Connie Garcia
McAllen Office 600 S. Bicentennial McAllen TX 78501 Telephone: 956-682-1247 FAX: 956-668-1303	Social Service Program Consultants: Edward Pumarejo, LSW Gregoria Lopez, SWA Eligibility Worker: Yolanda Segovia
Alice Office 412 East Main Alice TX 78332 Telephone: 361-668-0747 FAX: 361-668-8196	Social Service Program Consultant: Hector E. Gonzalez, SWA

1.3 TDH MAP


LUBBOCK
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EL PASO
TEMPLE
SAN ANTONIO
HOUSTON
HARLINGEN
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11
Regional Headquarters
State Participating City LHDs
State Participating County LHDs

1.4 Texas Family Code Compliance

1.4.1 Child Support

The *Texas Family Code,* section 231.006, places certain restrictions on child support obligors. Family Code 231.006(d) requires a person who applies for, bids on, or contracts for state funds to submit a statement that the person is not delinquent in paying child support. This law applies to an individual whose business is a sole proprietorship, partnership, or corporation in which the individual has an ownership interest of at least 25 percent of the business entity. This law does not apply to contracts/agreements with governmental entities or nonprofit corporations.

The law also requires that payments be stopped when notified that the contractor/provider is more than 30 days delinquent in paying child support. CSHCN payments will be placed on hold upon notification of a provider that is delinquent in child support payments.

1.4.2 Abuse and Neglect Reporting Requirements

The Texas Department of Health and the CSHCN Program have the expectation that providers comply with the provisions of state law as set forth in Chapter 261, Texas Family Code, related to the reporting of child abuse and neglect.

1.5 Clients Eligible for CHIP/CSHCN Benefits

The new Texas Children's Health Insurance Program (CHIP) offers comprehensive health care coverage to thousands of Texas children who are uninsured. CHIP provides services such as physician care, medications, medical equipment, therapies, hospitalization, and much more.

Many children in the CSHCN Program are eligible for CHIP. Children may receive CHIP and CSHCN benefits at the same time. CSHCN may pay meals, transportation, and lodging not available from CHIP. CSHCN is the payor of last resort for medical services.

Obtaining CHIP coverage is a good opportunity for families because it provides health care services to the CSHCN covered child and other children in the family.

To obtain more information regarding CHIP, contact the TexCare Partnership at 800-647-6558.

1.6 Provider Enrollment/Texas Provider Identifier (TPI)

On August 21, 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which included provisions to adopt specified standards for health care information to be transmitted electronically. One of the specified standards of HIPAA is the establishment of a unique provider identifier for every health care service provider. This unique identifier was referred to as the National Provider Identifier (NPI). The contract between TDH and NHIC requires that all NHIC TPIs convert to the NPI as required by the Health Care Financing Administration (HCFA). At the time this manual was produced, federal regulations for NPI had not been finalized, therefore NHIC is implementing the Texas Provider Identifier (TPI). Effective August 6, 2001, NHIC began requiring the use of a TPI in place of the traditional NHIC provider number. The TPI replaces all existing Medicaid and CSHCN provider numbers.

The TPI is a unique number assigned to each provider. It is a nine-character number composed of the following:

- A seven-character base that uniquely identifies the provider
- A two-character suffix that is assigned for each provider's type, specialty, subspecialty, location, tax identification number (TIN), and Medicare core number

All *R&S* reports are produced with the TPI number after August 6, 2001.

The *R&S* has the TPI number, and all inquiry information is based on the TPI. To reduce the administrative impact to you and your office, we encourage you to begin using your TPI. TPIs were mailed on May 3, 2001, to the accounting address on file at NHIC. If no accounting address was on file, the TPI was mailed to the physical address. If you use a billing service or vendor to submit claims to NHIC, it is imperative that you provide them with your TPI information.

A TPI is issued when NHIC determines that a provider qualifies for participation. All providers must submit claims to NHIC within 90 days from the date of service, even if a TPI has not been assigned. Although claims submitted by providers who are not enrolled in the CSHCN Program are denied by NHIC, these claims may be appealed after completion of the enrollment process. The appeal is considered for payment if submitted within 180 days from the date of the denial.

To enroll in the CSHCN Program, a provider of medical care or services must complete the required CSHCN Provider Enrollment Application and enter into a written Provider Agreement with CSHCN. These forms are supplied by NHIC Provider Enrollment for providers submitting claims to NHIC. Forms may also be downloaded from www.eds-nhic.com.

Enrollment application and the submission of completed forms must be sent to the Provider Enrollment Unit at the following address:

NHIC
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720-0795

All provider types (except for meals, lodging, transportation, and transportation of remains of clients) must be enrolled with Medicaid as a prerequisite to enrolling in the CSHCN Program. Contact CSHCN Customer Service at 800-568-2413 for enrollment requirements.

1.6.1 Claims Processed by the Vendor Drug Program

The following services must be billed electronically to the Vendor Drug Program:

- Aerosolized tobramycin (TOBI)
- Growth hormone products
- HIV/AIDS drugs
- Insulin syringes
- Medications for home use (including vitamins)
- Pulmozyme

Prior authorization requests for drugs requiring prior authorization must be submitted to the Vendor Drug Program. To contact the Vendor Drug Program, call 800-435-4165.

1.6.2 Services Provided by the Medical Transportation Program (MTP)

The Medical Transportation Program (MTP) makes travel arrangements for CSHCN clients. Clients must call the MTP to request travel assistance. To contact the MTP Program, call 877-933-8747.

1.6.3 Claims Processed by TDH-CSHCN

Effective July 1, 2001, services and provider types processed by TDH-CSHCN include:

- Advanced Practice Nurses (APNs)
- Augmentative Communication Devices (ACDs)
- Behavioral Health - outpatient and freestanding psychiatric inpatient facilities (five-day maximum per calendar year)
- Certified Registered Nurse Anesthetists (CRNA) Services
- Hospice
- Certified Respiratory Care Practitioner (CRCP) Services
- Renal Dialysis
- Vision - examinations and eyewear

Claims for services listed above must be addressed to:

TDH
CSHCN Services Program
1100 West 49th Street
Austin TX 78756-3179

Providers may contact the central TDH-CSHCN offices at the following numbers:

Important
The toll-free number is applicable within the State of Texas only.

Telephone Line	Number
Local	512-458-7355
Toll-Free	800-252-8023
CSHCN Fax	512-458-7417

Clients should be referred to the appropriate CSHCN toll-free telephone number or to their Social Service Program Consultant in the regional CSHCN office. This list is available under the heading "CSHCN Regional Offices" starting on page 1-3.

1.7 TDH Advisory Committee

The Children with Special Health Care Needs Advisory Committee (CSHCNAC) meets quarterly with the Texas Department of Health (TDH) to advise TDH on policies, procedures, rules, and issues relating to children with chronic illnesses and disabilities. Committee members participate on a voluntary basis and are appointed by the Board of Health.

This committee provides TDH with an avenue for two-way communication with providers and consumers. TDH updates the CSHCNAC on current activities, and committee members discuss community activities and issues. The committee members are involved with agencies and associations, assisting TDH in informing providers and consumers, and gathering input for policy making.

TDH appreciates CSHCNAC members for their contributions to policy and guidance in assuring accessible and quality health care for children who have medical needs that require services beyond a typical child's health care experience. The needs of these children and their families frequently require coordination among agencies and programs, both public and private. Committee members are experts in developing service delivery systems that promote the health and well being of children with special health care needs. Their input is invaluable in designing program rules and policies.

A list of the committee members and addresses may be obtained by calling 512-458-7355. Providers should think of the committee as representatives and may contact a member with ideas and issues concerning children with special health care needs.

1.7.1 Family Health Services Information and Referral Line

The Family Health Services Information and Referral Line is a statewide information and referral hotline that is designed to help women, children, and children with special health care needs find health and family support services in their areas. The Family Health Services Information and Referral Line is available from 8 a.m. to 5 p.m. (CST) Monday through Friday at 800-422-2956. Spanish speaking operators are available.

1.8 Claims Processed by NHIC-CSHCN

Compass21 is the claims and encounters processing system developed in a partnership between the Texas Department of Health (TDH) and NHIC. *Compass21* is an advanced Medicaid Management Information System (MMIS) that incorporates new claims processing methods that improve the existing MMIS by offering better access to data, flexibility for future program changes, and improved claims processing.

You still have two ways to submit claims to *Compass21*. The first and more popular is the electronic claims submission. Approximately 78 percent of claims processed by NHIC today are submitted electronically. We continue to accept paper claims; however, we encourage you to switch to electronic submission.

NHIC processes claims for the following services:

- Ambulance
- Ambulatory surgical procedures
- Dental
- Durable medical equipment
- Expendable medical supplies (except insulin syringes)
- Eye prostheses
- Gastrostomy devices
- Hemophilia blood factor products
- Home Health (skilled nursing care)
- Hospital outpatient services
- Independent laboratory services
- Inpatient hospitalization, except freestanding psychiatric facilities
- Inpatient rehabilitation
- Medical nutrition services
- Medical nutritional products
- Orthodontics
- Orthotics and prosthetics
- Outpatient occupational therapy
- Outpatient physical therapy
- Outpatient speech language pathology services
- Physician services, including telemedicine services
- Prescription shoes
- Total parenteral nutrition (TPN)/hyperalimentation
- Transportation of remains of deceased clients

All claims sent to NHIC for the first time must be addressed to:

NHIC-CSHCN
PO Box 200855
Austin TX 78720-0855

Appeals and other correspondence must be directed to a specific department or individual at the following address:

NHIC
ATTN: CSHCN Appeals
12545 Riata Vista Circle
Austin TX 78727-6524

The NHIC-CSHCN Customer Service Unit is available to answer questions about filing procedures, claim status, and general CSHCN information. The toll-free telephone number is 800-568-2413 or 512-514-3000. Representatives are available from 8 a.m. to 5 p.m. (CST) Monday through Friday.

NHIC processes claims from clients for the following services with dates of service on or after August 6, 2001:

- Drug co-pay
- Insurance Premium Payment Assistance (IPPA)
- Charges related to the transportation of remains of deceased clients

Clients may call NHIC at 877-888-2350 to obtain information about how to submit these expenses for payment.

1.9 NHIC-CSHCN Authorization Requirements

Prior authorization must be obtained before performing the following services:

- Anterior temporal lobectomies
- Bone marrow transplants/stem cell transplants
- Cleft/craniofacial surgical procedures
- Cranial molding devices (Dynamic Orthotic Cranioplasty™ [DOC]™ only)
- Custom (manual or all powered) wheelchair purchases and custom seating systems
- Inpatient admissions
- Inpatient rehabilitation admissions
- More than two nutritional assessments per calendar year
- More than four nutritional counseling sessions per calendar year
- Orthodontia
- Pediatric hospital cribs and their tops
- Reduction mammoplasties
- Rhizotomies
- Specific dental procedures, including inpatient admissions for dental surgical procedures (refer to “Dental” on page 3-1)
- Ultrasonic nebulizers, in specific instances (refer to “Respiratory Equipment” on page 14-1)

Authorization must be requested for the following services:

- Blood pressure devices, in specific instances (refer to “Blood Pressure Devices” on page 4-11)
- Diapers
- DME (with the exception of custom, manual, or powered wheelchairs, custom seating systems, and pediatric hospital cribs and their tops)
- Freestanding ambulatory surgery (not including procedures listed under “Prior Authorization”)
- Hemophilia supplies and blood factor products
- Home Health (Skilled nursing only)
- Hospital ambulatory surgery (outpatient hospital day surgery, not including procedures listed under “Prior Authorization”)
- Invasive cardiovascular surgical procedures
- Outpatient dental surgical procedures
- Medical nutritional products and services in specific instances (refer to “Authorization Requirements” on page 10-2 and “Medical Nutritional Products and Services HCFA-1500 Claim Form Example” on page 10-11)
- Nebulizers in specific instances (refer to “Respiratory Equipment” on page 14-1)
- Orthotics and prosthetics
- Outpatient physical, occupational, and speech language pathology therapies
- Prescription shoes
- Therapeutic apheresis

Authorization is a condition for reimbursement; it is not a guarantee of payment. It is each provider’s responsibility to verify client eligibility. Any service provided while the client is not eligible, or services provided beyond the limitations of the CSHCN Program, will not be reimbursed.

NHIC sends the client a copy of the letter sent to his or her provider anytime that an authorization request is denied or the requested services are reduced.

Refer to the specific provider type section of this manual for details on the above services that require authorization or prior authorization.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

1.9.1 Definition of Authorization

Authorization - a request submitted to the program, or its designated payment contractor, to provide a service the program will ultimately consider for reimbursement. The request must be submitted on a program-approved form and must contain all information necessary for the program to make a determination regarding coverage. The request can be submitted before the service is provided, but cannot be received by the program more than 90 days from the date the service was provided. If the service has already been provided, the authorization form can be attached to the claim, as long as it is received within the authorization (90 day) deadline. Only complete authorization requests can be accepted by the program. No extensions beyond the 90-day initial deadline will be given for providers to correct incomplete authorization requests. This 90-day deadline applies to all services requiring authorization (not **prior** authorization), including extensions and emergency situations.

Incomplete authorization requests, or claims for services requiring authorization but submitted without an attached authorization form or all required documentation, will be denied, and will be reconsidered only if resubmitted and received by the program within the initial 90-day authorization deadline. Requests to extend the deadline beyond 90 days from the date of service will not be considered.

1.9.2 Definition of Prior Authorization

Prior Authorization - A request submitted to the program, or its designated payment contractor, to provide a service the program will ultimately consider for reimbursement. The request must be submitted on a program-approved form and must contain all information necessary for the program to make a determination regarding coverage. Prior authorization must be obtained BEFORE the delivery of the service. However, if the service is provided after hours, or on a holiday/weekend, services may be “prior-authorized” if authorization is requested on the NEXT working day. A COMPLETE form must be received BEFORE the service is provided for authorization to be considered. Extensions to these deadlines will not be given by the program for providers to correct incomplete prior authorization requests.

Prior authorization requests for services must be received fully completed and on a program approved form before the service is provided.

Incomplete prior authorization requests will be denied, and will be reconsidered only if complete and received before the service is provided.

Exception: The prior authorization requirement is waived if the client does not have CSHCN eligibility when the request is received by NHIC-CSHCN. Claims for these services must meet the 90-day filing deadline.

In addition to requiring prior authorization, some services require that physicians and facilities be approved by TDH-CSHCN as a specialty team/center provider.

- For bone marrow/stem cell transplant services, the physician and the facility must be specialty team/center approved.
- For cleft/craniofacial surgical procedures, only the physician/dentist must be specialty team approved.
- **If specialty/team center requirements are not met, all services related to the surgery will be denied.**

Note: Anesthesiologists and assistant surgeons are not required to be specialty team/center enrolled. However, if a procedure or admission is denied by CSHCN because the primary surgeon or hospital is not appropriately specialty center enrolled, the assistant surgeon will also have claims denied.

Enrollment with NHIC does not automatically enroll the provider as a member of an approved specialty team/center. For more information, refer to “Specialty Team/Center” on page 8-2.

Note: Effective July 1, 2001, CSHCN no longer requires speciality team/center designation for invasive cardiovascular services.

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

NHIC-CSHCN Authorization Department
12545 Riata Vista Circle
Austin TX 78727-6524
FAX: 512-514-4222

Note: All inpatient admission/stays must be prior authorized using the "CSHCN Inpatient Admission Authorization Request Form" on page 8-40. All inpatient rehabilitation admissions must be prior authorized using the "CSHCN Inpatient Rehabilitation Admission Authorization Request Form" on page 8-41.

The request may be submitted by the hospital or physician provided all required information, indicating inpatient admission, is on the request form.

Both the facility and the physician/supplier must be enrolled in the CSHCN Program for claims for services provided either inpatient or outpatient to be considered for payment.

1.10 Provider Enrollment

To enroll in the CSHCN Program, a provider of medical care or services must complete the required CSHCN Provider Enrollment Application and enter into a written Provider Agreement with CSHCN. These forms are supplied by NHIC Provider Enrollment for providers submitting claims to NHIC or may be downloaded from www.eds-nhic.com.

Enrollment application and the submission of completed forms must be sent to the Provider Enrollment Department at the following address:

NHIC
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720-0795

A nine-character CSHCN TPI is issued when NHIC determines that a provider qualifies for participation. All providers must submit claims to NHIC within 90 days from the date of service, even if a TPI has not been assigned. Although claims submitted by providers who are not enrolled in the CSHCN Program are denied by NHIC, these claims may be appealed upon completion of the enrollment process. The appeal is considered for payment if submitted within 180 days from the date of the denial.

All provider types must be enrolled with the Texas Medicaid Program as a prerequisite to enrolling in the CSHCN Program. Contact CSHCN Customer Service (800-568-2413 or 512-514-3000) for enrollment requirements.

All provider types must be in compliance with the Texas Family Code as referenced in "Texas Family Code Compliance" on page 1-11.

Descriptions of the required enrollment forms are provided below.

Provider Enrollment Application – Required from all providers to participate in the CSHCN Program. The Provider Enrollment Application must be signed by the person who is applying for enrollment. If the applicant is unable to sign, then a letter showing "power of attorney" must be attached to the Provider Enrollment Application. If a temporary license number is the only number available, a copy of the temporary license must be attached. Additional documentation may be required depending on the type of provider.

Provider Agreement – Required by all providers to participate in the CSHCN Program. The Provider Agreement between NHIC-CSHCN and the provider furnishing the services under the program Rules states that the provider agrees to certain standards as a condition for participation. This form will not be accepted without a signature.

Provider's Temporary License (copy) – Required by all licensed professionals who have indicated on the CSHCN Provider Enrollment Application that their license is temporary. All providers are required to submit updated licensure as they are renewed. Not abiding by this license update

requirement may impact a provider's qualification to participate in the CSHCN Services Program. NHIC-CSHCN requests that updates of a provider's official license from the respective licensing board be submitted for updates in our system. Include your TPI on your license submission.

Power of Attorney Letter – Required when the applicant is not able to sign the Provider Enrollment Application.

Specialty Team/Center – CSHCN enrolled providers performing cleft/craniofacial procedures, or bone marrow/stem cell transplants also must be enrolled as members of an approved specialty team/center. Contact TDH-CSHCN at 512-458-7355 or 800-252-8023 for enrollment procedures. Specialty team/center applications will be reviewed by TDH-CSHCN and approved applications will be forwarded to NHIC. Refer to "Specialty Team/Center" on page 13-2 for additional information about services requiring specialty team/center requirements.

Enrollment with NHIC does not automatically enroll the provider as a member of an approved specialty team/center.

Note: Anesthesiologists and assistant surgeons are **not** required to be specialty team/center enrolled. However, if a procedure or admission is denied by CSHCN because the primary surgeon or hospital is not appropriately specialty center enrolled, the assistant surgeon will also have claims denied.

Out-of-State Providers – Out-of-state providers within 50 miles of the Texas border may be enrolled in the CSHCN Program. Services for these providers are restricted. See "Medical Services Provided Outside of Texas" on page 1-23 for additional information.

Providers Paid by TDH – Provider applications for providers and services who are reimbursed by TDH-CSHCN must be sent to TDH.

1.10.1 Clinical Laboratory Improvement Amendments of 1988 (CLIA)

1.10.1.1 CLIA Requirements

To be eligible for reimbursement by CSHCN, all providers performing laboratory tests must:

- Pay a fee to the Centers for Medicare and Medicaid Services (CMS).
- Receive a CLIA registration and/or certification number by contacting TDH at 512-834-6650 or 512-834-6686 or access CLIA information at www.tdh.state.tx.us/hcf/clia. Submit CLIA applications to the following address:

  TDH
  Health Facility Licensure and Certification Division
  1100 West 49th Street
  Austin TX 78756

- Notify NHIC of your CLIA number at the following address:

  NHIC
  ATTN: Provider Enrollment
  PO Box 200795
  Austin TX 78720-0795

Important
NHIC monitors claims submitted by **clinical laboratories** for CLIA numbers. Without a CLIA number on file with NHIC, claims for laboratory services will be denied.

1.10.1.2 CLIA Regulations

The Centers for Medicare and Medicaid Services (CMS) implemented the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective for dates of service on or after September 1, 1992. The CLIA regulations were published in the February 28, 1992 *Federal Register*.

Copies of the following regulations may be requested:

Appendix C: Interpretive Guidelines		
Paper copy	PB92-146-174	$67.50 (plus shipping and handling fees)
Diskette	PB93-505-717	$112.00 (plus shipping and handling fees)

Federal Regulations (*Federal Register*)		
HSQ176, 177, 179, 202, 206	PB93-154-615	$63.00

Federal Register – Final Test Categorization List		
July 26, 1993	PB93-218-386	$36.50 (plus shipping and handling fees)

Request copies of the CLIA regulations from the following address:

National Technical Information Services
5285 Port Royal Road
Springfield VA 22161
703-487-4650
800-553-NTIS

Or, access the HCFA Web site at www.cms.hhs.gov, then click on the CLIA link.

CLIA regulations set standards designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing (PT). These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratories (including those located in physicians offices), regardless of location, size, or type of laboratory, must meet standards based on the complexity of the test(s) they perform.

Refer to: "Provider Enrollment" on page 1-17 for more information about enrollment procedures.

1.10.2 Change of Address Request

Providers must promptly advise NHIC's Provider Enrollment Department of address changes (office or accounting), name changes, ownership changes, and Tax ID number changes. This information must be communicated in writing to NHIC. See "Provider Information Change Form" on page 1-20 for the Provider Information Change Form.

1.10.3 Provider Information Change Form

NOTE: This form is used to update CSHCN Provider information on file with NHIC (only).

Complete this form to update your NHIC provider file(s). Fax the completed form or mail to the address below.

PLEASE PRINT OR TYPE THE INFORMATION REQUESTED ON THIS FORM.

Date: _____ Nine-character CSHCN TPI:_____

If you have more than one NHIC TPI that also uses this same information, list the other TPIs [CSHCN and Medicaid]:

_____

Physical Address	**Accounting / Mailing Address**
(Cannot be a PO Box)	*(W-9 Form Required)*
_____	_____
_____	_____
_____	_____
_____	_____
Telephone	**Telephone**
_____	_____
Fax	**Fax**
_____	_____

Type of Change: (please check the appropriate selection below)

- ❑ **Change of physical address, phone and / or fax number**
- ❑ **Change of billing / mailing address, phone and / or fax number**
- ❑ **Change / add secondary address, phone and / or fax number**
- ❑ **Change of provider status (i.e., termination from plan, moved out of area, specialist, etc.), please give explanation**
- ❑ **Other (i.e., panel closing, capacity changes, age acceptance, etc.)**

Explanation Required: _____

Tax Information: IRS ID Number _____ Effective Date: _____

List the exact name reported to the IRS for the above Tax ID number: _____

Must be signed and dated or changes will not be processed.

Provider Signature: _____ Date: _____

E-mail Address: _____

Send your completed change form to:

NHIC
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720-0795
FAX: 512-514-4214

1.10.4 CSHCN Label Request Form

Before completing this form, please photocopy it for future use. Use this form to order labels:

Provider Name and Address: Physical: _____ _____ _____ Acctg: _____ _____ _____ Is this a change of address? ❑ Yes ❑ No	**Nine-character CSHCN TPI:** _____ Requested by: _____ Date of Request:_____ **Allow 3-4 weeks for delivery.**
NHIC provides mailing labels for ALL providers. Check the number below that is closest to your average monthly CSHCN filing: ❑ 36 ❑ 72 ❑ 108 ❑ 144 ❑ 180 ❑ Other	Affix your CSHCN label in the appropriate block of your claim form as indicated below: Claim Form Type — Block No. HCFA-1450 (UB-92) — 1 HCFA-1500 (12-90) — 33

Send this completed request to:

NHIC
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720-0795

If assistance is needed to complete this form, contact the NHIC-CSHCN Customer Service Unit at 800-568-2413 or 512-514-3000

1.11 Reimbursement

CSHCN Program reimbursements are available to all providers either by check or electronic funds transfer (EFT). Through EFT, NHIC deposits reimbursements directly into a provider's bank account.

CSHCN reimburses hospitals, physicians, and other suppliers of service. Each section of this manual gives a brief description of the methods used to reimburse each provider specialty.

1.11.1 Texas Medicaid Reimbursement Methodology (TMRM)

CSHCN reimburses physicians based on the Texas Medicaid Reimbursement Methodology (TMRM) adopted by Medicaid. This methodology is used to reimburse the following:

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

TMRM is based on Medicare's resource based relative value scale (RBRVS) with Medicaid modifications. Some of the differences include:

- Access-based fee adjustments for specific services
- A flat fee structure applicable on a statewide basis; there are no geographic or specialty differences in this system

Providers may determine the CSHCN payment for a service in one of the following ways:

- Identify the total relative value units (RVUs) (as published in the November 1991 *Federal Register*) and multiply this number by the TMRM conversion factor ($27.276). For anesthesia conversion factors see "Anesthesia" below.
- Contact the NHIC-CSHCN Customer Service Unit at 800-568-2413 or 512-514-3000. Have available your CSHCN TPI, date of service, type of service, and the procedure code.

Reimbursement information for provider types and services paid by TDH-CSHCN may be obtained by referring to the *TDH-CSHCN Provider Manual* or by contacting CSHCN at 800-252-8023 or 512-458-7355.

1.11.1.1 Anesthesia

Anesthesia services are reimbursed based on RVUs using the CPT anesthesia codes. The conversion factor for anesthesia services is $15.55.

Refer to: "Reimbursement" on page 5-1 for a full explanation of all factors involved in anesthesia reimbursement.

1.11.1.2 Physician Services in Hospital Outpatient Setting

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

This provision applies to those procedures performed in the outpatient department of the hospital (for example, clinics and emergency situations). If the eligible client is seen in the outpatient department of the hospital in an emergency situation, the condition that created the emergency must be documented on the claim form.

The following services are excluded from this limitation:

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

1.11.1.3 Clinical Laboratory Services – Outpatient Services

The Deficit Reduction Act of 1984 (DEFRA), requires clinical diagnostic laboratory tests performed in a physician's office by an independent laboratory or by a hospital laboratory for its outpatients be reimbursed on the basis of maximum fee schedules. The Texas Medicare carrier publishes the fee schedules annually.

1.11.1.4 Manual Pricing

When services are billed that do not have an established TMRM fee or a maximum fee schedule, NHIC-CSHCN medical staff determines the reimbursement amount by comparing the services to other services requiring a similar amount of skill and resources.

1.11.1.5 Maximum Allowable Fee Schedule

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

1.11.1.6 Hospital Reimbursement

Hospital services (including inpatient acute, rehabilitation, and/or outpatient services) are reimbursed at 80 percent of the rate authorized by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital's Medicaid interim rate.

1.11.1.7 Ambulatory Surgery Centers/Freestanding Surgical Centers

Reimbursement of ambulatory and freestanding surgical center procedures is based on the Centers for Medicare and Medicaid Services (CMS) approved Ambulatory Surgical Code Groupings (1-9 per Centers for Medicare and Medicaid Services [CMS] and group 10 per TDH) payment schedule. Providers are sent a list of these codes and payment categories upon enrollment with the Texas Medicaid Program, a prerequisite to enrollment in the CSHCN Program. Updates are supplied by the Texas Medicaid Program.

1.12 Medical Services Provided Outside of Texas

CSHCN will reimburse out-of-state providers in certain circumstances. Only providers physically located more than 50 miles from the Texas border will be considered "out-of-state" providers.

CSHCN may approve payment to out-of-state providers in unique circumstances in which the CSHCN Program participating physicians, the client, parent, or guardian, and the CSHCN Medical Director agree that:

1) An out-of-state provider is the provider of choice for quality care.
2) The same treatment or another treatment of equal benefit or cost is not available from Texas CSHCN providers.
3) The out-of state treatment should result in a decrease in the total projected CSHCN Program cost of the client's treatment.
4) The medical literature must indicate that the out-of-state treatment is accepted medical practice and is anticipated to improve the patient's quality of life.

Each case will be researched by CSHCN staff and a recommendation made for determination by the Commissioner of Health.

Inpatient and outpatient reimbursement rates for out-of-state providers will be negotiated. Physicians will be reimbursed according to the TMRM, unless the procedure is normally manually priced. The cost of transportation, meals, and lodging may be reimbursed for the CSHCN approved out-of state treatment. Travel costs will be negotiated with approval of specific travel options based on overall cost effectiveness.

The provider does not have to be enrolled in Texas Medicaid, but will have to enroll as a CSHCN provider for reimbursement to be made; specialty team/center requirements do not apply. Filing deadlines will apply, but normal authorization requirements and procedures do not apply as special approval is given by TDH-CSHCN.

After the claims are processed for the out-of-state services the provider number will be cancelled.

For more information contact:

TDH
ATTN: CSHCN Services Program
1100 W. 49th Street
Austin TX 78756-3179
800-252-8023
or
512-458-7355

1.13 Provider Responsibilities

1.13.1 CSHCN General Medical Record Documentation Requirements

NHIC routinely performs a retrospective review of all providers. This review may include comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

Note: This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.

Requirement	Mandatory/ Desirable
All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.	Mandatory
Each page of the medical record documents the patient's name and CSHCN identification number.	Mandatory
Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.	Mandatory
The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. The AMA's Current Procedural Terminology (CPT) descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.	Mandatory
Necessary follow-up visits specify time of return by at least the week or month.	Mandatory
The history and physical documents the presenting complaint with appropriate subjective and objective information.	Mandatory

Requirement	Mandatory / Desirable
The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need for the services.	Mandatory
Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.	Mandatory
Unresolved problems are noted in the record.	Mandatory
Immunizations are noted in the record as "complete" or "up-to-date."	Desirable
Personal data includes address, employer, home / work telephone numbers, sex, marital status, and emergency contacts.	Desirable

1.13.1.1 Retention of Records

The provider must maintain and retain all necessary records and claims to fully document the services and supplies provided to a client for full disclosure to CSHCN or designee. These records and claims must be retained for a period of **seven years from the date of service, or for clients under 21, until the client's 21st birthday, or until all audit questions, appeal hearings, investigations, or court cases are resolved**. These records must be made available promptly upon request to NHIC and representatives of TDH. Upon request, the provider will submit copies of such records, at no cost, to representatives of the above organizations.

If the provider places the required information in records that are in the custody of another legal entity, such as a hospital, the provider is responsible for obtaining a copy of such records at no cost, for use by NHIC or TDH, as requested by one of these entities, during any investigation or study of the appropriateness of the claims submitted by the provider.

1.13.1.2 Release of Confidential Information

Information concerning the diagnosis, evaluation, or treatment of a client by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical disorder is normally confidential information that the provider must disclose only to authorized persons. The client's signature is not required on the claim form for payment of a claim, but NHIC strongly recommends that the provider obtain written authorization from the client prior to releasing confidential medical information. A release must be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information printed on the back of the form. The client's authorization for release of such information is not required when the release is requested by and made to TDH-CSHCN or NHIC.

1.13.1.3 Utilization Control – General Provisions

Utilization review activities required by the CSHCN Program are accomplished through a series of monitoring systems developed to ensure that services are necessary and of the optimum quality and quantity. Both clients and providers are subject to utilization review monitoring. Utilization review procedures safeguard against unnecessary care and services, monitor quality, and ensure that payments are appropriate according to the payment standards defined by CSHCN.

One goal of utilization review is to identify the provider whose practice patterns are not consistent with the CSHCN requirements and the scope of benefits.

The principal approach to resolution of inappropriate use is education of the provider. This education must include either a provider representative visit or letter to assist with the technical aspects of the program and / or a physician visit, phone call, or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service. The purpose of the letter or the visit is to discuss the inappropriate practices so that the provider may institute measures to remedy the problem.

Depending on the intensity of the identified problem, the letter and / or visit may result in review of claims prior to payment. Medical staff develop parameters for prepayment review according to the identified problem. The purpose of the review is to provide additional information enabling the provider to understand the scope of benefits by correlating billing practices and medical policy as billing occurs. As part of the prepayment review process, providers may be required to submit documentation. The documentation is used to ascertain the medical necessity of the services rendered. Prepayment review occurs for a minimum of six months. Services not consistent with medical policy are adjudicated in accordance with the established policies.

Recoupment of excess payments for an intensity of service not supported by the medical documentation may occur at any phase in the review process.

A provider is removed from prepayment review after achieving compliance with the established medical policy. A follow-up review is performed to monitor continued appropriate utilization of resources.

When the provider is consistently noncompliant with policies, the provider history is provided to CSHCN for possible administrative sanctions.

1.13.1.4 Suspected Cases of Provider Fraud and Abuse

The Texas Department of Health is responsible for minimizing the opportunity for provider fraud and abuse. TDH takes appropriate action to protect clients and the CSHCN Program when providers of services are suspected of committing fraud or abuse. TDH is responsible for establishing criteria to identify cases of possible fraud and abuse and recouping all overpayments to a provider. Some circumstances may result in referral of a provider for legal evaluation for possible prosecution while other circumstances may result in administrative sanctions.

1.13.1.5 Provider Certification / Assignment

Providers of CSHCN services are required to certify compliance with, or agreement to, various provisions of state laws and regulations. Upon submitting a signed claim to NHIC-CSHCN, the provider certifies that the following provisions were upheld:

- Services were personally rendered by the **billing provider** or under the personal supervision of the billing provider. Exception: As allowed under substitute physician ruling.

Refer to: "Personal Supervision Versus Direct Supervision" on page 13-36.

- The information contained on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the diagnosis or treatment of the client.
- Medical records document all services billed.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees that are charged to private-pay patients.
- Services were provided without regard to race, color, sex, national origin, age, or handicap.
- The provider of medical care and services files a claim with the CSHCN Program, agreeing to accept the CSHCN reimbursement as payment in full for those services covered under the CSHCN Program. The CSHCN client, or others on the client's behalf, must not be billed for the amount above that which is paid on allowed services or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. However, the client may be billed for services that are not a CSHCN benefit. **Before providing services, providers should always discuss with and inform clients and their families of their liability for services not covered by the CSHCN Program.**
- The provider understands that endorsing or depositing a CSHCN check is accepting money from state or federal funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under state or federal laws.

Payment for services is made on behalf of clients to the provider of the service by NHIC in accordance with the limitations and procedures of the program.

If the claim is prepared by a billing service or printed by data processing equipment that is physically removed from the provider's office, it is permissible to print "Signature on File" in place of the provider's signature when the billing service obtains and retains a letter on file signed by the provider authorizing the submission of his claims. Providers delegating signatory authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

1.13.1.6 Billing Clients

CSHCN clients or parents / gaurdians of children eligible for CSHCN should not be billed for CSHCN covered services.

A provider must not require a down payment, bill, or take recourse against an eligible client for a denied or reduced claim for services that are within the amount, duration, and scope of benefits of the CSHCN Program if the action is the result of any of the following provider-attributable errors:

- Failure to submit a claim, including claims not received by NHIC
- Failure to submit a claim within the 90-day filing deadline
- Filing an incorrect claim
- Failure to resubmit a corrected claim within the 180-day resubmittal period
- Failure to appeal a claim within the 180-day appeal period
- Errors made in claims preparation, claims submission, or in the appeal process

A provider may bill the following to a client:

- Any service that is not a benefit of the CSHCN Program (for example, obstetrical care).
- All services incurred on noncovered days due to eligibility or inpatient hospital or inpatient rehabilitation day limitations. Total client liability must be determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered day.

A provider attempting to bill or recover money from a client in violation of the above conditions may be subject to exclusion from the CSHCN Program.

Each provider must furnish covered services to eligible CSHCN clients in the same manner, to the same extent, and of the same quality as services provided to other clients. Services made available to other clients must be made available to CSHCN clients if the services are covered by the CSHCN Program.

Clients must not be billed for the completion of a claim form even if it is a provider's office policy.

1.14 Client Eligibility

Applicants younger than age 19 applying or reapplying for CSHCN must apply to Medicaid, the Medically Needy Program (MNP), or TexCare Partnership (TCP). Applicants who are not U.S. citizens or U.S. legal residents, enrolled in CHIP or Medicaid, are exempt from this requirement. The written Medicaid and CHIP determination must be sent with the application for CSHCN.

If the Medicaid/TCP determination is not received with the CSHCN application, the applicant will be given 60 days to apply for Medicaid/MNP and return the determination to CSHCN. During this 60-day period, the applicant will be able to send in any additional information that CSHCN requires to process the application. If all information is received before the 60 days end, CSHCN will grant eligibility retroactive 15 days from the first day the application was received. If the Medicaid determination or any other information that is required to complete the application is not returned within the 60 days, then eligibility will begin 15 days retroactively from the date all information was received.

If the client/applicant has all the documentation required to approve their case except for the TCP determination, the program will approve the case for 60 days until the determination is received. Services will be suspended if the TCP determination is not received before the 60 days end.

Extensions are granted when requested.

CSHCN will not pay for any services until the client's application has been approved and the client is eligible to receive services.

Any questions concerning a client's eligibility for benefits covered by the CSHCN Program must be directed to the TDH-CSHCN central office (800-252-8023).

A person may be eligible for medical assistance under the CSHCN Program provided the following conditions are met:

- The client/applicant lives in Texas and is a "bona fide" resident who, if a minor child, is also the dependent of a "bona fide" Texas resident. A "bona fide" resident physically lives in Texas, intends to remain in Texas permanently or indefinitely, maintains living quarters in Texas, does not claim to be a resident of another state or country and has not come to Texas from another country for the purpose of obtaining medical care.
- The client/applicant must be under the age of 21. Persons with the diagnosis of cystic fibrosis are exempt from this requirement.
- The client/applicant's family must meet CSHCN Program financial eligibility criteria.
- The client/applicant's physician or dentist must attest to the program's Medical Certification Definition and provide a diagnosis/condition that meets the definition on the CSHCN Physician Assessment Form (T3-01E) contained in the CSHCN Application Booklet.

CSHCN financial and medical eligibility must be updated annually.

Important
The applicant must be eligible for medical assistance at the time the service is provided. It is not mandatory that the process of determining eligibility be completed at the time the service is provided; the client may receive limited retroactive eligibility. However, services or supplies will not be paid under the CSHCN Program if they are provided to a client before the effective date of his eligibility for CSHCN or after the effective date of his denial of eligibility.

Note: Having an application for CSHCN eligibility in process is not a guarantee that the applicant will become eligible. Contact TDH-CSHCN at 800-252-8023 for specific eligibility requirements.

1.14.1 Medical Care Identification Card

The CSHCN ID Card is designed to give clients, parents, and providers a quick way of verifying CSHCN Program eligibility. The card is designed to convey all of the information necessary to document identification information. Medicaid and/or insurance information listed (including CHIP) on the ID Card is valid at time of application and must be verified independently.

The ID cards are sent out annually with a one year coverage period. The card will bear the following statements:

> "To stay on CSHCN after this card runs out, you must fill out a new CSHCN application and send the application to TDH-CSHCN on or after (date). To get a new CSHCN application, call TDH-CSHCN at 800-252-8023."

Persons needing to renew their coverage must call or write CSHCN at the following address to request a new application:

TDH
CSHCN Program
1100 West 49th Street
Austin TX 78756-3179

Ask for this card when scheduling a client for an appointment. This card will give eligibility information. However, under certain circumstances, this card MAY NOT be valid at the time you see the client. Please verify client eligibility before providing services by calling CSHCN VIPS at 800-452-8729; AIS at 800-568-2413 or 512-514-3000, or TDH-CSHCN at 800-252-8023.

1.14.2 CSHCN Eligibility Card Sample

Children with Special Health Care Needs (CSHCN)
1100 West 49th Street
Austin TX 78756-3179
Automated Eligibility Inquiry: 512-458-7355
800-252-8023 or 800-452-8729

PARENT/GUARDIAN NAME
STREET ADDRESS
CITY, TX ZIP CODE

CSHCN Case # 9-123456-00
Name: CLIENT NAME
Birth: 06/05/89 **Sex:** M
Medicaid/Insurance
Medicaid Number: 123456789
Valid 6/8/02 **thru** 6/30/2003

CSHCN Eligibility Card

This card may be used for services only between the "valid" dates listed in the box above.

This is your CSHCN Eligibility card. If you already have a card, throw away the old one. Take this card with you when you visit CSHCN service providers. Do not loan this card to other people. Service providers can copy the card for their files. If you lose this card, call the CSHCN Eligibility Section. Whenever you call or write to CSHCN, use the case number shown on this card.

To stay on CSHCN after this card runs out, you must fill out a new CSHCN application and send the application to CSHCN on or after 01/18/2002. To get a new CSHCN application, call CSHCN at 1-800-252-8023.

Esta tarjeta es para conseguir servicios durante las fechas en la caja de arriba.

Esta es su tarjeta de elegibilidad para CSHCN. Si Ud. ya tiene tarjeta, tire la tarjeta vieja. Lleve esta tarjeta consigo para obtener servicios de provedores que son autorizados por CSHCN. No preste esta tarjeta a otras personas. Deje que los provedores hagan una copia de esta tarjeta para sus archivos. Si pierda Ud. esta tarjeta, llame a la linea gratis de Elegibilidad de CSHCN. Cuando Ud. llame o escriba a CSHCN, use el numero del caso ('case') que aperece en esta tarjeta.

Para continuar en CSHCN, debe mandarnos una nueva aplicación después de 01/18/2002. Para obtener una aplicación puede llamar a CSHCN al número 1-800-252-8023.

Provider Information

The client named on this card is eligible for CSHCN services for the period indicated. Service providers may duplicate this card for their files. Providers must be enrolled in the CSHCN Program. Prior authorization is required for some services. CSHCN may revoke eligibility in the event of policy changes, changes in client medical or financial condition, or error. See the CSHCN Provider Manual for details. For more information, contact the CSHCN Program.

Under certain circumstances, the eligibility card **may not** be valid at the time you see this client. Please verify client's CSHCN eligibility by calling CSHCN-VIPS at 800-452-8729 or CSHCN-AIS at 800-568-2413 or 512-514-3000.

Waiting List Information

CSHCN may establish a Waiting List if budgetary limitations exist. Clients may be placed on a waiting list for the CSHCN health benefits plan and/or Family Support Services (FSS). Removal of clients from the waiting lists may be determined by availability of funding.

In order to facilitate contacting clients on the waiting list, the CSHCN Program will collect information including, but not limited to, the following:

- Client name, address and telephone number
- Name, address, and telephone number of a contact person other than the client
- Date of the client's earliest application for services
- Date on which the client became eligible for services
- The client's functional limitations or needs
- Range of services needed by the client
- The date on which the client is scheduled for reassessment

A statewide waiting list for health benefits is maintained based on the date and time the client's application is processed and approved for CSHCN Program eligibility.

The waiting list is maintained continually from one fiscal year to the next. Clients must maintain program eligibility to remain on any waiting list. A lapse of program eligibility constitutes a loss of position on the health benefits waiting list.

Only those applications received on or after the effective date of the commencement of the waiting list will be affected.

Applications will be processed to completion with all required documentation and proofs. Clients will receive an approval letter advising of program eligibility dates and waiting list information. Clients will not receive a CSHCN Identification Card. Communication will be sent to the parents, guardian, and Public Health Regional Office where the client resides, and the client's physician/dentist to inform them of the CSHCN waiting list process.

If all documentation to make the application complete is received, except the TexCare Partnership (TCP) determination, the client will be placed on the waiting list when the application is approved (date/time). The TCP determination must be received before the client can be taken off the waiting list.

If Diagnosis and Evaluation (D&E) services are requested by the physician/dentist, the client's case will not be placed on the waiting list until after the client has been determined medically eligible for CSHCN. The time period allowed for diagnosis and evaluation services is 60 days from the date the completed application is received by CSHCN. Services related to the diagnosis and evaluation, and not requiring prior authorization, can be reimbursed up to 15 days before the receipt of the completed application.

The client will be placed on the waiting list regardless of the answer to the "Severe and life-threatening" question on the CSHCN Physician's Assessment Form.

Clients will be removed from the waiting list when it has been determined that the program is financially able to do so.

A client's eligibility period, after being removed from the waiting list, will be 12 months minus the time spent on the waiting list. The begin date of the financial/medical period will be the first day of the month released and will not receive retroactive eligibility.

A new program approval letter and CSHCN identification card will be issued with the eligibility dates and information regarding the range of services originally requested.

Clients remaining on the waiting list for 12 months will need to reapply for eligibility as their 12 month financial/medical eligibility will be deemed to have expired. These clients will receive notification by letter within 60 days of their 12 month expiration date.

Upon reapplication, the client must complete the application and be approved within 60 days of the prior coverage period's expiration to retain his/her place on the waiting list. If the reapplication process takes longer than the 60 day period, his/her place on the waiting list will be forfeited. The client will then be placed on the waiting list according to the approval date of his/her application, i.e., at the "bottom/end" of the list.

1.15 Clients Eligible for Medicaid/CSHCN Benefits

If Medicaid denies a claim with an Explanation of Benefits (EOB) 182 (client not eligible), but the family reports the client has Medicaid, you must appeal to Medicaid. Medicaid eligibility information may not have been received by Medicaid in time to pay the claim.

The expanded Medicaid THSteps Comprehensive Care Program (CCP) and Medicaid Home Health Services cover medically necessary services for enrolled clients under the age of 21. CSHCN does not consider reimbursement for services provided to children who are also eligible for Medicaid, with the exception of transportation of a deceased client's body.

CSHCN will not pay claims for Medicaid THSteps CCP eligible clients denied by Medicaid for any reason, including: late filing, limited client, duplicate services, incorrect claim form, or additional information required.

For additional information pertaining to the Medicaid THSteps CCP, call 800-846-7470.

CSHCN's information regarding Medicaid is printed on the CSHCN ID card. The coverage is indicated by the word "Medicaid" below the birth date in the CSHCN case number block. This information is obtained at the time of the application so it must be verified at the time of service provision.

If Medicaid is the payor of other benefits, the full CSHCN payment must be refunded. Providers must make the refund check payable to NHIC and send it to the attention of the Cash Disposition Unit at NHIC. The following information must be included:

- Client name and CSHCN number
- Copy of the *R&S* on which the claim was paid (Medicaid and CSHCN)
- Date of service
- Provider name, number, or both

1.15.1 Medically Needy Program

The Medically Needy Program (MNP) provides an access to Medicaid benefits for individuals and families whose income exceeds the eligibility limits under Temporary Assistance to Needy Families (formerly AFDC) or one of the Medical Assistance Only (MAO) Programs for children, but whose income is not enough to meet their medical expenses.

CSHCN requires all applicants to include a Medicaid determination along with their application. No services will be paid by CSHCN until Medicaid eligibility has been established.

CSHCN may ask clients to apply to the Medicaid/MNP when $2,000 or more in medical bills have been paid or are expected to be paid by CSHCN. Clients will be given 60 days to apply to the Medicaid/MNP and send the determination to CSHCN. A client's CSHCN eligibility will be terminated if he or she does not comply with the request to apply to Medicaid/MNP. CSHCN client benefits will not be limited during this 60-day period.

1.15.2 MNP Spend Down Processing

The MNP is not an assistance program in itself; it provides a way to access Medicaid benefits. The applicant must meet the basic Temporary Assistance to Needy Families (formerly AFDC) eligibility requirements. Eligibility may be determined with or without spend down (the difference between the applicant's net income and the MNP income limits). If the applicant is eligible without spend down (income is below the Medically Needy income limits), the applicant is certified to be Medicaid eligible. If spend down is required, the spend down amount will have to be met to obtain Medicaid coverage.

Important
Include the CSHCN case number and the CSHCN client name on all documentation sent to CSHCN or the MNC.

If spend down is applicable, the client is issued a Medical Bills Transmittal (Form 1120) which indicates the spend down amount and the months of potential coverage (limited to the month of application and any of the three months before the application month). All medical bills (for all family members) must be submitted for application toward their spend down to the National Heritage Insurance Company (NHIC) Medically Needy Clearinghouse (MNC) along with the Form 1120. A MNP case will not be finalized until the Form 1120 has been received. Charges from the bills are applied in date-of-service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

1.15.2.1 CSHCN/MNP Spend Down Processing

The CSHCN Program will assist in the submission of medical bills for the CSHCN eligible client required to apply for Medicaid coverage through the spend down process. The NHIC MNP Clearinghouse will accept paid or unpaid medical bills from CSHCN for application toward their spend down regardless of the date of service. This process will enable the Clearinghouse to expedite the culmination of the case and inform the Texas Department of Human Services (TDHS) when the spend down has been met.

When the spend down has been met and the client has been certified Medicaid eligible, CSHCN will then consider payment of the spend down amount (patient liability) for covered services.

1.15.3 Provider Assistance

Providers may assist clients by:

- Submitting bills to NHIC-MNP for the CSHCN client that are not payable by the program
- Submitting bills to NHIC-MNP for services provided to any other member of the family
- Providing clients/families with current itemized statements
- Encouraging clients to submit all their medical bills incurred from all providers at the same time

When submitting bills, they must be itemized showing the provider's name, patient's name, CSHCN case number, MNP case number, dates of service, services provided, charge for each service, total charges, amounts of payments, dates of payments, and total due.

Bills for past accounts must be current statements (dated in the last 60 days) from the provider, verifying the outstanding status of the account and the current balance due. Accounts with payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's Explanation of Benefits (EOB) or an Explanation of Medicare Benefits (EOMB) showing the specific services covered and amounts paid.

If additional information is requested by the Clearinghouse, the applicant has 30 days from the date of the Clearinghouse's letter to respond. The provider may assist by furnishing the additional information to the applicant or sending it directly to the Clearinghouse in a timely manner.

The Clearinghouse does not pay bills; they apply them toward the spend down only. The provider must file a Medicaid claim after eligibility has been established to have reimbursement considered by the Medicaid Program. During the spend down period there is no Medicaid coverage and bills must not be sent to Medicaid. A claim that is inadvertently filed to Medicaid will be denied due to ineligibility of the client.

Providers may make inquiries regarding status, months of potential eligibility, Medicaid or case number, and general case information by contacting the NHIC Medicaid Customer Service Department at 800-925-9126.

To inquire about the status of a CSHCN/MNP case, contact the TDH-CSHCN/MNP Section at 800-252-8023.

1.15.4 Claims Filing

The client is responsible for informing his or her medical providers of his or her Medicaid eligibility and making arrangements to pay the charges used to meet the spend down amount. For CSHCN clients, the CSHCN Program will consider paying the charges used to meet the spend down for covered services.

The Clearinghouse will notify the client of:

- Which bills/charges were used to meet the spend down
- Which bill/charges the client is financially responsible for
- Which bills/charges the provider should submit to Medicaid for consideration of payment

Claims for unpaid bills not applied toward spend down or not previously sent to or paid by CSHCN must be received by NHIC for Medicaid consideration within 90 days from the date eligibility was added to NHIC's client eligibility file (Add Date). These bills must be on the appropriate claim form (for example, HCFA-1500, HCFA-1450).

The client's payment responsibilities are as follows:

- If the entire bill was used to meet spend down, the client is responsible for payment of the entire bill. For CSHCN clients, submit the bill to CSHCN for payment consideration.
- If a portion of one of the bills was used to meet the spend down, the client is responsible for paying the portion applied toward the spend down. For CSHCN clients, submit the bill to CSHCN for payment consideration.

Claims are subject to the following:

- The claim must show the total billed amount for the services provided. Charges for ineligible days or spend down amounts must not be deducted or "noncovered" on the claim.
- A client's payment toward spend down must not be reflected on the claim submitted to NHIC.
- Special note: Payments made by the client for services that were not used in the spend down but were incurred during an eligible period must be reimbursed to the client before the provider files a claim to NHIC.

Once eligibility has been established, the client is eligible to receive the same care and services available to all other Medicaid clients.

1.16 Third Party Resources

Federal and state laws require that the CSHCN Services Program use CSHCN funds for the payment of most medical services only after all reasonable measures have been taken to use a client's third party resources.

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

- Private Health Insurance
- Dental Insurance Plan
- Health Maintenance Organization (HMO)
- Automobile Liability Insurance
- Preferred Provider Organization (PPO)
- Cause of Action (Lawsuit)
- Medicare
- CHAMPUS/CHAMPVA
- Employee Welfare Plan
- Union Health Plan
- Children's Health Insurance Program (CHIP)
- Prescription Drug Card

Even though Medicaid is considered a non-TPR source when the client is eligible for both CSHCN and Medicaid, Medicaid must be billed before billing CSHCN.

A copy of the Medicaid Remittance and Status report must be submitted with the claim and received at NHIC-CSHCN within 90 days from the date of disposition (for example, denial, payment, request for refund, or recoupment of payment by Medicaid).

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

Eligible clients must not be held responsible for billed charges in excess of the TPR payment for services covered under the CSHCN Program. If the third party resource pays less than the CSHCN allowable amount for covered services, the provider may submit a claim to NHIC for any additional allowable amount. CSHCN will not reimburse providers for co-pays or provider discounts deducted from TPR payments.

If the client has other third party coverage, CSHCN may pay deductibles/coinsurance for the client as long as the combination of insurance and CSHCN payment does not exceed CSHCN's fee schedule in use at the time of service.

Exception: By law, CSHCN cannot reimburse for CHIP deductibles or coinsurance.

1.16.1 Health Maintenance Organization (HMO)

Important
CSHCN will not reimburse providers for client co-pays. Providers may collect co-pays for CSHCN clients with private insurance.

CSHCN will consider payment for services specifically excluded or limited by HMOs but covered by CSHCN. An Explanation of Benefits (EOB) will be required from the HMO. Payment of those services must not exceed CSHCN's maximum allowable fees for those services.

CSHCN will not provide assistance for the following:

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

Note: **Providers may collect co-pays for CSHCN clients with private insurance.**
NHIC-CSHCN will reimburse clients for medication co-pays. Clients should contact NHIC-CSHCN at 877-888-2350 for additional information.

1.16.2 Identification Card

Insurance coverage is indicated by the word "Insurance" below the birth date in the CSHCN case number block. The information is obtained at the time of the application, so it must be verified at the time services are rendered.

1.16.3 Claims Filing

When a CSHCN client has other health insurance, that resource must be billed before billing the CSHCN Program. All claims for clients with other insurance coverage must reference the following information (refer to "Claims Information" at the end of each section), whether or not a copy of the explanation of benefits from the insurance company is attached:

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

1.16.4 Verbal Denials

Occasionally, providers may call the other insurance resource and receive a verbal denial. In these situations, the provider must indicate the following information in block 11 of the HCFA-1500 Claim Form:

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

If a third party resource has not responded or delays payment/denial of a provider's claim for more than 110 days after the date the claim was billed, CSHCN will consider the claim for payment. The following information is required:

- Name and address of the third party resource
- Date the third party resource was billed (used to calculate the filing deadline)
- A statement signed and dated by the provider that no disposition has been received from the third party resource within 110 days from the date the claim was filed

When a claim is denied by NHIC because of the client's other coverage, information identifying the third party resource appears on the provider's *Remittance and Status (R&S)* Report. The claim must not be refiled with NHIC until disposition from the third party resource has been received or until 110 days have elapsed since the billing of the claim to the TPR source, with no disposition received. A statement from the client or family member indicating that they no longer have this resource is **not** sufficient documentation to reprocess the claim.

When a provider is advised by a third party resource that benefits have been paid to the client, that information must be indicated on the claim with the date and amount of payment made to the client, if available. If a denial was sent to the client, refer to the required information on verbal denials. This information will enable NHIC to consider the claim for payment.

1.16.5 Filing Deadlines

Claims that involve a TPR have the following deadlines applied:

- Claims with a valid disposition must be submitted to NHIC within 90 days from the disposition (payment or denial).
- As a courtesy to the provider, if more than 110 days have elapsed from the date a claim was filed to the third party resource and no response has been received, the claim may be submitted to NHIC for consideration of payment. The following information is required:
  - Name and address of the third party resource
  - Date the third party resource was billed (used to calculate the filing deadline)
  - A statement signed and dated by the provider that no disposition has been received from the third party resource within 110 days from the date the claim was filed
- In addition to the above, there is a 365-day filing deadline from the date of service. **This means that a fully documented claim must be received by NHIC within 365 days of the date of service.** However, when another third party resource recoups a payment made in error on a claim that was never submitted to NHIC, the provider must send the claim for special handling to the attention of the Third Party Resources Unit at NHIC within 90 days of the TPR action, if the 365-day filing period has been exceeded.

NHIC does not have the authority to waive state or federal mandates such as filing deadlines.

1.16.6 Blue Cross Blue Shield Non-Participating Physicians

Blue Cross Blue Shield (BCBS) currently has procedures in place to pay assigned claims directly to nonparticipating providers. A nonparticipating provider is eligible to receive direct reimbursement from BCBS, when assignment is accepted. However, only payment dispositions are sent to the provider. Explanation of benefits regarding denials are sent only to the client.

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

Physicians who treat CSHCN clients with BCBS private insurance and who are nonparticipating with BCBS must follow the procedures below:

- Do not provide the CSHCN client with a bill or anything the client could use as a bill. An informational statement may be given. To avoid confusion, write “Information Only” clearly on the copy of the statement.
- Bill BCBS directly, accepting assignment. When payment from BCBS has been received, the claim may be filed with NHIC-CSHCN to seek additional payment up to the CSHCN allowable amount.
- If no BCBS disposition is received within 110 days from the date the claim was billed to BCBS, file the claim to NHIC-CSHCN and furnish the following 110 day information: indicate “nonparticipating BCBS,” the date BCBS was billed, and a statement signed and dated by the provider that no disposition has been received from the third party resource within 110 days from the date the claim was billed.

Reminder: A claim must be filed with NHIC-CSHCN within 365 days of the date of service.

1.16.7 Refunds to NHIC-CSHCN Resulting from Other Insurance

If CSHCN makes payment for a claim and payment is received from another resource for the same services, a refund to NHIC-CSHCN is required. These refunds are not to be held until the end of an accounting year. Because providers must accept assignment, they must accept CSHCN payment as payment in full for covered services and they must not use payment by another third party resource to make up the difference between the amount billed and the CSHCN payment. Any payment received from another third party resource must be refunded to NHIC, up to 100 percent of the CSHCN payment.

Providers must use the following guidelines to determine the amount to be refunded to NHIC:

- When CSHCN pays more than the other resource pays, the amount of the other payment is due as a refund to NHIC.

Example	
Total billed	$300
CSHCN payment	$200
Other resource payment	$150
Amount to be refunded to NHIC	$150

- When CSHCN pays less than the other resource, the amount paid by CSHCN is due as a refund.

Example	
Total billed	$300
CSHCN payment	$200
Other resource payment	$250
Amount to be refunded to NHIC	$200

1.16.8 Accident-Related Claims

NHIC monitors all accident claims to determine whether another resource may be liable for the medical expenses of CSHCN clients. Providers are requested to ask clients whether the medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers must enter the appropriate code and date in block 10 of the HCFA-1500 Claim Form, or blocks 32ab–35ab on the HCFA-1450 (UB-92) Claim Form.

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

The following information must be included on these claims:

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

1.16.8.1 Accident Resources and Refunds

Acting on behalf of CSHCN, NHIC has the authority to recover payments from any settlement, court judgment, or other resources awarded to a CSHCN client. In most cases, NHIC works directly with the attorneys, courts, and insurance companies to seek reimbursement for CSHCN payments. However, if a provider receives a portion of a settlement for which CSHCN has made payment, the provider must make a refund to NHIC. Any provider filing a lien for the entire billed amount must contact the Third Party Resources Unit at NHIC to coordinate CSHCN post payment activities. Providers may contact TPR by calling 800-846-7307 or 512-514-4451.

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

1.17 CSHCN Program Limitations and Exclusions

The following services and supplies are not CSHCN benefits. **This list is not all-inclusive:**

- Abortions
- Acute acne treatment
- Allergy treatment services except antibiotic desensitization
- Autopsies
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Chiropractic treatment
- Custodial care
- Donor search for bone marrow/stem cell transplants
- Fetal medical and surgical services
- Genetic services – except pathology (cytogenetic studies including tissue culture for chromosome analysis and chromosome analysis with karyotyping and banding are covered)
- Inpatient admissions for behavioral health is limited to five days per calendar year
- Inpatient hospital tests that are not specifically ordered by the physician/doctor who is responsible for the diagnosis or treatment of the patient's condition
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
- More than 60 days of inpatient hospitalization per calendar year

Note: An additional 60 hospital days begins the date of hospital admission for an approved bone marrow/stem cell transplant.

- More than 90 days of inpatient rehabilitation per calendar year
- Portable X-ray services
- Procedures and services that are considered experimental or investigational
- Recreational therapy
- Respite services
- Routine newborn services
- Separate fees for completing or filing a CSHCN claim form which is to be incorporated in the provider's usual and customary charges to all patients
- Services or supplies for which benefits are available under any other contract, policy or insurance
- Services or supplies for which claims were not submitted within the filing deadline
- Services or supplies not reasonable and necessary for diagnosis or treatment
- Services or supplies not specifically provided by the CSHCN Program
- Services or supplies provided before the effective date of the designation by CSHCN as a client, or after the effective date of the denial of eligibility
- Services or supplies provided to a client after a finding has been made during utilization review procedures that indicate these services or supplies are not medically necessary
- Services payable by any health, accident, other insurance coverage or by any private or other governmental benefit system, or any legally liable third party
- Services provided by ineligible, suspended, or excluded providers
- Social and educational counseling
- Solid organ transplants and related services (liver, kidney, lung, heart, pancreas)
- Sterilizations, infertility, obstetrics, and family planning services
- Substance abuse treatment
- Telephone calls, computer calculations, reports, and medical testimony

The following procedures are not covered. **This list is not all-inclusive:**

- Ambulatory blood pressure monitoring
- Augmentation mammoplasties, breast reconstruction
- Biofeedback therapy
- Cardiokymography
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Chemonucleolysis intervertebral disc
- Color vision and dark adaption exams
- Continuous tissue temperature monitoring
- Craniotomy for lobotomy
- Dermabrasion/chemical peel
- Dressings/supplies billed in physician's office
- Ear piercing or repair
- Ear protector attenuation measurements
- ECMO (extracorporeal membrane oxygenation)
- Ergonovine provocation test
- Extracorporeal photophoresis
- Fabric wrapping of abdominal aneurysms
- Hair analysis, treatment, and electrolysis
- Hyperthermia and hypothermia
- Implantation of antiesophageal reflux device

- Implantation/removal/evaluation of automatic implantable cardioverter-defibrillation pads and electrodes
- Intermittent positive pressure breathing (IPPB) (physician services)
- Intersex surgery (except to repair/treat congenital defects)
- Intra-aortic balloon counterpulsation; monitoring or supervision of pump technician
- Lipectomies and rhytidectomies
- Manipulation of chest wall, including percussion
- Masters EKG
- MRI of chest, abdomen, myocardium, bone marrow
- Nail bed reconstruction
- Nipple exploration/reconstruction and related services
- Noninvasive electrical stimulation to aid bone healing (physician services)
- Obsolete diagnostic tests
- Obstetrical tests
- Orthomolecular therapy
- Orthoptic training
- Outpatient cardiac rehabilitation
- Pediatric pneumogram
- Penile plethysmography, nocturnal tumescence test
- Peripheral and thermal angioplasty
- Peyronie disease treatment
- Phlebotomy-therapeutic
- Photokymography
- Polysomnography
- Prolonged extracorporeal circulation
- Prolotherapy
- Prostate treatment (massage and surgery)
- Quest test (infertility)
- Routine blood drawing for specimens
- Salivary gland and duct diversion/ligation
- Sclerosing solution injections for telangiectasia
- Silicone/collagen injections (cosmetic)
- SPECT imaging
- Speech prosthesis insertion
- Sterilization reversal
- Tattooing
- Thermogram (lumbar and cervical)
- Transfer factor
- Travel allowance for specimen collection for home bound clients
- Treatment of hidradenitis

1.18 NHIC Claims Information

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

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

1.18.1 NHIC Processing Procedures

CSHCN claims filed with NHIC are subject to the following procedures:

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

1.18.2 Claims Filing Deadlines

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

- If a filing deadline falls on a weekend or holiday, the filing deadline is extended to the next business day following the weekend or holiday.
- Inpatient claims filed by a hospital must be submitted to NHIC within 90 days from the discharge date. Hospitals may submit interim claims prior to discharge. These claims must be submitted to NHIC within 90 days from the last date of service on the claim.
- Outpatient hospital services must be submitted to NHIC within 90 days from the date of service.
- All other claims must be submitted to NHIC within 90 days from each date of service.
- Claims for services not processed by NHIC that are submitted to NHIC in error, must be received by the CSHCN central office within 90 days of the date on the NHIC *R&S* report.

Reminder: If you are trying to obtain authorization for services that have been performed, or that will be performed, your claim must still be received by NHIC-CSHCN according to the usual 90-day filing deadline. The 90-day authorization deadline is for services requiring authorization (not **prior** authorization), including extensions and emergency situations.

The **following exceptions** to the claims filing deadline apply to all claims submitted to NHIC regardless of provider type:

- When a service is a benefit of Medicare, Medicaid, and CSHCN, and the client is covered by all programs, the claim must be filed with Medicare first, then with Medicaid. Claims denied by Medicaid must be submitted to CSHCN within 90 days from the date of Medicaid disposition. A copy of the disposition must be submitted with the claim.
- When a service is billed to another insurance resource, the filing deadline is 90 days from the date of disposition by the other resource.
- When a service is billed to a third party resource that has not responded, the filing deadline is 12 months from the date of service. If 110 days have elapsed without a response from the third party biller, the claim may be submitted to NHIC.

Exceptions to the filing deadline are considered by TDH when one of the following situations exists:

- A catastrophic event occurs that substantially interferes with normal business operations of the provider, or damage or destruction of the provider's business office or records by a natural disaster, including but not limited to fire, flood, or earthquake; or damage or destruction of the provider's business records by circumstances that are clearly beyond the control of the provider

including, but not limited to, criminal activity. The damage or destruction of business records or criminal activity exception does not apply to any negligent or intentional act of an employee or agent of the provider because these persons are presumed to be within the control of the provider. The presumption can only be rebutted when intentional acts of the employee or agent lead to termination of employment and filing of criminal charges against the employee or agent. The provider must submit independent evidence of insurable loss; medical, accident, or death records; or police or fire report substantiating the exception of damage, destruction, or criminal activity.

- Delay or error in the eligibility determination of a client or a delay due to erroneous written information from other state agencies, TDH, or NHIC. The provider must submit the written document that contains the erroneous information or explanation of the delayed information.
- Delay due to electronic claim or system implementation problems. The provider must submit the written repair statement, invoice, computer or modem-generated error report (indicating attempts to transmit the data failed for reasons outside the control of the provider), or the explanation for the system implementation problems. The documentation must include a detailed explanation made by the person making the repairs or installing the system, specifically indicating the relationship and impact of the computer problem or system implementation to claims submission, and a detailed statement explaining why alternative billing procedures were not initiated after the delay in repairs or system implementation was known.

The CSHCN Program allows for payment of bills past the deadline, only if the Commissioner of Health waives the filing deadline upon determination that good cause and exceptional circumstances have been shown.

Implementation of this rule must adhere to the following procedure:

1) Provider must request waiver in writing.
   - Provider must identify an operational problem causing the inability to file on time.
   - Provider also must state that the stated operational problem has been resolved or that steps are being taken to resolve problem.
   - Provider must acknowledge in writing that this is a one-time only waiver request for the identified problem.
2) Bills must be valid and payable in all ways except the billing deadline.
3) Only one waiver per provider for the stated problem will be requested of the Commissioner. Therefore all outstanding bills related to the identified problem must be considered at one time. The waiver request memo to the Commissioner will include total dollar amount for each provider's waiver. If some bills for the identified time frame have not been received by the time the waiver memo is sent to the Commissioner, the total dollar amount included in the memo should include sufficient funds to cover anticipated bills. Claims submitted for waiver request must be submitted by the provider in accordance with instructions from CSHCN.
4) CSHCN staff will notify the provider of the outcome of the request.

Send exceptions to the filing deadline to:

TDH
CSHCN Appeals
1100 West 49th St
Austin TX 78756-3179
FAX: 800-441-5133

Note: Correspondence greater than 10 pages must be mailed.

1.18.3 Appeal Time Limits

All appeals of denied claims and requests for adjustments on paid claims must be received by NHIC within 180 days from the date of disposition of the claim, which is the date of the *R&S* on which that claim appears.

1.18.4 Claims with Incomplete Information

Claims lacking the information necessary for processing are listed on the *R&S* with an explanation of benefits (EOB) code requesting the missing information. Providers must resubmit a signed, completed/corrected claim with a copy of the *R&S* on which the claim appears to NHIC within 180 days from the date on the *R&S* to be considered for payment. Hospitals are not required to resubmit inpatient itemized charges if they were included with the original submission.

1.19 Coding

1.19.1 Diagnosis Coding

The **only** diagnosis coding structure accepted by the CSHCN Program is the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). CSHCN requires providers to provide ICD-9-CM diagnosis codes on their claims. Diagnosis codes must correspond to the highest level of specificity available. A written description of the diagnosis is not required.

1.19.2 Procedure Coding

1.19.2.1 HCPCS

The procedure coding system used by CSHCN is called Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System, more commonly known as HCPCS. HCPCS gives health care providers and third party payors a common coding structure for determining reimbursement.

HCPCS is designed around a five-character numeric or alpha-numeric base for all procedure codes. To ensure an up-to-date coding structure, HCPCS is updated annually using the latest edition of the CPT-4 manual, nationally established Centers for Medicare and Medicaid Services (CMS) codes, and codes assigned locally by the Medicare carrier or Medicaid. In recognition of local needs and rapidly expanding medical technology, HCPCS consists of three levels of codes.

1.19.2.2 Level I

CPT-4 Codes – the American Medical Association's (AMA) Physicians' *Current Procedural Terminology, 4th Edition*:

- **All numeric**, consisting of five digits
- Represents 80 percent of HCPCS
- Maintenance is the responsibility of the AMA, which updates on a yearly basis
- Updates by the AMA are coordinated with Centers for Medicare and Medicaid Services (CMS) before Centers for Medicare and Medicaid Services (CMS) distribution of modifications to third party payors
- Anesthesia codes from CPT-4

Note: Claims for anesthesia must have the CPT-4 anesthesia procedure code listed. Narrative descriptions or CPT-4 surgical codes will result in claim denial.

1.19.2.3 Level II

Centers for Medicare and Medicaid Services (CMS) (HCPCS) Codes

- Codes for both physician and non physician services not contained in CPT-4 (for example, ambulance, durable medical equipment, prostheses, and some medical codes)
- Updating is the responsibility of the Centers for Medicare and Medicaid Services (CMS) Maintenance Task Force
- All **alpha-numeric**, consisting of a single alpha character (A-V) followed by four numeric digits

The single alpha character signifies the following:

Character	Description
A	Supplies, ambulance, chiropractic
B	Enteral and parenteral therapy
D	Dental
E	DME and oxygen
H	Rehabilitation services
J	Drugs (administered other than orally)
K	ICD-9 CM Surgery (infomational only)
L	Orthotic and prosthetic procedures
M	Medical
P	Laboratory
Q	Temporary procedures
R	Radiology
V	Vision and hearing services (nonphysician); speech/language pathology services (nonphysician)

1.19.2.4 Level III

Local Codes

- Not contained in the other two levels
- Based on local reporting practices in all contract areas
- Maintenance is the responsibility of the local carrier (NHIC); however, Centers for Medicare and Medicaid Services (CMS) is informed for potential national application
- Some are **numeric-alpha** consisting of four numeric digits followed by a single alpha character
- Some are **alpha-numeric** consisting of a single alpha character (W – Z) followed by four numeric digits

Character	Description
W	DME and X-ray
X	Surgical and laboratory
Y	Prosthetics, supplies, x-ray, and radiation therapy
Z	Injections, medical

NHIC encourages all providers to precode their claims. Claims are processed faster and more accurately if providers furnish this information. By precoding claims, providers ensure precise and concise representation of the services provided and are assured of reimbursement based on the correct code. If providers precode claims, a narrative description is not required and does not need to be included unless the code is a not otherwise classified or unlisted code.

The carrier for the Texas Medicare Program has coding manuals available for physicians and suppliers with codes not available in CPT-4. CSHCN utilizes Medicaid-only codes that are developed for procedures covered by the Medicaid Program. These codes are published in regularly scheduled bulletins.

HCPCS codes are used by all CSHCN providers to show what procedures are performed **except** for inpatient hospitals submitting facility charges on the HCFA-1450 (UB-92) Claim Form. These charges should be billed using revenue codes.

1.19.2.5 Modifiers

Modifiers further describe and qualify services provided. A modifier is placed after the five-digit procedure code. Examples of frequently used modifiers are listed starting at "General Modifiers" on page 1-44.

1.19.2.6 General Modifiers

Modifier	Description
2A	The lesion is actinic keratosis.
25	Significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service: the physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier -57.
26	Professional component: used for laboratory and radiological procedures.
3S	Total component lab/radiology service.
50	Bilateral procedure: unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session must be identified by the appropriate five-digit code describing the first procedure. The **second** (bilateral) procedure is identified by adding modifier "50" to the procedure code.
51	Multiple procedures: when multiple procedures, other than evaluation and management services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier -51 to the additional procedure or service code(s) or by the use of the separate five digit modifier 09951. Note: This modifier should not be appended to designated "add-on" codes.
52	Reduced services: under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier -52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be used as an alternative to modifier -52. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers -73 and -74 (see modifiers approved for ASC hospital outpatient use).
53	Discontinued procedure: under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier -53 to the code reported by the physician for the discontinued procedure or by use of the separate five digit modifier code 09953. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers -73 and -74 (see modifiers approved for ASC hospital outpatient use).
54	Surgical care only: Surgeons who do not provide the postoperative care for a patient **must** bill the surgery code with modifier "54." The modifier will reimburse the surgeon at 80 percent of the allowable amount.

Modifier	Description
55	Physicians who provide only the postoperative care must bill the appropriate visit codes and must use modifier “55” to indicate that only postoperative services were provided. Services indicated as postoperative care only by use of the modifier will not be denied as part of the global surgical fee.
57	Decision for surgery
6A	Injectible medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available.
6B	The patient has a temperature over 102 (documented on the claim) and a high blood level of antibiotic is needed quickly.
62	Two surgeons: Two surgeons perform the specific procedure(s).
66	Surgical team: Two surgeons are necessary to perform the highly complex surgical procedure(s).
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia: due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block [s] or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier -73 or by use of the separate five digit modifier code 09973. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.
74	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia: due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block[s], general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of the modifier -74 or by use of the separate five digit modifier code 09974. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.
76	Repeat procedure by same provider. The provider may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier “76” to the repeated service.
77	Repeat procedure by another physician: the physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated procedure/service or the separate five digit modifier code 09977 may be used.
78	Return to the operating room for a related procedure during the postoperative period: the physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure; this subsequent procedure is related to the first and requires the use of the operating room.
80	Assistant surgeon: surgical assistant services.
81	Minimum assistant surgeon: minimum surgical assistant services.
82	Assistant surgeon (when qualified resident surgeon not available).
8A	Assistant surgeon in a case involving exceptional medical circumstances, such as emergency or life threatening situations, requiring immediate attention.
8B	Assistant surgeon when primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his or her patients.
8C	Assistant surgeon in a case involving a complex surgical procedure and qualifies for more than one physician.
91	Repeat clinical diagnostic laboratory test.
AA	Anesthesia services personally furnished by an anesthesiologist.
AD	Supervision of more than four concurrent anesthesia services by anesthesiologist. Also used when a modifier is not used on a claim. Total time units for claim will be 1.

Modifier	Description
AS	Physician assistant services for assistant-at-surgery (team member).
AT	Acute treatment. Must be used to indicate the necessity of an acute condition for OT, PT, OMT, or chiropractic services.
CC	Procedure code change. Used when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed.
DS	Blood services.
D4	Outpatient surgical service.
D9	Supply/other miscellaneous service.
ET	Emergency treatment.
EX	Excision/destruction is due to at least one of the following signs or symptoms: inflamed, bleeding, infected, itching, irritated, growing, limiting motion or function.
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
GT	Via interactive audio and video telecommunication
GQ	Via asynchronus telecommunications system
JI	This injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.
LT	Left side. This modifier is used to identify procedures performed on the left side of the body.
OC	Injection is medically necessary as the oral route is contraindicated, or an acceptable oral equivalent is not available.
PA	Physician assistant services for assistant-at-surgery (team member).
PO	Indicates necessary equipment is in physician's office for RAST/MAST testing or pap smears.
Q5	Informal reciprocal arrangement (period not to exceed 14 continuous days).
Q6	Locum tenens or temporary arrangement (up to 90 days).
QJ	Medically directed by a physician, two concurrent procedures.
QL	Ambulatory surgical center (ASC) facility services.
QO	Medically directed by a physician, three concurrent procedures.
QQ	Medically directed by a physician, four concurrent procedures.
RT	Right side. This modifier is used to identify procedures performed on the right side of the body.
S1	Medical service.
S2	Surgical care only: surgical service.
S3	Consultation service.
SF	A second opinion was ordered by a professional review organization.
SG	Ambulatory surgical center (ASC) facility service.
SH	This drug/supply was used/administered entirely in the hospital outpatient facility; no portion was taken home by the patient.
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit

Modifier	Description
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe
TC	Technical component. Under some circumstances, a charge may be made for the technical component alone. The modifier "TC" is used for radiological procedures.
Y	Second surgical opinion. Use "SF" for services ordered by a PRO.
Y4	Purchase – new equipment, durable medical equipment (DME).
Z6	DME rental equipment.
ZC	DME used equipment. **Note: CSHCN does not reimburse for used equipment.**

1.19.2.7 Surgeons

Modifier	Description
Y	Second surgical opinion. Use "SF" for services ordered by a PRO.
S2	Surgical care only: surgical service.
54	Surgical care only: surgeons who do not provide the postoperative care for a patient **must** bill the surgery code with modifier "54." This modifier will reimburse the surgeon at 80 percent of the profile amount.
55	Physicians who provide only the postoperative care must bill the appropriate visit codes and **must** use modifier "55" to indicate that only postoperative care services were provided. Services indicated as postoperative care only by use of this modifier will not be denied as part of the global surgical fee.
57	Decision for surgery.
62	Two surgeons: two surgeons perform the specific procedure(s).
66	Surgical team: two surgeons are necessary to perform the highly complex surgical procedure(s).
78	Return to the operating room for a related procedure during the postoperative period: the physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure; this subsequent procedure is related to the first and requires the use of the operating room.

1.19.2.8 Assistant Surgeons in Teaching Facilities

Modifier	Description
AS	(HCFA) Physician assistant services for assistant-at-surgery (team member).
8A	Assistant surgeon in a case involving exceptional medical circumstances, such as emergency or life-threatening situations, requiring immediate attention.
8B	Assistant surgeon when primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his/her patients.
8C	Assistant surgeon in a case involving a complex surgical procedure and qualifies for more than one physician.
80	Assistant surgeon: surgical assistant services.
81	Minimum assistant surgeon: minimum surgical assistant services.
82	Assistant surgeon (when qualified resident surgeon is not available).
PA	Physician assistant services for assistant-at-surgery (team member)

1.19.2.9 Excision of Lesions / Masses

Modifier	Description
EX	Excision / destruction is due to at least one of the following signs or symptoms: inflamed, bleeding, infected, itching, irritated, growing, limiting motion or function.
2A	The lesion is actinic keratosis.

1.19.2.10 Hand and Foot Surgical Modifiers

Modifier	Description
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

1.19.2.11 Injections

Modifier	Description
6A	Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available.
6B	The patient has a temperature over 102 (documented on the claim) and a high blood level of antibiotic is needed quickly.
ET	Emergency treatment.
JI	This injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.
OC	Injection is medically necessary as the oral route is contraindicated, or an acceptable oral equivalent is not available.

1.19.2.12 Labs / Radiology

Modifier	Description
3S	Total component lab/radiology services.
76	Repeat procedure by same provider. The provider may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier "76" to the repeated service.
77	Repeat procedure by another physician: the physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated procedure/service or the separate five digit modifier code 09977 may be used.
91	Repeat clinical diagnostic laboratory test.

1.19.2.13 Anesthesia

One of the following modifiers **must** be used by physicians in conjunction with the CPT-4 anesthesia code for anesthesia services:

Modifier	Description
AA	Anesthesia services personally furnished by anesthesiologist.
AD	Medical supervision by a physician of more than four concurrent anesthesia services by anesthesiologist. Also used when a modifier is not submitted on the claim. Total time units for claim will be 1.
QJ	Medically directed by physician, two concurrent procedures.
QO	Medically directed by physician, three concurrent procedures.
QS	Monitored anesthesia care service
QQ	Medically directed by physician, four concurrent procedures.
QX	CRNA service; with medical direction by a physician
QZ	CRNA service; without medical direction by a physician
2X	CRNA medically directed

Note: CRNA providers are enrolled and reimbursed by TDH-CSHCN.

1.19.2.14 Place of Service (POS) Coding

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

POS	Description
1	Office (O)
2	Home (H)
3	Inpatient hospital (IH)
4	Skilled nursing facility (SN)
5	Outpatient hospital (OH), ambulatory surgical center
6	Independent laboratory (L)
8	Nursing home (NH)
9	Other location

1.20 Claims Filing Instructions

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

Claims must contain the billing provider's complete name, address, and TPI. NHIC provides adhesive labels printed with this information; they must be placed in the appropriate block of the claim form to ensure correct claim identification. A claim without a provider name, address, or TPI will not be processed. Labels may be requested using the form described in "Claims Information" on page 13-66.

1.20.1 Provider Types and Selection of Claim Forms

1.20.1.1 HCFA-1500

The following services must be billed on a HCFA-1500 Claim Form when requesting payment for medical services and supplies under the CSHCN Program:

- Ambulance
- DME
- Freestanding ambulatory surgery center
- Gastrostomy devices
- Independent laboratory, radiology, and radiation therapy
- Medical nutritional products and services
- Orthosis and prosthesis
- Outpatient therapy (PT, OT, and SLP)
- Physician (M.D. and D.O.)
- Podiatry
- TPN/Hyperalimentation
- Transportation of remains of deceased clients (providers should contact CSHCN for assistance in obtaining and completing forms)
- Any other authorized provider of medical services and supplies not specifically required to use a different claim form when submitting claims to NHIC

Providers are responsible for obtaining these forms from a printer of their choice (see claim examples in each specialty chapter).

1.20.1.2 HCFA-1450 (UB-92)

The following services must be billed using the HCFA-1450 (UB-92) Claim Form when requesting payment:

- Home Health (skilled nursing service)
- Inpatient hospital
- Outpatient hospital
- Ambulatory surgical center (hospital-based)
- Inpatient rehabilitation

Providers are responsible for obtaining these forms from a printer of their choice (see claim examples in each specialty chapter).

1.20.1.3 CSHCN Dental Claim

Dental and orthodontia services must be billed using the CSHCN Dental Claim form when requesting payment.

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

Refer to: "CSHCN Dental Claim Form Example" on page 3-18.

1.20.1.4 Electronic Claims Submission

For claim submission, eligibility inquiry, and electronic *R&S* report transactions, billing vendors use National Standard Transaction Formats such as HCFA-1500, HCFA-1450 (UB-92), ANSI, or EDIFACT.

TDHconnect software has also been upgraded. Distribution of TDHconnect version 2.0 began on May 3, 2001. If you are currently using TDHconnect version 1.6, the new software has been mailed to you.

Claims submitted electronically to NHIC must be submitted using the updated specifications or TDHconnect version 2.0.

Minimum and recommended PC requirements for use of TDHconnect version 2.0 are listed below.

1.20.1.5 Minimum Hardware Requirements

- Computer with a Pentium-class processor (Recommended: 200 MHz or higher)
- CD-ROM drive
- Modem that supports 9600 bps or higher (Recommended: 28800 bps or greater)
- 100 MB hard disk space for installation
- 50 MB hard disk space per user per year for database
- 800 x 600 VGA (monitor resolution), 256 colors

1.20.1.6 Operating System

- Microsoft Windows 95 and 16 MB of RAM or
- Microsoft Windows 98 and 24 MB of RAM or
- Microsoft Windows ME and 32 MB of RAM or
- Microsoft Windows NT 4.0 (Service Pack 5 or higher) and 24 MB of RAM or
- Microsoft Windows 2000 and 64 MB of RAM

1.20.1.7 Software

- Microsoft Internet Explorer 4.01 Service Pack 2 or higher (5.0 included on CD)

1.20.1.8 Recommended Hardware Requirements

Minimum requirements with the following hardware specifications for better performance at your desktop:

- Computer with a Pentium 200-MHz or higher processor
- 48 MB of RAM if using Microsoft Windows 95 or later
- 64 MB of RAM if using Microsoft Windows NT 4.0
- Modem that supports 28800 bps or Higher

1.20.1.9 Dates on Claims

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

Example: August 6, 2001, is entered as 08062001.

1.20.1.10 Span Dates

If you submit paper claims currently and have provided services on consecutive days, you may bill four consecutive days per claim detail. Effective for claims submitted on and after August 6, 2001, your dates of service may span more than four consecutive days as long as the dates are in the same month and year. You must indicate in the quantity billed the number of dates you are billing.

For example, services were provided each day from August 6, 2001 to August 16, 2001. When submitting the paper claim, you could enter your “from” date of service as 08062001 and 08162001 as the “to” date of service. The quantity would be 11.

Note: Claims submitted with a quantity billed that is not equal to the number of days indicated in the date of service fields will be denied. When the claim is processed, *Compass21* will create multiple details consisting of four consecutive days each so that the claim appears on your *R&S* report with one detail for each four days billed. Using the example above, you will see three details as illustrated below.

Note: If the number of details created during this process is greater than 28, the claim will deny as exceeding the maximum details per claim.

Detail	From DOS	To DOS	Qty Billed
1	08062001	08092001	4
2	08102001	08132001	4
3	08142001	08162001	3

1.20.1.11 Hospital Billing

Hospitals submitting inpatient claims on paper may submit up to 56 service lines per claim. When the claim is submitted, *Compass21* performs a “merge function” that lumps together like revenue codes to reduce the number of service lines to 28 or less. Because of the merge function, it is important to understand that when the claim appears on your *R&S* report you will not see the 56 service lines submitted, but rather the results of merged details. If the merge function is unable to merge the number of service lines to 28, the claim will deny as exceeding the maximum details per claim.

For more information on electronic claim submission, contact the TexMedNet Help Desk at 888-863-3638.

1.21 *Remittance and Status* (*R&S*) Report

The *R&S* report provides information on pending, paid, denied, adjusted, and incomplete claims. NHIC provides *R&S* reports to give providers detailed information about the status of claims submitted to NHIC. The *R&S* also identifies receivables established as a result of inappropriate payments. These receivables will be recouped from payments of subsequent claim submissions.

A separate *R&S* is prepared for each TPI and each program. For example, a provider with the same TPI for traditional Medicaid and Medicaid managed care will have two *R&S* reports – one for Medicaid and one for managed care. Providers can determine which program the *R&S* is for by looking at the top center of the *R&S*. The first line will read “National Heritage Insurance Company”; the second line will identify the program for which the *R&S* is received.

The *R&S* report is available in electronic format (*ER&S*) at 6 a.m. each Monday.

Providers must retain copies of all *R&S* reports for a minimum of five years. Do not send original *R&S* reports back with incomplete claims or appeals; instead, submit copies of the *R&S* reports to NHIC with appeals and incomplete claims.

A sample of the new, enhanced *R&S* reports can be found at “Remittance and Status (R&S) Reports Examples” on page 1-61. NHIC will continue to provide all the same information that we have in the past but some changes have been made. These changes are:

- Information is displayed in rows rather than columns.
- Incomplete claims will appear in the “Paid or Denied and Incomplete Claims” section.
- Increased number of Explanation of Benefits (EOBs) and Explanation of Pending Claims (EOPs); at the claim level we have increased from 2 to 4 messages and at the detail level from 3 to 5 messages per detail.
- EOB codes and EOP codes are five characters.
- Descriptions of EOBs and EOPs will be in an Appendix at the end of the *R&S* rather than at the bottom of the page that they appear on.
- Financial transactions will appear in one of the following categories: accounts receivable, IRS levies, claim refunds, payouts (system and manual), claim reissues, and claim voids.
- Internal control number (ICN) will be 24 digits.
- The primary diagnosis submitted on the claim will appear with the claim header information.

1.21.1 Banner Pages

These pages serve two purposes. First, they print the provider’s name and address in a location that appears in the window of the envelope. Second, they are used to inform providers of new policies and procedures. The title pages include the following information:

- NHIC address for submitting paper appeals
- Provider’s name, address, and telephone number
- Unique *R&S* number specific to each report
- TPI
- Report sequence number (a cumulative number of *R&S* reports the provider has received for the calendar year)
- Date of the week being reported on the *R&S*
- Tax identification number
- Page number (*R&S* begins with page 1)
- AIS TPI conversion (TPI converted for AIS use)
- AIS telephone number for AIS inquiry call

Subsequent pages of the *R&S* report provide changes in policy/claims information weekly.

1.21.2 *R&S* Explanation of the Row Headings and Sections

Row Heading / Section	Explanation
Patient name	Lists the client's last name and first name as indicated on the provider's claim. This field is truncated to display 13 characters.
Claim number	The 24-digit internal control number (ICN) assigned by NHIC for a specific claim. The format for the NHIC claim number is **PPPCCCMMMCCYYJJJBBBBBSSS.** **PPP**: *Compass21* Program 400: CSHCN **CCC**: Claim Type 020: Physician supplier / Genetics 021: Dental 023: Outpatient hospital / HHA 040: Inpatient hospital **MMM**: Media Source (Region) 010: Paper 011: Paper adjustment 020: TDHconnect 021: TDHconnect adjustment 030: Electronic 031: Electronic adjustment 041: AIS adjustment **CCYY**: Year in which the claim was received **JJJ**: Julian date on which the claim was received **BBBBB**: NHIC internal batch number **SSS**: NHIC Internal claim sequence within the batch
CSHCN number	The client's CSHCN number.
Patient account number	If a patient account number is used on the provider's claim, it appears here.
Medical record number	If a medical record number is used on the provider's claim, it appears here.
Medicare number	If the claim is a result of an automatic crossover from Medicare, the Medicare claim number appears directly under the NHIC claim number.
EOB	Any explanation of benefits code that applies to the entire claim (header level) will print here. Up to four EOB codes at the header level display.
Diagnosis	The primary diagnosis listed on the provider's claim.
Service dates	Format MMDDYYYY (month, day, year) in "From" and "To" dates of service.
TOS / Procedure / Accommo-dation Code	Indicates by code the specific service provided to the client. The two-digit type of service (TOS) appears first followed by a HCPCS procedure code. A three-digit code represents a hospital accommodation or ancillary revenue code.
Billed quantity	Indicates the quantity billed per claim detail.
Billed charge	Indicates the charge billed per claim detail.
Allowed quantity	Indicates the quantity NHIC has allowed per claim detail.
Allowed charge	Indicates the charges NHIC has allowed per claim detail.

Row Heading / Section	Explanation
Place of service (POS) column	Includes the POS to the left of the Paid Amount. A two-digit numeric code identifying the POS will be indicated in this field.
Paid amount	The final amount allowed for payment per claim detail. Also appearing in this field is the amount paid by another insurance resource. The other insurance amount is preceded by a minus (-) symbol, and this amount is subtracted from the total of the paid amounts appearing in this field. The total paid amount for the claim appears on the claim total line.

1.21.3 Explanation of Benefit (EOB) Codes and Explanation of Pending Status (EOPS)

EOB and EOPS Codes	Explanation
Codes	These codes explain the payment or denial of the provider's claim. The EOB codes are printed next to and / or directly below the claim. An explanation of all EOBs appearing on the *R&S* report are printed in the Appendix at the end of the *R&S* report. The EOPS will appear only in the "Claims In Process" section of the *R&S* report. The codes explain the status of pending claims and are not an actual denial or final disposition.
Modifier	Modifiers have been developed to describe and qualify services provided. For dental services, two modifiers are printed. The first modifier is the tooth identification (TID) and the second is the surface identification (SID).

1.21.4 *R&S* Explanation of Headings

1.21.4.1 Paid or Denied and Incomplete Claims

"Paid or Denied and Incomplete Claims" is centered on the top of each page in this section. Claims in this section finalized the week before the preparation of the *R&S* report. The claims are listed by claim type and in client name order. The reported status of each claim will not change unless the provider, TDH, or NHIC initiates further action.

NHIC cannot process incomplete claims. Only paper claims will deny as incomplete. Bills filed electronically without required information are rejected. Users are required to retrieve the response file to determine the reason for rejections.

Incomplete claims may be submitted as original claims only if the resubmission is received by NHIC within the original filing deadline. Otherwise the claim must be received within 180 days of the date on the *R&S*. These claims must be resubmitted to the address indicated at the top of the *R&S* for payment consideration. Providers must send a signed, completed / corrected claim along with a copy of the *R&S* page that displays the original incomplete claim.

A copy of the corresponding page of the *R&S* must accompany each corrected claim submitted.

Adjustments to Claims. "Adjustments to Claims" is centered at the top of each page in this section. Adjustments are listed by claim type. Media types 011, 021, 031, and 041 appear in this section. An adjustment prints in the same format as a paid or denied claim.

The adjusted claim is listed first on the *R&S*. Immediately below is the claim as originally processed. The dollar amounts on the original claim are followed by a minus (-) symbol indicating the original payment is voided. The net adjustment amount is the difference between the claim total for the original claim and the claim total for the adjusted claim. If the total amount of money to be recouped is not available on the current *R&S*, it is taken from future payments. EOB 00601 prints below the claim indicating the amount is to be recouped later, "A receivable has been established in the amount of the original payment: 1%. Future payments will be withheld or reduced until such amount is paid in full."

When an adjustment has been set up (EOB 00601), and enough money is available on the next *R&S*, EOB 00097 prints, "Payment adjusted on following client." The original ICN and *R&S* date appears. The dollar amount to be recouped is listed in the Original Amount column. The amount changes until all money is recouped.

In the "Adjustments to Claims" section, the amount identifying the NET DIFFERENCE (difference between the original claim payment and the adjusted claim payment) appears below the prior claim payment. If the net difference is a positive amount, the amount will be added to the current check-write. If the net difference is a negative amount, a minus sign will show before the dollar amount, and that amount will be deducted from the current checkwrite.

1.21.4.2 Financial Transactions

All accounts receivables, IRS levies, payouts, refunds, reissues, and voids appear in this section of the *R&S*. The financial transactions section does not use the *R&S* form column headings. Additional subheadings are printed to identify the financial transactions. References to "FYE" represent the provider's fiscal year end based on cost report information and does not apply to all providers. The following are descriptions of the six types of financial transactions.

Accounts Receivables. Accounts receivables identify money subtracted from the provider's current payment owed to NHIC. Specific claim data is not given on the *R&S* unless the accounts receivable setup is claim specific. An accounts receivable (A/R) control number is provided that should be referenced when corresponding with NHIC. If the withholding is related to a specific claim and not an EOB 00601 previously described, a separate letter with this information is sent to the provider. Accounts receivable appear on the *R&S* in the following format:

Row Heading / Section	Explanation
Control number	A control number that should be referenced when corresponding with NHIC.
Setup date	The date the financial transaction was originally processed.
Percentage to recoup	The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
Maximum amount to recoup per period	The amount to be withheld each week or month. This will be blank if the provider elects to have a percentage withheld each week or month.
Setup amount	The total amount owed NHIC.
Prior A/R balance	The amount owed from a previous *R&S*.
Recent action	Date the last transaction on the A/R occurred.
Applied amount	Amount subtracted from the current *R&S*.
Last Update	The date the last transaction on the A/R occurred.
EOB	The EOB code that corresponds to the reason code for the A/R.
Last name, first name	If the A/R is claim-specific, the name of the patient on the claim.
ICN	If the A/R is claim specific, the ICN of the original claim.

IRS Levies. The payments withheld from a provider's checkwrite as a result of a notice from the IRS of a levy against the provider will be displayed in the IRS levies section of the *R&S*. Payments are withheld until the levy is satisfied or released. Although the current payment amount is lowered by the amount of the levy payment, the provider's 1099 earnings are not lowered. IRS levies are reported in the following format:

Row Heading / Section	Explanation
Control number	NHIC control number to reference when corresponding with NHIC.
Effective date	The date the levy was originally set up.
Percentage to withhold	The percentage of the provider's payment that is withheld each week unless the provider elects to have a specific amount withheld each week.
Maximum amount withheld per period	The amount to be withheld on a periodic basis. This will be blank if the provider elects to have a percentage withheld each week.
Setup amount	The total amount owed NHIC.
Previous balance	The amount owed from a previous *R&S*.
Applied amount	Amount subtracted from the current *R&S*.
Remaining A/R balance	Amount still owed on the levy (this amount becomes the "previous balance" on the next *R&S*.
Last update	The date the last transaction on the levy occurred.

Claim Refunds. Claim refunds are identified by the EOB 00124, "Thank you for your refund; your 1099 liability has been credited." This message verifies that dollars refunded to NHIC for incorrect payments have been received and posted. Claim refunds appear on the *R&S* in the following format:

Row Heading / Section	Explanation
Control number	A control number assigned to the refund. This number should be referenced when corresponding with NHIC.
Setup amount	The amount of the refund check received.
MICR number	The check number of the refund check.
Issue date	The date of the refund check.
Amount applied this cycle	The amount of funds applied during the current checkwrite.
Balance remaining	Amount of the refund yet to be applied by NHIC.
Fiscal year	The fiscal year for which this refund is applicable.
EOB	The EOB code that corresponds to the reason code assigned.
ICN	The claim number of the claim to which the refund was applied this cycle.
Name	The patient's first name, middle initial, and last name on the applicable claim.
ID	The patient's CSHCN number.
Service date	Format MMDDYYYY (month, day, year) in "From" date of service.
Total billed	Total billed amount of the claim being refunded.
Total applied	Refund amount applied to the claim.

Payouts. Payouts are dollars NHIC owes to the provider. NHIC processes two types of payouts: system payouts that increase the weekly check amount and manual payouts that result in a separate check being sent to the provider. Specific claim data is not given on the *R&S* for payouts. If the payout is claim-related, a separate letter with this information is sent to the provider. A control number is given which should be referenced when corresponding with NHIC.

System Payouts appear on the *R&S* in the following format:

Row Heading / Section	Explanation
Control number	NHIC control number to reference when corresponding with NHIC.
Payout amount	Amount of the payout.
Fiscal year	The fiscal year for which this refund is applicable.
EOB	The EOB code that corresponds to the reason code assigned.

Manual Payouts appear on the *R&S* in the following format:

Row Heading / Section	Explanation
Control number	NHIC control number to reference when corresponding with NHIC.
Payout amount	Amount of the payout.
Fiscal year	The fiscal year for which this refund is applicable.
EOB	The EOB code that corresponds to the reason code assigned.
Refund check number	The number of the refund check issued by NHIC.
Refund check amount	The amount of the refund check that will be mailed to the provider.

Claim Reissues. Claim reissues are identified by the EOB 00122, “This claim is a reissue of a previous claim (ICN) paid on (Date).” For example, EOB 00122 is used if a check is lost in the mail and must be reissued to the provider. The message follows each claim that has been reissued. Every claim paid on the original check is reprinted in the financial section. The claims are printed in the same format described in the Paid or Denied Claims section.

Claim Voids. Claim voids are identified by the EOB 00134, “Voided claim – this has been credited to net IRS amount.” This occurs when the NHIC check has been returned and voided. Claims originally paid on the check are listed and the amounts credited to the provider’s 1099. Claim voids print in the same format as claim refunds.

1.21.4.3 Claims Payment Summary

This section summarizes payments, adjustments, and financial transactions listed on the *R&S*. The section has two categories: one for the current week’s totals and one for the year-to-date totals.

Example: If the provider is receiving a check (or electronic funds transfer) on this particular *R&S*, the following information is given: “Payment summary for check number (Check #) or (directly deposited by EFT) in the amount of ($ Amount). Note that items marked with an asterisk (*) do not affect your 1099 earnings.” The check number also is printed on the check that accompanies the *R&S*.

1.21.4.4 Headings for the Claims Payment Summary Section

Heading	Explanation
Claims paid	Indicates the number of claims processed for the week and the year-to-date total.
Payout amount	The total amount of payouts made to the provider by NHIC.
Backup withholding	The total refund amount paid to the provider by NHIC due to backup withholding.
Amounts stopped or voided	The total amount of claims that were voided with no reissuance of payment plus the amount of voided checks received by NHIC and posted on the provider's behalf.
Accounts receivable recoupments	The total amount withheld from the provider's payment due to accounts receivable.
IRS levy amount	The amount remitted to IRS and withheld from the providers payment due to an IRS levy.
Claims amount	The net amount allowed for the week's payment. If there are no adjustments recouping money showing negative paid amounts, the claims amount is the total of all paid amounts on the individual claims. If there are adjustments showing negative paid amounts, the claims amount is the total paid amount minus the adjustment recoupment.
Amounts withheld	The total amount withheld from the provider's payment.
Earnings reported to the IRS	The amount added for this week into the provider's earnings. This figure is the "Claims Amount" minus any "Withheld" or "Credit Amounts." This column also gives weekly and year-to-date totals. The year-to-date IRS amount is the net total of reportable payments for tax purposes.

1.21.4.5 Claims In Process

In the "Claims In Process" section, the *R&S* may list up to five Explanation of Pending Status (EOPS) messages per claim. The claims listed in this section are in process and cannot be appealed for any reason until they appear in either the "Paid, Denied, & Incomplete" or "Adjustments" section of the *R&S*. NHIC is listing the pending status of these claims for informational purposes only. The pending messages should not be interpreted as a final claim disposition.

All claims and appeals on claims NHIC has "in process" from the provider are listed on the *R&S* weekly. NHIC provides the following information on the *R&S*:

- Patient name
- Claim number
- CSHCN number
- Initial date of service
- Billed charge (total billed)
- EOPS code

1.21.4.6 EOB Codes Appendix

The appendix lists the descriptions of all EOBs that appeared on the *R&S* report. EOBs appear in numerical order.

1.21.4.7 EOPS Codes Appendix

The appendix lists the description of all EOPS that appeared on the *R&S* report. EOPS appear in numerical order.

1.21.5 Appeals

There are three ways to appeal a claim in *Compass21* – electronically, AIS, and on paper.

1.21.5.1 Electronic appeals

Appeals may be submitted electronically through TexMedNet or TDHconnect. One enhancement to this process is that providers now receive an acceptance or rejection report for appeals just as they do for new day claim submissions.

1.21.5.2 AIS Appeals

Telephone appeals may still be done, but they will be done through the Automated Inquiry System (AIS) using the keypad of your touch-tone phone. You may appeal via phone the following:

- PCN
- Date of birth
- Date of onset
- Place of service
- Type of service
- Quantity billed
- Prior authorization number
- Beginning date of service
- Ending date of service

You may no longer appeal TPR/OI, diagnosis code, or procedure code through phone appeals. You may either appeal these denials electronically or on paper. A maximum of 15 appeals per call may be submitted through AIS.

1.21.5.3 Paper Appeals

With the improvement in electronic appeals and the ability to request appeals through AIS, NHIC recommends that you use one of these two options for appealing claims. However, we will still accept and process paper appeals.

Providers may not appeal the following:

1) Claims appearing in the Pending Claims section of the *R&S*. You cannot appeal a claim that has not appeared as a Paid or Denied Claim.
2) Claims appearing in the Paid or Denied and Incomplete Claims section of the *R&S* that are incomplete. Incomplete claims will appear with one or more EOB code(s). You will need to correct the information and submit a new claim with the *R&S* within 180 days of the date on the *R&S*. Providers filing claims electronically will never have a claim denied as incomplete. Claims submitted electronically without required information will be rejected.
3) Zero paid claims: These are claims that appear in the Paid or Denied and Incomplete Claims Section of the *R&S* and the allowed charge and the paid amount are $0. These claims must be resubmitted as a new day claim with the *R&S* within 180 days of the date on the *R&S*. Providers that submit claims electronically that appear on the *R&S* as zero paid may resubmit the claim electronically within 180 days of the date on the *R&S*.

1.21.6 Remittance and Status (*R&S*) Reports Examples

1.21.6.1 Banner Page *R&S*

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                                              National Heritage Insurance Company
                                              CSHCN Remittance and Status Report
                                                      Date: MM/DD/CCYY

                          Mail original claim to:                                     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          National Heritage Insurance Company                         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          P.O. Box 200855                                             XXXXXXXXXXXXXXXXXXXXXXXXX
                          Austin, Texas 78720-0855                                    XXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
                                                                                      (XXX) XXX-XXXXX
                          Mail all other correspondence to:
                          National Heritage Insurance Company                         Provider ID:  XXXXXXX-XX
                          12545 Riata Vista Circle                                    Report Seq. Number:  99
                          Austin, Texas 78727-6524                                    R&S Number:  999999999

                          (800) 568-2413
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XXXXXXXXXXXXXXXXXXXXXXXXXX                             YOUR CSHCN AIS NUMBER IS          *XX*XXXXXX*
XXXXXXXXXXXXXXXXXXXX                                   FOR AIS INQUIRY CALL TOLL FREE 1-800-568-2413
XXXXXXXXXXXXXXXXX, XX, XXXXX XXXX                      THE PROVIDER MANUAL PROVIDES DETAILS.
(XXX) XXX-XXXX                                         PHYSICAL ADDRESS ON RECORD
                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                                       XXXXXXXXXXXXXXXXXXXX
                                                       XXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX

                                                       (XXX) XXX-XXXX
```

1.21.6.2 Banner Page *R&S*

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                                   National Heritage Insurance Company
                                   CSHCN Remittance and Status Report
                                          Date: MM/DD/CCYY

            Mail original claim to:                                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            National Heritage Insurance Company                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            P.O. Box 200855                                           XXXXXXXXXXXXXXXXXXXXXXXXX
            Austin, Texas 78720-0855                                  XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
                                                                      (XXX) XXX-XXXXX
            Mail all other correspondence to:
            National Heritage Insurance Company                       Provider ID:  XXXXXXX-XX
            12545 Riata Vista Circle                                  Report Seq. Number:  99
            Austin, Texas 78727-6524                                  R&S Number:  999999999

            (800) 568-2413
            (512) 514-3000
                                                                                                      Page 9 of 9,999
                                               BANNER PAGE
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XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                                                                                   X
```

1.21.6.3 Paid or Denied & Incomplete R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

PATIENT NAME	CLAIM NUMBER	CSHCN #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS		
-----SERVICE DATES-----	PROC/	-----BILLED-----		-----ALLOWED-----								
FROM TO	TOS DRG	QTY CHARGE	QTY CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD

********** PAID OR DENIED & INCOMPLETE CLAIMS
****

XXXXXXXXXXXX	PPPCCCRRNNCCYYJJJBBBSSS			999999999	999999999999999		999999999		999999999999999	XXXXX	XXXXX	XXXXX	XXXXX		XXXXXX	
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
					$9,999,999.99		$9,999,999.99		$9,999,999.99	CLAIM	TOTAL					
XXXXXXXXXXXX	PPPCCCRRNNCCYYJJJBBBSSS			999999999	999999999999999		999999999		999999999999999	XXXXX	XXXXX	XXXXX	XXXXX		XXXXXX	
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
					$9,999,999.99		$9,999,999.99		$9,999,999.99	CLAIM	TOTAL					
XXXXXXXXXXXX	PPPCCCRRNNCCYYJJJBBBSSS			999999999	999999999999999		999999999		999999999999999	XXXXX	XXXXX	XXXXX	XXXXX		XXXXXX	
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
					$9,999,999.99		$9,999,999.99		$9,999,999.99	CLAIM	TOTAL					

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 180 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638. CLAIMS WITH AN ALLOWED CHARGE OF $0.00 AND A PAID AMOUNT OF $0.00 MUST BE RESUBMITTED WITH A COMPLETED CLAIM AND A COPY OF THIS R&S PAGE TO THE FIRST ADDRESS LISTED ABOVE WITHIN 180 DAYS FROM THE DATE OF THE R&S.

1.21.6.4 Adjustments R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

PATIENT NAME	CLAIM NUMBER		CSHCN #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOB	EOB	EOB	EOB	DIAGNOSIS		
-----SERVICE DATES-----		PROC/	-----BILLED-----		-----ALLOWED-----								
FROM	TO	TOS	DRG	QTY	CHARGE	QTY	CHARGE	POS	PAID AMT	EOB	EOB	EOB	EOB	EOB	MOD	MOD

********** ADJUSTMENTS **********

ADJUSTMENT CLAIM:

XXXXXXXXXXXX	PPPCCCRRNNCCYYJJJBBBSSS			999999999	999999999999999		999999999		999999999999999	XXXXX	XXXXX	XXXXX	XXXXX		XXXXXX	
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
					$9,999,999.99		$9,999,999.99		$9,999,999.99	CLAIM	TOTAL					

123 THE CLAIM REPORTED ABOVE IS AN ADJUSTMENT TO PREVIOUS CLAIM 999999999999999999999999 WHICH APPEARS ON R&S DATED MM/DD/CCYY.

ORIGINAL CLAIM:

XXXXXXXXXXXX	PPPCCCRRNNCCYYJJJBBBSSS			999999999	999999999999999		999999999		999999999999999	XXXXX	XXXXX	XXXXX	XXXXX		XXXXXX	
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	999.9	9,999,999.99	999.9	9,999,999.99	99	9,999,999.99	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XX	XX
					$9,999,999.99		$9,999,999.99		$9,999,999.99	CLAIM	TOTAL					

601 A RECEIVABLE HAS BEEN ESTABLISHED IN THE AMOUNT OF THE ORIGINAL PAYMENT: $999,999,999.99. FUTURE PAYMENTS WILL BE REDUCED OR WITHHELD UNTIL SUCH AMOUNT IS PAID IN FULL.

IF YOUR APPEAL HAS BEEN DENIED, YOU HAVE THE RIGHT TO REAPPEAL THE DECISION TO NHIC OR TDH. REFER TO THE PROVIDER MANUAL SPECIFIC TO YOUR PROGRAM FOR INSTRUCTIONS ON APPEALING CLAIMS.

****

IF YOU NEED TO APPEAL ANY CLAIM ON THIS PAGE, YOU MAY APPEAL ELECTRONICALLY FOR THE MOST EXPEDITIOUS PROCESSING. OTHERWISE, MAKE ONE COPY OF THIS PAGE FOR EACH CLAIM TO BE APPEALED, CIRCLE THE CLAIM YOU ARE APPEALING AND DESCRIBE YOUR APPEAL. YOUR APPEAL MUST BE RECEIVED WITHIN 180 DAYS FROM THE DATE OF THE R&S. FOR INFORMATION REGARDING THE ELECTRONIC PROCESS CALL 1-888-863-3638.

1.21.6.5 System Payouts R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

PAYOUT CONTROL NUMBER	PAYOUT AMOUNT	FYE	EOB	---------- REFUND ---------- CHECK #	CHECK AMOUNT	PATIENT NAME	PCN	DOS

********** FINANCIAL TRANSACTIONS
****

SYSTEM PAYOUTS

YOUR PAYMENT AND 1099 LIABILITY HAVE BEEN INCREASED FOR THE REASON INDICATED BELOW.

999999999999999	9,999,999.99	CCYY	XXXXX	99999	9,999,999.99	XXXXXXXXXXXX X	XXXXXXXXX	MM/DD/CCYY
999999999999999	9,999,999.99	CCYY	XXXXX	99999	9,999,999.99	XXXXXXXXXXXX X	XXXXXXXXX	MM/DD/CCYY

TOTAL SYSTEM PAYOUTS $9,999,999.99

****
*

1.21.6.6 Manual Payouts *R&S*

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

PAYOUT CONTROL NUMBER	PAYOUT AMOUNT	FYE	EOB	CHECK #	---------- REFUND ---------- CHECK AMOUNT	PATIENT NAME	PCN	DOS

********** FINANCIAL TRANSACTIONS
****

MANUAL PAYOUTS

A CHECK HAS BEEN SENT SEPARATELY AS PAYMENT FOR THE ITEM(S) LISTED BELOW. YOUR 1099 LIABILITY HAS BEEN INCREASED.

999999999999999	9,999,999.99	CCYY	XXXXX	99999	9,999,999.99	XXXXXXXXXXXXX X	XXXXXXXXX	MM/DD/CCYY
999999999999999	9,999,999.99	CCYY	XXXXX	99999	9,999,999.99	XXXXXXXXXXXXX X	XXXXXXXXX	MM/DD/CCYY
Subtotal	$9,999,999.99							
TOTAL MANUAL PAYOUTS	$9,999,999.99							

****
*

1.21.6.7 Accounts Receivable R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

CONTROL NUMBER	RECOUPMENT RATE MAXIMUM PERIODIC RECOUPMENT AMOUNT	ORIGINAL DATE ORIGINAL AMOUNT	PRIOR DATE PRIOR BALANCE	APPLIED AMOUNT	REMAINING BALANCE	FYE	EOB	PATIENT NAME CLAIM NUMBER
********** FINANCIAL TRANSACTIONS **********								
ACCOUNTS RECEIVABLE								
YOUR PAYMENT WAS REDUCED BY THE APPLIED AMOUNTS SHOWN BELOW FOR THE REASONS INDICATED.								
999999999999999	999% 9,999,999.99	MM/DD/CCYY 9,999,999.99	MM/DD/CCYY 9,999,999.99	9,999,999.99	9,999,999.99	CCYY	XXXXX	XXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXX
999999999999999	999% 9,999,999.99	MM/DD/CCYY 9,999,999.99	MM/DD/CCYY 9,999,999.99	9,999,999.99	9,999,999.99	CCYY	XXXXX	XXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXX
999999999999999	999% 9,999,999.99	MM/DD/CCYY 9,999,999.99	MM/DD/CCYY 9,999,999.99	9,999,999.99	9,999,999.99	CCYY	XXXXX	XXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXXXXX
TOTAL ACCOUNTS RECEIVABLE				$9,999,999.99	$9,999,999.99			

****
*

1.21.6.8 Voids and Stops *R&S*

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

********** FINANCIAL TRANSACTIONS
****

VOIDS AND STOPS

CHECK NUMBER:	9999999999	CHECK AMOUNT:	9,999,999.99	R&S NUMBER:	9999999999	R&S DATE:	MM/DD/CCYY
CHECK NUMBER:	9999999999	CHECK AMOUNT:	9,999,999.99	R&S NUMBER:	9999999999	R&S DATE:	MM/DD/CCYY
CHECK NUMBER:	9999999999	CHECK AMOUNT:	9,999,999.99	R&S NUMBER:	9999999999	R&S DATE:	MM/DD/CCYY

TOTAL VOID/STOP CHECK AMOUNTS $9,999,999.99

****
*

1.21.6.9 Refunds *R&S*

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

********** FINANCIAL TRANSACTIONS
****

REFUNDS
REFUND CHECK #9999999999 DATED MM/DD/CCYY WAS RECIVED BY NHIC AND APPLIED AS FOLLOWS:

CLAIM-SPECIFIC:

ICN	PATIENT NAME	MEDICAID NUMBER	DATE OF SERVICE	TOTAL BILLED	AMOUNT APPLIED THIS CYCLE	EOB
XXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX X	999999999999999	MM/DD/CCYY	9,999,999.99	9,999,999.99	XXXXX
XXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX X	999999999999999	MM/DD/CCYY	9,999,999.99	9,999,999.99	XXXXX
	XXXXXXXXXXXX X	999999999999999			9,999,999.99	XXXXX
Subtotal Claim-Specific					$9,999,999.99	

NON-CLAIM SPECIFIC:

A/R CASH CONTROL NUMBER	FYE	EOB	AMOUNT APPLIED THIS CYCLE
XXXXXXXXXXXXXXXXXXXXXXXX	CCYY	XXXXX	9,999,999.99

PAYOUT CASH CONTROL NUMBER	FYE	EOB	AMOUNT APPLIED THIS CYCLE
XXXXXXXXXXXXXXXXXXXXXXXX	CCYY	XXXXX	9,999,999.99

Subtotal Non-Claim Specific $9,999,999.99

TOTAL REFUNDS $9,999,999.99

****
*

1.21.6.10 IRS Levy Information R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

CONTROL NUMBER	MAXIMUM RECOUPMENT RATE	MAXIMUM RECOUPMENT AMOUNT	ORIGINAL DATE	ORIGINAL AMOUNT	PRIOR BALANCE	PRIOR DATE	CURRENT AMOUNT	REMAINING BALANCE

********** FINANCIAL TRANSACTIONS
****

IRS LEVY INFORMATION:

A PAYMENT IN THE AMOUNT OF $9,999,999.99 WAS REMITTED ON YOUR BEHALF TO THE INTERNAL REVENUE SERVICE DUE TO THE LEVY THAT IS DESCRIBED BELOW.

999999999999999	999%	9,999,999.99	MM/DD/CCYY	9,999,999.99	9,999,999.99	MM/DD/CCYY	9,999,999.99	9,999,999.99
999999999999999	999%	9,999,999.99	MM/DD/CCYY	9,999,999.99	9,999,999.99	MM/DD/CCYY	9,999,999.99	9,999,999.99
999999999999999	999%	9,999,999.99	MM/DD/CCYY	9,999,999.99	9,999,999.99	MM/DD/CCYY	9,999,999.99	9,999,999.99

TOTAL LEVY PAYMENT $9,999,999.99

****
*

1.21.6.11 Backup Withholding Penalty Information R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

CONTROL NUMBER	ORIGINAL DATE	WITHHELD AMOUNT

********** FINANCIAL TRANSACTIONS
****

BACKUP WITHHOLDING PENALTY INFORMATION:

OUR RECORDS INDICATE THAT YOU HAVE BEEN ASSESSED A PENALTY BY THE INTERNAL REVENUE SERVICE FOR NON-COMPLIANCE WITH BACKUP WITHHOLDING REQUIREMENTS. THEREFORE, YOUR PAYMENT HAS BEEN LOWERED AND THE PENALTY AMOUNT HAS BEEN REMITTED TO THE INTERNAL REVENUE SERVICE. 31% OF YOUR PAYMENT AMOUNT WILL BE WITHHELD WEEKLY UNTIL NHIC RECEIVES a W9 or letter 147C as requested in a B-Notice previously sent to your facility or office.

999999999999999	MM/DD/CCYY	9,999,999.99

****
*

1.21.6.12 Explanation of EOPS Messages R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

PATIENT NAME	CLAIM NUMBER	CSHCN #	PATIENT ACCT #	MEDICAL RECORD #	MEDICARE #	EOPS	EOPS	EOPS	EOPS	DIAGNOSIS

-----SERVICE DATES----- FROM	TO	TOS	PROC/ DRG	QTY	-----BILLED----- CHARGE	QTY	-----ALLOWED----- CHARGE	POS	PAID AMT	EOPS	EOPS	EOPS	EOPS	EOPS
XXXXXXXXXXXX	PPPCCCRRNNCCYYJJJBBBSSS			999999999	999999999999999		999999999		999999999999999	XXXXX	XXXXX	XXXXX	XXXXX	XXXXXX
MM/DD/CCYY					9,999,999.99					XXXXX	XXXXX	XXXXX	XXXXX	XXXXX
MM/DD/CCYY					9,999,999.99					XXXXX	XXXXX	XXXXX	XXXXX	XXXXX
MM/DD/CCYY					9,999,999.99					XXXXX	XXXXX	XXXXX	XXXXX	XXXXX
PENDING CLAIMS TOTAL					$9,999,999.99									

********** THE FOLLOWING CLAIMS ARE BEING PROCESSED **********

THE EXPLANATION OF PENDING STATUS (EOPS)CODES LISTED ARE NOT FINAL CLAIM DENIALS OR PAYMENT DISPOSITIONS. THE EOPS CODES IDENTIFY THE REASONS WHY A CLAIM IS IN PROCESS. BECAUSE THESE CLAIMS ARE CURRENTLY IN PROCESS, NEW INFORMATION CANNOT BE ACCEPTED TO MODIFY THE CLAIM UNTIL THE CLAIM FINALIZES AND APPEARS AS FINALIZED ON YOUR R&S REPORT. PLEASE REFER TO THE LAST SECTION OF THIS REPORT FOR THE TEXTUAL MESSAGES THAT CORRESPOND TO THE EOPS CODES USED ON THIS REPORT.

****

IF YOUR CLAIM HAS NOT APPEARED ON AN R&S AS PAID, DENIED OR PENDING WITHIN 30 DAYS OF SUBMISSION TO NHIC, PLEASE CONTACT TELEPHONE INQUIRY AR 1-800-925-9126 AND/OR SEE CLAIMS FILING INSTRUCTIONS IN YOUR PROVIDER MANUAL.

1.21.6.13 Summary R&S

National Heritage Insurance Company
CSHCN Remittance and Status Report
Date: MM/DD/CCYY

Mail original claim to:
National Heritage Insurance Company
P.O. Box 200855
Austin, Texas 78720-0855

Mail all other correspondence to:
National Heritage Insurance Company
12545 Riata Vista Circle
Austin, Texas 78727-6524

(800) 568-2413
(512) 514-3000

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
(XXX) XXX-XXXXX

Provider ID: XXXXXXX-XX
Report Seq. Number: 99
R&S Number: 999999999

PAYMENT SUMMARY [FOR CHECK or FOR DIRECT DEPOSIT BY EFT] 9999999999 IN THE AMOUNT OF $ZZZ,ZZZ,ZZ9.99. NOTE THAT ITEMS MARKED WITH AN ASTERISK(*) DO NOT AFFECT YOUR 1099 EARNINGS.

	--------- CLAIMS PAID ---------		---------- PAYOUTS ----------	
	NUMBER	AMOUNT	SYSTEM	MANUAL **
CURRENT PROCESSED	999,999	999,999,999.99	999,999,999.99	999,999,999.99
YEAR-TO-DATE TOTALS	999,999	999,999,999.99	999,999,999.99	999,999,999.99

	ACCOUNT RECEIVABLE RECOUPMENTS	--- AMOUNTS PAID TO IRS DUE TO: * --- LEVIES	BACKUP WITHHOLDING
WITHHOLDINGS / DEBITS			
CURRENT PROCESSED	999,999,999.99	999,999,999.99	999,999,999.99
YEAR-TO-DATE TOTALS	999,999,999.99	999,999,999.99	999,999,999.99

MISCELLANEOUS	EARNINGS REPORTED TO IRS	APPROVED TO PAY/DENY CLAIMS	PENDING CLAIMS	AMOUNTS STOPPED / VOIDED	CLAIM-RELATED REFUNDS	OTHER A/R REFUNDS
CURRENT PROCESSED	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99
YEAR-TO-DATE TOTALS	999,999,999.99			999,999,999.99	999,999,999.99	999,999,999.99

HOLDS
YOUR PAYMENT IN THE AMOUNT OF $999,999,999.99 WAS HELD FOR THE FOLLOWING REASON. XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

** MANUAL PAYOUTS ARE REMITTED BY SEPARATE CHECK OR EFT. MANUAL PAYOUTS INCREASE 1099 EARNINGS.

1.21.6.14 Explanation of EOB Messages *R&S*

```
                         National Heritage Insurance Company
                        CSHCN Remittance and Status Report
                                 Date: MM/DD/CCYY

           Mail original claim to:                               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
           National Heritage Insurance Company                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
           P.O. Box 200855                                       XXXXXXXXXXXXXXXXXXXXXXXXX
           Austin, Texas 78720-0855                              XXXXXXXXXXXXXXXXXXXX, XX, XXXXX XXXX
                                                                 (XXX) XXX-XXXXX
           Mail all other correspondence to:
           National Heritage Insurance Company                   Provider ID:  XXXXXXX-XX
           12545 Riata Vista Circle                              Report Seq. Number:  99
           Austin, Texas 78727-6524                              R&S Number:  999999999

           (800) 568-2413
           (512) 514-3000
                                                                                                          Page 9 of 9,999
-------------------------------------------------------------------------------------------------------------------------
                                     EXPLANATION OF BENEFITS CODES MESSAGES
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THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOB CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT  (listed in numerical order.)

XXXXX
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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THE FOLLOWING ARE THE DESCRIPTIONS OF THE EOPS CODES THAT APPEAR ON THIS REMITTANCE AND STATUS REPORT  (listed in numerical order.)

XXXXX
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXX
      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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1.22 Automated Inquiry System (AIS) User Guide

Reminder: The provider's AIS code is printed on page 1 of the weekly *R&S* report.

Dialing 800-568-2413 gives you access to the CSHCN AIS and NHIC-CSHCN Customer Service. These lines were combined to offer CSHCN providers a higher level of service. This change makes getting information easier with our recent online enhancements and advanced technology.

This telephone number offers the following information and services:

- Client eligibility
- Claims status
- CSHCN check status (for claims paid by NHIC)
- Fax back service
- Automated appeals
- Customer service connection
- Provider enrollment assistance

1.22.1 Hours of Operation

Claim status, client eligibility, and check amount information is available from the new CSHCN AIS line at 800-568-2413.

- Eligibility information is available 24-hours a day, seven days a week.
- All other information is available 6 a.m. to 6 p.m. CST, Monday through Friday.

1.22.2 NHIC-CSHCN AIS Instructions

CSHCN AIS will prompt you to enter your nine-digit TPI number.

If your CSHCN TPI is 15000999, enter 15000999, followed by the pound (#) button.

1.22.2.1 Claim Status

- Press 1 followed by the (#) sign.
- Enter the CSHCN client number.
- Enter the earliest date of service or admission date on the claim as MMDDYYYY.
- Enter the exact billed amount on the claim, without decimal.
- Press 2 followed by the (#) sign on paid or denied claims to hear EOB messages.

1.22.2.2 Client Eligibility and Add Date

- Press 2 followed by the (#) sign.
- Enter the CSHCN client number or the Social Security number and date of birth.
- Enter date of birth as MMDDYYYY.
- Enter date of service as MMDDYYYY.

1.22.2.3 Check Amount

- Press 3 followed by the (#) sign.

This AIS telephone number is a toll-free call. Dial 800-568-2413 or 512-514-3000. Refer to the title page of our *R&S* report for the precoded CSHCN AIS TPI.

1.22.2.4 Fax Back Service

- Choose option 4 followed by the (#) sign.
- To obtain a list of available documents, press 1 followed by the (#) sign.
- Enter your 10-digit fax number beginning with the area code, followed by the pound (#) sign.
- Your fax number will be repeated for verification. If correct, a list of documents will be sent to the fax number entered.
- To request a specific document from the fax back server, press 2 followed by the (#) sign.
- Enter your 10-digit fax number beginning with the area code, followed by the pound (#) sign.
- Your fax number will be repeated for verification. If correct, the documents you requested will be sent to the fax number entered.

1.22.2.5 Automated Appeals

Detailed instructions can be obtained through the fax back service (option 4#). The document number is 101.

- Press 5 followed by the (#) sign to access the Appeals menu. Only three fields may be changed per claim.

Note: The billing TPI on the ICN entered must match the TPI entered into AIS when you called.

- Enter the claim number you wish to appeal, followed by the pound (#) sign. If the claim number is invalid, re-enter the 15-24 digit claim number, followed by the pound (#) sign. Listen carefully to the message to determine which element of the claim you wish to change.
- Depending on the item you wish to change, you may be prompted to choose to correct the same information on all lines of the claim.
- Press 1 followed by the (#) sign to correct all lines with the same information.
- Press 2 followed by the (#) sign if you want to change one line item only.
- Depending on the claim type, you may be prompted to enter the item line number.
- Listen carefully to the messages that follow, as AIS guides you through making your corrections and submitting your appeal.
- Write down the ICN of the new claim.

1.22.2.6 What fields can I change through AIS?

- Place of Service (option 11)
- Type of Service (option 22)
- Authorization Number (option 33)
- Quantity Billed (option 44)
- CSHCN client PCN number (option 55)
- Beginning Date of Service (option 66)
- Ending Date of Service (option 77)
- Date of Onset (option 99)

1.22.2.7 Things to Remember about AIS Appeals

- Only three fields per claim may be changed through AIS.
- Multiple claims may be appealed during one call, but only 15 items (total) may be changed per call.
- To appeal another claim, press 1 followed by the (#) sign.
- If the claim is currently in process, it cannot be appealed.
- A claim cannot be appealed if it has been denied with an unappealable EOB.
- A claim cannot be appealed if it is past the 180-day appeal deadline.
- If the claim entered is a Medicaid internal control number, re-enter using the correct CSHCN claim number followed by the pound (#) sign. For Medicaid information, dial 800-925-9126 to connect with the NHIC AIS for Medicaid.

Ambulance

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2.2 Reimbursement 2-1
2.3 Benefits and Limitations 2-1
2.3.1 Emergency Ground Transportation 2-2
2.3.2 Nonemergency Ground Transportation 2-2
2.3.3 Air Ambulance Services 2-2
2.3.4 Billing for Ambulance Services 2-3
2.4 Claims Information 2-3
2.4.1 Ambulance HCFA-1500 Claim Form Instructions 2-4

2.1 Enrollment

Ambulance providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

A hospital-operated ambulance provider must enroll as an ambulance provider and submit claims using the ambulance TPI, not the hospital TPI.

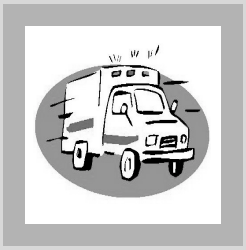
Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

2.2 Reimbursement

Ambulance providers are reimbursed the lower of the billed amount or the amount allowed by the Texas Medicaid Program.

The payment rates represent a global payment. Supplies and other services related to the transport are included in a global payment.

The ambulance provider is responsible for the integrity of the information regarding the client's condition necessitating the transport and the medical necessity of the transport. The ambulance provider may be sanctioned, including exclusion from the CSHCN Program, for completing or signing a claim form that includes false or misleading representation of the client's condition or of the medical necessity of the transport.



2.3 Benefits and Limitations

CSHCN provides coverage for emergency ground, nonemergency ground, and air ambulance transportation for eligible clients. Procedure codes and descriptions on the claim are required to correspond to the circumstance at the time of service and are classified according to emergency

or nonemergency categories. Providers are expected to exercise discretion in the use of ambulance services. Claims for transportation by ambulance where other methods of transport would not be hazardous to the client will not be covered by the program.

CSHCN will not reimburse for the return trip of an empty ambulance, waiting time for an ambulance, or any other contingencies.

2.3.1 Emergency Ground Transportation

An emergency is defined as the sudden onset of a life threatening situation in which a severe debilitating condition or death would result if immediate medical care were not provided. When the condition of the client is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance transport is an emergency service.

The following HCPCS codes are to be used when submitting ambulance claims for payment for emergency ground transportation:

HCPCS Code	Description
A0010	Ambulance service, basic life support (BLS) base rate, emergency transport, one way
A0020	Ambulance service, (BLS) per mile, transport, one way
Y6002	Ambulance service, flat rate (when no mileage billed on claim)

The reimbursement rate is all-inclusive and no additional charges will be paid such as oxygen, staff, supplies, clean up, waiting time, etc.

2.3.2 Nonemergency Ground Transportation

When the client has a medical problem requiring treatment in another location and he or she is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance transport is considered a nonemergency service. A severely disabled client is defined as one whose physical handicap limits his mobility to the extent that he must be transported by litter, requires life support systems, and an ambulance is the most appropriate means of transport.

To meet CSHCN requirements, the nonemergency transfer must be to or from a scheduled medical appointment at the nearest appropriate CSHCN facility for indicated care that is CSHCN approved.

The degree of disability and the current medical problem requiring the transfer must be indicated clearly on the claim. The following HCPCS codes will be considered for payment:

HCPCS Code	Description
A0150	Nonemergency ambulance, flat rate
Y6005	Nonemergency transportation, ambulance, base rate, one way
Y6007	Nonemergency ambulance mileage

2.3.3 Air Ambulance Services

CSHCN coverage for air ambulance transfers is limited to instances in which the client’s pickup point is inaccessible by land, or when great distance interferes with the immediate admission to a medical treatment facility appropriate for the client’s condition.

The following HCPCS codes will be considered for payment:

HCPCS Code	Description
A0030	Ambulance service, conventional air service, transport, one way
A0040	Ambulance service, air, helicopter service, transport
Y6104	Air ambulance mileage

2.3.4 Billing for Ambulance Services

Claims for ambulance services must include the number of loaded miles traveled. If mileage is not included on the claim, only the base rate will be reimbursed. Flat rates are all-inclusive; mileage amounts requested in addition to the flat rate will be denied. The claim must show the service was an emergency to be paid at emergency rates. If an emergency is not indicated on the claim, the claim will be paid at nonemergency rates.

2.4 Claims Information

Ambulance services must be submitted to NHIC in an approved electronic format or on a HCFA-1500 claim form. Electronic billers should submit the following information, with the exception of the ambulance run sheet, into the comment field along with the client's blood pressure, pulse, and respiration readings:

- Ambulance run sheet (must include signature of the EMT transporting the client), facility transferring records, or emergency room records
- Distance of transport
- Time of transport
- Acuity of client

Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

2.4.1 Ambulance HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident-related, indicate the date of injury or the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in Block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/01"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** - Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional - Any alpha-numeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional - All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers, if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

2.4.1.1 Ambulance HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Pye, Sherrie

3. PATIENT'S BIRTH DATE MM DD YY: 02 02 90 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 341 Tosser Way

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Houston STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 12345 TELEPHONE (INCLUDE AREA CODE): 123-555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

b. AUTO ACCIDENT? ☐ YES ☒ NO

c. OTHER ACCIDENT? ☐ YES ☒ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 250 . 80
2. 780 . 60
3. 337 . 00
4. 780 . 30

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
06	01	02	06	01	02	3	9	A0010			1	40 00	1				
1																	
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 40 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

John Spindle

SIGNED DATE 06 01 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

Junction Hospital
332 Junction Street

Houston, Texas 77883

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Spindle Ambulance
4000 Main Street
Houston, TX 77883

PIN# GRP# 123456789

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
HCFA 1500 FORM OWCP - 1500 FORM RRB - 1500
AMBULAN1

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECTION

3

Dental

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3.1 Enrollment

Dental providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

3.2 Reimbursement

Reimbursement for Dental Services will be the lower of the billed amount or the amount allowed by the CSHCN fee schedule or the amount allowed by the Texas Medicaid Program.

3.3 Benefits and Limitations

CSHCN provides coverage for dental services to program eligible clients. Coverage of dental services is limited to what is necessary to prevent, treat, or correct dental and oral complications.

3.3.1 Orthodontia

Orthodontic procedures require **prior** authorization and may be reimbursed for the following diagnoses:

Diagnosis Code	Description
52400–52409	Major anomalies of jaw size
52410–52419	Anomalies of relationship of jaw to cranial base
74900–74925	Cleft palate and cleft lip
75400	Certain congenital musculoskeletal deformities of skull, face, and jaw
75555	Acrocephalosyndactyly
75600	Anomalies of skull and face bones

Use the following procedure codes when submitting requests for prior authorization and/or claims for orthodontic procedures:

Procedure Code	Description
D8999	Unspecified orthodontic procedure, by report
Z2009	Diagnostic work up - approved
Z2010	Diagnostic work up - not approved
Z2011	Orthodontic appliance, upper
Z2012	Orthodontic appliance, lower
Z2013	Orthodontic adjustments, per month
Z2014	Orthodontic retainer, upper
Z2015	Orthodontic retainer, lower
Z2016	Premature appliance removal (per arch)
Z2017	Special orthodontic appliance
Z2018	Crossbite work up
1000D	Appliance with horizontal projections
1001D	Appliance with recurved springs
1002D	Arch wires for cross bite correction for total treatment
1003D	Banded maxillary expansion appliance
1004D	Bionator
1005D	Bite block
1006D	Bite plate with push springs
1007D	Bite plate/bite plane
1008D	Bonded expansion device
1009D	Brackets
1010D	Chateau appliance (face mask palatal expander and hawley)
1011D	Coffin spring appliance
1012D	Crib
1013D	Crossbite therapy, fixed appliance
1014D	Crossbite therapy, removable appliance
1015D	Distalizing appliance with springs
1016D	Expansion device
1017D	Face mask (protraction mask)
1018D	Fixed expansion appliance
1019D	Fixed lingual arch

Procedure Code	Description
1020D	Fixed mandibular holding arch
1021D	Fixed rapid palatal expander
1022D	Frankel appliance
1023D	Functional appliance for reduction of anterior openbite and crossbite
1024D	Headgear (face bow)
1025D	Herbst appliance (fixed or removable)
1026D	Inter-occlusal cast cap surgical splints
1027D	Intrusion arch
1028D	Jasper jumpers
1029D	Lingual appliance with hooks
1030D	Mandibular anterior bridge
1031D	Mandibular bihelix (similar to quad helix for mandibular expansion to attempt non-extrac)
1032D	Mandibular lip bumper
1033D	Mandibular fixed 2x4 retainer
1034D	Mandibular fixed 3x3 retainer
1035D	Mandibular fixed 4x4 retainer
1036D	Mandibular lingual 6x6 arch wire
1037D	Mandibular removable expander with bite plane-crozat
1038D	Mandibular ricketts rest position splint
1039D	Mandibular splint
1040D	Maxillary anterior bridge
1041D	Maxillary bite-opening appliance with anterior springs
1042D	Maxillary lingual arch with spurs
1043D	Maxillary-mandibular distallizing appliance
1044D	Maxillary quad helix with finger springs
1045D	Maxillary retainer with pontics
1046D	Maxillary schwarz
1047D	Maxillary splint
1048D	Mobile intraoral arch-MIA
1049D	Modified quad helix appliance
1050D	Modified quad helix appliance with appliance
1051D	Nance appliance
1052D	Nasal stent
1053D	Occlusal orthotic device
1054D	Orthopedic appliance
1055D	Other mandibular utilities
1056D	Other maxillary utilities
1057D	Palatal bar
1058D	Post surgical retainer
1059D	Quad helix appliance held with transpalatal arch horizontal projections
1060D	Quad helix maintainer
1061D	Rapid palatal expander RPE such as quad helix HAAS or Menne
1062D	Removable bite plate
1063D	Removable mandibular retainer
1064D	Removable maxillary retainer

Procedure Code	Description
1065D	Removable prosthesis
1066D	Sagittal appliance (2-way)
1067D	Sagittal appliance (3-way)
1068D	Stapled palatal expansion appliance
1069D	Surgical arch wires
1070D	Surgical splints (surgical stent/wafer)
1071D	Surgical stabilizing appliance
1072D	Thumb-sucking appliance
1073D	Tongue thrust appliance
1074D	Tooth positioner (full maxillary and mandibular)
1075D	Tooth positioner with arch
1076D	Transpalatal arch
1077D	Two bands with transpalatal arch and horizontal projections forward
1078D	With appliance
8110D	Crossbite therapy, removable appliance
8120D	Crossbite therapy, fixed appliance

3.4 Authorization Requirements

Dental services listed below require **prior** authorization. All orthodontia must be **prior** authorized. CSHCN does not require the submission of X-rays, models, etc., for prior authorized services. All prior authorization requests must include specific rationale for the requested service. Reimbursement for appliance adjustments is limited to one per month, per client. Newborn appliances and surgical archwires do not require authorization and may be adjusted more than once per month.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

Refer to: "CSHCN Dental Authorization Request Form/Orthodontics Prior Authorization Request Form" on page 3-19.

The following procedure codes must be prior authorized:

Procedure Code	Description
D0999	Unspecified diagnostic procedure, by report
D2542	Onlay - metallic - two surfaces
D2780	Crown - 3/4 cast high noble metal
D2781	Crown - 3/4 cast predominately base metal
D2782	Crown - 3/4 cast noble metal
D2783	Crown - 3/4 porcelain/ceramic
D2953	Each additional cast post - same tooth
D2957	Each additional prefabricated post - same tooth
D2999	Unspecified restorative procedure, by report
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - bicuspids
D3348	Retreatment of previous root canal therapy - molar
D3460	Endodontic endosseous implant
D3470	Intentional reimplantation (including necessary splinting)

Procedure Code	Description
D3999	Unspecified endodontic procedure, by report
D4245	Apically positioned flap
D4249	Clinical crown lengthening - hard tissue
D4266	Guided tissue regeneration - resorbable barrier, per site
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)
D4270	Pedicle soft tissue graft procedure
D4271	Free soft tissue graft procedure (including donor site surgery)
D4273	Subepithelial connective tissue graft procedure (including donor site surgery)
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)
D4999	Unspecified periodontal procedure, by report
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth - complete denture (each tooth)
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5810	Interim complete denture (maxillary)
D5811	Interim complete denture (mandibular)
D5820	Interim partial denture (maxillary)
D5821	Interim partial denture (mandibular)
D5850	Tissue conditioning, maxillary
D5851	Tissue conditioning, mandibular
D5860	Overdenture - complete, by report
D5861	Overdenture - partial, by report
D5862	Precision attachment, by report
D5899	Unspecified removable prosthodontic procedure, by report
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis

Procedure Code	Description
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant (in the bone)
D6020	Abutment placement or substitution: endosteal implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Dental implant supported connecting bar
D6080	Implant maintenance procedure, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
D6090	Repair implant supported prosthesis, by report
D6095	Repair implant abutment, by report
D6100	Implant removal, by report
D6199	Unspecified implant procedure, by report
D6210	Pontic - cast high noble metal
D6211	Pontic - cast predominantly base metal
D6212	Pontic - cast noble metal
D6240	Pontic - porcelain fused to high noble metal

Procedure Code	Description
D6241	Pontic - porcelain fused to predominantly base metal
D6242	Pontic - porcelain fused to noble metal
D6245	Pontic - porcelain/ceramic
D6250	Pontic - resin with high noble metal
D6251	Pontic - resin with predominantly base metal
D6252	Pontic - resin with noble metal
D6519	Inlay/onlay - porcelain/ceramic
D6520	Inlay - metallic - two surfaces
D6530	Inlay - metallic - three or more surfaces
D6543	Onlay - metallic - three surfaces
D6544	Onlay - metallic - four or more surfaces
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6720	Crown - resin with high noble metal
D6721	Crown - resin with predominantly base metal
D6722	Crown - resin with noble metal
D6740	Crown - porcelain/ceramic
D6750	Crown - porcelain fused to high noble metal
D6751	Crown - porcelain fused to predominantly base metal
D6752	Crown - porcelain fused to noble metal
D6780	Crown - 3/4 cast high noble metal
D6781	Crown - 3/4 cast predominately based metal
D6782	Crown - 3/4 cast noble metal
D6783	Crown - 3/4 porcelain/ceramic
D6790	Crown - full cast high noble metal
D6791	Crown - full cast predominantly base metal
D6792	Crown - full cast noble metal
D6920	Connector bar
D6940	Stress breaker
D6950	Precision attachment
D6970	Cast post and core in addition to fixed partial denture retainer
D6971	Cast post as part of fixed partial denture retainer
D6972	Prefabricated post and core in addition to fixed partial bridge retainer
D6973	Core build up for retainer, including any pins
D6975	Coping - metal
D6976	Each additional cast post - same tooth
D6977	Each additional prefabricated post - same tooth
D6980	Fixed partial denture repair, by report
D6999	Unspecified, fixed prosthodontic procedure, by report
D7260	Oroantral fistula closure
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft (all others)
D7290	Surgical repositioning of teeth

Procedure Code	Description
D7291	Transeptal fiberotomy, by report
D7310	Alveoloplasty in conjunction with extractions - per quadrant
D7320	Alveoloplasty not in conjunction with extractions - per quadrant
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410	Radical excision - lesion diameter up to 1.25 cm
D7420	Radical excision - lesion diameter greater than 1.25 cm
D7430	Excision of benign tumor - lesion diameter up to 1.25 cm
D7431	Excision of benign tumor - lesion diameter greater than 1.25 cm
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical methods, by report
D7480	Partial ostectomy (guttering or saucerization)
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7820	Closed reduction of dislocation
D7880	Occlusal orthotic device, by report
D7899	Unspecified TMD therapy, by report
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous by report
D7955	Repair of maxillofacial soft and hard tissue defect
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva
D7980	Sialolithotomy
D7983	Closure of salivary fistula
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9220	General anesthesia - first 30 minutes
D9221	General anesthesia - each additional 15 minutes
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
D9420	Hospital call
D9610	Therapeutic drug injection, by report
D9630	Other drugs and/or medicaments, by report
D9920	Behavior management, by report
D9940	Occlusal guard, by report
D9950	Occlusion analysis - mounted case
D9952	Occlusal adjustment - complete

Procedure Code	Description
D9974	Internal bleaching - per tooth
D9999	Unspecified adjunctive procedure, by report

The following procedure codes do not require authorization or prior authorization and may be used when submitting claims:

Procedure Code	Description
D0120	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
D0150	Comprehensive oral evaluation
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0210	Intraoral - complete series (including bitewings)
D0220	Intraoral - periapical first film
D0230	Intraoral-periapical-each additional film
D0240	Intraoral - occlusal film
D0250	Extraoral - first film
D0260	Extraorfal - each additional film
D0270	Bitewing - single film
D0272	Bitewings - two films
D0274	Bitewings - four films
D0277	Vertical bitewings - 7 to 8 films
D0290	Posterior-anterior or lateral skull and facial bone survey film
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0321	Other temporomandibular joint films, by report
D0322	Tomographic survey
D0330	Panoramic film
D0340	Cephalometric film
D0350	Oral/facial images (includes intra and extraoral images)
D0415	Bacteriologic studies for determination of pathologic agents
D0425	Caries susceptibility tests
D0460	Pulp vitality tests
D0470	Diagnostic casts
D0501	Histopathologic examinations
D0502	Other oral pathology procedures, by report
D1110	Prophylaxis - adult
D1120	Prophylaxis - child
D1201	Topical application of fluoride (including prophylaxis) - child
D1203	Topical application of fluoride (excluding prophylaxis) - child
D1204	Topical application of fluoride (excluding prophylaxis) - adult
D1205	Topical application of fluoride (including prophylaxis) - adult
D1351	Sealant - per tooth
D1510	Space maintainer - fixed - unilateral
D1515	Space maintainer - fixed - bilateral
D1520	Space maintainer - removable - unilateral

Procedure Code	Description
D1525	Space maintainer - removable - bilateral
D1550	Recementation of space maintainer
D2110	Amalgam - one surface, primary
D2120	Amalgam - two surfaces, primary
D2130	Amalgam - three surfaces, primary
D2131	Amalgam - four or more surfaces, primary
D2140	Amalgam - one surface, permanent
D2150	Amalgam - two surfaces, permanent
D2160	Amalgam - three surfaces, permanent
D2161	Amalgam - four or more surfaces, permanent
D2330	Resin-based composite -one surface, anterior
D2331	Resin-based composite - two surfaces, anterior
D2332	Resin-based composite - three surfaces, anterior
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2336	Resin-based composite crown - anterior-primary
D2337	Resin-based composite crown, anterior-permanent
D2380	Resin-based composite - one surface, posterior-primary
D2381	Resin-based composite - two surfaces, posterior-primary
D2382	Resin-based composite - three or more surfaces, posterior-primary
D2385	Resin-based composite - one surface, posterior-permanent
D2386	Resin-based composite - two surfaces, posterior-permanent
D2387	Resin-based composite - three surfaces, posterior-permanent
D2388	Resin-based composite - four or more surfaces, posterior-permanent
D2410	Gold foil - one surface
D2420	Gold foil - two surface
D2430	Gold foil - three surface
D2510	Inlay - metallic - one surface
D2520	Inlay - metallic - two surfaces
D2530	Inlay - metallic - three surfaces
D2543	Onlay - metallic - three surfaces
D2544	Onlay - metallic - four or more surfaces
D2610	Inlay - porcelain/ceramic - one surface
D2620	Inlay - porcelain/ceramic - two surfaces
D2630	Inlay - porcelain/ceramic - three or more surfaces
D2642	Onlay - porcelain/ceramic - two surfaces
D2643	Onlay - porcelain/ceramic - three surfaces
D2644	Onlay - porcelain/ceramic - four or more surfaces
D2650	Inlay - resin-based composite composite/resin - one surface
D2651	Inlay - resin-based composite composite/resin - two surfaces
D2652	Inlay - resin-based composite composite/resin - three or more surfaces
D2662	Onlay - resin-based composite composite/resin - two surfaces
D2663	Onlay - resin-based composite composite/resin - three surfaces
D2664	Onlay - resin-based composite composite/resin - four or more surfaces
D2710	Crown - resin (laboratory)
D2720	Crown - resin with high noble metal
D2721	Crown - resin with predominantly base metal

Procedure Code	Description
D2722	Crown - resin with noble metal
D2740	Crown - porcelain/ceramic substrate
D2750	Crown - porcelain fused to high noble metal
D2751	Crown - porcelain fused to predominantly base metal
D2752	Crown - porcelain fused to noble metal
D2790	Crown - full cast high noble metal
D2791	Crown - full cast predominantly base metal
D2792	Crown - full cast noble metal
D2910	Recement inlay
D2920	Recement crown
D2930	Prefabricated stainless steel crown - primary tooth
D2931	Prefabricated stainless steel crown permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2940	Sedative filling
D2950	Core buildup, including any pins
D2951	Pin retention - per tooth, in addition to permanent restoration
D2952	Cast post and core in addition to crown
D2954	Prefabricated post and core in addition to crown
D2955	Post removal
D2960	Labial veneer (resin laminate) - chairside
D2961	Labial veneer (resin laminate) - laboratory
D2962	Labial veneer (porcelain laminate) laboratory
D2970	Temporary crown (fractured tooth)
D2980	Crown repair, by report
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restorations)
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restorations)
D3310	Anterior (excluding final restoration)
D3320	Bicuspid (excluding final restoration)
D3330	Molar (excluding final restoration)
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
D3410	Apicoectomy/periradicular surgery - anterior
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	Apicoectomy/periradicular surgery - molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3430	Retrograde filling - per root
D3450	Root amputation - per root
D3910	Surgical procedure for isolation of tooth with rubber dam

Procedure Code	Description
D3920	Hemisection (including any root removal), not including root canal therapy
D3950	Canal preparation and fitting of performed dowel or post
D4210	Gingivectomy or gingivoplasty - per quadrant
D4211	Gingivectomy or gingivoplasty, per tooth
D4220	Gingival curettage, surgical, per quadrant, by report
D4240	Gingival flap procedure, including root planing - per quadrant
D4260	Osseous surgery (including flap entry and closure) - per quadrant
D4320	Provisional splinting - intracoronal
D4321	Provisional splinting - extracoronal
D4341	Periodontal scaling and root planing - per quadrant
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular, per tooth, by report
D4910	Periodontal maintenance procedures (following active therapy)
D4920	Unscheduled dressing change (by someone other than treating dentist)
D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5610	Repair resin denture base
D5620	Repair cast framework
D5630	Repair or replace broken clasp
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D6930	Recement fixed partial denture
D7110	Single tooth
D7120	Each additional tooth
D7130	Root removal - exposed roots
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption

Procedure Code	Description
D7510	Incision and drainage of abscess - intraoral soft tissue.
D7520	Incision and drainage of abscess - extraoral soft tissue
D7670	Alveolus - stabilization of teeth, closed reduction splinting
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D9110	Palliative (emergency) treatment of dental pain - minor procedures
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia
D9230	Analgesia - anxiolysis, inhalation of nitrous oxide
D9430	Office visit for observation only (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9910	Application of desensitizing medicaments
D9930	Treatment of complication (post-surgical) - unusual circumstances, by report
D9951	Occlusal adjustment - limited
Z2008	Initial orthodontic visit

3.5 Dental Treatment in Hospitals

Except for those procedures requiring **prior** authorization, admission to ambulatory surgical centers (outpatient and freestanding) for the purpose of performing dentistry services must be authorized with NHIC.

Inpatient hospital admissions require **PRIOR** authorization.

For outpatient dental reconstructions/restorations, procedure code F-X2990 may be reimbursed to ambulatory surgical centers.

3.6 Doctor of Dentistry Services as a Limited Physician

CSHCN covers services provided by a doctor of dentistry (DDS, DMD, or DDM) if the services are covered and furnished within the dentist's scope of practice as defined by Texas State law. Dentists (DDS, DMD, or DDM) desiring participation as a dentist-physician must be separately enrolled as a dentist-physician.

When treating clients with cleft/craniofacial anomalies, dental providers must conform with the CSHCN rules for Cleft/Craniofacial Specialty team/center enrollment.

Refer to: "Specialty Team/Center" on page 13-2.

Dentists who are oral and maxillofacial surgeons are qualified to perform reconstructive facial surgery involving the bony skeleton of the face, including midface osteotomies and cleft lip and palate repairs. If the client has third-party insurance coverage available which requires that such surgery be performed by a physician, CSHCN cannot consider a claim for payment unless all third-party payor requirements have been met.

3.6.1 Surgery

The following surgery codes are payable to dentists enrolled in the CSHCN Program as a dentist-physician:

Procedure Codes			
10060 – 10061	10120 – 10121	10140	10160
10180	11440 – 11446	12011 – 12018	12051 – 12057
13131 – 13132*	13300	20000 – 20005	20200 – 20205
21010	21015	21025 – 21026	21029
21030	21031	21032	21034
21040 – 21041	21044 – 21045	21050	21060
21116	21240 – 21243	21310	21343 – 21344
21345	21346 – 21348	21355	21356 – 21366
21385 – 21395	21400 – 21401	21406 – 21408	21421
21422 – 21423	21431	21432 – 21436	21440
21445	21450 – 21451	21452	21453
21454 – 21470	21480 – 21485	21490	29800 – 29804
30580 – 30600	40490	40500	40510 – 40520
40830 – 40831	40840 – 40845	41000 – 41009	41010
41015 – 41018	41100 – 41105	41108	41110 – 41114
41115	41116	41250 – 41252	41520
41822 – 41823	42000	42100	42104 – 42107
42120	42160	42180 – 42182	42300 – 42305
42310 – 42320	42325 – 42326	42330 – 42340	42400 – 42405
42410 – 42415	42650	42660	42665
42810			

* Procedure codes 13131 and 13132 are payable for repairs to the forehead, cheeks, chin, mouth, and neck only.

3.6.2 Cleft / Craniofacial Surgery

The following surgery codes are payable to a dentist-physician **only if the dentist-physician is also enrolled as a member of a CSHCN approved cleft-craniofacial team. These procedures must be prior authorized:**

Procedure Codes			
21079 – 21088	21089	21100	21110
21120 – 21123	21125 – 21127	21137 – 21139	21141 – 21160
21172 – 21180	21181	21182 – 21184	21188
21193 – 21196	21198	21206	21208 – 21209
21210 – 21215	21230 – 21235	21244 – 21249	21255
21256	21260 – 21263	21267 – 21268	21270
21275	21280 – 21282	21295 – 21296	21299
30460 – 30462	30520	40650 – 40654	40700 – 40720
42200 – 42225	42226 – 42227	42235	42260

3.6.3 Evaluation and Management

The following evaluation and management services are payable to a dentist-physician:

Procedure Codes			
99201 – 99205	99211 – 99215	99218 – 99220	99221 – 99223
99231 – 99233	99238	99241 – 99245	99251 – 99255
99261 – 99263	99281 – 99285		

3.6.4 X-Ray Procedures

The following diagnostic X-ray procedures are payable to a dentist-physician:

Procedure Codes			
70100 – 70110	70140 – 70150	70328 – 70330	70332
70355			

3.6.5 Anesthesia

Each dentist licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas who has obtained a permit to administer anesthesia from the TSBDE in accordance with rules of the TSBDE 109.71 through 109.177, and who is enrolled as a CSHCN provider, may be reimbursed for anesthesia services on CSHCN clients having dental/oral and maxillofacial surgical procedures. These services must be performed in the dental office (POS 1) or hospital (POS 3 or 5) in accordance with all applicable rules for physician administration and supervision of anesthesia services.

The following anesthesia services are payable to a dentist-physician:

Procedure Codes			
00100 – 00102	00160 – 00164	00170 – 00172	00190 – 00192
99100	99140		

3.7 Dental Claim Filing Instructions

Providers billing for dental services may bill electronically or use the Dental Claim Form.

3.7.1 Dental Claim Electronic Billing

Electronic billers must submit dental claims in NSF or X.12 837 formats. Specifications are available to providers developing in-house systems and software developers and vendors. Because each software package is different, field locations may vary. Contact the software developer or vendor for this information. Direct questions and development requirements to the TexMedNet Help Desk at 888-863-3638.

3.7.2 Dental Claim Form Paper Billing

Claims must contain the billing provider's full name, address, and/or TPI. NHIC provides adhesive labels printed with this information, and they should be placed in the appropriate block of the claim form to ensure correct claim identification. **A claim without a provider name, address, or TPI cannot be processed.**

Refer to: "Dental Claim Form Instructions" on page 3-16.
"CSHCN Dental Claim Form Example" on page 3-18.

3.7.3 Dental Claim Form Instructions

The instructions describe what information must be entered in each of the block numbers of the Dental Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC.**

Block No.	Description NHIC Use	Guidelines
1	Patient's name	Enter patient's first name, middle initial, and last name.
2	Patient's relationship to employee Patient's relationship to insured	If block 11 is checked "YES," check the appropriate box for the relationship of patient to person who carries dental insurance.
3	Patient's sex	Indicate the patient's sex by checking the appropriate box.
4	Patient's date of birth	Enter numerically the month, date, and year (MM/DD/YY) the client was born.
6	Employee/subscriber name and mailing address/Patient's Address	Enter the patient's complete address.
7	Employer/subscriber Soc. Sec. or ID Number/CSHCN Number	Enter the patient's nine-digit CSHCN client number.
9	Employer (Company) Name of referring dentist or other source and address	Enter the complete name, address, and ZIP code or the TPI of the referring/ordering dentist (if applicable).
10	Group number/*facility*	If the services were provided in a facility other than the provider's, enter the TPI number or name, address, and ZIP code of that facility.
11	Is patient covered by another dental plan?	Indicate by checking the appropriate box. If yes, complete 12a and enter the total amount paid by the other carrier in the carrier pays block and the date of payment in block 14c.
12a 12b	Name and address of carrier(s) Group no.(s)	Enter name, address, and policy number of dental insurance carrier that may pay in full or in part for the services billed on this form. Insured's name: Name of person who has dental insurance policy.
14c	Employee/subscriber birth date TPR paid date	Enter the date of disposition from the other insurance.
16	Dentist's name, address, ZIP code	Enter the dentist name, street, city, state, and ZIP code.
17	Address where payment should be remitted	Enter the address of the billing provider.
18	Dentist Social Security Number or T.I.N.	Enter dentist's social security number or tax identification number.
19	Dentist license number	Enter dentist's license number
20	Phone number	Enter the telephone number of the provider.
22	Place of treatment	Place an "X" in the appropriate box: office, hospital, or other. Use the "HOSP" box to indicate outpatient hospital and the "Other" box to indicate inpatient hospital. The "ECF" box is not used by NHIC.
23	Radiographs or models enclosed? No. of X-rays enclosed	Indicate by checking the appropriate box. If yes, enter the number of X-rays enclosed when billing for services requiring X-rays.
24	Is treatment result of occupational illness or injury.	If applicable, indicate yes or no. If yes, provide a brief description and dates.
25	Is treatment the result of auto accident?	Indicate by checking the appropriate box. If yes, provide a brief description and dates.
26	Is treatment the result of other accident?	Services due to emergency, trauma – Indicate by checking the appropriate box. **If a box is checked, information about the condition must be provided to the right of the block.**
27	If prosthesis, is this initial placement	Check "Yes" for initial placements, check "No" for replacements. If replacement, list reason.
28	Date of prior placement	Enter date of original placement if replacement is billed.

Block No.	Description NHIC Use	Guidelines
29	Is treatment for orthodontics?	Indicate by checking the appropriate box.
30a	Tooth number or letter	Enter the appropriate tooth number for permanent teeth (01-32) or the appropriate letter for primary teeth (ØA - ØT) as indicated on the claim form. When spacers or partials are required, mark the missing teeth with an "X" on the claim form. Enter "99" for all supernumerary teeth regardless of location in maxilla or mandible. Narrative of location required.
30b	Surfaces	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL). The block is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. M – Mesial F – Facial B – Buccal or labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal
30c	Describe procedures or dental services for each date given	Enter a concise, specific description of all billed services provided to the patient.
30d	Date of service	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is applicable for a single procedure, each date must be given (for example, 02/17, 18, 2002).
30e	Procedure number	Enter the appropriate dental procedure code(s) for the procedure(s) (such as D0110).
30f	Charges	Enter usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
30g	For administrative use only This space is for members of a dental clinic.	Any member of the clinic who provided services to a client must identify the member's individual TPI number next to the procedure or service they performed on that patient.
31	Remarks for unusual services	
	Enter the PAN (if applicable) Signature of dentist	PAN number Below block 31 the dentist or an authorized representative must sign their name and the date. A billing service may print "Signature on file" in place of the dentist's signature if the billing service obtains and retains a letter signed by the provider authorizing this practice on file.
	License number	
	TPI	Enter nine-digit TPI number or affix one of the NHIC preprinted labels in block 16. Preprinted labels can be requested by calling 800-568-2413.
	Total Fee charged	Enter the total of the separate charges on this page of the claim.
	Carrier pays	Enter any amount paid by the other insurance or other sources known at the time of submission of the claim. Indicate the source of each payment and date in blocks 11, 12a, and 14c.
	Your patient's account number	**Optional** – Use the space below the signature for the patient account number.

3.7.3.1 CSHCN Dental Claim Form Example

Dental Claim Form

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1. ☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services
2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐ M ☐ F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other_____
18. Employer/School
Name_____ Address_____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐ Married ☐ Single ☐ Other | 30. Sex ☐ M ☐ F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan
☐ No (Skip 32–37) ☐ Yes: ☐ Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐ M ☐ F | 36. Plan/Program Name
37. Employer/School
Name_____ Address_____
38. Subscriber/Employee Status
☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School
Name_____ Address_____
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐ Yes, How many?_____ ☐ No | 54. Is treatment for orthodontics? ☐ Yes ☐ No
If service already commenced:
Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No
If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes
Brief description and dates_____
57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither
Brief description and dates_____

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent			Primary		
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	A B C D E	F G H I J	Total Fee	
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K	Payment by other plan	
				Max. Allowable	
				Deductible	
				Carrier %	
				Carrier pays	
				Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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3.7.3.2 CSHCN Dental Authorization Request Form / Orthodontics Prior Authorization Request Form

Submit to CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6524 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First name:	**Last name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / ZIP:		

Dental Procedures:

CDT / NHIC dental codes, including anesthesia codes:	
TID, SID, and POS:	
Anticipated date of service:	

Orthodontic Procedures:

CDT / NHIC codes for each orthodontic procedure:	
Estimated month of placement for each appliance:	
Estimated number of adjustments for each appliance:	

Provider Information:

Provider name / TPI number (print or type):	
Provider phone number:	
Provider FAX number:	
Provider address:	
Provider contact name:	
Provider Signature:	X

Revisions to initial treatment plans must be submitted to NHIC-CSHCN.

SECTION

4

Durable Medical Equipment (DME)

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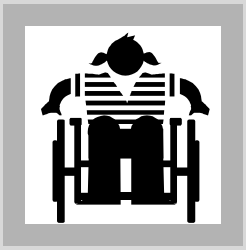


4.1 Enrollment

DME providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, and have completed the CSHCN enrollment process and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number or will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

CSHCN maintains a list of manufacturers whose products may be authorized for reimbursement. **Only** products manufactured by companies on this list may be reimbursed by CSHCN. This list is reviewed and updated annually by TDH CSHCN staff. The approved list of manufacturers is published in the *CSHCN Provider Manual* annually.

The following is the CSHCN criteria for approval of custom DME manufacturers. The manufacturer must produce a **quality** line of equipment as evidenced by the following:

1) The manufacturer (through guarantees/warranties) **must** substantiate the products' quality/durability.
2) The manufacturer must have been in business for five consecutive years or longer to demonstrate the company's stability and reliability.
3) The manufacturer must be able to show evidence of positive results from QA/safety tests of their equipment (e.g., crash test results).
4) The manufacturer must have community-based resources available for service and repair of their equipment.
5) TDH CSHCN research with medical/rehabilitation personnel will result in consensus to recommend the manufacturer's products.

CSHCN enrolls custom and noncustom DME providers. Custom DME providers can provide both custom and noncustom equipment. Noncustom DME providers can only provide noncustom DME.

Custom DME is medical equipment that has been made or modified specifically to address the INDIVIDUAL client's needs.

Providers who wish to enroll with CSHCN as Customized Durable Medical Equipment Vendors must submit the following documentation:

1) A completed CSHCN Provider Enrollment form.
2) Evidence of having current certification from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) as an Assistive Technology Supplier (ATS) and/or Assistive Technology Practitioner (ATP) **or**;
3) Three separate letters of recommendation from practicing occupational therapists or physical therapists serving a pediatric population. These letters must include the name, address, and telephone number of the recommending therapist, place of therapist's employment and number of years the therapist has worked with the specific Custom DME Applicant in providing custom DME. CSHCN requires that the letter of recommendation be made by a physical or occupational therapist not employed by the applicant, nor receiving any form of compensation for the letter of recommendation **and**;

4) The Custom DME Provider Agreement that lists the terms that they agree to, if approved. The provider agreement, "CSHCN Provider Enrollment Form: Customized Durable Medical Equipment Vendors," indicates agreement with the following:
   - To provide new and not used, reconditioned or damaged equipment or parts.
   - To ensure that clients are measured and equipment is assembled and fitted by knowledgeable staff.
   - To request authorization or prior authorization for equipment based on the recommendations, preferably written, of the client, physician, therapist and vendor team whenever possible.
   - To ensure that equipment is delivered with all accessories, by staff experienced in the fitting of DME, directly to the person specified in the delivery instructions. That the parent, client, or guardian sign a documentation of receipt at the time of delivery, and not at any other time, and only when the item, with all accessories, meets the satisfaction of the parent, client, or guardian.
   - To provide instruction to the family, client, or guardian on the proper use and maintenance of the equipment.
   - To provide free inspection, adjustments and maintenance between the fourth and the fifth months after delivery of a power chair.
   - To loan a medically appropriate item to the client, at no charge to the client, if the prescribing physician determines immediate need from the time the authorization is received by the vendor and until the prescribed item is delivered.
   - No accessories, inserts, or other positioning devices shop-built by a vendor will be purchased unless specifically approved by CSHCN Medical Review Staff after review of medical justification submitted from the prescribing physician or occupational or physical therapist. Detailed cost justification will also be required.
   - To never reclaim an item that has been delivered and the documentation of receipt form signed by the parent, client or guardian, even if CSHCN denies vendor payment due to the vendor's failure to comply with claims processing deadlines.

Note: DME provided through the CSHCN program becomes the possession of the client.

   - To use objective occupational therapists and/or physical therapists to perform the wheelchair/equipment evaluations and to make equipment recommendations for CSHCN clients. For example, therapists will **not** be hired or paid by the DME provider or DME company to perform these evaluations.

Note: Any evidence of noncompliance with items above will be grounds for removal of the provider from the CSHCN provider list or other sanctions as agreed upon by the medical reviewers.

Custom DME consists of:

- Custom fitted wheelchairs (manual and power) and positioning components
- Scooters
- Standers (prone and supine)
- Gait trainers
- Special needs strollers
- Special needs car seats
- Purchase of above equipment
- Travel chairs
- Portable wheelchair ramps

Noncustom DME is medical equipment that could be obtained from a store or a mail order company and would not require adaptation or modification for the client's use. Noncustom DME consists of:

- Standard wheelchairs
- Ambulation aids
- Transfer boards
- Adaptive feeder seats
- Hospital beds
- Hygiene equipment
- Hospital cribs/enclosed beds
- TENS units
- Glucose monitors
- Portable paraffin units and portable hydrocollator units
- Feeding equipment (parenteral and enteral)
- Rental or purchase of above equipment

4.2 Reimbursement

DME is reimbursed at a specified discounted percentage off the manufacturer's suggested retail price (MSRP) or according to a maximum allowable fee schedule. The discounted price includes vendor costs. The reimbursement rates for the rental or purchase of DME and supplies are as follows:

- Noncustomized – The lower of the billed amount or the amount allowable by the Centers for Medicare and Medicaid Services (CMS), if available, or the Texas Medicaid Program
- Customized, nonpowered equipment-the lower of the billed amount or the MSRP less 18 percent
- Power wheelchairs – The lower of the billed amount or the MSRP less 15 percent
- Other – When no MSRP has been published, the lower of the billed amount or the dealer's cost plus 25 percent
- Delayed delivery penalty – A claim submitted for customized DME that was delivered to the client more than 75 days after the authorization date shall be reduced by 10 percent

The provider is required to provide the HCPCS, Medicaid local codes, or CSHCN custom DME codes when requesting authorization and when submitting claims. The provider must agree to accept CSHCN's reimbursement as "payment in full." Repairs are reimbursed at list price of part plus labor time. Use Medicaid local code 5806X, Labor for repair or modification to existing equipment, per hour, when requesting authorization and/or claim submission.

Any piece of DME that exceeds $1000.00 will require documentation that a less expensive alternative does not exist; or if one does exist, documentation must be submitted that clearly states why any less expensive alternatives would not meet the client's needs. Occasionally, equipment under $1000.00 may require similar documentation when specifically requested by CSHCN.

Providers must have a client or their representative complete the "Documentation of Receipt Form" found in "CSHCN Documentation of Receipt for DME Equipment" on page 4-27 when the equipment is delivered. The date of delivery on the Documentation of Receipt Form is the date of service that should appear on the claim. The provider should retain this form; do not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

Exception: For specialized individual needs, and when approved by medical review, specific non-CSHCN covered items may be authorized when medically justified. CSHCN and the vendor will negotiate the reimbursement amount at the time of authorization.

CSHCN will pay for repairs if the item was purchased by the Program; or, as an exception, it was obtained new **(not used and a copy of receipt is submitted to document this)** through another source, but are a CSHCN approved item (e.g. hospital bed, stander, or wheelchair). All manufacturers' warranties must be upheld.

CSHCN authorizes portable ramps through this DME policy. “Portable ramps” may be defined as: a ramp that is not physically attached to the dwelling, that may be moved, and that meets standards as set by the Americans with Disabilities Act (ADA). This does **not** include permanent ramps or home modifications, nor does it include vehicle modifications.

4.3 Benefits and Limitations

CSHCN may reimburse medically necessary and appropriate DME. DME is considered equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, that is generally not useful to a person in the absence of illness, injury or disability, and that is appropriate for use in the home or community setting. The item must be prescribed by a licensed physician, must be covered by CSHCN, and may require authorization/prior authorization. Requests for authorization/prior authorization must be submitted in writing. Requests for equipment that require PRIOR authorization must be complete and received before the requested date of service. Written requests for prior authorization are required for custom, manual, or power wheelchairs and their seating systems, pediatric hospital cribs and their tops, and other specified DME. CSHCN may reimburse both custom and noncustom DME. Refer to “CSHCN Durable Medical Equipment Authorization Request Form” on page 4-24.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

CSHCN considers requests for coverage for the following types of durable medical equipment and services:

- Rehab equipment – purchase, rental, modification and/or repair of such items as ambulation aids, wheelchairs (manual and power), standers, hospital beds, hygiene equipment, etc.
- Miscellaneous equipment – such as transcutaneous electric nerve stimulator (TENS), hydrocollator and paraffin units, and special needs car seats

4.4 Wheelchairs

4.4.1 Wheelchair Assessment Forms

Effective October 1, 2000, CSHCN requires that an assessment by a physical or occupational therapist (not employed by the DME provider requesting prior authorization) be performed when a custom manual or power wheelchair and/or a seating system is requested. Assessments also are required when an existing seating system is modified.

CSHCN approved custom DME providers are required to submit these assessments with their requests for the wheelchairs. Therapists must use the “CSHCN Wheelchair/Seating Evaluation Form” on page 4-28 and the “CSHCN Measuring Worksheet” on page 4-33.

4.4.2 Manual Wheelchairs

Manual wheelchairs may be either noncustom or custom DME depending on if it has been modified or in any way customized to the individual client’s needs.

CSHCN may pay for a manual wheelchair when medically necessary for any nonambulatory client enrolled in CSHCN. The physician or therapist is responsible for documentation indicating nonfunctional ambulation or situations in which ambulation is contraindicated, or when ambulation is not

adequate for independently accessing the community. An assessment using the "Wheelchair/Seating Evaluation Form" completed a physical or occupational therapist (not employed by the DME vendor requesting prior authorization) must be submitted when requesting authorization for a custom wheelchair and/or seating system. CSHCN will not pay for wheelchairs for children who are residents of state nursing facilities or ICF-MR facilities. This is the responsibility of the facility licensed to care for the child. Rental must be considered for short-term needs when the total cost is expected to be less than the purchase price. If public funds were used for payment of a wheelchair within the last three years, specific justification is required to give authorization for a new chair.

Eligible clients may receive a manual wheelchair in addition to a powered wheelchair or travel chair. The manual chair will be purchased as a backup; therefore, cost and accessories should be minimal. Aside from having a manual wheelchair backup for a powered wheelchair, **CSHCN will not authorize purchase of more than one form of mobility equipment per eligible client**.

No more than one manual wheelchair may be authorized in a three-year period without documentation of medical necessity for a second or replacement wheelchair. If the wheelchair has been stolen or damaged in an accident, a police report will be required to justify replacement if within three years of receipt.

Rehab DME providers are required to provide loaner wheelchairs free of charge when the purchase of a wheelchair is approved by the CSHCN Program if an immediate need for a wheelchair is indicated in the seating assessment form or other documentation.

4.4.3 Power Wheelchairs

Model specific power wheelchairs, including scooters must be prior authorized through CSHCN according to the criteria under "Approval Criteria for Power Wheelchairs" on page 4-6. Eligible children may receive, or already have, a manual wheelchair or travel chair in addition to the power wheelchair. The manual chair will be purchased as a back-up; therefore, cost and accessories should be minimal. Written requests for prior authorization of power wheelchairs should be submitted on the "CSHCN Durable Medical Equipment Authorization Request Form" on page 4-24. If public funds were used for payment of a power wheelchair within the last five years, specific justification, including a police report if the wheelchair has been stolen or damaged in an accident, is required to give authorization for a new power wheelchair.

4.4.3.1 Approval Criteria for Power Wheelchairs

Age: 18 months to 21 years. (As the normal child is walking and exploring by 18 months to two years, CSHCN supports providing powered chairs to match normal developmental milestones.)

Level of Physical Function: The child must have control of some body part to operate a powered wheelchair. Level of function must be defined by one of the following:

- Unable to self propel a manual wheelchair, even if adapted, **or,**
- Self-propulsion is possible, but activity is extremely labored leaving the child exhausted at necessary destination, such as classroom or school bathroom, **or,**
- Self-propulsion is possible, but contrary to treatment regimen. Examples include joint protection/energy conservation and preservation of cardiovascular or respiratory function.

Cognitive level:

- The child needs to be able to receive and follow directions related to driving/controlling the chair.
- The child's personality is such that the wheelchair will not be used as a weapon.
- Home assessment: The therapist assessing the client is required to ask pertinent questions found on the "Wheelchair/Seating Evaluation Form" to ensure safe use and selection of the appropriate powered wheelchair. CSHCN requires that an assessment by a physical or occupational therapist, not employed by the requesting DME vendor, be submitted with the prior authorization request for a custom wheelchair and/or seating system.

4.4.4 Wheelchair Positioning Equipment

Wheelchair positioning equipment includes but is not limited to tilt-in-space options, solid backs and seats, abductors, cushions, and shoe holders. The equipment may be covered based on the individual child's seating/positioning needs as detailed in the "Wheelchair/Seating Evaluation Form."

4.4.5 Wheelchair Ramps

CSHCN authorizes **only** portable ramps. *"Portable ramps" may be defined as: a ramp that is not physically attached to the dwelling, that may be moved (disassembly may be required, e.g., in the case of a modular ramp), and it should meet standards as set by the Americans with Disabilities Act (ADA)*. Portable ramps for wheelchairs, to allow access to the client's home, may be authorized if the need is documented. CSHCN will authorize requests for ramps only to allow access to two entrances to the client's home. Once two accessible entrances have been provided, the client/family would not be expected to require another ramp/replacement ramp. Requests for replacement would require medical review and documentation of need including an explanation of what happened to the previous ramp. The ramp is expected to go with the client if he or she changes residential locations; CSHCN will **not** replace portable ramps due to the client's relocation. Ramps may need to be modified to fit a different dwelling if the client moves; CSHCN will pay for these required modifications rather than purchasing a replacement ramp.

4.5 Travel Chairs

Travel chairs may be either custom or noncustom DME depending on if they have been modified or in any way customized to the individual client's needs. Travel chairs are generally lighter weight chairs than a noncustom manual wheelchair, and are designed for ease of pushing the chair by an attendant/caretaker rather than being self-propelled. Travel chairs have little flexibility for customization. Using the same guidelines as for manual wheelchairs, travel chairs may be prior authorized for clients who are unable to self-propel a manual wheelchair, and who are not appropriate for a powered wheelchair due to cognitive issues, inaccessibility of the home, type of diagnoses, or level of physical function.

4.6 Adaptive Strollers

Adaptive strollers may be either custom or noncustom DME depending on if they have been modified or in any way customized to the individual client's needs.

Adaptive strollers are mobility devices that resemble regular strollers purchased for healthy infants and toddlers. Adaptive strollers have a limited range of accessories that allow some positioning for clients with minor postural problems. Adaptive strollers may only be authorized when medically necessary and when the following conditions are met:

- The stroller has a firm back and seat, or insert
- A stroller (rather than a wheelchair) is specifically recommended by the licensed therapist completing the wheelchair evaluation
- The requested stroller meets **all** recommendations made in the wheelchair evaluation
- The client is not expected to develop motor skills necessary for self-propulsion and is not expected to need a travel chair or wheelchair within two years of the request date, **or**
- The client is expected to be ambulatory within one year of the request date.

Requests for clients older than two years must meet the above criteria, and in addition, there must be medical documentation of the reason for a stroller versus a wheelchair. Medical documentation should indicate that a client's particular condition, stature, and need for positioning allow adequate support from a stroller (completion of the wheelchair evaluation would serve as medical documentation).

4.7 Ambulation Aids

4.7.1 Crutches, Walkers, Gait/Ambulation Belts, and Canes

Ambulation aids may be either custom or noncustom DME depending on if they have been modified, or in any way customized, to the individual client's needs.

Crutches, walkers, gait/ambulation belts, and canes may be authorized for any condition resulting in limited functional ambulation. The provider is required to submit authorization requests and claims with the appropriate HCPCS code. These items cannot be considered for rental.

4.7.2 Gait Trainers (Supported or Sling Walkers)

Giat trainers may be either custom or noncustom DME depending on if they have been modified, or in any way customized, to the individual client's needs.

The purpose of the gait trainer is to begin weight bearing (important for bone health and muscle strength) and preambulation activities. Prompts are built into the equipment that can be removed gradually as ambulation development occurs. The gait trainer should be needed at home and not just in school or the therapy clinic (CSHCN will not cover equipment for use solely in schools or clinics).

Questions the provider needs to address include the following:

- Client's condition, functional level, height and weight
- Is the client expected to be ambulatory and if so, when
- The time, frequency, and location where the gait trainer will be used
- The length of time the gait trainer is expected to be needed (should be a minimum of six months)
- The plan for training the school and home caregivers in the correct and safe use of the equipment

Additional medical necessity is needed when a gait trainer is requested for a child who has a standing frame/table.

4.7.3 Transfer Boards

Transfer boards may be approved for any covered condition that results in paralysis or significant weakness of both lower extremities. This item cannot be considered for rental.

4.7.4 Prone or Supine Standers

Prone or supine standers may be authorized for clients with diagnoses such as cerebral palsy, spina bifida, paraplegia, or other conditions resulting in paralysis of both lower extremities, when prescribed by a practitioner licensed to do so. The medical condition must indicate the need for a standing program that must specifically be provided in the home environment. As many clients receive standing programs at school, the home standing program should coordinate with the school plan. CSHCN provided standers will be for use in the client's home environment **only**; schools and therapy providers must provide their own equipment for standing programs in settings outside the client's home. The equipment provided for home use need **not** be identical to the equipment used in the school setting where they have to accommodate a variety of changing postural issues and where they require more heavy duty equipment due to the increased use, wear and tear on the equipment. DME vendors providing standers MUST be enrolled as Custom DME vendors.

The following documentation should be included with an authorization request:

- Client's condition, functional level, height and weight
- Frequency and amount of time of client's standing program (e.g., 45 minutes, three times daily)
- The anticipated medical benefits expected from the stander

- Name of therapist who will be coordinating school and home standing programs, or who will be monitoring home standing program
- Plan for training the school and home caregivers in the correct and safe use of the equipment

4.8 Hygiene Equipment

Hygiene equipment may be either custom or noncustom DME depending on if they have been modified, or in any way customized, to the individual client's needs.

Hygiene equipment should be rented if for short-term use and if it is more cost-effective. Documentation of anticipated independence with the equipment is required for rental and purchase. Additionally, equipment may be authorized for clients who are nonambulatory to assist the parents and enhance safety in the care of clients with spina bifida, cerebral palsy, and other paralytic conditions. Examples of hygiene equipment include:

- Bath seats/chairs*
- Tub rails (not wall-mounted)
- Manual/hydraulic bathtub lifts
- Commode/potty chairs
- Hygiene adaptations (e.g., raised toilet seats)
- Patient lifts

  *Bath chairs may be purchased for clients who are older than 1 year old or weigh more than 30 pounds. Bath chairs may be covered for clients when the medical condition indicates the need for support when bathing.

The following documentation should be included with an authorization request:

- Client's height, weight, and age
- Client's condition and functional level
- Anticipated amount of time the client will need the equipment

4.9 Adaptive Feeder Seats

Adaptive feeder seats may be authorized for any condition resulting in postural insecurity, including cerebral palsy and spina bifida.

4.10 Hospital Beds (Manual and Electric)

Hospital beds (manual and electric) and/or accessories may be purchased for the long term care of clients whose conditions have progressed to the point at which they are severely neurologically and/or orthopedically limited, and so on. Documentation should include diagnosis, age of client, height and weight of client, and limitation of the caretaker. All requests require medical review for the purchase of electric hospital beds.

Hospital beds (manual and electric) with accessories may be rented, if the need is short term (not to exceed six months). The anticipated rental cost must be less than the purchase price.

Examples of short-term needs include:

- Post surgery
- Client's life expectancy is very limited (six months or less), as certified by the prescribing physician

Electric hospital beds may be purchased (long-term use) or rented (short-term use) if:

- The client is able to assist with his or her personal care and can physically operate the controls; **or**
- The caretaker is physically limited and cannot crank a manual bed; **or**
- The caretaker needs to be able to adjust the bed quickly to assist with client's personal care

The following HCPCS codes must be used for authorization and claims payment:

HCPCS Code	Description
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height, hi-lo, any type side rails, with mattress
E0256	Hospital bed, variable height, hi-lo, any type side rails, without mattress
E0260	Hospital bed, semi-electric (head, foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head, foot adjustment), with any type side rails, without mattress
E0265	Hospital bed, total electric (head, foot, height adjustment), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, height adjustment), with any type side rails, without mattress
E0270	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress
E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head, foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head, foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot, height adjustment), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot, height adjustment), without side rails, without mattress
E0298	Hospital bed, heavy duty, extra wide with any type side rails, with mattress
E0305	Bed side rails, half length
E0310	Bed side rails, full length

4.11 Hospital Cribs

CSHCN covers procedure code 5832x, hospital cribs/enclosed beds, if documentation supporting medical necessity/appropriateness is submitted with the request for prior authorization. Requests for cribs/enclosed beds must be prior authorized and are referred for medical review.

Documentation indicating strictly a behavioral control need will **not** be authorized. A diagnosis alone without documentation of medical necessity and functional skills is sufficient information to approve a hospital crib or enclosed bed.

Documentation must include:

- Client's diagnosis, medical needs, developmental level, and functional skills. A diagnosis alone without documentation of medical necessity and functional skills is **insufficient** information to approve a hospital crib or enclosed bed.
- Age, length/height, and weight of client
- Describe any other less-restrictive devices that have been used, the length of time used, and why they were ineffective
- Why a regular child's crib, regular bed, or standard hospital bed cannot be used
- Name of manufacturer and the manufacturer's retail price

The protective crib top/bubble top may also be prior authorized based on the criteria previously listed. Requests must be made to CSHCN using the "CSHCN Durable Medical Equipment Authorization Request Form" on page 4-24.

4.12 TENS Units

Transcutaneous Electric Nerve Stimulator (TENS) units may be authorized for rental or purchase for the management of pain when prescribed by a physician. Medical review is required. Replacement electrodes may be authorized as a supply item if a TENS unit has been previously purchased by CSHCN. Reimbursement is at Medicare allowable rates.

Documentation of a home program developed and monitored by an occupational or physical therapist or the client's physician must be submitted with the authorization request. No more than one TENS unit may be authorized in a two-year period without documentation of medical necessity for the second unit.

4.13 Portable Paraffin Units and Portable Hydrocollator Units

Portable paraffin units and portable hydrocollator may be authorized for clients with juvenile rheumatoid arthritis or similar conditions resulting in decreased range of motion and joint pain. Documentation of a home program developed and monitored by an occupational or physical therapist or the client's physician must be submitted with the authorization request. No more than one portable paraffin or portable hydrocollator unit may be authorized in a two-year period without documentation of medical necessity for the second unit.

4.14 Glucose Monitors

Glucose monitors may be authorized for clients with diabetes mellitus. Documentation must include documentation of the client's/caretaker's training in the proper use of the glucose monitor, and review of safe blood glucose level readings with instructions of glucose levels that should be reported to the physician. No more than one glucose monitor may be authorized per two years without justification of medical necessity for a second glucose monitor. If a blood glucose monitor with features beyond the basic model is preferred, the client's parent or guardian must pay the difference in the cost. To submit claims or requests for authorization, use procedure code E0607, Home blood glucose monitor. Refer to "Expendable Medical Supplies" on page 5-1 for information related to other supplies pertaining to blood glucose testing.

4.15 Blood Pressure Devices

CSHCN may cover blood pressure devices for home use when the equipment is prescribed by a physician for one of the following diagnoses. Blood pressure devices may be purchased **for clients with** the following diagnoses:

Diagnosis Code	Description
41411	Other forms of chronic ischemic heart disease; aneurysm of coronary vessels
4150–4169	Diseases of pulmonary circulation
4240–4243	Other diseases of the endocardium
4251	Cardiomyopathy; hypertrophic obstructive cardiomyopathy
4253	Cardiomyopathy; endocardial fibroelastosis
4254	Cardiomyopathy; other primary cardiomyopathies
426–4269	Conduction disorders
427–42732	Cardiac dysrhythmias
42781	Other specified cardiac dysrhythmia; sinoatrial node dysfunction
588	Disorders resulting from impaired renal function; renal osteodystrophy
591	Hydronephrosis
59371–59373	Other disorders of kidney and ureter; vesicoureteral reflux with reflux nephropathy

Diagnosis Code	Description
745–74519	Bulbus cordis anomalies and anomalies of cardiac septal closure
7452	Tetralogy of Fallot
7453	Common ventricle
7454	Ventricular septal defect
7455	Ostium secundum type atrial septal defect
7456	Endocardial cushion defects
7457	Cor biloculare

Requests for diagnoses other than those listed above and/or for electronic blood pressure devices for clients over 12 months of age require authorization and documentation of medical necessity. Providers must maintain documentation to support medical necessity in the medical record. To submit claims for blood pressure devices, use the following procedure codes:

Procedure Code	Description
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
A4670	Automatic blood pressure monitor
5243X	Digital blood pressure and pulse monitor

An electronic blood pressure device may be rented for home use for clients less than 12 months of age with the diagnoses listed above. To submit claims for electronic blood pressure devices, use procedure code 5127X, Electronic Blood Pressure device (for example, Dynamap) rental, per month.

4.16 Burn Care Garments

CSHCN may pay for burn care products for program eligible clients. The burn must be second or third degree with hypertrophic scarring. The garment to be reimbursed must be specific to the location of the burn. Burn care management garments may also be reimbursed for other conditions (i.e., large hemangiomas or lymphangiomas), with documentation from the physician regarding medical necessity. Use the following codes when submitting claims for services:

Procedure Code	Description
100BG	Custom burn garment
5272X	Jobst stocking, 1 pair
5284X	Jobst vest

4.17 Special Needs Car Seats and Travel Restraints

CSHCN may reimburse for special needs car seats when medically necessary and appropriate. Services and equipment will be provided through a network of trained providers and must be authorized. CSHCN may reimburse for travel restraints for the transportation of children with special positioning requirements.

CSHCN reimburses special needs car seats and travel restraints using the same methodology as custom manual rehabilitation equipment. In filing claims for car seats and travel restraints, follow the same procedures as for customized equipment.

4.17.1 Car Seats

CSHCN will consider reimbursement of the following special needs car seats only:

Procedure Code	Description
5229X	Columbia orthopedic positioning seat
5389X	Gorilla positioning seat

Vendors providing special needs car seats must be approved custom rehabilitation providers and have received approved training from the manufacturer of the product requested, i.e., Snug Seat, Inc. for the Gorilla positioning seat, and Columbia Medical Manufacturing Corp, for the Columbia orthopedic positioning seat. The comprehensive training includes correct use of car seats for children with special needs and proper installation of top tethers. Completion of each provider's training program will be certified by the respective manufacturer. Authorizations will not be provided to a provider until training has been completed and NHIC receives notification from the manufacturer that the required training was provided. Vendors must provide the name of the individual installing the car seat on the CSHCN DME Authorization Request Form.

Installation of the top tether is essential for proper use of the car seat and must be provided by the vendor. Providers may not bill CSHCN for the installation of the top tether. This cost is paid to the provider by the manufacturer.

Vendors providing the service must keep a statement on record that has been signed and dated by the child's parent or guardian and the provider stating all of the following:

- A top tether has been installed by a manufacturer-trained provider in the automobile or vehicle in which the child will be transported
- Parent training in the correct use of the car seat has been provided by a manufacturer-trained provider
- Parent has received instruction and has demonstrated the correct installation and use of the car seat to a manufacturer-trained vendor

4.17.2 Documentation for Authorization of Car Seats

Requests for authorization of special needs car seats must include the following written documentation:

- Actual weight and height must be provided (child must weigh 40 pounds or more or be taller than 40 inches in height)
- Description of child's postural condition, specifically documenting head and trunk control
- Expected long-term need of the car seat for the child

Careful consideration should be given to the manufacturer's listed weight limitation when fitting the child for a car seat. Twelve months of anticipated growth should be taken into consideration.

CSHCN will consider replacement after seven years (normal useful life) **or** if the vehicle has been involved in an accident. Snug Seat, Inc. will replace car seats at no cost following an accident if a police report from the accident is provided.

Car seat accessories, available from the manufacturers for correct positioning, may be authorized when medically necessary.

4.17.3 Travel Restraints

The CSHCN Program may reimburse the E-Z-On modified vest travel restraint, Model 101 M2, for children whose medical condition requires them to be transported in either a prone or supine position. Authorization is required. Requests for authorization must be submitted for medical review with documentation supporting medical need.

Use procedure code 5370X, E-Z Modified Vest, Model 101 M2, Travel Restraint, when requesting authorization or submitting claims for reimbursement.

4.18 Gastrostomy Devices

CSHCN may reimburse for low-profile gastrostomy devices (gastrostomy buttons) for clients with diagnosis V4410, when prescribed by a physician. The following devices may be covered:

Procedure Code	Description
5234X	Gastrostomy device, obturated, mushroom type
5235X	Gastrostomy kit, nonobturated, balloon type

Authorization for low profile gastrostomy devices is not required. Documentation supporting medical necessity must be submitted with the claim or the above diagnosis, if applicable.

4.18.1 Nonobturated Gastrostomy Devices

Nonobturated gastrostomy kits may be reimbursed to physicians, pharmacies, medical suppliers and home health agencies. Two devices may be reimbursed per year, per client. Additional devices may be reimbursed if documentation submitted with the claim indicates medical necessity.

4.18.2 Obturated Gastrostomy Devices

Obturated gastrostomy devices may be reimbursed only to physicians. Two devices may be reimbursed per year, per client. Additional devices may be reimbursed if documentation submitted with the claim indicates medical necessity.

4.19 Noncovered Rehabilitation and Therapeutic DME

Noncovered rehabilitation and therapeutic DME includes, but is not limited to:

- Adaptive furniture, bolsters, wedges
- Continuous passive motion (CPM) equipment
- Corner chairs, floor sitters
- Creepers
- Electrical stimulation (ES) and electrical stimulation functional (FES) units
- Home modifications, including ramps (except portable ramps for wheelchairs)
- Parallel bars
- Powered equipment (with the exception of powered wheelchairs and electric beds)
- Pressure relief beds
- Vehicle modifications
- Vocational, educational, and recreational equipment, even when adapted

Other miscellaneous durable medical equipment may be authorized based on review of documentation of medical necessity, which must be submitted with an authorization request.

For specialized individual needs, and when approved by medical review, specific non-CSHCN covered items may be authorized when medically justified. The discounted amount will be negotiated by CSHCN and the provider.

4.20 Covered DME – Custom and Noncustom

The following CSHCN procedure codes should be used when submitting requests for authorization/prior authorization and/or submitting claims for DME:

Procedure Code	Description	Manufacturer
53ACD	Premier Classic	Everest and Jennings manual wheelchairs
53ACD	Universal	Everest and Jennings manual wheelchairs
53ACD	Traveler	Everest and Jennings manual wheelchairs
53ACD	SPF II	Everest and Jennings manual wheelchairs
53ACD	Vista	Everest and Jennings manual wheelchairs
53ACD	P2 Plus	Everest and Jennings manual wheelchairs
53BCD	Quickie Kidz	Quickie Designs/Sunrise Medical
53BCD	Quickie T45	Quickie Designs/Sunrise Medical
53BCD	Quickie LX 7 LXI (available with one-arm drive)	Quickie Designs/Sunrise Medical
53BCD	Quickie GP, GPV, and GPS	Quickie Designs/Sunrise Medical
53BCD	Quickie 2 & 2 HP (available with one-arm drive)	Quickie Designs/Sunrise Medical
53BCD	Quickie TS (Tilt in space)	Quickie Designs/Sunrise Medical
53BCD	Zippie & Zippie TS (Tilt in space)	Quickie Designs/Sunrise Medical
53BCD	Zippie GS/GS Transit option (must use Quickie Seating)	Quickie Designs/Sunrise Medical
53BCD	Zippie 2 (available with one-arm drive)	Quickie Designs/Sunrise Medical
53BCD	Quickie TNT	Quickie Designs/Sunrise Medical
53BCD	Breezy Series	Quickie Designs/Sunrise Medical
53CCD	Action comet	Invacare Manual Wheelchairs
53CCD	Action allegro	Invacare Manual Wheelchairs
53CCD	Action A-T	Invacare Manual Wheelchairs
53CCD	Action solo tilt	Invacare Manual Wheelchairs
53CCD	Action A-4	Invacare Manual Wheelchairs
53CCD	Action orbit	Invacare Manual Wheelchairs
53CCD	Action XTRA	Invacare Manual Wheelchairs
53CCD	Action Jr.	Invacare Manual Wheelchairs
53CCD	Action MVP	Invacare Manual Wheelchairs
53CCD	Action Patriot & Patriot SL	Invacare Manual Wheelchairs
53CCD	Invacare 9000 SL/XT/XDT	Invacare Manual Wheelchairs
53CCD	Youth mobile 3000 & 9000	Invacare Manual Wheelchairs
53DCD	Sting	ETAC/Snug seat
53DCD	Elite	ETAC/Snug seat
53ECD	One arm drive primus & picco	Meyra
53ECD	Mono drive	Meyra
53FCD	Fortress Power 2000 PD	Optiway Technology
53FCD	Fortress Power 2000 FS	Optiway Technology
53HCD	Travel chair #6302 and 6332	Ortho-Kinetics
53ICD	Panther Wheelchair	Snug Seat
53KCD	The Solution (stroller)	Freedom Designs
53KCD	Kid-EZ (B) 1 & 2 (stroller)	Kid-Kart/Sunrise Medical
53KCD	Kid-EX (B) 1 & 2 (stroller)	Kid-Kart/Sunrise Medical

Procedure Code	Description	Manufacturer
53KCD	Kid-TLC (B) 1 & 2 (stroller)	Kid-Kart/Sunrise Medical
53KCD	Kelly Plus chair #6412	Ortho-Kinetics
53KCD	Snug seat 1 & 2	Snug Seat
53MCD	Growth guidance seating system	Mobility Plus/Mulholland
53MCD	VGF Plus and Sprite	Mobility Plus/Mulholland
53NCD	Sieger Pediatric Wheelchair	Otto Bock
53PCD	Multi-adjustable chair (M.A.C.)	Gunnell
53PCD	TNT lite	Gunnell
53PCD	TNT pediatric	Gunnell
53QCD	Kid Power	Everest and jennings power wheelchairs
53QCD	Power Lancer	Everest and jennings power wheelchairs
53RCD	Invacare action power 9000	Invacare Power Chairs
53RCD	Invacare Action Ranger II front or rear wheel drive	Invacare Power Chairs
53RCD	Invacare Action Storm Arrow front or rear wheel drive	Invacare Power Chairs
53RCD	Invacare Action Storm junior front or rear wheel drive	Invacare Power Chairs
53RCD	Invacare Action Storm Ranger X front or rear wheel drive	Invacare Power Chairs
53RCD	Invacare Action Power Tiger with orbit base	Invacare Power Chairs
53TCD	Wheelchair accessories or seating systems (Avanti)	Canyon Products
53UCD	Spectrum 1 & Spectrum 1 folding tilt wheelchair	Freedom Designs
53UCD	Spectrum 3 & Spectrum 3 folding tilt wheelchair	Freedom Designs
53UCD	Spectrum spirit	Freedom Designs
53UCD	Spectrum small fry	Freedom Designs
53VCD	Modular Seating System	Adaptive Equipment Systems
53VCD	Temper Foam Cushion	Alimed Tempered Foam Cushions
53VCD	Seating Systems and Accessories	Avanti Seating System
53VCD	Wheelchair seating accessories	Bodypoint Designs
53VCD	Modular back system	Cascade
53VCD	Drop base	Cascade
53VCD	Hensinger head & chest support (#6610) & accessories	Danmar
53VCD	Modular adptive seating system	Freedom Designs
53VCD	Adult, narrow adult, and child cushion	Kee Goebel Temper Foam
53VCD	Cushions - foam	Lumex
53VCD	Quickie seating systems (Jay Fit & Conventional seating)	Quickie Designs/Sunrise Medical
53VCD	Sure fit sitting orthosis	Snug Seat
53VCD	All head supports EXCEPT hydro supports	Whitmyer Biomechanix
53XCD	Kuschall Kuschkin 1000& 3000 wheekchair	Everest and jennings manual wheelchairs
53XCD	Kuschall Munchkin 3000 wheelchair	Everest and jennings manual wheelchairs

Procedure Code	Description	Manufacturer
53XCD	Kuschall Kuschkin 1000& 3000 wheelchair	Kuschall
53XCD	Kuschall Munchkin 3000 wheelchair	Kuschall
53YCD	Zippie P500	Quickie Designs/Sunrise Power Chairs
53YCD	Quickie P100 & P1100	Quickie Designs/Sunrise Power Chairs
53YCD	Quickie S525	Quickie Designs/Sunrise Power Chairs
53YCD	Quickie P210	Quickie Designs/Sunrise Power Chairs
53YCD	Quickie P300	Quickie Designs/Sunrise Power Chairs
53YCD	Quickie P320	Quickie Designs/Sunrise Power Chairs
53ZCD	Three wheeler pony II #4314 (small) and 4315 (medium)	Ortho-Kinetics
55ACD	Folding walkers (standard rolling, extra wide, fold-down seat, swivel wheel, “bail,” standard U brace)	Guardian/Sunrise Medical
55ACD	Pediatric walker - folding, non-folding	Guardian/Sunrise Medical
55ACD	Strider prescription walkers	Guardian/Sunrise Medical
55ACD	Pediatric forearm crutches - standard; prestige	Guardian/Sunrise Medical
55ACD	Rigid walker and folding (lightweight) walkers	Lumex
55ACD	Reciprocal Walker (Walk-A-Matic)	Lumex
55ACD	Preston deluxe child wheeled walker (PC1763)	Preston
55ACD	Adjustable mobilizer - Wheeled walker (PC1770-1773)	Preston
55CCD	Prone stander (all sizes)	Theradept
55CCD	Supine stander (all sizes)	Theradept
55DCD	2 Wheel and 4 wheel walker	Kaye Products
55DCD	Kaye prone & vertical stander	Kaye Products
55FCD	Bugsy postural walker	Otto Bock
55FCD	Spee-Dee Gait trainer	Otto Bock
55GCD	Prone stander toddler/child/junior	Mobility Plus/Mulholland
55GCD	Walkabout and Wheelabout	Mobility Plus/Mulholland
55HCD	Pediatric gait trainers 22, 24, 26	Rifton
55HCD	Intermediate gait trainer 27	Rifton
55HCD	Pony gait trainer	Snug Seat
55ICD	Giraffe stander 100-1000, 401-1000, 402-1000 (prone only)	Snug Seat
55ICD	Gazelle standing frame (sized 2 & 3) (Size 1 if caregiver has documented physical limitation	Snug Seat
55JCD	Adaptive prone stander #6801 and accessories	Ortho-Kinetics
55JCD	Upright standing frame #6860 and accessories	Ortho-Kinetics
55KCD	All Prone standers 62, 93, 94, 59	Rifton
55KCD	All Supine standers 40, 41	Rifton
55KCD	Freedom standers 74, 75	Rifton
55MCD	Portable ramps to access home	EZ-Access ramps
55MCD	Home care ramps	Guardian/Sunrise Medical

Procedure Code	Description	Manufacturer
55MCD	Portable ramps to access home	Handi-ramp
55MCD	Portable ramps to access home	Prairie View Ramps
57ACD	Roho high-profile therapeutic	Roho Cushions (Floatation)
57ACD	Roho low-profile therapeutic	Roho Cushions (Floatation)
57ACD	Roho mini max and accessories	Roho Cushions (Floatation)
57ACD	Roho enhancer and Nexus	Roho Cushions (Floatation)
57ACD	Roho quadtro and quadtro low profile	Roho Cushions (Floatation)
57BCD	Jay GS cushion & back	Jay Products/Sunrise Medical
57BCD	Jay cushion & back	Jay Products/Sunrise Medical
57BCD	Jay Adjustable solid seat	Jay Products/Sunrise Medical
57BCD	Jay Modular back	Jay Products/Sunrise Medical
57BCD	Jay Active cushion	Jay Products/Sunrise Medical
57BCD	Jay Xtreme cushion & back	Jay Products/Sunrise Medical
57BCD	Jay combi	Jay Products/Sunrise Medical
57BCD	Jay Lumbar supports	Jay Products/Sunrise Medical
57BCD	Jay J2 cushion & back	Jay Products/Sunrise Medical
57BCD	Jay Rave	Jay Products/Sunrise Medical
57BCD	Jay Deep Contour	Jay Products/Sunrise Medical
57CCD	Evolution seat cushion	Cascade
57CCD	Pro-form seat cushion	Cascade
57CCD	Isch-dish pressure relief cushion	Embracing concepts
57ECD	Headgear (helmet)	Danmar
57HCD	Columbia orthopedic positioning carseat 2000	Columbia
57ICD	Gorilla special needs car seat	Snug Seat
57LCD	E-Z-On Modified vest (model 101 M2)	E-Z-On products
57MCD	Eating/drinking aids (only with medical review approval)	Lumex
57MCD	Feeder seat (small, medium, and large, NOT extra large) wedge optional	Tumbleforms (Proeston or Sammons Cat.)
65ACD	Non-adjustable bath chairs & access. (no wheeled base option) Model # B-400 series (child, adolescent and adult	Anthros Medical
65ACD	Wrap around bath support 7200, 7300, 7700	Columbia
65ACD	Reclining bath chair 8500, 8600, 8700	Columbia
65ACD	Accessories for bath chair 8825, 8850, 8875	Columbia
65ACD	Tub transfer bench	Guardian/Sunrise Medical
65ACD	Pediatric bath chair (98400, 98402, 98404, 98440)	Guardian/Sunrise Medical
65ACD	Shower chair	Guardian/Sunrise Medical
65ACD	Shower chair	Lumex
65ACD	Bath seat	Lumex
65ACD	Tub transfer bench	Lumex
65ACD	Adaptive shower chair #6902 and accessories	Ortho-Kinetics
65ACD	TLC Bath chair #6701, 6741, 6781 and accessories	Ortho-Kinetics

Procedure Code	Description	Manufacturer
65ACD	Blue Wave Bath/Shower chairs and accessories	Rifton
65BCD	Tub grab bar (if clamp style/not wall mounted)	Guardian/Sunrise Medical
65BCD	Bath tub safety rails	Lumex
65CCD	Tublift	Guardian/Sunrise Medical
65CCD	Hoyer accessories	Guardian/Sunrise Medical
65CCD	Hoyer bathroom unit	Hoyer Lifts/Guardian
65CCD	Hoyer accessories	Hoyer Lifts/Guardian
65DCD	Toilet Support 4200, 4400, 4700, 4800	Columbia
65DCD	Positioning commode 5200, 5300, 5700, 5800	Columbia
65DCD	Commode chair standard; with padded seat and backrest	Guardian/Sunrise Medical
65DCD	Adaptive commode #6901	Ortho-Kinetics
65DCD	Blue Wave Toileting system and accessories	Rifton
65ECD	Accessories to toilet support 4925	Columbia
65ECD	Toilet seat reducer 4950, 4960	Columbia
65ECD	Soft-flex splash guard 4975	Columbia
65ECD	Toilet safety frame	Guardian/Sunrise Medical
65ECD	Raised toilet seat	Guardian/Sunrise Medical
65ECD	Raised toilet seat	Lumex
65FCD	Shower/commode chair, 99200 series	Guardian/Sunrise Medical

4.21 Modifier Requirements

For durable medical equipment procedures, use one of the following modifiers:

Modifier	Description
Y4	(Medicare) Purchase – New Equipment (DME)
Z6	Medicare (DME) Rental Equipment

4.22 Claims Information

DME services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the provider of their choice; NHIC does not supply the forms.

When completing a HCFA-1500 claim form, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

4.22.1 DME HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident-related, indicate the date of injury or the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in Block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related must to be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alpha-numeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file, a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

4.22.1.1 DME HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Williams, Sarah M.

3. PATIENT'S BIRTH DATE MM DD YY: 08 12 97 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1201 Carning Place

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Plano STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 75432 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Paul Burnes, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 907 . 00 3. ____ . ____
2. 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	2	9	5235X			1	120	00	1				
2																			
3																			
4																			
5																			
6																			

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 120 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

David Patton

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
General Supply Company
1902 Bunker Hill
Hillsboro, TX 74932

PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
DURABLE MEDICAL EQUIPMENT FORM OWCP - 1500 FORM RRB - 1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

4

4.22.1.2 CSHCN Durable Medical Equipment Authorization Request Form

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6524 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

For specialized seating or custom wheelchair purchase requests complete the 6-page CSHCN wheelchair seating evaluation form in addition to this form.

Client Information:

First name:	**Last name:**	**CSHCN #:**	
Date of birth:	**Diagnoses (ICD-9-CM):**		
Address / City / ZIP:			
Client's height:		**Client's weight:**	

Part 1 - The following information must be provided for ALL equipment requests.
Item is to be: Purchased ❑ Modified ❑ Repaired ❑ Rented ❑ Service Date:_____
(Required for rentals)

Description of item(s): _____

_____

_____

Equipment needed for: Lifetime ❑ < 6 months ❑ > 6 months ❑ > 1 year ❑ Other:_____
I certify that the patient's medical condition is such that all equipment requested above is medically necessary.

Physician's signature (required): X_____ **Date signed:**_____
Print or Type Physician's name: X_____
(some items may require additional medical justification)

Part 2 - Must be completed and signed by the VENDOR. The equipment description and pricing information indicated below must be completed. For custom DME requests, attach manufacturer's price sheet(s) for each item.

EQUIPMENT DESCRIPTION:			PRICING INFORMATION:			
Brand name or HCPCS code:	**Model #:**	**Item Description:**	**HCPCS Price:**	**OR**	**Cost / Retail Price**	**CSHCN Price**
			Total:			

DME Provider Information:

DME Provider Name (print or type):
TPI No.:
Phone number:
Fax number:
Address / City / ZIP:
Orthotist / Prosthetist name (print or type):
Signature of DME provider or representative: X
Date:

CSHCN DME Authorization Request Form (continued)

Submit this page (in addition to page 1) if requesting authorization for gait trainers or standers. Include a plan for training caretakers/family on the correct, safe use of the equipment and monitoring the client's need for increases or decreases in time using the equipment at home.

Client Information:

Client name:	**CSHCN #:**

Additional Information for Gait Trainer Requests:

Child's condition/functional level:	
Is the child expected to be ambulatory and if so, when:	
The time, frequency, and location where the gait trainer will be used:	
The length of time the gait trainer is expected to be needed:	
Growth potential of the equipment:	
Therapist's signature: X	**Print/Type Name:**
Phone number:	**Date:**

Additional Information for Prone or Supine Stander Requests:

Child's condition/functional level:	
Anticipated benefits expected from the stander:	
Frequency and amount of time of the child's standing program (e.g., 45 minutes 3x daily):	
Frequency the stander will be used at home:	
Length of time the stander is expected to be needed (growth potential):	
Therapist's signature: X	**Print/Type Name:**
Phone number:	**Date:**

CSHCN DME Authorization Request Form (continued)

Submit this page (in addition to page 1) if requesting authorization for car seats, bathroom equipment, or hospital cribs/enclosed beds.

Client Information:

Client name:	**CSHCN #:**

Additional Information for Special Needs Car Seat or Travel Restraint Requests:

Postural Control	
Head control _____good _____ fair _____poor	
Trunk control _____good _____fair _____poor	
Equipment requested:	
Gorilla by Snug Seat ❑	**Columbia car seat model #2000 ❑**
Name of certified installer:	
Name of person completing form:	**Phone number:**

Additional Information for Hygiene Equipment Requests:

Equipment requested:	
Is this replacement equipment? No ❑ Yes ❑	
If yes, why can't existing equipment be used?	
Tone: High ❑ Low ❑ Fluctuating ❑ Absent ❑	
Head control: Good ❑ Fair ❑ Poor ❑	**Upper extremity: Good ❑ Fair ❑ Poor ❑**
Trunk control: Good ❑ Fair ❑ Poor ❑	**Lower extremity: Good ❑ Fair ❑ Poor ❑**
Transfers: Dependent ❑ Independent ❑	
Name of person completing form:	**Phone number:**

Additional Information for Hospital Crib/Enclosed Bed Requests:

Medical needs, developmental level, and functional skills:	
Describe any other less-restrictive devices that have been used, the length of time used, and why ineffective:	
Why a regular child's crib, regular bed, or standard hospital bed cannot be used:	
Therapist or doctor's signature: X	**Date:**
Print or Type Name:	

4.22.1.3 CSHCN Documentation of Receipt for DME Equipment

This form must be kept in the client's file for all Durable Medical Equipment, Orthotics and Prosthetics, and Prescription Shoes. For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

THIS FORM MUST BE RETAINED BY THE DME PROVIDER. IT SHOULD NOT BE SUBMITTED WITH THE CLAIM.

Client Information:

First name:	**Last name:**
CSHCN #:	
Name of supplier (print or type):	

Equipment Information:

Item	No. Received	Description (include Model # for DME)	Manufacturer's Serial # (for DME only)

I certify that on _____ (mm/dd/yyyy):

The client received the equipment as prescribed by the physician

The equipment has been properly fitted to the client and/or meets the client's needs

The client, the parent or guardian of the client, and/or the primary caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

Print or Type Name: _____

X _____ _____

Signature of client, parent, or client representative — Date signed

Print or Type Name: _____

X _____ _____

Signature of DME supplier — Date signed

THE RECEIVING PARTY AND DME SUPPLIER MUST SIGN AND DATE THIS FORM AT THE TIME THE EQUIPMENT IS ACTUALLY DELIVERED.
Refer to the *CSHCN Provider Manual* for instructions on completing this form.

4.22.1.4 CSHCN Wheelchair / Seating Evaluation Form

Submit this form with the DME Authorization Request Form.

CLIENT'S NAME: _____
Last Name *First Name*

CLIENT'S CSHCN#: _____ DATE OF BIRTH: _____

DIAGNOSIS: _____

_____

HT: _____ WT: _____

* *

NOTE: A CURRENT WHEELCHAIR SEATING ASSESSMENT CONDUCTED BY A PHYSICAL OR OCCUPATIONAL THERAPIST MUST BE COMPLETED FOR PURCHASE OF OR MODIFICATIONS (INCLUDING NEW SEATING SYSTEMS) TO A CUSTOMIZED WHEELCHAIR. PLEASE ATTACH MANUFACTURER INFORMATION, DESCRIPTIONS AND AN ITEMIZED LIST OF RETAIL PRICES OF ALL ADDITIONS THAT ARE NOT INCLUDED IN BASE MODEL PRICE.

* *

Complete I-VI for manual wheelchairs
Complete I-VII for power wheelchairs

I. NEUROLOGICAL FACTORS
Indicate client's muscle tone: Hypertonic ❑ Absent ❑ Fluctuating ❑ Other ❑ *Describe client's muscle tone*:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:
Describe reflexes present:

II. POSTURAL CONTROL:

Head Control:	Good ❑	Fair ❑	Poor ❑	None ❑
Trunk Control:	Good ❑	Fair ❑	Poor ❑	None ❑
Upper Extremities:	Good ❑	Fair ❑	Poor ❑	None ❑
Lower Extremities:	Good ❑	Fair ❑	Poor ❑	None ❑

III. MEDICAL/SURGICAL HISTORY AND PLANS:

Is there history of decubitis/skin breakdown? Yes ❑ No ❑

If yes, please explain:

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures; degree of spinal curvature):

Describe other physical limitations or concerns (i.e., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

If surgery is anticipated, please indicate the procedure and expected date:

IV. FUNCTIONAL ASSESSMENT:

Ambulatory Status: Nonambulatory ❑ With assistance ❑

Short distances only ❑ Community ambulatory ❑

Indicate the client's ambulation potential:

expected within 1 year ❑ not expected ❑ expected in future within ___ years ❑

Wheelchair Ambulation:

Is client totally dependent upon wheelchair? Yes ❑ No ❑

If no, please explain:

Indicate the client's transfer capabilities:				
	maximum assistance	❑	moderate assistance	❑
	minimum assistance	❑	independent	❑
Feeding:	maximum assistance	❑	moderate assistance	❑
	minimum assistance	❑	independent	❑
Is the client tube fed?	Yes ❑	No ❑		
If yes, please explain:				
Dressing:	maximum assistance	❑	moderate assistance	❑
	minimum assistance	❑	independent	❑
Describe other activities performed while in wheelchair:				
V. ENVIRONMENTAL ASSESSMENT				
Describe where client resides:				
Is the home accessible to the wheelchair?	Yes ❑	No ❑		
Are ramps available in the home setting?	Yes ❑	No ❑		
Describe the client's educational/vocational setting:				
Is the school accessible to the wheelchair?	Yes ❑	No ❑		
Are there ramps available in the school setting?	Yes ❑	No ❑		
If client is in school, has a school therapist been involved in the assessment?	Yes ❑	No ❑		
Name of school therapist: Name of school:	School therapist's phone #:			
Describe how the wheelchair will be transported:				

Describe where the wheelchair will be stored? *(home and/or school)*	
Describe other types of equipment that will interface with the wheelchair?	
VI. REQUESTED EQUIPMENT:	
Describe client's current seating system, including the mobility base:	
Describe why current seating system is not meeting client's needs:	
Describe the equipment requested:	
Describe the medical necessity for mobility base requested:	
Describe the medical necessity for the seating system requested:	
Describe the growth potential of equipment requested in number of years: _____	
Describe any anticipated modifications/changes to the equipment within the next three years:	
Therapist's name: (print or type)	Therapist's signature:
Therapist's title:	Date:
Therapist's phone number: (_____) _____	
Therapist's employer *(name)*:	Therapist's address: *(work or employer address)*

VII. POWER WHEELCHAIRS: ***(Complete if a power wheelchair is being requested)***	
Describe the medical necessity for power vs. manual wheelchair: *(Justify any accessories such as power tilt or recline)*	
Is client unable to operate a manual chair even when adapted? Yes ❑ No ❑	
Is self propulsion possible but activity is extremely labored? Yes ❑ No ❑ *If yes, please explain:*	
Is self propulsion possible but contrary to treatment regimen? Yes ❑ No ❑ *If yes, please explain:*	
How will the power wheelchair be operated? *(hand, chin, etc.)*	
Is the client physically and mentally capable of operating power wheelchair safely and with respect to others? Yes ❑ No ❑	
Is the caregiver capable of caring for power wheelchair and understanding how it operates? Yes ❑ No ❑	
How will training for the power equipment be accomplished?	
Therapist's name: (print or type)	Therapist's signature:
Therapist's title:	Date:
Therapist's phone number: (_____) _____	
Therapist's employer: *(name)*	Therapist's address: *(work or employer address)*

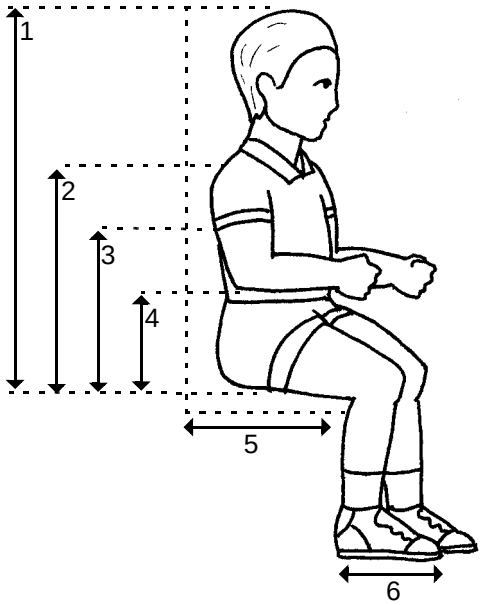
4.22.1.5 CSHCN Measuring Worksheet

CLIENT'S NAME:_____ CLIENT'S CSHCN#: _____

DATE OF BIRTH:_____ HEIGHT: _____ WEIGHT: _____

DATE WHEN MEASURED: _____ MEASURER'S NAME: _____

MEASURER'S PHONE #:_____



1. _____ 1. Top of head to bottom of buttocks
2. _____ 2. Top of shoulder to bottom of buttocks
3. _____ 3. Arm pit to bottom of buttocks
4. _____ 4. Elbow to bottom of buttocks
5. _____ 5. Back of buttocks to back of knee
6. _____ 6. Foot length
7. _____ 7. Head width
8. _____ 8. Shoulder width
9. _____ 9. Arm pit to arm pit
10. _____ 10. Hip width
11. _____ 11. Distance to bottom of left leg (popliteal to heel)
12. _____ 12. Distance to bottom of right leg (popliteal to heel)

ADDITIONAL COMMENTS: _____

_____

_____

_____

_____

_____

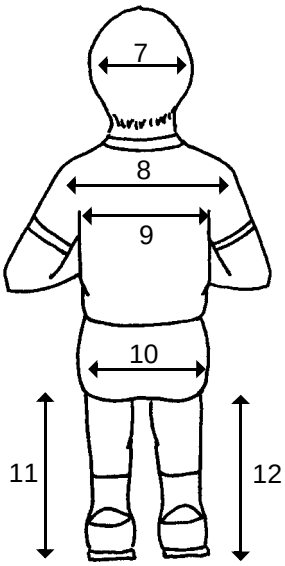
_____

_____

_____

_____

_____



SECTION

5

Expendable Medical Supplies

5.1 Enrollment 5-1
5.2 Reimbursement 5-1
5.3 Benefits and Limitations 5-1
5.3.1 Examples of Covered Supplies 5-1
5.3.2 Diapers 5-2
5.4 Authorization Requirements 5-2
5.5 Claims Information 5-3
5.5.1 Expendable Medical Supplies HCFA-1500 Claim Form Instructions 5-3

5.1 Enrollment

Providers of expendable medical supplies must be enrolled and active in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

5.2 Reimbursement

Expendable medical supplies are reimbursed based on the lower of the billed amount or amount allowed by Centers for Medicare and Medicaid Services (CMS), if available, or by Texas Medicaid. Supplies are reimbursed using the HCPCS or Medicaid local codes.

To be reimbursed, CSHCN requires the provider to submit an itemized claim form for the supplies provided.

5.3 Benefits and Limitations

CSHCN provides coverage for expendable medical supplies for eligible clients. A medical supply is defined as an item necessary to carry out a medical procedure or to maintain the client's optimal level of health **at home**. Most medical supplies are "expendable," meaning not reusable and will be discarded after use.

Supplies are only covered for those clients residing at home.

5.3.1 Examples of Covered Supplies

The following categories of medical supplies are covered by CSHCN; this list is not all-inclusive:

- **Respiratory care supplies**, such as tubing, suction catheters, oxygen masks, nasal cannulas, supplies for cleansing respiratory equipment, etc.
- **Ostomy and Catheterization supplies**, such as pouches, wafers, cleaning solutions, tape, syringes, skin disinfectants, catheters, etc.
- **Feeding supplies**, such as feeding bags for pumps, tubing, nasogastric tubes, etc. (Enteral feeding pumps are considered DME.)
- **Dressings**, such as tape, bandages, masks, eye patches, ace wraps, etc.
- **Diabetic care**, such as testing supplies, lancets, etc. (Glucose monitors are considered DME.)
- **Incontinence supplies**, such as urinary catheters, gloves, lubricants, skin disinfectants, etc. Diapers can be authorized only for those eligible clients who are 4 years old or older and who are incontinent as a direct complication of their medical condition. Diapers require authorization (refer to “Diapers” on page 5-2).
- **Miscellaneous supplies** used in treatment of a medical condition.

Articles of daily living are not a CSHCN benefit.

5.3.2 Diapers

A statement of medical necessity must be on file with NHIC for reimbursement of diapers. See “CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services” on page 5-7. Diapers may be approved for clients who are 4 years old or older, with the following diagnoses:

ICD-9-CM Diagnosis Codes					
04200	34300–34390	43822	59100	75320	75679
13800	34400–34409	43830	59800–59890	75321	76740
18800–18990	34410	43831	59910	75322	80500–80590
19100–19290	34461	43832	74100–74190	75323	80600–80650
22500–22590	34481–34489	43840	74200	75329	95200–95219
23770	34500–34590	43841	74220	75350	
25520	35900	43842	74230	75360	
33130–33140	35910	43850–43853	74240	75370	
33320	43600	43881–43882	74251–74259	75380	
33370	43820	43889	75110–75150	75670	
33600	43821	43890	75270	75671	

If diapers are required for a client whose diagnosis is not listed above, requests will be considered after review of documentation of medical necessity.

Providers should use the following procedure codes when submitting claims and/or requests for authorization for diapers:

Procedure Code	Description
5108X	Small diaper
5109X	Medium diaper
5110X	Large diaper
5111X	Extra large diaper
5112X	Small pull-up
5113X	Medium pull-up

5.4 Authorization Requirements

Diapers require authorization. Diapers can be authorized only for those clients who are four years of age and older and who are incontinent as a direct complication of their medical condition. An annual authorization request form must be submitted by the vendor and signed by the client's physician.

Other expendable medical supplies do not require authorization.

Refer to: "CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services" on page 5-7.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submissions.

5.5 Claims Information

Expendable medical supplies must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

5.5.1 Expendable Medical Supplies HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident-related, indicate the date of injury or the accident.

Block No.	Description	Guidelines
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech-language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.

Block No.	Description	Guidelines
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alpha-numeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

5.5.1.1 Expendable Medical Supplies HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): May, Sharon P.

3. PATIENT'S BIRTH DATE MM DD YY: 08 12 95 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1500 Sansin Court

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Austin STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 75067 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jim Smith, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 042 . 00
2. 138 00
3. _____ . _____
4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	2	9	5110X				48	00	120				
2																			
3																			
4																			
5																			
6																			

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 48 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Signature on File

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Super X Drugstore
104 South Main
Austin, TX 75067

512-555-1234

PIN# GRP# 987654321

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
EXPENDABLE MEDICAL SUPPLIES FORM OWCP - 1500 FORM RRB - 1500

5.5.1.2 CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6524 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First name:	**Last name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / ZIP:		

Product Information:

CSHCN may approve diapers for a client if the client is incontinent, is over 4 years of age, and has a CSHCN diagnosis approved for diapers. See the *CSHCN Provider Manual* for a list of diagnoses. CSHCN does not require a Medical Necessity Form for medical nutritional products for clients with the diagnosis of cancer, cystic fibrosis, HIV, phenylketonuria, Crohn's disease, infantile cerebral palsy, or spastic hemiplegia. For products, refer to the Medical Nutritional Products and Services section of this manual.

This medical necessity form is for: ❑ Diapers / pull-ups / briefs Height _____
❑ Medical nutritional products Weight _____

Procedure code / Number of diapers needed per month:	
Procedure code / Name of medical nutritional products:	
Number of cans needed per month:	**Can Size:**
Liquid concentrate ❑ **Liquid (ready-to-feed)** ❑ **Powder** ❑ **Other** ❑	

Nutrition Counseling and Assessment Information:

To request prior authorization for: ❑ More than 2 nutrition assessments per calendar year, or
❑ More than 4 nutrition counseling visits per calendar year

Check the appropriate box above, and document medical necessity below.

Attending Physician / Dietitian Information:

Printed or typed name:	
Address / City / ZIP of physician:	**Dietitian:**
Phone number of physician:	**Dietitian:**
Fax number of physician:	**Dietitian:**
Physician's signature: X	**Date:**
Dietitian's signature: X	**Date:**

This form is valid for 12 months from the date signed.

SECTION

6

Freestanding Surgical Center

6.2 Reimbursement 6-1
6.3 Benefits and Limitations 6-1
6.4 Authorization Requirements 6-2
6.5 Claims Information 6-3
6.5.1 Freestanding Surgical Center HCFA-1500 Claim Form Instructions 6-3

6.1 Enrollment

To enroll in the CSHCN Services Program, a freestanding surgical center must be enrolled in Medicaid, have a valid Provider Agreement with CSHCN, and have completed the CSHCN enrollment process. The freestanding surgical center must meet and comply with all applicable state laws.

Refer to: "Provider Enrollment" on page 1-17 of the General section for more detailed information regarding CSHCN provider enrollment procedures.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88).

Refer to: "CLIA Requirements" on page 1-18 for more information about CLIA.

6.2 Reimbursement

CSHCN provides coverage for services performed in connection with or directly related to surgical procedures performed in the freestanding surgical center and approved by CSHCN. Physician services performed in a freestanding surgical center must be billed by the physician and are reimbursed separately.

Reimbursement for freestanding surgical center procedures is based on the Centers for Medicare and Medicaid Services (CMS)-approved Ambulatory Surgical Code Groupings (1-9 per Centers for Medicare and Medicaid Services [CMS] and group 10 per TDH) payment schedule. Approved procedures are listed by body system and payment group with applicable HCPCS codes noted.

6.3 Benefits and Limitations

All facility services in a freestanding surgical center and provided in conjunction with the surgery (for example, lab, radiology, anesthesia) are considered part of the inclusive charge and must not be itemized or billed separately.

Only those procedures specified on the Centers for Medicare and Medicaid Services (CMS)-approved list and selected TDH CSHCN procedures are payable to a freestanding surgical center.

6.4 Authorization Requirements

1) To be considered for payment, all surgeries performed in a freestanding surgical center must be authorized. Certain procedures require **prior** authorization. See "NHIC-CSHCN Authorization Requirements" on page 1-15 for more information. **In addition to requiring prior authorization, some services require that both the physician and facility be approved by TDH-CSHCN as a specialty team/center provider.**
2) Authorization is a condition for reimbursement; it is not a guarantee of payment. It is the responsibility of each provider to verify client eligibility. **Services provided to a client not eligible for services or provided beyond the limitations of the CSHCN Program are not reimbursed.**
3) Authorization requests for services requiring authorization (not **prior** authorization) must be received by NHIC within the 90-day authorization deadline. This 90-day deadline is for all services requiring authorization (not **prior** authorization), including extensions and emergency situations. The surgery authorization request form can be found at "CSHCN Surgery Authorization Request Form" on page 6-7.

Important
For a list of approved procedures, the freestanding surgical center may contact NHIC-CSHCN Customer Service at 800-568-2413 or 512-514-3000.

Authorization requests received more than 90 days after the date of service are denied.

Authorization will not be given if the client is not CSHCN eligible when the request is received by NHIC-CSHCN. The client must not be eligible for Medicaid. All claims must meet the 90-day filing deadline.

The following requirements must be met for services to be authorized:

- Clients must be 24 months of age or older
- Providers must be designated as American Society of Anesthesiologists (ASA) Level I or II
  - ASA I/P1 Normal healthy patient
  - ASA II/P2 Patient with mild systemic disease
- Patient physical statuses P3, P4, P5, or P6 do **not** allow services to be authorized in a freestanding surgical center:
  - ASA III/P3 Patient with severe systemic disease
  - ASA IV/P4 Patient with severe systemic disease that is a constant threat to life
  - ASA V/P5 Moribund patient who is not expected to survive without the operation
  - ASA VI/P6 Declared brain-dead patient whose organs will be removed for donor purposes
- Documentation of the client's physical status must be on the authorization request form.
- Requests must include the surgeon and/or attending physician's name on the authorization request form. The physician must be enrolled in the CSHCN Program for services to be authorized.
- Requests for authorization and all other applicable documentation must be received by NHIC within the deadline. Mail or fax requests to the following address:

NHIC-CSHCN Authorization Department
12545 Riata Vista Circle
Austin TX 78727-6524
FAX: 512-514-4222

Refer to: The "CSHCN Surgery Authorization Request Form" on page 6-7.

- CSHCN does not authorize procedures when the CSHCN client is eligible for Medicaid. If Medicaid requires the service or procedure to be authorized, requests for services for clients eligible for Medicaid must be sent to the Texas Medicaid Program.

In addition to requiring prior authorization, some services require that both physicians and facilities be approved by TDH-CSHCN as a specialty team/center provider.

Refer to: "Provider Enrollment" on page 1-17 for enrollment procedures on becoming an approved specialty team/center provider.

- For bone marrow/stem cell transplant services, both the physician and the facility must be specialty team/center approved.

- For cleft/craniofacial surgical procedures, only the physician/dentist must be specialty team approved.
- **If specialty team/center requirements are not met, all services related to the surgery will be denied.**

Refer to: "Services Requiring Physician Prior Authorization" on page 13-61 for more information and a list of specific procedure codes requiring this special designation.

6.5 Claims Information

Freestanding surgical center services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1500 Claim Form. Providers may purchase HCFA-1500 Claim Forms from the vendor of their choice; they are not supplied by NHIC. See "Claims Filing Instructions" on page 1-50 for more information on electronic claims submission.

6.5.1 Freestanding Surgical Center HCFA-1500 Claim Form Instructions

Instructions for correct claims completion are provided below. Blocks not referenced are not required for processing by NHIC and may be left blank.

The following instructions describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no.	Enter the patient's nine-digit CSHCN client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. **Hospital to Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. Refer to "Verbal Denials" on page 1-35 for more information on verbal denials and the 110-day rule. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of current illness or injury	If the services provided are accident-related, indicate the date of injury or the accident.

Block No.	Description	Guidelines
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and zip code and/or the TPI (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN. Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech-language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician.
19	Reserved for Local Use	
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate – Anesthesiologists use "AA," "AD," "QJ," "QO," or "QQ." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).

Block No.	Description	Guidelines
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alpha-numeric characters (up to 15) in this block are referenced on the Remittance and Status (*R and S*) Report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and zip code, or the TPI of the facility where the service was provided. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, zip code, and telephone number	Affix one of the preprinted labels to this block. In lieu of the label, enter the CSHCN TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or by calling 800-568-2413 or 512-514-3000.

6.5.1.1 Freestanding Surgical Center HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Reddig, Sarah J.

3. PATIENT'S BIRTH DATE MM DD YY: 08 12 97 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 901 East Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Del Rio STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 78840 TELEPHONE (INCLUDE AREA CODE): 123-555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Charles Sotos, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 9876543-21

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 162 . 90 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 123456789

	24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	5	F	31625			1	400	00					
2																			
3																			

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 400 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Raquel Del Sol

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Del Rio Surgery Center
345 Morning Star
San Antonio, TX 77777

PIN# GRP# 1234567-89

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
SURGERY FORM OWCP - 1500 FORM RRB - 1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

6.5.1.2 CSHCN Surgery Authorization Request Form

CSHCN Surgery Authorization Request Form

Submit to CSHCN Authorization Department, 12545 Riata Vista Circle, Austin, TX 78727 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, option 2#.

Client Information:

First name:	**Last Name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / Zip:		

Procedure Information:

Surgical Procedure(s) Requested (CPT Codes):	
Anticipated Date of Surgery:	
Facility Name / CSHCN TPI:	
Inpatient Surgery? ❑Yes ❑No	**Outpatient Surgery?** ❑Yes ❑No
Surgeon Name / CSHCN TPI:	

Freestanding Surgical Center Information:

If freestanding surgical center, indicate patient's physical status (ASA level) below:

_____ASA I / P1 NORMAL HEALTHY PATIENT
_____ASA II / P2 PATIENT WITH MILD SYSTEMIC DISEASE

Please note: If the patient's physical status is P3, P4, P5, or P6 services may not be authorized in a freestanding surgical center (see descriptions below).

ASA III / P3.....PATIENT WITH SEVERE SYSTEMIC DISEASE

ASA IV / P4.....PATIENT WITH SEVERE SYSTEMIC DISEASE THAT IS A CONSTANT THREAT TO LIFE

ASA V / P5.....MORIBUND PATIENT WHO IS NOT EXPECTED TO SURVIVE WITHOUT THE OPERATION

ASA VI / P6.....DECLARED BRAIN-DEAD PATIENT WHOSE ORGANS ARE BEING REMOVED FOR DONOR PURPOSES

Other Insurance Info: (check each that apply)	❑None ❑Yes	If Yes: ❑Private ❑Medicare ❑Medicaid

Please include additional information as applicable (documentation for procedures, medical necessity, etc.). For the procedures rhizotomy, craniectomy for anterior temporal lobectomy, and bone marrow / stem cell transplant, see the provider manual for specific criteria needed to accompany the request for each of these.

Signature of Provider:	**Date:**
Print or Type Provider Name:	**Phone Number:**
Provider Address / City / Zip:	**FAX Number:**
CSHCN TPI:	**Contact Name:**

SECTION

7

Home Health (Skilled Nursing) Care

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7.1 Enrollment

Home health agencies providing skilled nursing services must be actively enrolled in the Texas Medicaid Program, have a valid provider agreement with CSHCN, have completed the CSHCN enrollment process, be a licensed and certified Home and Community Services Support agency (HCSSA), and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

7.2 Reimbursement

Skilled Nursing Care is reimbursed according to a maximum allowable fee schedule. Use the following procedure codes when submitting requests for authorization and/or claims:

Procedure Code	Description
100NV	Home Health, RN nurse visit, per hour
200NV	Home Health, LVN nurse visit, per hour

7.3 Benefits and Limitations

The CSHCN Services Program provides coverage for skilled nursing services in the home when provided by a CSHCN enrolled HCSSA.

For reimbursement by CSHCN, skilled nursing services must meet the following conditions:

- Services must be provided by a CSHCN enrolled HCSSA
- A physician must prescribe services
- Services must be medically necessary and appropriate
- A Registered or Licensed Vocational Nurse must provide services

- Services are provided according to an established Plan of Care
- Services are authorized

7.4 Authorization Requirements

Requests for skilled nursing hours must be submitted in writing to NHIC using the CSHCN Home Health Plan of Care (refer to "CSHCN Home Health Plan of Care" on page 7-10) within 90 days of the date of service.

Skilled nursing services are authorized and reimbursed by the hour. The number of skilled nursing hours that can be authorized/reimbursed is limited to 200 hours per calendar year per client. An additional 200 hours of service per client per calendar year may be authorized with documented justification of medical necessity. Skilled nursing can include, but is not limited to, the following:

- Periodic nursing assessment of a client
- Skilled nursing visits for administration of medications including IV therapy
- Skilled nursing visits for acute illness, surgery, and/or transition to the home
- Education of the primary caregiver and the client about the disease/illness process and the skills needed to care for the client's medical needs
- Medical treatments that require the skills of a licensed nurse

Skilled nursing services intended for respite or child care are not a benefit.

CSHCN covers other services, therapies, supplies, and equipment that may be provided in the home. See each specific chapter for guidelines.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submissions.

Nursing services will not be reimbursed if provided in conjuction with the administration of total parenteral nutrition (TPN)/hyperalimentation. The reimbursement for this service is an all-inclusive fee.

Skilled nursing to provide blood or blood products in the home is not a benefit.

7.5 Claims Information

Home Health services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1450 (UB-92) claim form. Providers may purchase HCFA-1450 (UB-92) claim forms from the vendor of their choice; NHIC does not supply the forms.

Services and/or supplies that exceed the 27 items per page limitation must be submitted on separate HCFA-1450 (UB-92) claim forms.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

7.5.1 Home Health HCFA-1450 (UB-92) Claim Form Instructions

The instructions describe what information must be entered in each of the block numbers of the HCFA-1450 (UB-92) Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1	Provider name, address, and telephone number	Enter the hospital name, street, city, state, ZIP code, and telephone number. Preprinted labels may be requested by writing NHIC Provider Enrollment.
3	Patient control number	Optional: any alphanumeric character (limit 16) entered in this block will be referenced on the *R&S*.
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 331 Home health agency* * Use TOB 331 only. All other TOBs are invalid and will deny.	Enter the three-digit type of bill (TOB) code 1st Digit - Type of Facility 1 Hospital 3 Home health agency 7 Clinic (RHC, FQHC) 2nd Digit - Bill Classification 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and x-rays) 3rd Digit - Frequency 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim - first claim 3 Interim - continuing claim 4 Interim - last claim 5 Late charge(s) only claim
6	Statement covers period	For inpatient and home health claims, enter the beginning and ending dates of service billed. For inpatient claims, this is usually the dates of admission and discharge.
7	Covered days	For inpatient claims, enter the total days represented on this claim that are to be covered. Usually this is the difference between the admission and discharge dates. In all circumstances the number in this block will be equal to the number of covered accommodation days listed in block 46.
8	Noncovered days	For inpatient claims, enter the total days represented on this claim that are not covered. The sum of blocks 7 and 8 must equal the total days billed as reflected in block 6.
12	Patient name	Enter the patient's last name, first name, and middle initial.
13	Patient address	Enter the patient's complete address as described (street, city, state, and ZIP code).
14	Patient birth date	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born.
15	Patient sex	Indicate the patient's sex by entering an "M" or "F."
17	Admission date	Enter numerically the date (MM/DD/YY) of admission for inpatient claims; date of service for outpatient claims; start of care (SOC) for home health claims.
18	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for nonpatients (TOB 141) or home health claims (TOB 331).
19	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in block 20.)

Block No.	Description	Guidelines
20	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3: 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
21	Discharge hour (required field)	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 20 Expired or did not recover 30 Still patient
23	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
24-30	Condition codes	Enter the two-digit condition code "05" and date the legal claim was filed for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient if this condition is applicable to the claim.
32ab-35ab	Occurrence codes and dates	Enter the appropriate code(s) and date(s). Blocks 54, 61, 62, and 84 must also be completed as required.
36	Occurrence span codes and dates	For inpatient claims, enter code "82" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39	Value codes	Accident Hour – For inpatient claims, if the patient was admitted as the result of an accident, enter the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.

Block No.	Description	Guidelines
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations first in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is to be used for the accommodation rate. a. Revenue code "001" is for the total charge and must be the last revenue code on the list. **Exception: Electronic billers must not use revenue code "001." Use of this code will cause the claim billed amount to be doubled. Electronic billers should not put a code in this block.** b. **Radiology** – Professional services by a physician must be billed separately by the physician. c. **Laboratory** – If laboratory work is sent out, the name and address or nine-digit Medicaid TPI of the laboratory where the work was forwarded must be entered. d. **Anesthesia** – Professional services by a physician or CRNA must be billed separately by the physician or CRNA. e. **Medical/Surgical Supplies** – Itemize these services provided in the inpatient facility (such as infusion pumps, traction setups, and crutches for inpatient use only). If provided to all admitted patients, admission kits should be billed using revenue code "270." f. Charges for fetal monitoring must be billed using revenue code "732."
44	HCPCS/rates	Inpatient: Enter the accommodation rate per day. Enter the date of service numerically (MM/DD/YY) for each service rendered along with the block number of the diagnoses listed in blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and/or supply must be itemized on the claim form. Outpatient: Outpatient claims must have the appropriate HCPCS code or narrative description. **Do not use revenue codes for billing these services.** Enter the date of service numerically, and the block number of the diagnosis listed in blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, identify the primary diagnosis. Each service except for medical/surgical and IV supplies and medication must be itemized on the claim or an attached statement. For example: a. **Emergency Room** – Bill as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 pm). Indicate other times on the same line as the procedure code. b. **Operating Room** – Bill as "Operating Room." c. **Recovery Room** – Bill as "Recovery Room" or "Cast Room" as appropriate. d. **Injections** – Must have "Inj. – name, strength, quantity" or the injection code. e. **Drugs** and **Supplies** – Take-home drugs and supplies are not a benefit of the CSHCN Program. Drugs administered in the outpatient setting must be billed with the modifier "SH." The drug description must include the name, strength, and quantity. f. **Radiology** – The description should provide the location and the number of views. As an alternative, identify the HCPCS code. Professional services by a physician must be billed separately by the physician. The license number of the ordering physician must be in block 83.

Block No.	Description	Guidelines
		g. **Laboratory** – Provide a complete description or use the procedure codes for the laboratory procedures. Professional services by a physician must be billed separately by the physician. The license number of the ordering physician must be in block 83. If laboratory work is sent out, the name of the test and the name and address or Medicaid number of the laboratory where the work was forwarded must be entered. h. **Nuclear Medicine** – Provide a complete description. i. **Day Surgery** – Day surgery should be billed as an inclusive charge. Services provided in conjunction with the surgery (lab, radiology, anesthesia) should not be billed separately. **NOTE:** The UB-92 Claim Form is limited to 27 items per outpatient claim. If necessary, IV supplies (Y7112) and central supplies (Y7107) may be combined on the charge detail and considered as single items with the appropriate quantities and total charges.
45	Service date	Enter the date of service numerically corresponding to each procedure for outpatient claims.
46	Units of service	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in block 46 should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
51	TPI	Enter the nine-digit TPI.
54	Prior payments	Enter amounts paid by any TPR and complete blocks 32, 61, 62, and 84 as required.
58	Insured's Name	If other health insurance is involved, enter the insured's name.
60	CSHCN identification number	Enter the patient's nine-digit CSHCN number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number (PAN) for home health services, freestanding psychiatric facilities, freestanding rehabilitation facilities, and for surgery if one was issued.
65	Employer name	Enter the name of the client's employer if health care might be provided. Complete block 66.
66	Employer location	Enter the complete address if an employer name is identified in block 65.
67	Principal diagnosis code	Enter the ICD-9-CM diagnosis code for the principal diagnosis to the highest level of specificity available.
68-75	Other diagnosis codes	Enter the ICD-9-CM diagnosis code to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block.
76	Admitting diagnosis	Enter the ICD-9-CM diagnosis code in block E indicating the cause of admission or include narrative.
79	Procedure coding method	Enter code "5" for HCPCS or code "9" for ICD-9-CM. Code "9" is used only on inpatient hospital billings.
80-81 a,b,c,d,e	Principal and other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date each was performed.

Block No.	Description	Guidelines
82	Attending physician ID	For inpatient claims, enter the physician's license number or UPIN of the provider who performed the service or is responsible for the treatment and plan of care in the following format: 11233333 1 = Two-digit state indicator (for example, TX for Texas) 2 = Licensing board indicator examples B = MD or DO D = Dentist P = Podiatrist 3 = License number Example: TXBL1234 If the provider has a temporary license number, enter "TEMPO." Example: TXBTEMPO
83 a,b	Other physician ID	For inpatient claims, enter the license number for the provider who performed the principle surgical procedure. If the same as block 83, state "SAME." For outpatient claims, enter the license number for the following: The ordering physician for all laboratory and radiology services (If a different physician ordered laboratory or radiology services, enter his license number in block 82.) If the referring physician is a resident, blocks 82 and 83 must identify the physician who is supervising the resident.
84	Remarks	This block is used to explain special situations such as the following: The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. If a patient stays beyond dismissal time, indicate the medical reason if any additional charge is made. If billing for a private room, the medical necessity must be indicated and signed by the physician. If services are the result of an accident the cause and location of the accident must be entered in this block. The time must be entered in block 39. If laboratory work is sent out, the name and address or the TPI of the facility where the work was forwarded must be entered in this field. If the patient is deceased, enter the date of death. If services were rendered on the date of death, enter the time of death. If the services were the result of a referral from a family planning provider, write "Family Planning Referral." If services were provided at another facility, indicate the name and address of the facility where the services were rendered. Enter the date of onset for patients receiving dialysis services.
85	Provider representative signature	The hospital representative must sign their name. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by a hospital representative authorizing this practice.
86	Date bill submitted	Enter the date the bill was signed.

7.5.2 Occurrence Codes

Code	Description	Guidelines
01	Auto accident/auto liability insurance involved	Enter the date of auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.
02	Auto or other accident/no-fault involved	Enter the date of an accident, including auto or other, where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.
03	Accident/TORT liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/employment-related	Enter the date of an accident which allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with workers' compensation insurance or an employer. Only services that are not covered by workers' compensation may be considered for payment by CSHCN.
05	Other accident	Enter the date of an accident not described by the above codes. Use this code to report that you have developed for other casualty related payors and have determined that there are none.
06	Crime victim	Enter the date on which a medical condition resulted from alleged criminal action.
24	Date other insurance denied	Enter the date of denial of coverage by a third party resource.
25	Date benefits terminated by primary payor	Enter the last date for which benefits are being claimed.
27	Date home health plan of treatment was established	Enter the date the current plan of treatment was established.
50	Date other insurance paid	Enter the date of payment from a third party resource.
51	Date claim filed with other insurance	Enter the date a claim was filed with a third party resource.

7.5.2.1 Home Health Skilled Nursing HCFA-1450 (UB-92) Claim Form Example

APPROVED OMB NO. 0938-0279

Home Nursing Services
2214 Health Care
Dallas, Texas 75235

2

3 PATIENT CONTROL NO.: 12345678

4 TYPE OR BILL: 331

5 FEDERAL TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7 COV.D. | 8 N-C.D. | 9 C-I.D. | 10 L-RD | 11

12 PATIENT NAME: Lake, William W.

13 PATIENT ADDRESS: 2200 Trape Lane | CITY: Harlingen | STATE: TX | ZIP: 78550

14 BIRTH DATE: 02141998 | 15 SEX: M | 16 MS | ADMISSION 17 DATE: 081501 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO.: 123456 | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 CODE	OCCURENCE DATE	33 CODE	OCCURENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURENCE DATE	36 CODE	OCCURENCE SPAN FROM	THROUGH	37 A B C
a											
b											

38

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

	42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		Skilled Nursing Visit, per hour, RN	1-100NV	060102	1	50 00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13			Total charges			50 00		
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	All Health Insurance						
B	CSHCN	123456789					
C							

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL.	60 CERT - SSN - -HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Lake, Susan K.	S	123456789	All Mart Corp.	G1234
B	Lake, William W.		123456789		
C					

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
123456789		All Mart Corp.	1200 Hwy. 6, Dallas, Texas 75474

67 PRIN.DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADMIN. DIAG. CD.	77 E-CODE	78
12345	V1234										

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID: TXBA1234

83 OTHER PHYS. ID: TXBN1234

OTHER PHYS. ID:

84 REMARKS

Dressing changes, post surgery

85 PROVIDER REPRESENTATIVE: X Dolores Jones

86 DATE: 06 10 02

UB - 92 HCFA - 1450
HHSNV

copy 1

I CERTIFY THAT THE CERTIFICATIONS IN THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

7.5.2.2 CSHCN Home Health Plan of Care

Submit to CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6524 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First name:	**Last name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / ZIP:		

Provider Information:

Provider name / TPI No:	
Phone number:	
Fax number:	
Contact person:	
Address / City / ZIP:	
Provider signature:	X

Requested Services:

Start of care date (mm / dd / yy):	**End of care date:**
Status: New ❑ Extension ❑ Revision ❑	
Skilled nursing hours (amount, frequency, duration):	
	(___ hours) / (___ times a ____) / (for ___ wks / months)
Total number of hours requested:	
If hours from a previous authorization were not used, please complete the following:	
Service dates affected:	
Original number of hours requested for the service dates:	
Actual number of hours used for these service dates:	
Reason hours were not used:	
RN name: **(print or type)**	**RN signature: X**
Date:	**Phone number:**

CSHCN Home Health Plan of Care (continued):

Client Information:

First name:	Last Name:	CSHCN #:

Physician Section:

The following information must be completed by a physician.

Recent health history:	
Brief statement of medical necessity for in-home skilled nursing services:	
Treatments:	
Medications (primary):	
Nutritional requirements:	
Safety or precautionary measures:	
Developmental / functional status:	
Prognosis:	
Name and Date last seen by a physician:	
Print or type name of physician:	**Date last seen:**
Progress summary:	
I conclude that the client requires care as requested on this referral and treatment plan for home health services.	
Physician's signature: X	
Date signed:	**Phone number:**

SECTION

8

Hospital

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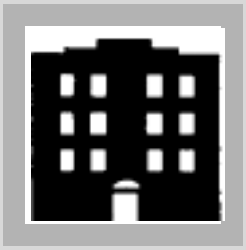

8.1 Enrollment

To enroll in the CSHCN Services Program, a hospital must be enrolled in Medicaid, have a valid Provider Agreement with CSHCN, and have completed the NHIC-CSHCN enrollment process.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88).

Refer to: For more information about CLIA, refer to "CLIA Requirements" on page 1-18.

8.1.1 Continuity of Hospital Eligibility through Change of Ownership

Under procedures set by TDH, a change in ownership of a hospital does not terminate Medicaid eligibility; therefore, CSHCN participation may be continued subject to the following requirements:

- Recertification as a Title XIX (Medicaid) hospital is obtained
- A new CSHCN agreement between the hospital under new ownership and CSHCN is obtained

8.1.2 Specialty Team / Center

In addition to requiring prior authorization, some services require that both physicians and facilities be approved by TDH-CSHCN as a specialty team / center provider.

Refer to: "Provider Enrollment" on page 1-17 for enrollment procedures on becoming an approved specialty team / center provider.

- For bone marrow / stem cell transplant services, the physician and the facility must be specialty team / center approved.
- For cleft / craniofacial surgical procedures, only the physician / dentist must be specialty team approved.
- **If the specialty team / center requirements are not met, all services related to the surgery are denied.**

Refer to: "Services Requiring Physician Prior Authorization" on page 13-61 for the list of specific procedure codes requiring this special designation.

8.2 Reimbursement

8.2.1 Inpatient

Inpatient hospital (including acute and / or rehabilitation services) stays are reimbursed at 80 percent of the rate equivalent to the hospital's Medicaid interim rate, which is based on a percentage of the Medicaid hospital's standard charges derived from the Medicaid hospital's most recent tentative or final Medicaid cost report settlement. CSHCN does not have a separate cost settlement process.

Hospitals are not required to submit itemized charge tickets with their HCFA-1450 (UB-92) Claim Form for inpatient stays. The itemized charges must be retained by the facility for a period of at least five years from the date of service.

8.2.2 Outpatient

Outpatient services are reimbursed at 80 percent of the rate equivalent to the hospital's Medicaid interim rate, which is based on a percentage of the Medicaid hospital's most recent tentative or final Medicaid cost report settlement.

8.2.3 Hospital-Based Ambulatory Surgical Center

All surgical procedures performed in a hospital-based ambulatory surgical center must be billed using the appropriate procedure code. If there is no procedure code in the Fee Schedule that will cover the services, use procedure code Y9999 and give a description of services. Day surgery payment represents a global payment. It is not appropriate to bill separately for any supplies or other services related to the surgery.

Reimbursement of day surgeries is based on the Centers for Medicare and Medicaid Services (CMS)-approved Ambulatory Surgical Code Groupings (1 through 9 per Centers for Medicare and Medicaid Services [CMS] and Group 10 per TDH) payment schedule. Providers are sent a list of these codes and payment categories after enrollment with the Texas Medicaid Program (a prerequisite to enrolling with CSHCN) and when periodic updates occur. The rates implemented by Medicaid on April 1, 1995 remain in effect. To acquire a list of procedures and their rates, contact NHIC-CSHCN Customer Service at 800-568-2413 or 512-514-3000.

8.2.4 Laboratory

All clinical laboratory services are reimbursed at 60 percent of the prevailing charge except for those hospitals identified by Medicare as “sole community” hospitals. These hospitals are reimbursed at 62 percent of the prevailing charge for clinical laboratory services provided to hospital outpatients and at 60 percent for hospital nonpatients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory.

8.2.5 Radiology

Outpatient radiology procedures are reimbursed at 80 percent of the rate equivalent to the hospital’s Medicaid interim rate, which is based on a percentage of the Medicaid hospital’s most recent tentative or final Medicaid cost report settlement.

8.3 Benefits and Limitations

Inpatient hospital services include medically necessary items and services ordinarily furnished by a CSHCN enrolled hospital or by an approved, enrolled out-of-state hospital. Effective for dates of service on or after October 11, 2001, inpatient hospital care will be limited to 60 days per calendar year. Bone marrow and stem cell transplant clients may receive an additional 60 days. Hospital services must be medically necessary, prior authorized, and are subject to the utilization review requirements of the CSHCN Program. Inpatient hospital services are reimbursed up to a total of sixty days per year, which may accrue intermittently or consecutively.

Emergency admissions are not required to be prior authorized, but authorization must be requested the next working day after the admission date for coverage of the entire stay. Emergency admissions are defined as those that are medically necessary for the same day admission from the emergency room or from a provider’s office or clinic. If authorization for the emergency admission is not requested, the CSHCN Program will pay only for the emergency care and stabilization services in the first 24 hours. If an authorization request is made later than the next business day and is approved, only the emergency care and stabilization services in the first 24 hours, the day of the authorization request and subsequent days that are approved will be paid.

Inpatient hospitalizations for behavioral health conditions are limited to a maximum of 5 days per calendar year. No extensions are granted.

Inpatient hospital services include the following items and services:

- Room and board in semi-private 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 are reimbursed up to the hospital’s charge for the most prevalent semi-private accommodations. Private accommodations are not subject to the semi-private rate if 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 reasonable and necessary for the treatment of illness or injury provided they are available without cost.
- All medically necessary ancillary services/supplies ordered by a physician.

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

8.3.1 Authorization

All inpatient admissions must be **prior** authorized. Friday and weekend admissions should not occur unless an emergency exists. The Inpatient Admission Authorization Request Form must be completed and submitted to the CSHCN claims contractor with the written request. **Emergency** admissions are not required to be prior authorized, but must be requested by the next working day after the admission date for coverage of the entire stay. Emergency admissions are defined as those that are medically necessary for the same day admission from the emergency room or from a provider's office or clinic. If authorization for the emergency admission is not requested, CSHCN will only cover the emergency care and stabilization services in the first 24 hours. If an authorization request is made later than the next business day following admission and is approved, the day the authorization request was received and subsequent days that were approved will be paid.

If prior authorization for a **nonemergency** inpatient admission is not requested and approved before the admission; and if a request for authorization is made subsequently and approved, then only the day the authorization request was received and subsequent days that were approved will be paid.

Program authorization is not an absolute guarantee of payment. **Authorization is a condition for reimbursement; it is not a guarantee of payment**. Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

Important
All inpatient admissions must be prior authorized.

It is the responsibility of each provider to verify client eligibility. Any service provided while the client is not eligible, or services provided beyond the limitations of the CSHCN Program, cannot be reimbursed.

Some procedures require prior authorization and specialty team/center approval.

Important
Authorization or prior authorization will not be given if the client is not eligible for CSHCN when the request is received by NHIC-CSHCN. All claims for these services must meet the 90-day filing deadline.

Authorization and prior authorization requests must include the surgeon's and/or attending physician's name on the authorization request form. These physicians must be enrolled in the CSHCN Program.

When requesting an extension that will include a surgical procedure, document the surgical procedure as part of the medical necessity for the extension.

Include all supporting documentation showing medical necessity for the extended inpatient stay.

The "CSHCN Inpatient Admission Authorization Request Form" on page 8-40 must be completed and submitted with your written request. All applicable information must accompany the request documenting the medical necessity for the inpatient admission and each extension.

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

NHIC-CSHCN Authorization Department
12545 Riata Vista Circle
Austin TX 78727-6524
FAX: 512-514-4222

8.3.2 Inpatient Rehabilitation Services

8.3.2.1 Benefits/Limitations

CSHCN may reimburse inpatient rehabilitation services when the client is:

- Over 4 years of age and sufficiently alert to respond to interventions and to participate with the rehabilitation team in setting own treatment goals as well as being an active participant in therapeutic activities, **or**
- Less than 4 years of age, sufficiently alert to respond to interventions and to participate with the rehabilitation team. Parent(s) or caregiver(s) actively participate in setting treatment goals and learning therapeutic management.

In addition, at least one of the following criteria must be met 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, **or**
- There is no documentation of previous inpatient comprehensive rehabilitation effort, **or**
- The client experiences a loss of previous level of functional independence through complications or recurrent illness and 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
- Post polio
- Neoplasms
- Head injuries
- Late effects of infections i.e., Guillain Barre Syndrome
- Cerebrovascular diseases

Congenital conditions e.g., spina bifida and cerebral palsy, may be considered when there has been a recent change in medical and functional status e.g., post spinal surgery.

8.3.2.2 Authorization Requirements

Prior authorization is required for inpatient rehabilitation services. A maximum of 90 days inpatient rehabilitation may be prior authorized per calendar year. Requests must be submitted in writing with documentation of medical necessity including the diagnosis and/or condition of the client, and a treatment plan. The Inpatient Rehabilitation Admission Prior Authorization Request Form on pages 8-39 and 8-40 must be submitted for the initial request and each extension. Include all supporting documentation showing medical necessity for the extended inpatient stay.

The inpatient rehabilitation program must include medical management, two or more therapies (e.g., respiratory therapy, speech language pathology services, physical therapy, occupational therapy), and rehabilitation nursing.

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.

The inpatient rehabilitation provider must be approved by CSHCN as an Inpatient Rehabilitation Facility/Unit before a prior authorization may be approved.

Prior authorization may be approved in 14 day increments, not to exceed 90 days per calendar year, and the CSHCN Inpatient Rehabilitation Prior Admission Authorization Request Form must document medical necessity for inpatient rehabilitation services. All requests must include anticipated goals (initial request) and progress towards goals (request for additional days).

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 day previously prior authorized.

Requests for extensions will not be approved if:

1) The client has met treatment goals as determined by the rehabilitation team and/or the CSHCN Medical Director or designee; **or**

2) The client has failed to make progress toward remaining treatment goals during the currently authorized period; **or**
3) The client no longer requires inpatient rehabilitation and therapeutic goals can be met on an outpatient basis; **or**
4) The request was received after the last inpatient day prior authorized; **or**
5) The 90-day calendar maximum has been exhausted.

8.3.2.3 Exceptions

Acute Medical Episodes:

If a client develops an acute medical condition during his or her inpatient rehabilitation admission that prevents his or her participation in program activities, CSHCN should not be billed for inpatient rehabilitation services. Acute care, inpatient or outpatient, that is covered by CSHCN may require authorization and must be billed as acute care services.

8.4 Day Surgery

Claims for scheduled outpatient day surgeries must be filed using type of bill (TOB) 131 for outpatient hospitals and the hospital's ambulatory surgical center TPI. When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. Surgical procedures performed in the hospital's outpatient departments (emergency room, treatment rooms) are to be billed under the hospital's TPI.

Routine X-ray and laboratory services directly related to the surgical procedure are not reimbursed separately. Payment for these services is included in the reimbursement of the surgical procedure. All nonroutine laboratory and X-ray services should be billed separately using the hospital's full care TPI.

Day surgery services include prosthetic devices such as intraocular lens (IOL) when supplied by the day surgery facility and implanted, inserted, or otherwise applied during a covered surgical procedure. The cost of the prosthetic device is included in the facility fee for the procedure.

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

8.4.1 Complications / Medically Necessary Stays Following Scheduled Day Surgeries

Providers must bill the scheduled day surgery using the hospital's ambulatory surgical center TPI. If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 24 hours). This outpatient observation stay must be billed using the hospital's TPI. 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 should be included on the claim. The principal diagnosis to be used is the complication of the surgery that necessitated the extended stay.

8.4.2 Complications Following Unscheduled (Emergency) Day Surgeries

Providers must bill the unscheduled day surgery as an outpatient claim using the hospital's TPI. If a complication occurs, the same guidelines presented in "Complications Following Scheduled Day Surgeries" must be followed with the exception being that the date of admission on the outpatient claim must reflect the date of first contact with client.

8.5 Billing Clarification

When patient status changes from observation to inpatient admission, the date of admission is the date the patient was first placed on observation status. The rule **always** applies, regardless of the length of time the patient was in observation (less than 24 hours) or whether the date of inpatient admission is on the following day. The only exception to this rule is when the decision to formally admit the client is made after the midnight census hour; the date of the inpatient admission would then be the following calendar day.

8.6 Inpatient Hospital Services

Inpatient hospital services include medically necessary items and services ordinarily furnished by a CSHCN hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year of inpatient hospital care, which may accrue intermittently or consecutively. Once 60 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the next calendar year.

Important
An additional 60-day limitation of hospital days begins on the date of hospital admission for an approved bone marrow/stem cell transplant.

Hospital services must be medically necessary, prior authorized, and are subject to the utilization review requirements of the CSHCN Program. Reimbursement for services cannot exceed the limitations of the CSHCN Program.

Inpatient hospital services include the following items and services:

- Room and board in semi-private 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 are reimbursed up to the hospital's charge for the most prevalent semi-private accommodations. Private accommodations are not subject to the semi-private rate if 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 reasonable and necessary for treatment of illness or injury, provided they are not available without cost.
- All medically necessary ancillary services/supplies ordered by a physician.

8.7 Hospital Laboratory Services

Providers who perform both the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component. Providers who perform only the interpretation must bill for the interpretation component. Claims will be paid based on the order they are received. For example, if a claim is received for the total component and NHIC has already made payment for the technical and/or interpretation component for the same procedure, same dates of services, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

The American Medical Association (AMA) has discontinued the general multichannel automated panel codes 80002 through 80019 and G0058 through G0060. These panel codes are being discontinued because the panel does not define exactly what tests are performed. The Medicare policy pertaining to laboratory paneling procedures was implemented by the CSHCN Program.

The new organ and disease panel codes 80048, 80050, 80051, 80053, 80061, 80069, 80072, and 80076 must be used instead of the general multichannel automated Panel Codes: 80002 through 80019 and G0058 through G0060. Claims submitted with the general multichannel codes will be denied for incorrect procedures.

CPT codes 80002 through 80019 and G0058 through G0060 are not usable as billing codes, but the payment amounts associated with pricing of these automated profiles will continue. For example, if two automated profile tests are performed, the individual codes for the two automated tests must be billed instead of code 80002. For pricing, count the number of automated profile tests

billed, and payment will be at the same rate as the former code 80002. Centers for Medicare and Medicaid Services (CMS) continues to provide updated pricing for the deleted profiles of automated tests.

The new organ or disease panels include the following codes:

80048 – Basic metabolic panel includes:	
Calcium	82310
Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Potassium	84132
Sodium	84295
Urea nitrogen (BUN)	84520

80050 – General health panel includes:	
Comprehensive metabolic panel	80053
Thyroid stimulating hormone (TSH)	84443
Hemogram, automated and manual differential WBC count (CBC)	85022
Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	85025

80051 – Electrolyte panel includes:	
Carbon dioxide	82374
Chloride	82435
Potassium	84132
Sodium	84295

80053 – Comprehensive metabolic panel includes:	
Albumin	82040
Bilirubin total	82247
Calcium	82310
Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Phosphatase, alkaline	84075
Potassium	84132
Protein, total	84155
Sodium	84295
Transferase, aspartate amino (AST) (SGOT)	84450
Transferase, alanine amino (ALT) (SGPT)	84460
Urea nitrogen (BUN)	84520

80061 – Lipid panel includes:	
Cholesterol, serum, total	82465
Lipoprotein, direct measurement, high density (HDL) cholesterol	83718
Triglycerides	84478

80069 – Renal function panel includes:	
Albumin	82040
Calcium	82310
Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Phosphorus, inorganic	84100
Potassium	84132
Sodium	84295
Urea nitrogen (BUN)	84520

80072 – Arthritis panel includes:	
Uric acid, blood chemical	84550
Sedimentation rate, erythrocyte, nonautomated	85651
Fluorescent noninfectious agent, screen, each antibody	86255
Rheumatoid factor, qualitative	86430

80074 – Acute Hepatitis Panel	
Hepatitis B core antibody (HbcAb), IgM antibody	86705
Hepatitis A antibody (HAAb),IgM antibody	86709
Hepatitis C antibody	86803
Hepatitis B surface antigen (HbsAg)	87340

80076 – Hepatic function panel includes:	
Albumin	82040
Bilirubin, total	82247
Bilirubin, direct	82248
Phosphatase, alkaline	84075
Protein, total	84155
Transferase, aspartate amino (AST) (SGOT)	84450
Transferase, alanine amino (ALT) (SGPT)	84460

80090 – TORCH Antibody Panel	
Antibody, cytomegalovirus (CMV)	86644
Antibody, herpes simplex, non-specific type test	86694
Antibody, rubella	86762
Antibody, toxoplasma	86777

Outpatient and nonpatient claims for laboratory services must only reflect tests actually performed by the hospital laboratory except in the following circumstances:

- Hospital laboratories may bill for all of the tests performed on a specimen if some, but not all, of the tests are done by another laboratory on referral from the hospital submitting the claim. The billing hospital must enter the name and TPI of the performing laboratory in block 84 of the HCFA-1450 (UB-92) Claim Form and must enter the performing laboratory's TPI next to the service provided by the performing laboratory.
- Hospitals may bill a handling fee (99001) for collecting and forwarding a specimen to a referral laboratory if the specimen is collected by venipuncture or catheterization. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more laboratories; this must be documented on the claim.

Refer to: "Laboratory Paneling" on page 9-8 for more detailed information regarding laboratory paneling procedures.

- Laboratory tests generally performed as a panel (chemistries, CBCs, urinalysis) must be billed with the appropriate HCPCS panel code. This policy applies to laboratory tests performed by a hospital laboratory.

8.7.1 Complete Blood Counts (CBC)

The codes for a complete blood count [CBC (with or without differential and / or platelet count)] and the individual components are listed below. If only one component is performed, bill the appropriate individual code. If two of the components are performed, use procedure code X7619. If three or more of the components are performed on the same day, they must be combined and billed as procedure code 85022 or 85031. Procedure code X7619 may not be billed on the same day as procedure code 85021, 85022 or 85031.

CBC	Description
85021	Blood count; hemogram, automated (RBC, WBC< HgB, Hct and indices only)

CBC with Differential	Description
85022	Blood count; hemogram, automated, and manual differential WBC count (CBC)
85031	Blood count; hemogram, manual, complete CBC (RBC, WBC, HgB, Hct, differential and indices)

CBC with Differential and Platelet	Description
85023	Blood count; hemogram and platelet count, automated, and manual differential WBC count (CBC)
85024	Blood count; hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)

Components of CBC	Description
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
85008	Blood count; manual blood smear examination without differential parameters
85009	Blood count; differential WBC count, buffy coat

Components of CBC	Description
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
85027	Blood count; hemogram and platelet count, automated
85041	Blood count, red blood cell (RBC) only
85048	Blood count; white blood cell (WBC)

If a platelet count (85590 or 85595) is performed on the same day as a CBC, use procedure code 85023, 85024 or 85025. If 85590 or 85595 are billed on the same day as 85023, 85024, 85025, or 85027, then 85590 or 85595 will be denied as part of another procedure.

Platelet estimation (85585) will not be paid when performed on the same day as 85023, 85024, 85025, 85027, 85590, or 85595. Platelet estimation can be billed on the same day of service as 85021, 85022, or 85031.

The following specialized blood counts may be billed in addition to a CBC when performed on the same day:

Procedure Code	Description
84044	Blood count; reticulocyte, manual
85045	Blood count; reticulocyte count, flow cytometry
85046	Blood count, reticulocytes, hemoglobin concentration

8.7.2 Cancer Screening

The following procedure codes are covered services:

Procedure Code	Description
G0103	Prostate cancer screening; prostate specific antigen test (PSA) total
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0122	Colorectal cancer screening; barium enema

Colorectal Cancer Screening. Screening colonoscopy is recommended once every 24 months for individuals at high risk for colorectal cancer. High risk individuals include persons with one or more of the following:

- Close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyposis;
- Family history of familial adenomatous polyposis;
- Family history of hereditary nonpolyposis colorectal cancer;
- Personal history of colorectal cancer, or
- Inflammatory bowel disease, including Crohn’s Disease, and ulcerative colitis

A screening colonoscopy may be covered for the following diagnoses:

Diagnosis Code	Description
V1005	Personal history of malignant neoplasm of the large intestine
V1006	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
V1600	Family history of malignant neoplasm of gastrointestinal tract
V1850	Family history of certain other specific conditions, digestive disorders
55500	Regional enteritis of small intestine
55510	Regional enteritis of large intestine
55520	Regional enteritis of small intestine with large intestine
55590	Regional enteritis of unspecified site
55600	Ulcerative (chronic) enterocolitis
55610	Ulcerative ileocolitis
55620	Ulcerative (chronic) proctitis
55630	Ulcerative (chronic) proctosigmoiditis
55680	Other ulcerative colitis
55690	Ulcerative colitis, unspecified
55820	Toxic gastroenteritis and colitis
55890	Other and unspecified noninfectious gastroenteritis and colitis

8.7.3 Cytogenetics Testing

Genetic testing is limited to diagnoses 20280 through 20298, Lymphomas, and 20400 through 20891, Leukemia. Effective for dates of service on or after March 1, 1999, the following procedure codes are payable for the above diagnoses only:

Procedure Code	Description
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (e.g., diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88264	Chromosome analysis; analyze 20-25 cells
88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivates and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (e.g., for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells
88291	Cytogenetics and molecular cytogenetics; interpretation and report

The cytogenetics procedure codes are divided into three tables. Details are in the following tables.

Each provider may be paid one culture procedure (Table A) and one chromosome analysis procedure (Table B) for the same client on the same day. Each client is limited to six culture procedures (Table A) and six chromosome analysis procedures (Table B) per 365 days. Each client is limited to one molecular cytogenetics procedure (Table C) per 365 days.

The procedures listed in Tables A and C may be reimbursed when billed together for the same date of service. Only one procedure per table will be reimbursed; the others will be denied as “part of.”

In Table B, **only one procedure code may be reimbursed** for each of the following subcategories. The other procedure codes will be denied as “part of.”

- 88245, 88248, and 88249 (when billed together, only one of these procedure codes will be reimbursed)
- 88261 through 88264
- 88280 and 88283

Table A: Procedure Codes for Tissue Culture

Procedure Code	Description
88230	Tissue culture for non-neoplastic disorders; lymphocyte
88233	Tissue culture for chromosome analysis; skin or other solid tissue biopsy
88237	Tissue culture for neoplastic disorders; bone marrow blood cells
88239	Tissue culture for neoplastic disorders; solid tumor

Table B: Procedure Codes for Chromosome Analysis

Procedure Code	Description
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE) 20-25 cells
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (e.g., for ataxia telangiectasia, Fanconi anemia, Fragile X)
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (e.g., Diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88261	Chromosome analysis; count 5 cells, 1 karyotype with banding
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding
88264	Chromosome analysis; analyze 20-25 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	Chromosome analysis; additional specialized banding technique (e.g., NOR, C-banding)

Table C: Procedure Codes for Molecular Cytogenetics

Procedure Code	Description
88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivates and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (e.g., for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells

Procedure codes 88250 and 88260 are not a benefit.

8.7.4 Cytopathology of Sites Other Than Vaginal, Cervical, or Uterine

Procedure Code	Description
Physician in the office (POS 1)	
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, any other source; preparation, screening and interpretation
88162	Cytopathology, any other source; extended study involving over 5 slides or multiple stains
Physician in the outpatient (POS 5) and inpatient (POS 3) hospital	
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, any other source; preparation, screening and interpretation
88162	Cytopathology, any other source; extended study involving over 5 slides or multiple stains
Outpatient hospital lab (POS 5) or independent lab (POS 6)	
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, any other source; preparation, screening and interpretation
88162	Cytopathology, any other source; extended study involving over 5 slides or multiple stains

When procedure code 88160 and/or 88161 is billed with 88162, 88160, and/or 88161 will be denied as part of 88162.

When procedure code 88160 is billed with 88161, 88160 will be denied as part of 88161.

8.7.5 Cytopathology of Vaginal, Cervical, or Uterine Sites

Because of the technical nature of processing and interpreting a pap smear or specimen for cytopathology, pathologists will be the only physician specialty reimbursed with the following exception:

Other physician specialties equipped to perform pap smears in their offices must have modifier “PO” (performed in office) on the claim form.

Procurement and handling of the pap smear or specimen for cytopathology is considered part of the evaluation and management of the client and will not be reimbursed separately.

A pathologist must report the place of service according to where the pap smear is interpreted. Therefore, the pap smear codes must be billed in the following manner:

Procedure Code	Description
88150	Physician in the office (POS-1), outpatient hospital lab (POS-5) or independent lab (POS-6)
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation

When procedure code 88150 is billed with 88155, 88150 will be denied as part of 88155.

Ferritin and Iron Studies

CSHCN may reimburse procedure code 85536, Iron stain, peripheral blood. It is payable when billed with any of the following diagnoses:

Diagnosis Code	Description
27500	Hemochromatosis
28000	Iron deficiency anemia, secondary to blood loss (chronic)
28010	Iron deficiency anemia, secondary to inadequate dietary iron intake
28080	Other specified iron deficiency anemias
28090	Iron deficiency anemia, unspecified
28100	Pernicious anemia

Diagnosis Code	Description
28110	Other vitamin B12 deficiency anemia
28120	Folate-deficiency anemia
28190	Unspecified deficiency anemia
28280	Other specified hereditary hemolytic anemias
28290	Hereditary hemolytic anemia, unspecified
28390	Acquired hemolytic anemia, unspecified
28500	Sideroblastic anemia
28521	Anemia in end-stage renal disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic illness
28590	Anemia, unspecified
53600	Achlorhydria
57380	Other specified disorders of liver
57390	Unspecified disorder of liver
57930	Other and unspecified postsurgical nonabsorption
57980	Other specified intestinal malabsorption
57990	Unspecified intestinal malabsorption
58500	Chronic renal failure
58600	Renal failure, unspecified
V5600	Extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V5680	Other dialysis

If procedure codes 85535, Iron stain, RBC or bone marrow smears, and 85536, Iron stain, peripheral blood, are billed on the same day, the claim must state clearly that one of the procedures was an iron stain or bone marrow.

8.7.6 Helicobacter Pylori (H. Pylori)

Procedure code 83013 and 83014, Helicobacter pylori, breath test (including drug and breath sample collection kit), is a benefit. This code is considered a clinical lab service. Procedure code 87338, Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiqualitative, multiple step method, helicobacter pylori, stool, is a benefit of the CSHCN Services Program. This procedure is not payable on the same date of service and the same provider as procedure code 83013 and/or 83014. If a gastrointestinal endoscopy is performed within 90 days of the H. Pylori test, procedure codes 43200, 43202, 43234, 43235, and 43239 will be denied. These services can be appealed with submission of medical documentation that supports performance of the endoscopy.

8.7.7 Latex Sensitivity Testing

CSHCN will cover radioallergosorbent (RAST) testing for CSHCN clients when used to detect latex sensitivity for program eligible clients with spina bifida and urogenital conditions.

Use procedure code 86003, Allergen specific IGE; quantitative, or semi-quantitative, each allergen, when billing for RAST testing.

Requests for RAST testing are covered for the following diagnoses:

Diagnosis Code	Description
59330	Stricture or kinking of ureter
59340	Other ureteric obstruction
59350	Hydroureter
59370–59373	Vesicoureteral reflux
59382	Ureteral fistula
59610	Intestinovesical fistula
59800–59890	Urethral stricture
59910	Urethral fistula
61900–61980	Female genital fistula
61990	Unspecified fistula involving female genital tract
74100–74193	Spina bifida (includes Arnold-Chiari/Chiari II)
75220–75249	Congenital anomalies of genital organs
75261	Hypospadias and epispadias and other penile anomalies, hypospadias
75262	Hypospadias and epispadias and other penile anomalies, epispadias
75263	Hypospadias and epispadias and other penile anomalies, congenital chordee
75270	Indeterminate sex and pseudohermaphroditism
75320	Congenital obstructive defect of renal pelvis and ureter, unspecified obstructive defect of renal pelvis and ureter
75321	Congenital obstructive defect of renal pelvis and ureter, congenital obstruction of ureteropelvic junction
75322	Congenital obstructive defect of renal pelvis and ureter, congenital obstruction of ureterovesical junction
75323	Congenital obstructive defect of renal pelvis and ureter, congenital ureterocele
75329	Congenital obstructive defect of renal pelvis and ureter, other
75340	Other specified anomalies of ureter
75350	Exstrophy of urinary bladder
75360	Atresia and stenosis of urethra and bladder neck
75370	Anomalies of urachus
75380	Other specified anomalies of bladder and urethra

Latex sensitivity for other CSHCN covered diagnoses will be considered on appeal with medical documentation.

If the physician performs the test in the office, a modifier PO must be used, indicating that the necessary equipment to perform the test is in the office.

8.7.8 Urinalysis

A similar methodology that is used with chemistry tests is applied when two or more components of a urinalysis are performed on the same day and billed separately. The billed services are also denied if not paneled appropriately and must be resubmitted with urinalysis codes 81000, 81001, 81002, or 81003. The following codes are subject to this methodology:

Procedure Code	Description
81000	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated with microscopy
81001	Urinalysis by dipstick or tablet reagent; with microscopy, automated
81002	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated
81003	Urinalysis by dipstick or tablet reagent; without microscopy, automated
81005	Urinalysis, qualitative or semiquantitative except immunoassays
81015	Urinalysis, microscopy only
81020	Urinalysis, two or three glass test
84578	Urobilinogen, urine, qualitative
84583	Urobilinogen, urine, semiquantitative

If procedure code 81015, Urinalysis, microscopic only, is billed in addition to routine urinalysis codes 81000 or 81001, procedure code 81015 is denied as part of 81000 or 81001. If 81015 is billed with urinalysis codes 81002 or 81003, both codes are denied requiring paneling into either 81000 or 81001. If 81015 is billed separately with one or more of the above components on the same day, both 81015 and the other component are denied and should be combined and billed as a urinalysis.

When performing bacterial urine culture with antibiotic sensitivities, use procedure code 87086, Culture, bacterial, urine; qualitative, colony count. The modifier “UA” must be used to indicate the specimen source was urine when billing for laboratory test 82947, Glucose. When blood is the specimen source, no modifier is required. If 82947 is billed with the modifier in addition to procedure code 81000 (Urinalysis), 82947 will be denied as part of 81000.

8.7.9 Repeated Procedures (Modifier 76 or 91)

The use of Modifier 76 or 91 is limited as follows:

- Modifiers 76 and 91 must not be used when billing the initial procedure. They must be used to indicate the repeated procedure.
- If a repeated procedure performed by the same provider on the same day is billed without Modifier 76 or 91, it is denied as a duplicate procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of Modifier 76 or 91, the detail will be denied without documentation of the time the services were rendered.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 or 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

Certain procedure codes have been removed from modifiers 76 and 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each antigen. (e.g., agglutinins, febrile, [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal any claims that have been denied for documentation of time. Most procedure codes initially requiring modifiers 76 or 91 will continue to be audited for the 76 and 91 modifiers.

8.7.10 Hospital Radiology Services

8.7.10.1 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (78472, 78473, 78481, 78483, 78494, and 78496) is a covered benefit for the CSHCN Program.

8.7.10.2 Computerized Axial Tomography (CAT) Scan

Scout views and reconstruction are considered part of any CAT scan procedure and are not reimbursed in addition to any other CAT scan. Procedure codes 76375, Coronal, sagittal, multi-planar, oblique, three-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging or other tomographic modality, and procedure code 76380, Computerized tomography limited or localized follow-up study, are denied when billed on the same day as any other CAT scan. Procedure codes 76375 and 76380 are paid if billed as an independent procedure.

Freestanding facilities may bill for CAT scans for technical component only. The radiologist or neurologist who then reads the scan may bill for interpretation only. In addition, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill for interpretation.

8.7.10.3 Low Osmolar (Nonionic) Contrast Material (LOCM)

Low osmolar contrast material used with intrathecal, intra-arterial, and/or intravenous radiological procedures may be reimbursed separately when medically indicated for clients with but not limited to the following high-risk conditions:

- History of allergic reaction to contrast material with the exception of a heat or flushing sensation or a single episode of nausea or vomiting
- History of asthma
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension
- Generalized severe debilitation
- Sickle cell disease

The LOCM is reimbursed as a drug furnished as incidental to a physician's service. Payment is limited to services performed in the office (POS 1), freestanding radiation centers (POS 6), and outpatient facilities (POS 5). LOCM used on clients in the inpatient hospital setting of a TEFRA reimbursed hospital is included in the TEFRA payment and no additional payment is made. **Low** osmolar contrast material used for the procedures that specify "without contrast" should be billed, and the **low** osmolar contrast injection material should be billed separately.

Radiological procedures that specify "with contrast" include payment for **high** osmolar contrast material and no additional payment is made for **low** osmolar contrast material.

Specific products currently available are billed as follows:

Procedure Code	Description
1173Y	Isovue 200, 50 ml
1179Y	Isovue 300, 50 ml
1180Y	Isovue 300, 100 ml
1170Y	Omnipaque 240, 50 ml
1174Y	Omnipaque 300, 50 ml
1175Y	Omnipaque 300, 100 ml
1176Y	Omnipaque 350, 100 ml
1171Y	Optiray 240, 50 ml
1172Y	Optiray 240, 100 ml
1177Y	Optiray 320, 50 ml
1178Y	Optiray 320, 100 ml

Magnetic resonance imaging (MRI) procedures that specify “with contrast” include payment for “para-magnetic contrast”; therefore, **low** osmolar contrast material is not reimbursed separately.

Procedure Code	Description
A4644	Supply of low osmolar contrast material (100-199 mgs of iodine), e.g., Omnipaque 140 and 180, Optiray 160
A4645	Supply of low osmolar contrast material (200-299 mgs of iodine), e.g., Omnipaque 210 and 240, Optiray 240, Isovue 200
A4646	Supply of low osmolar contrast material (300-399 mgs of iodine), e.g., Hexabrix, Optiray 320, Omnipaque 300 and 350, Isovue 300 and 370

When submitting a claim for procedure codes A4644 through A4646, the name of the drug and the number of ccs or mls used must be indicated. If the drug and volume are not indicated, procedure codes A4644 through A4646 are denied with EOB message 384, “Medication charges must indicate the name of the drug, route of administration and the dosage.”

8.7.10.4 Magnetic Resonance Angiography (MRA)

Magnetic resonance angiography is a technique which allows noninvasive visualization and study of blood vessels through either two-dimensional or three-dimensional image reconstruction. The CSHCN Program will reimburse MRA procedures of the head and neck for program eligible clients with specific diagnoses. The use of MRA in other areas of the body is not covered by CSHCN.

Payment for MRA of the head and/or neck is limited to the following diagnoses:

Diagnosis Code	Description
43000	Subarachnoid hemorrhage
43100	Intracerebral hemorrhage
43200	Nontraumatic extradural hemorrhage
43210	Subdural hemorrhage
43290	Intracranial hemorrhage NOS
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction
43490	Cerebral artery occlusion, unspecified, without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
43600	Acute but ill-defined cerebrovascular diseases
43730	Nonruptured cerebral aneurysm
43800	Late effects of cerebrovascular disease
43810	Late effects of cerebrovascular disease, speech and language deficits, unspecified
43811	Late effects of cerebrovascular disease, speech and language deficits, aphasia
43812	Late effects of cerebrovascular disease, speech and language deficits, dysphasia
43819	Late effects of cerebrovascular disease, other speech and language deficits
43820	Late effects of cerebrovascular disease, hemiplegia affecting unspecified side
43821	Late effects of cerebrovascular disease, hemiplegia affecting dominant side
43822	Late effects of cerebrovascular disease, hemiplegia affecting non-dominant side
43830	Late effects of cerebrovascular disease, monoplegia of upper limb affecting unspecified side
43831	Late effects of cerebrovascular disease, monoplegia of upper limb affecting dominant side
43832	Late effects of cerebrovascular disease, monoplegia of upper limb affecting non-dominant side
43840	Late effects of cerebrovascular disease, monoplegia of lower limb affecting unspecified side

Diagnosis Code	Description
43841	Late effects of cerebrovascular disease, monoplegia of lower limb affecting dominant side
43842	Late effects of cerebrovascular disease, monoplegia of lower limb affecting non-dominant side
43850	Late effects of cerebrovascular disease, other paralytic syndrome affecting unspecified side
43851	Late effects of cerebrovascular disease, other paralytic syndrome affecting dominant side
43852	Late effects of cerebrovascular disease, other paralytic syndrome affecting non-dominant side
43853	Late effects of cerebrovascular disease, other paralytic syndrome, bilateral
43881	Other late effect of cerebrovascular disease, apraxia
43882	Other late effect of cerebrovascular disease, dysphagia
43889	Other late effect of cerebrovascular disease
43890	Unspecified late effects of cerebrovascular disease

The following procedure codes must be used when submitting a claim for MRA of the head and/or neck with or without contrast material(s).

Diagnosis Code	Description
70544	Magnetic resonance angiography, head; without contrast material(s)
70545	Magnetic resonance angiography, head; with contrast material(s)
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s)
70547	Magnetic resonance angiography, neck; without contrast material(s)
70548	Magnetic resonance angiography, neck; with contrast material(s)
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s)

8.7.10.5 Magnetic Resonance Imaging (MRI)

Magnetic resonance imaging (MRI) is a noninvasive nuclear procedure for imaging tissues of high fat and water content that are poorly seen with other radiologic techniques. The CSHCN Services Program covers MRI procedures for specific diagnoses. **MRI procedures do not require authorization.** MRI procedures with appropriate diagnosis codes are as follows:

Procedure Code	Description		
70336	MRI, temporomandibular joint, TMJ		
Diagnosis Codes – Payable for procedure code listed above			
17000–17010	90920	V1060–V1069	V7110
19850	99000	V1071–V1079	V7642
21300–21310	V1001–V1002	V1081–V1082	
23770–23772	V1022	V1340	

Procedure Code	Description		
70540	MRI, orbit, face and neck		
Diagnosis Codes – Payable for procedure code listed above			
17000–17010	23770–23772	V1071–V1079	V1240–V1249

Diagnosis Codes – Payable for procedure code listed above			
17100	90920	V1081–V1082	V7110
19010	99000	V1084	V7642
19500	V1001–V1002	V1087	
19850	V1022	V1089	
21300–21310	V1060–V1069		

Procedure Code	Description		
70551	MRI, brain; without contrast		
70552	MRI, brain; with contrast		
70553	MRI, brain; without contrast, followed by contrast, and further sequences		
Diagnosis Codes – Payable for procedure codes listed above			
19100–19190	25320–25330	43730	V1020–V1029
19200–19210	25370	71000	V1030
19430–19440	32400	74100–74103	V1040–V1049
19830–19840	32600	74200	V1050–V1059
22500–22520	33140	74230–74240	V1060–V1069
22730–22740	34800	74781	V1071–V1079
23700–23710	43000	90920	V1081–V1089
23750–23760	43100	99000	V1369
23770–23772	43200–43290	V1000–V1009	V7110
23960	43600	V1011–V1012	V8000

Procedure Code	Description		
72141	MRI, spinal canal and contents, cervical; without contrast		
72142	MRI, spinal canal and contents, cervical; with contrast		
72156	MRI, spinal canal and contents, cervical; without contrast, followed by contrast and further sequences		
Diagnosis Codes – Payable for procedure codes listed above			
17020	33600–33690	90920	V1060–V1069
19220–19230	72110	95200–95209	V1071–V1079
19830–19850	72120	95280	V1081–V1089
21320	72150–72170	99000	V1340
21390	74100–74101	V1000–V1009	V1369
22530–22540	74190–74191	V1011–V1012	V7110
23750–23760	74230	V1020–V1029	V8000
23770–23772	74251–74259	V1030	V8210
32410	80605–80609	V1040–V1049	
32600	80615–80619	V1050–V1059	

Procedure Code	Description
72146	MRI, spinal canal and contents, thoracic; without contrast
72147	MRI, spinal canal and contents, thoracic; with contrast
72157	MRI, spinal canal and contents, thoracic; without contrast, followed by contrast and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17020	33600–33690	80630–80639	V1050–V1059
19220–19230	72120	90920	V1060–V1069
19830–19850	72141	95210–95219	V1071–V1079
21320	72150–72170	95280	V1081–V1089
21390	74100	99000	V1340
22530–22540	74102	V1000–V1009	V1369
23750–23760	74190	V1011–V1012	V7110
23770–23772	74192	V1020–V1029	V8000
32410	74251–74259	V1030	
32600	80620–80629	V1040–V1049	

Procedure Code	Description
72148	MRI, spinal canal and contents, lumbar; without contrast
72149	MRI, spinal canal and contents, lumbar; with contrast
72158	MRI, spinal canal and contents, lumbar; without contrast, followed by contrast and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17020	32600	74251–74259	V1050–V1059
19220–19230	33600–33690	80640–80670	V1060–V1069
19830–19850	72130	90920	V1071–V1079
21320	72142	95220–95280	V1081–V1089
21390	72150–72170	99000	V1340
22530–22540	74100	V1000–V1009	V1369
23750–23760	74103	V1011–V1012	V7110
23770–23772	74190	V1030	V8000
32410	74193	V1040–V1049	

Procedure Code	Description
72195	MRI, pelvis; without contrast material(s)
72196	MRI, pelvis; without contrast material(s)
72197	MRI, pelvis; without contrast material(s), followed by contrast material(s) and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17060	21360	90920	V1040–V1049
17160	21390	99000	V1050–V1059
18500	23340	V1000–V1009	V1060–V1069
19530	23770–23772	V1011–V1012	V1071–V1089
19850	73210	V1020–V1029	V7110
23650	73342	V1030	V7680–V7690

Procedure Code	Description		
73218	MRI, upper extremity, other than joint; without contrast material(s)		
73219	MRI, upper extremity, other than joint; with contrast material(s)		
73220	MRI, upper extremity, other than joint; without contrast material(s) followed by contrast material(s) and further sequences		
73221	MRI, any joint of lower extremity; without contrast material(s)		
73222	MRI, any joint of upper extremity; with contrast material(s)		
73223	MRI, any joint of upper extremity; without contrast material(s) followed by contrast material(s) and further sequences		
Diagnosis Codes – Payable for procedure codes listed above			
17040–17050	21340–21350	73341	V1089
17120	21390	90920	V1340
19540	23770–23772	99000	V7110
19850	73230	V1081–V1082	V8000

Procedure Code	Description		
73718	MRI, lower extremity, other than joint; without contrast material(s)		
73719	MRI, lower extremity, other than joint; with contrast material(s)		
73720	MRI, lower extremity, other than joint; without contrast material(s) followed by contrast material(s) and further sequences		
73721	MRI, any joint of lower extremity; without contrast material(s)		
73722	MRI, any joint of lower extremity; with contrast material(s)		
73723	MRI, any joint of lower extremity; without contrast material(s) followed by contrast material(s) and further sequences		
Diagnosis Codes – Payable for procedure codes listed above			
17070–17080	21360–21390	73342–73344	V1089
17130	23770–23772	90920	V1340
19550	73210	99000	V7110
19850	73240–73250	V1081–V1082	V8000

A freestanding MRI facility may bill for the technical portion only. The radiologist or neurologist who then reads the MRI may bill for interpretation only. In addition, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill for interpretation.

All medically necessary radiology services provided to hospital patients must be ordered by the client's attending or consulting physician. These services must be documented in the client's medical record.

Reimbursement for hospital radiology services is limited to the technical portion of services rendered.

8.7.10.6 Positron Emission Tomography

The CSHCN Program covers positron emission tomography (PET), as part of the diagnostic workup for those clients with uncontrolled complex partial seizures. The intent of the PET must be to locate and document a seizure focus in preparation for possible surgery. Procedure code 78608, Brain imaging, positron emission tomography, metabolic imaging, must be used when requesting PET.

Payment for PET is limited to the following diagnoses:

Diagnosis Code	Description
34540	Partial epilepsy with impairment of consciousness, without mention of intractable epilepsy
34541	Partial epilepsy with impairment of consciousness, with intractable epilepsy

8.7.10.7 Technetium TC 99M Tetrofosmin

Procedure code A9502, Supply of radiopharmaceutical diagnostic imaging agent, technetium TC-99M tetrofosmin, per unit dose, is a benefit, without age restriction. It is payable in the office, inpatient, and outpatient settings. Payable providers are:

- Physicians
- Radiation treatment centers
- Inpatient/outpatient hospitals

Inpatient and outpatient services are reimbursed at 80 percent of the rate equivalent to the hospital's Medicaid interim rate.

8.7.11 Outpatient Services

An outpatient is an individual who is provided ambulatory services in a hospital but is not admitted for inpatient care. Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and provided by a CSHCN hospital or under the direction of a physician to an outpatient. Supplies provided by a hospital supply room for use in physician's offices in the treatment of clients are not reimbursable as outpatient services.

Outpatient hospital services include those services performed in the emergency room or clinic setting of a hospital. In instances of sudden illness or injury, the client may receive treatment in the emergency room and be discharged, admitted for observation, or may be admitted for further care as an inpatient. If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be billed on the inpatient hospital claim form as an ancillary charge.

The modifier "SH" must be entered on the outpatient claim detail to indicate oral medications or miscellaneous supplies which were administered or used at the hospital. Take-home drugs and supplies must be billed directly to the Vendor Drug Program.

8.7.11.1 Aerosol Treatment

CSHCN will reimburse for aerosol therapy. Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are appropriate methods of treatment for certain acute medical problems. Aerosol treatment must be coded W0006 for aerosol therapy or W0007 for inhalers. When billing for Pentamidine isethionate, inhalation solution use procedure code J2545. **Pentamidine is limited to treatment of pneumocystis carinii.**

8.7.11.2 Blood Factor Products

CSHCN reimburses for blood factor products and other pharmaceuticals for program eligible clients with diagnoses 28600 through 28640. Reimbursement for blood factor products will be the lower of either the billed price or the United States Public Health Service (USPHS) price in effect on the date of service plus a dispensing fee of $0.04 per unit (or per microgram for factor VIIa). **Authorization is required for blood factor products in the home.** The physician's prescription must accompany the authorization request form.

Refer to: "CSHCN Authorization Form for Hemophilia Blood Factor Products" on page 8-43.

When submitting claims, products must be identified by product name and manufacturer or by National Drug Code (NDC), and the following HCPCS codes should be used:

Procedure Code	Description
J7190	Factor VIII (antihemophilic factor [human]), per IU
J7191	Factor VIII (antihemophilic factor [porcine]), per IU
J7192	Factor VIII (antihemophilic factor [recombinant]), per IU
J7193	Factor IX (antihemophilic factor, purified, nonrecombinant) per IU

Procedure Code	Description
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7198	Anti-inhibitor, per IU
J7199	Hemophilia clotting factor, not otherwise classified
Q0187	Factor VIIa (coagulation factor, recombinant) per 1.2 mg

Whether provided in a hospital outpatient facility, in a physician's office, or in the client's home, all ancillary services such as infusion supplies, administration, and home delivery expenses are included in reimbursement for the product as described above. Claims for services should be submitted to NHIC-CSHCN.

Documentation of medical necessity is required for approval of blood factor products for any diagnosis other than 28600 through 28640 with the exception of procedure code Q0187, Factor VIIa, coagulation factor, recombinant, per 1.2 mg which is only payable for diagnoses 28600 through 28610. Procedure codes J7193 and J7195, Factor IX, per IU, are only payable for diagnosis code 28610.

When submitting claims where the dispensed units are more than 999, submit a quantity of 1 and indicate the specific number of units provided on the claim form.

8.7.11.3 Outpatient Hospital Day Surgery

All surgical procedures on the Centers for Medicare and Medicaid Services (CMS)/TDH approved list performed in a hospital ambulatory surgical center must be authorized within the 90-day authorization deadline, except as noted below. Authorization must be requested in writing or faxed to 512-514-4222, and must include documentation of medical necessity and the surgeon's or attending physician's name. These physicians must be enrolled in the CSHCN Program. The "CSHCN Surgery Authorization Form" on page 13-71 must be completed and submitted with your written request.

The following codes do not require authorization:

Procedure Code	Description
36000	Introduction of needle or intracatheter, vein
51600	Injection procedure for cystography or voiding urethrocystography
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610	Injection procedure for retrograde urethrocystography
62270	Spinal puncture, lumbar, diagnostic

Routine x-ray and laboratory services directly related to the surgical procedure are not reimbursed separately. Payment for these services is included in the reimbursement of the surgical procedure. All nonroutine laboratory and x-ray services must be billed separately.

Hospital ambulatory surgical services include prosthetic devices, such as intraocular lens (IOL), when supplied by the hospital ambulatory surgical center and implanted, inserted, or otherwise applied during a covered surgical procedure. The cost of the prosthetic device is included in the facility fee for the procedure.

Emergency outpatient surgical procedures must be filed with separate charges for all services, using the hospital's outpatient TPI.

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 in accordance with billing instructions found in "Claims Information" on page 8-30. 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.

Ambulatory surgery claims submitted according to the above guidelines will facilitate claims processing and will help to ensure appropriate reimbursement for services rendered.

8.7.11.4 Outpatient Observation

Use of observation rooms in an institutional facility is a covered benefit of the CSHCN Program and does **not** require authorization. Facilities must determine the client's status using the following guidelines:

- The client is considered an outpatient if he or she is expected to remain in the hospital for less than 24 consecutive hours and is discharged to home from the outpatient setting. Charges for an observation room must be coded Y0013 and submitted as an outpatient claim. The hospital may designate any of the facilities' beds as observation.
- Charges for an observation room in the inpatient setting must be coded with revenue code 760. The date of inpatient admission for an observation room patient must be the date the client is admitted to the observation room. This rule will always apply except in those cases when the decision to formally admit the client is made after the midnight census hour; the date of the inpatient admission would then be the following calendar day. **Outpatient emergency room charges are not payable in addition to observation room charges.**

Important
Inpatient admissions require prior authorization.

Some clients, while not requiring hospital admission, may require an extended period of observation in the hospital environment as an outpatient. While the continued outpatient observation period may be medically necessary, admission to the hospital may not be medically necessary.

Hospitals may elect to bill medically necessary services provided during the period of observation as outpatient services. The CSHCN Program considers reimbursement of those services provided during the first 23 hours (less than 24 hours) of an outpatient observation period based on the facility's reimbursement rate and the medical necessity of the service. Clients may not be held liable for those outpatient services provided on or after the 24th hour.

8.7.12 Procedures Requiring Specialty Team/Center Approval

In addition to requiring prior authorization, some services require that both physicians and facilities be approved by TDH-CSHCN as a specialty team/center provider.

Refer to: "Provider Enrollment" on page 1-17 for enrollment procedures on becoming an approved specialty team/center provider.

- For bone marrow/stem cell transplant services, both the physician and the facility must be specialty team/center approved.
- For cleft/craniofacial surgical procedures, only the physician/dentist must be specialty team approved.
- **If the specialty team/center requirements are not met, all services related to the surgery will be denied.**

Refer to: "Specialty Team/Center" on page 13-60 for more information and a list of specific procedure codes requiring this special designation.

8.7.13 Radiation Services

Refer to: "Radiology Services" on page 13-39 for more detailed information regarding radiation therapy services.

The CSHCN Program benefits include payment for the technical portion of radiation therapy services provided in an inpatient setting. Covered services include clinical treatment planning and management and clinical brachytherapy. Hospitals must use revenue code 333, Radiation therapy, on the HCFA-1450 (UB-92) Claim Form when submitting charges for these services.

Freestanding radiation therapy facilities (specialty 98) and outpatient hospitals are reimbursed only for the technical component for services rendered in POS 5 for the services listed in this section. Outpatient radiation therapy is limited to a maximum of five facility services every seven days beginning with the first date of service.

Note: Drugs given during the course of therapy will be reimbursed separately.

The following radiation therapy services provided in an outpatient setting will be allowed only once per day unless documentation of medical necessity supports the need for repeated services:

- Treatment planning
- Simulation aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Intracavitary radioelement application
- Interstitial radioelement application
- Facility therapy
- Port films
- Exam rooms
- Radioisotope therapy
- Remote afterloading high intensity brachytherapy
- Treatment delivery
- Localization

8.7.13.1 Clinical Brachytherapy

Procedure Code	Description
77781	Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters
77782	5-8 source positions or catheters
77783	9-12 source positions or catheters
77784	Over 12 source positions or catheters
77789	Surface application of radioelement
77799	Unlisted procedure, clinical brachytherapy

8.7.13.2 Clinical Treatment Planning

Procedure Code	Description
77280	Therapeutic radiology simulation aided field setting; simple
77285	Intermediate
77290	Complex
77295	Three-Dimensional

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

Procedure Code	Description
77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment only when prescribed by the treating physician
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)
77310	Intermediate (3 or more treatment ports directed to a single area of interest)
77315	Complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77326	Brachytherapy isodose calculation; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)

Procedure Code	Description
77327	Intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328	Complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)
77332	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	Intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	Complex (Irregular blocks, special shields, compensators, wedges, molds, or casts)
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services

8.7.13.4 Radiation Treatment Delivery/Port Films

Procedure Code	Description
77401	Radiation treatment delivery, superficial and/or ortho voltage
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	6 - 10 MeV
77404	11 - 19 MeV
77406	20 MeV or greater
77407	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	6 - 10 MeV
77409	11 - 19 MeV
77411	20 MeV or Greater
77412	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (for example, electron or neutrons); up to 5 MeV
77413	6 - 10 MeV
77414	11 - 19 MeV
77416	20 MeV or Greater
77417	Therapeutic radiology port film(s)

8.7.13.5 Radioisotope Therapy

Procedure Code	Description
Y9311	P32 (Phosphorus)
Y9312	RA-RN (Radium - Radon)
Y9313	CS (Cesium)
Y9314	I131 (Iodine)
Y9315	Radioisotope, Other

8.7.13.6 Strontium-89

CSHCN coverage for Strontium-89 is limited to a total of 10 mci intravenously injected every 90 days for any provider. Use procedure code A9600, Supply of therapeutic radiopharmaceutical, Strontium-89 chloride, per mci.

Reimbursement will be limited to hospital facilities, free-standing radiation treatment centers (POS 5), and the office setting (POS 1). Strontium-89 provided in the inpatient setting (POS 3) is part of the TEFRA reimbursement, and no separate payment will be made.

Coverage of A9600 is limited to the following diagnosis codes:

Diagnosis Code	Description
17400	Malignant neoplasm of female breast; nipple and areola
17410	Malignant neoplasm of female breast; central portion
17420	Malignant neoplasm of female breast; upper-inner quadrant
17430	Malignant neoplasm of female breast; lower-inner quadrant
17440	Malignant neoplasm of female breast; upper-outer quadrant
17450	Malignant neoplasm of female breast; lower-outer quadrant
17460	Malignant neoplasm of female breast; axillary tail
17480	Malignant neoplasm of female breast; other specified sites
17490	Malignant neoplasm of female breast; breast (female), unspecified
17500	Malignant neoplasm of male breast; nipple and areola
17590	Malignant neoplasm of male breast; other and unspecified sites
18500	Malignant neoplasm, prostate
19850	Secondary malignant neoplasm bone

The quantity used, per mci, must appear on the claim.

The following services are not benefits of the CSHCN Program:

Procedure Code	Description
77321	Special teletherapy port plan, particles hemi-body, total body
77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	Special medical radiation physics consultation
77470	Special treatment procedure (e.g., total body irradiation, hemi-body irradiation, per oral, vaginal cone irradiation)
77600–77620	Hyperthermia
77790	Supervision, handling, loading of radioelement

Therapeutic radiology simulation-aided field setting, 77295, (three-dimensional), is payable to freestanding therapy facilities (specialty 98) and outpatient hospitals (POS 5). Outpatient hospitals are reimbursed at their reimbursement rate and children's hospitals are paid at their TEFRA reimbursement rate. Procedure code 77295 is payable once per day. The following codes are denied when billed on the same day as 77295:

Procedure Code	Description
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)
77310	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)
77315	Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)

8.8 Claims Information

Inpatient and outpatient hospital services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1450 (UB-92) Claim Form. Providers may purchase HCFA-1450 (UB-92) Claim Forms from the vendor of their choice; they are not supplied by NHIC. See "Claims Filing Instructions" on page 1-50 for information on electronic claims submissions.

Services and/or supplies which exceed the 27 items per page limitation must be submitted on additional HCFA-1450 (UB-92) Claim Forms (do not combine onto one page).

Instructions for proper claims completion are provided below. Blocks which are not referenced are not required for processing by NHIC and may be left blank.

8.8.1 Hospital HCFA-1450 Claim Form Instructions

The following instructions describe what information must be entered in each of the block numbers of the HCFA-1450 (UB-92) Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1	Provider name, address, and telephone number	Enter the hospital name, street, city, state, ZIP code, and telephone number. Preprinted labels may be requested by writing NHIC Provider Enrollment.
3	Patient control number	Optional: any alpha-numeric character (limit 16) entered in this block will be referenced on the R and S.
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges)	Enter the three-digit type of bill (TOB) code 1st Digit – Type of Facility 1 Hospital 2nd Digit – Bill Classification 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and x-rays) 3rd Digit – Frequency 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim
6	Statement covers period	For inpatient claims, enter the beginning and ending dates of service billed. For inpatient claims, this is usually the dates of admission and discharge.
7	Covered days	For inpatient claims, enter the total days represented on this claim that are to be covered. Usually this is the difference between the admission and discharge dates. In all circumstances the number in this block will be equal to the number of covered accommodation days listed in block 46.
8	Noncovered days	For inpatient claims, enter the total days represented on this claim that are not covered. The sum of blocks 7 and 8 must equal the total days billed as reflected in block 6.
12	Patient name	Enter the patient's last name, first name, and middle initial.
13	Patient address	Enter the patient's complete address as described (street, city, state, and zip code).
14	Patient birth date	Enter numerically the month, day, and year (MM/DD/YY) the client was born.
15	Patient sex	Indicate the patient's sex by entering an "M" or "F."
17	Admission date	Enter numerically the date (MM/DD/YY) of admission for inpatient claims; date of service for outpatient claims; start of care (SOC) for home health claims.
18	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for **inpatient** claims or time of treatment for **outpatient** claims. Code 99 is not acceptable. This block is not required for nonpatients (TOB 141).

Block No.	Description	Guidelines
19	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in block 20.)
20	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
21	Discharge hour (required field)	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of “30”), leave the block blank. Code 99 is not acceptable.
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient’s status as of the statement “through” date. 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 20 Expired or did not recover 30 Still patient
23	Medical record number	Enter the patient’s medical record number (limited to ten digits) assigned by the hospital.
24-30	Condition codes	Enter the two-digit condition code “05” and date the legal claim was filed for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient if this condition is applicable to the claim.
32ab-35ab	Occurrence codes and dates	Enter the appropriate code(s) and date(s). Blocks 54, 61, 62, and 84 must also be completed as required.
36	Occurrence span codes and dates	For inpatient claims, enter code “82” if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39	Value codes	Accident Hour – for inpatient claims, if the patient was admitted as the result of an accident, enter the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.

Block No.	Description	Guidelines
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations first in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is to be used for the accommodation rate. a. Revenue code "001" is for the total charge and must be the last revenue code on the list. **Exception: Electronic billers must not use revenue code "001." Use of this code will cause the claim billed amount to be doubled. Electronic billers should not put a code in this block.** b. **Radiology** – Professional services by a physician must be billed separately by the physician. c. **Laboratory** – If laboratory work is sent out, the name and address or nine-character Medicaid TPI of the laboratory where the work was forwarded must be entered. d. **Medical / Surgical Supplies** – Itemize these services provided in the inpatient facility (such as infusion pumps, traction setups, and crutches for inpatient use only). If provided to all admitted patients, admission kits should be billed using revenue code "270."
44	HCPCS/rates	Inpatient: Enter the accommodation rate per day. Outpatient: Outpatient claims must have the appropriate HCPCS code or narrative description. **Do not use revenue codes for billing these services.** Enter the date of service numerically, and the block number of the diagnosis listed in blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, identify the primary diagnosis. Each service except for medical/surgical and IV supplies and medication must be itemized on the claim or an attached statement. For example: a. **Emergency Room** – Bill as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in block 18, using 00 to 23 hours military time (such as 1350 for 1:50 pm). Indicate other times on the same line as the procedure code. b. **Operating Room** – Bill as "Operating Room." c. **Recovery Room** – Bill as "Recovery Room" or "Cast Room" as appropriate. d. **Injections** – Must have "Inj. – name, strength, quantity" or the injection code. e. **Drugs** and **Supplies** – Take-home drugs and supplies are not a benefit of the CSHCN Program. Drugs administered in the outpatient setting must be billed with the modifier "SH." The drug description must include the name, strength, and quantity. f. **Radiology** – The description should provide the location and the number of views. As an alternative, identify the HCPCS code. Professional services by a physician must be billed separately by the physician. The license number of the ordering physician must be in block 83. g. **Laboratory** – Provide a complete description or use the procedure codes for the laboratory procedures. Professional services by a physician must be billed separately by the physician. The license number of the ordering physician must be in block 83. If laboratory work is sent out, the name of the test and the name and address or CSHCN number of the laboratory where the work was forwarded must be entered. h. **Nuclear Medicine** – Provide a complete description. i. **Day Surgery** – Day surgery should be billed as an inclusive charge. Services provided in conjunction with the surgery (lab, radiology, anesthesia) should not be billed separately. **NOTE:** The UB-92 Claim Form is limited to 27 items per outpatient claim. If necessary, IV supplies (Y7112) and central supplies (Y7107) may be combined on the charge detail and considered as single items with the appropriate quantities and total charges.
45	Service date	Enter the date of service numerically corresponding to each procedure for outpatient claims.

Block No.	Description	Guidelines
46	Units of service	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in block 46 should always represent hours spent in observation.
47	Total charges	Enter the total charges for each service provided.
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
51	CSHCN TPI	Enter the nine-digit CSHCN TPI.
54	Prior payments	Enter amounts paid by any TPR and complete blocks 32, 61, 62, and 84 as required.
58	Insured's Name	If other health insurance is involved, enter the insured's name.
60	CSHCN identification number	Enter the patient's nine-digit CSHCN number.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number (PAN).
65	Employer name	Enter the name of the client's employer if health care might be provided. Complete block 66.
66	Employer location	Enter the complete address if an employer name is identified in block 65.
67	Principal diagnosis code	Enter the ICD-9-CM diagnosis code for the principal diagnosis to the highest level of specificity available.
68-75	Other diagnosis codes	Enter the ICD-9-CM diagnosis code to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block.
76	Admitting diagnosis	Enter the ICD-9-CM diagnosis code in block E indicating the cause of admission or include narrative.
79	Procedure coding method	Enter code "5" for HCPCS or code "9" for ICD-9-CM. Code "9" is used only on inpatient hospital billings.
80-81 a,b,c,d,e	Principal and other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date each was performed.

Block No.	Description	Guidelines
82	Attending physician ID	For inpatient claims, enter the physician's license number or UPIN of the provider who performed the service or is responsible for the treatment and plan of care in the following format: 11233333 1 = Two-digit state indicator (for example, TX for Texas) 2 = Licensing board indicator examples B = MD or DO D = Dentist P = Podiatrist 3 = License number Example: TXBL1234 If the provider has a temporary license number, enter "TEMPO." Example: TXBTEMPO
83 a,b	Other physician ID	For inpatient claims, enter the license number for the provider who performed the principle surgical procedure. If the same as block 83, state "SAME." For outpatient claims, enter the license number for the following: The ordering physician for all laboratory and radiology services (if a different physician ordered laboratory or radiology services, enter his license number in block 82). If the referring physician is a resident, blocks 82 and 83 must identify the physician who is supervising the resident.
84	Remarks	This block is used to explain special situations such as the following: If a patient stays beyond dismissal time, indicate the medical reason if any additional charge is made. If billing for a private room, the medical necessity must be indicated and signed by the physician. If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in block 39. If laboratory work is sent out, the name and address or the TPI of the facility where the work was forwarded must be entered in this field. If the patient is deceased, enter the date of death. If services were rendered on the date of death, enter the time of death. If services were provided at another facility, indicate the name and address of the facility where the services were rendered.
85	Provider representative signature	The hospital representative must sign his or her name. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by a hospital representative authorizing this practice.
86	Date bill submitted	Enter the date the bill was signed.

8.8.2 Occurrence Codes

Code	Description	Guidelines
01	Auto accident/auto liability insurance involved	Enter the date of auto accident. Use this code to report an auto accident that involves auto liability insurance requiring proof of fault.
02	Auto or other accident/ no-fault involved	Enter the date of an accident, including auto or other, where no-fault coverage allows insurance immediate claim settlement without proof of fault. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with the no-fault insurer.
03	Accident/TORT liability	Enter the date of an accident (excluding automobile) resulting from a third party's action. This incident may involve a civil court action in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/employment-related	Enter the date of an accident which allegedly relates to the patient's employment and involves compensation or employer liability. Use this code in conjunction with occurrence codes 24, 50, or 51 to document coordination of benefits with workers' compensation insurance or an employer. Only services that are not covered by workers' compensation may be considered for payment by CSHCN.
05	Other accident	Enter the date of an accident not described by the above codes. Use this code to report that you have developed for other casualty related payors and have determined that there are none.
06	Crime victim	Enter the date on which a medical condition resulted from alleged criminal action.
24	Date other insurance denied	Enter the date of denial of coverage by a third party resource.
25	Date benefits terminated by primary payor	Enter the last date for which benefits are being claimed.
50	Date other insurance paid	Enter the date of payment from a third party resource.
51	Date claim filed with other insurance	Enter the date a claim was filed with a third party resource.

8.8.2.1 Inpatient – Other Insurance HCFA-1450 (UB-92) Claim Form Example

APPROVED OMB NO. 0938-0279

Texas Hospital 209 W. 45th El Paso, TX 77905 915-555-1234	2	3 PATIENT CONTROL NO. 12345	4 TYPE OR BILL 111

5 FEDERAL TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV.D.	8 N-C.D.	9 C-I.D.	10 L-RD	11
7777777	060102	060402	3	0			

12 PATIENT NAME	13 PATIENT ADDRESS	CITY	STATE	ZIP
Cries, Bob J.	1200 Whispering Pines	El Paso	TX	77903

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03241997	M	14	060102	09	1	1	11	01	123456								

	32 CODE	OCCURENCE DATE	33 CODE	OCCURENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURENCE DATE	36 CODE	OCCURENCE SPAN FROM	THROUGH	37
a	51	060102	50	060102								A
b												B
												C

8	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	120	Semi-private room			3	360	00				1
2											2
3	250	Pharmacy			10	125	84				3
4											4
5	300	Laboratory				78	00				5
6											6
7	320	Radiology				168	00				7
8											8
9	360	OR Services				704	00				9
0											10
1	370	Anesthesia				216	50				11
2											12
3	710	Recovery Room				75	00				13
4											14
5											15
6											16
7	001		Total charges			1727	99				17
8											18
9											19
0											20
1											21
2											22
3											23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A	CSHCN	1234567-89						A
B								B
C								C

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P.REL.	60 CERT - SSN - -HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	Bob J. Cries		9111111100	Mutual of Omaha	Group #6042	A
B						B
C				567 Redbird Atlanta, GA 54101	Policy #5479014	C

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
123456789			

67 PRIN.DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADMIN. DIAG. CD.	77 E-CODE	78
21370									21370		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	
	7765	060102	7765 A	060102	B		TXBE1234	a
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	
a	C		D		E		TXBE1234	b

84 REMARKS	OTHER PHYS. ID	
b		a
c		b
d	85 PROVIDER REPRESENTATIVE	86 DATE
	X Sally Smith	06 09 02

UB - 92 HCFA - 1450
INPT, OTHER

copy 1

I CERTIFY THAT THE CERTIFICATIONS IN THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

8.8.2.2 Outpatient HCFA-1450 (UB-92) Claim Form Example

APPROVED OMB NO. 0938-0279

Texas Hospital 209 W. 45th El Paso, TX 77905 915-555-1234	2	3 PATIENT CONTROL NO. 123456789	4 TYPE OR BILL 131
	5 FEDERAL TAX NO. 5555555	6 STATEMENT COVERS PERIOD FROM THROUGH	7 COV.D. 8 N-C.D. 9 C-I.D. 10 L-RD 11

12 PATIENT NAME	13 PATIENT ADDRESS	CITY	STATE	ZIP
Baker, Ann C.	6789 Ave. A	Austin, TX 78711		

14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
03241997	F		060102	12					123456								

CONDITION CODES

32 CODE	OCCURENCE DATE	33 CODE	OCCURENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURENCE DATE	36 CODE	OCCURENCE SPAN FROM	THROUGH	37
a 24	060102										A
b											B
											C

8

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

	42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		Bronchoscopy with biopsy	F-31625	060102	1	425 00		
7			Total charges			425 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	CSHCN	123456789					
B							
C							

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL.	60 CERT - SSN - -HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Baker, Ann C.		911111100		
B					
C					

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
123456789			

67 PRIN.DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADMIN. DIAG. CD.	77 E-CODE	78
16290											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID: 9876543-21

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Sally Smith

86 DATE: 06 09 02

UB - 92 HCFA - 1450
CORFCCP

copy 1

I CERTIFY THAT THE CERTIFICATIONS IN THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

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8.8.2.3 Outpatient Hospital Day Surgery HCFA-1450 (UB-92) Claim Form Example

APPROVED OMB NO. 0938-0279

Texas Hospital
209 W. 45th
El Paso, TX 77905
915-555-1234

2

3 PATIENT CONTROL NO.: 123456789

4 TYPE OR BILL: 131

5 FEDERAL TAX NO.: 5555555

6 STATEMENT COVERS PERIOD FROM THROUGH

7 COV.D. | 8 N-C.D. | 9 C-I.D. | 10 L-RD | 11

12 PATIENT NAME: Baker, Ann C.

13 PATIENT ADDRESS: 6789 Ave. A | CITY: Austin | STATE: TX | ZIP: 78711

14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
03241997	F		060102	12					123456								

CONDITION CODES

	32 CODE	OCCURENCE DATE	33 CODE	OCCURENCE DATE	34 CODE	OCCURENCE DATE	35 CODE	OCCURENCE DATE	36 CODE	OCCURENCE SPAN FROM	THROUGH	37
a	24	060102										A
b												B
												C

8

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

	42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		Bronchoscopy with biopsy	F-31625	060102	1	425 00		
2								
3								
4								
5								
6								
7								
8								
9								
0								
1								
2								
3								
4								
5								
6								
7			Total charges			425 00		
8								
9								
0								
1								
2								
3								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	CSHCN	123456789					
B							
C							

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL.	60 CERT - SSN - -HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Baker, Ann C.		911111100		
B					
C					

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
123456789			

67 PRIN.DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADMIN. DIAG. CD.	77 E-CODE	78
16290											

OTHER DIAG. CODES

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID: 9876543-21

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Sally Smith

86 DATE: 06 09 02

UB - 92 HCFA - 1450
CORFCCP

copy 1

I CERTIFY THAT THE CERTIFICATIONS IN THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

8.8.2.4 Inpatient Rehabilitation HCFA-1450 (UB-92) Claim Form Example

APPROVED OMB NO. 0938-0279

Greatland Hospital Center 4004 Elm Loop Westville, TX 78596 512-555-1234	2	3 PATIENT CONTROL NO. 123456789	4 TYPE OR BILL 111

5 FEDERAL TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV.D.	8 N-C.D.	9 C-I.D.	10 L-RD	11
5555555	060102	063102	07	0			

12 PATIENT NAME	13 PATIENT ADDRESS	CITY	STATE	ZIP
Lei, Wei Chu	6789 Courtland Circle	Westville, TX 79065		

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
12161994	M		060102	10	3	1	13	01	123456								

32 CODE	OCCURENCE DATE	33 CODE	OCCURENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURENCE DATE	36 CODE	OCCURENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

8	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
1	128	Room & Board - Semi Private (two bed)			30	5480	00		
2									
3	270	Medical/Surgical Suplies and Devices				1084	08		
4									
5	301	Laboratory-Chemistry				241	76		
6									
7	412	Repiratory Services-Inhalation Services				318	88		
8									
9	422	Physical Therapy-Hourly Charge				943	50		
0									
1									
2									
3									
4									
5									
6									
7			Total charges			8068	22		
8									
9									
0									
1									
2									
3									

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	CSHCN	123456789					
B							
C							
	57	DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P.REL.	60 CERT - SSN - -HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Lei, Wei Chu		911111100		
B					
C					

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
123456789			

67 PRIN.DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADMIN. DIAG. CD.	77 E-CODE	78
71431									71431		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		TXBC1234
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		

84 REMARKS	OTHER PHYS. ID
a	
b	
c	85 PROVIDER REPRESENTATIVE / 86 DATE
d	X Sally Smith / 06 09 02

UB - 92 HCFA - 1450
CORFCCP

copy 1

I CERTIFY THAT THE CERTIFICATIONS IN THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

8

8.8.2.5 CSHCN Inpatient Admission Authorization Request Form

CSHCN Inpatient Admission Authorization Request Form

Submit to CSHCN Authorization Department, 12545 Riata Vista Circle, Austin, TX 78727 or FAX to: 512-514-4222

For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First name:	**Last name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / Zip:		

Procedure Information:

Surgical procedure(s) requested (ICD-9-CM vol. 3):		
Surgeon name / CSHCN TPI:		
Number of days requested:		❑ **Inpatient** ❑ **Extension**
Date of admit:		**Anticipated date of discharge:**
Facility name / CSHCN TPI:		
Attending physician name / CSHCN TPI:		
Other insurance info: (please check each that apply)	❑ **None** ❑ **Yes**	**If Yes:** ❑ **Private** ❑ **Medicare** ❑ **Medicaid**

Medical Necessity Information:

Please document medical necessity by indicating which items listed below pertain to this hospital stay and include additional comments as necessary:

Comments:
❑ Surgical admit ❑ Chemotherapy ❑ ER admit ❑ Intensive care ❑ IV fluids ❑ IV medications ❑ Transfusions (excluding bone marrow / stem cell transplants*) ❑ Diagnostics ❑ Lab ❑ Radiology ❑ Persistent symptoms (e.g., seizures, fever) ❑ Post operative complications

***For bone marrow / stem cell transplants refer to your CSHCN provider manual for specific criteria that must accompany each request.**

Signature of Provider:	**Date:**
Print or Type Provider Name:	**Phone Number:**
Provider Address / City / Zip:	**FAX #:**
CSHCN TPI:	**Contact Person:**

8.8.2.6 CSHCN Inpatient Rehabilitation Admission Authorization Request Form

CSHCN Inpatient Rehabilitation Admission
Prior Authorization Request Form

Submit to CSHCN Authorization Department, 12545 Riata Vista Circle, Austin, TX 78727 or FAX to: 512-514-4222

For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First name:	**Last name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / Zip:		

Procedure Information:

Number of days requested:	❑ **Rehab** ❑ **Rehab Extension**	
Date of admit:	**Anticipated date of discharge:**	
Facility name / CSHCN TPI:		
Attending physician name / CSHCN TPI:		
Other insurance info: (check each that apply)	❑ **None** ❑ **Yes**	**If Yes:** ❑ **Private** ❑ **Medicare** ❑ **Medicaid**

Information Required for Initial Rehab Admission Authorization:

Name of team physician:	**Date of onset of condition:**
Is the patient sufficiently alert to participate with the rehab team? _____ **in setting own treatment goals (n / a for patients < 4 years old)** _____ **in therapeutic activities (must complete for patients of all ages)**	
Has the patient received inpatient rehab at an earlier date? ❑ **Yes** ❑ **No**	
If yes, why needed now?	
Has the patient lost previous level of attained functional independence through complications or recurrent illness and reattainment of functional independence is feasible? ❑ **Yes** ❑ **No**	
If child is under 4 years of age, will parent / caregiver be present during inpatient rehab stay and participate in setting treatment goals? ❑ **Yes** ❑ **No**	
If the patient has a congenital condition, what recent change has occurred in medical and functional status that warrants inpatient rehab?	
If no recent change, justification for inpatient rehab must be sent along with this request form.	
An initial authorization of up to 14 days is requested to determine patient's ability to progress toward treatment goals as a result of inpatient rehab: ❑ **Yes** ❑ **No**	

8

CSHCN Inpatient Rehabilitation Admission
Prior Authorization Request Form (continued)

First Name:	Last Name:	CSHCN #:

Information Required for Authorization Extension:

This request is for an extension after a 14 day authorization. ❑
Key for functional levels:
A. needs NO ASSISTANCE to independently perform activity.
B. needs ONLY STANDBY ASSISTANCE to independently perform activity.
C. needs MINIMAL ASSISTANCE to independently perform activity.
D. needs MODERATE ASSISTANCE to independently perform activity.
E. needs MAXIMUM ASSISTANCE to independently perform activity.
F. needs TOTAL CARE - no independent performance.

Functional Level and Progress:

FUNCTIONAL ACTIVITY (List all activities from treatment plan)	FUNCTIONAL LEVEL ON INITIAL EVALUATION–Give dates	ANTICIPATED FUNCTIONAL LEVEL–Give projected date	PRESENT FUNCTIONAL LEVEL–Give current date
e.g. w/c mobility	D. 1/6/02	A. 2/15/02	C. 1/29/02

I certify that the treatment goals cannot be met through outpatient rehabilitation services and significant progress can be attained in cognitive and/or mobility and self care activities:	
Signature of Provider:	Date:
Print or Type Provider Name:	Phone Number:
Provider Address/City/Zip:	FAX #:
CSHCN TPI:	Contact Name:

8.8.3.1 CSHCN Authorization Form for Hemophilia Blood Factor Products

CSHCN Authorization Form for Hemophilia Blood Factor Products

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin, TX 78727-6524 or FAX to 512-514-4222

For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First Name:	Last Name:
CSHCN #:	DOB:
Diagnoses (ICD-9-CM):	
Address/City/State/ZIP:	

Provider Information:

Name (print or type):	TPI #:
Phone #:	FAX #:
Address/City/State/ZIP:	
Contact name:	Provider Signature:

Prescribing Physician's Name: _____ **Telephone Number:** _____

Product Information:

Product Name/Manufacturer:	
National Drug Code (NDC):	
HCPCS Code:	Quantity (per I.U.):

8

SECTION

9

Independent Laboratory

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9.1 Enrollment

An independent (freestanding) laboratory enrolled in the CSHCN Program is defined as a facility that meets the following criteria:

- Facility independent from a physician's office or hospital
- Meets staff, equipment, and testing capability standards for certification by TDH
- Medicare certified and enrolled as a Medicaid provider

9.2 Clinical Laboratory Improvement Amendments of 1998 (CLIA)

9.2.1 CLIA Requirements

To be eligible for reimbursement by CSHCN, all providers performing laboratory tests must:

- Pay a fee to the Centers for Medicare and Medicaid Services (CMS).
- Receive a CLIA registration and/or certification number by contacting TDH at 512-834-6650 or 512-834-6686 or access CLIA information at www.tdh.state.tx.us/hcf/clia. Submit CLIA applications to the following address:

  TDH
  Health Facility Licensure and Certification Division
  1100 West 49th Street
  Austin TX 78756

- Notify NHIC of your CLIA number at the following address:

  NHIC
  ATTN: Provider Enrollment
  PO Box 200795
  Austin TX 78720-0795

9.2.2 CLIA Regulations

The Centers for Medicare and Medicaid Services (CMS), formerly The Health Care Financing Administration (HCFA), implemented the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective for dates of service on or after September 1, 1992. The CLIA regulations were published in the February 28, 1992 *Federal Register*.

Copies of the following regulations may be requested:

Appendix C: Interpretive Guidelines		
Paper copy	PB92-146-174	$67.50 (plus shipping and handling fees)
Diskette	PB93-505-717	$112.00 (plus shipping and handling fees)

Federal Regulations (*Federal Register*)		
HSQ176, 177, 179, 202, 206	PB93-154-615	$63.00

***Federal Register*-Final Test Categorization List**		
July 26, 1993	PB93-218-386	$36.50 (+shipping an handling fees)

Request copies of the CLIA regulations from the following address:

National Technical Information Services
5285 Port Royal Road
Springfield VA 22161
703-487-4650
800-553-NTIS

These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. CLIA regulations set standards designed to improve quality in all laboratory testing and included specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing (PT). Under CLIA 88, all clinical laboratories (including those located in physicians offices), regardless of location, size, or type of laboratory must meet standards based on the complexity of the test(s) they perform.

Important
NHIC-CSHCN monitors claims submitted by **clinical laboratories** for CLIA numbers. Without a CLIA number on file with CSHCN, claims for laboratory services will be denied.

9.2.2.1 Limits of Waiver and Physician Performed Microscopy Procedure (PPMP) CLIA Certificates

CLIA certificates may limit the holder to performing only certain tests. CSHCN bills must accurately reflect those services authorized by the CLIA Program and no other procedures. There are two types of certificates that limit holders to only certain test procedures and these are “Waiver” and “PPMP” certificates. A description of those test procedures follows.

Waiver Certificate. Holders of a waiver certificate are authorized to perform only the following tests:

Procedure Code	Description
80061	Lipid panel
81002	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated without microscopy
81003	Urinalysis, by dip stick or tablet reagent; w/o microscopy, automated
82044	Albumin; urine, microalbumin, semiquantitative (e.g., reagent strip assay)
82270	Blood, occult; feces screening, 1-3 simultaneous determinations
82273	Blood; other sources, qualitative
82465	Cholesterol, serum (cholestech LDX)
82947	Glucose; quantitative (cholestech LDX)
82950	Glucose; post glucose dose (hemocue B-glucose photometer)
82951	Glucose; tolerance test (hemocue B-glucose photometer)
82952	Glucose; tolerance test (hemocue B-glucose photometer)
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use
82985	Glycated protein
83036	Hemoglobin; glycated
83518	Immunoassay analyte other than infect agent antibody/antigen, quali/semiquanti, sngl step
83718	Lipoprotein; HDL (cholestech LDX)
83986	pH, body fluid (All qualitative color comparison pH testing - body fluids, other than blood)
84478	Triglycerides (cholestech LDX)
84999	Unlisted chemistry procedure
85013	Blood count; spun microhematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin (Hemoglobin by single instrument with self contained component features to perform specimen/reagent interaction, providing direct measurement and readout)
85610	Prothrombin time
85651	Sedimentation rate, erythrocyte; nonautomated
86308	Heterophile antibodies; screening
86318	Immunoassay for infectious agent antibody (QuickVue one-step H.Pylori test for whole blood)
87072	Culture or direct bacterial identification method (serim pyloritek test kit)

Physician Performed Microscopy Procedure (PPMP) Certificates. Holders of PPMP certificates are authorized to perform all the procedures listed above in addition to the following tests:

Procedure Code	Description
G0026	Fecal leukocyte examination
Q0111	Wet mount, including preparations of vaginal, cervical or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated with microscopy
81001	Urinalysis automated, with microscopy
81015	Urinalysis; microscopic only
89190	Nasal smear for eosinophils

9.3 Reimbursement

CSHCN provides coverage for laboratory services according to maximum fees. Clinical laboratory services are reimbursed at the least of the national fee schedule or the billed amount. Some services (e.g., anatomical pathology) are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM).

Effective for dates of service on or after September 1, 1999, CSHCN will pay only up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider. Providers who perform both the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component. Providers who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, will be denied. Claims will be paid based on the order they are received.

For example, if a claim is received for the total component and NHIC has already made payment for the technical and/or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

In compliance with state laws, NHIC reimburses independent laboratories for most CSHCN services according to maximum fees established by federal law, Medicare, or TDH. Clinical laboratory services are reimbursed at the lesser of the national fee schedule or the billed amount.

As the result of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, independent laboratories are not directly reimbursed by CSHCN when providing tests to clients registered as hospital inpatients or hospital outpatients. Reimbursement must be obtained from the hospital. These services cannot be billed to the client.

9.3.1 Clinical Laboratory Services – Outpatient Services

The Deficit Reduction Act of 1984 (DEFRA), requires clinical diagnostic laboratory tests performed in a physician's office by an independent laboratory or by a hospital laboratory for its outpatients be reimbursed on the basis of maximum fee schedules. The Texas Medicare carrier publishes the fee schedules on an annual basis. By federal law, CSHCN payment cannot exceed that allowed by Medicare.

9.4 Benefits and Limitations

Refer to: "Reimbursement" on page 1-22 of the General section for more information about reimbursement methodologies.

The CSHCN Program only covers professional and technical services that an independent laboratory is certified by Medicare to perform.

Providers who perform both the technical services and the interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component. Providers who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, will be denied. Claims will be paid based on the order they are received. For example, if a claim is received for the total component and NHIC has already made payment for the technical and/or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

Independent laboratories involved with providing laboratory tests to clients registered as hospital inpatients or hospital outpatients are not directly reimbursed. Reimbursement must be obtained from the hospital.

9.4.1 Cancer Screening

The following procedure codes are covered services:

Procedure Code	Description
G0103	Prostate cancer screening; prostate specific antigen test (PSA) total
G0107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations

9.4.1.1 Colorectal Cancer Screening

Screening colonoscopy is recommended once every 24 months for individuals at high risk for colorectal cancer. High risk individuals include persons with one or more of the following:

- Close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyposis;
- Family history of familial adenomatous polyposis;
- Family history of hereditary nonpolyposis colorectal cancer;
- Personal history of colorectal cancer, or
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis

A screening colonoscopy may be covered for the following diagnoses:

Diagnosis Code	Description
V1005	Personal history of malignant neoplasm of the large intestine
V1006	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
V1600	Family history of malignant neoplasm of gastrointestinal tract
V1850	Family history of certain other specific conditions, digestive disorders
55500	Regional enteritis of small intestine
55510	Regional enteritis of large intestine
55520	Regional enteritis of small intestine with large intestine
55590	Regional enteritis of unspecified site
55600	Ulcerative (chronic) enterocolitis
55610	Ulcerative ileocolitis
55620	Ulcerative (chronic) proctitis

Diagnosis Code	Description
55630	Ulcerative (chronic) proctosigmoiditis
55680	Other ulcerative colitis
55690	Ulcerative colitis, unspecified
55820	Toxic gastroenteritis and colitis
55890	Other and unspecified noninfectious gastroenteritis and colitis

9.4.2 Cytogenetics Testing

Genetic testing is limited to diagnoses 20280 through 20298, Lymphomas, and 20400 through 20891, Leukemia. Effective for dates of service on or after March 1, 1999, the following procedure codes are payable for the above diagnoses only:

Procedure Code	Description
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (e.g., diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88264	Chromosome analysis; analyze 20-25 cells
88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivates and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (e.g., for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells
88291	Cytogenetics and molecular cytogenetics; interpretation and report

The cytogenetics procedure codes are divided into three tables. The tables are detailed below.

Each provider may be paid one culture procedure (Table A) and one chromosome analysis procedure (Table B) for the same client on the same day. Each client is limited to six culture procedures (Table A) and six chromosome analysis procedures (Table B) per 365 days. Each client is limited to one molecular cytogenetics procedure (Table C) per 365 days.

The procedures listed in Tables A and C may be reimbursed when billed together for the same date of service. Only one procedure per table will be reimbursed; the others will be denied as “part of.”

In Table B, **only one procedure code may be reimbursed** for each of the following subcategories. The other procedure codes will be denied as “part of.”

- 88245, 88248, and 88249 (when billed together, only one of these procedure codes will be reimbursed)
- 88261 through 88264
- 88280 and 88283

Table A: Procedure Codes for Tissue Culture

Procedure Code	Description
88230	Tissue culture for non-neoplastic disorders; lymphocyte
88233	Tissue culture for chromosome analysis; skin or other solid tissue biopsy
88237	Tissue culture for neoplastic disorders; bone marrow blood cells
88239	Tissue culture for neoplastic disorders; solid tumor

Table B: Procedure Codes for Chromosome Analysis

Procedure Code	Description
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE) 20-25 cells
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (e.g., for ataxia telangiectasia, Fanconi anemia, Fragile X)
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (e.g., Diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88261	Chromosome analysis; count 5 cells, 1 karyotype with banding
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding
88264	Chromosome analysis; analyze 20-25 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	Chromosome analysis; additional specialized banding technique (e.g., NOR, C-banding)

Table C: Procedure Codes for Molecular Cytogenetics

Procedure Code	Description
88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivates and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (e.g., for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells

Procedure codes 88250 and 88260 have been deleted and are no longer a benefit.

9.4.3 Cytopathology of Sites Other Than Vaginal, Cervical, Uterine

Procedure Code	Description
Physician in the office (POS 1)	
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, any other source; preparation, screening and interpretation
88162	Cytopathology, any other source; extended study involving over 5 slides or multiple stains
Physician in the outpatient (POS 5) and inpatient (POS 3) hospital	
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, any other source; preparation, screening and interpretation
88162	Cytopathology, any other source; extended study involving over 5 slides or multiple stains
Outpatient hospital lab (POS 5) or independent lab (POS 6)	
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, any other source; preparation, screening and interpretation
88162	Cytopathology, any other source; extended study involving over 5 slides or multiple stains

When procedure code 88160 and/or 88161 is billed with 88162, 88160 and/or 88161 are denied as part of 88162.

When procedure code 88160 is billed with 88161, 88160 is denied as part of 88161.

9.4.4 Cytopathology of Vaginal, Cervical, Uterine Sites

Because of the technical nature of processing and interpreting a pap smear or specimen for cytopathology, pathologists are the only physician specialty reimbursed with the following exception:

Exception: Other physician specialties equipped to perform pap smears in their offices must have modifier "PO" (performed in office) on the claim form.

Procurement and handling of the pap smear or specimen for cytopathology is considered part of the evaluation and management of the client and is not reimbursed separately.

A pathologist must report the place of service (POS) according to where the pap smear is interpreted. Pap smear procedure codes must be billed according to the place of service.

Procedure Code	Description
Physician in the office (POS 1)	
88142	Cytopathology, cervical/vaginal, auto thin layer prep; manual screen under physician supervision
88150	Cytopathology, slides, cervical/vaginal; manual screening under physician supervision
88155	Cytopathology, slides, cervical/vaginal, definitive hormonal evaluation (list separately in addition to technical and interpretation)
Outpatient hospital lab (POS 5) or independent lab (POS 6)	
88150	Cytopathology, slides, cervical/vaginal; manual screening under physician supervision
88155	Cytopathology, slides, cervical/vaginal, definitive hormonal evaluation (list separately in addition to technical and interpretation)

When procedure code 88150 is billed with 88155, 88150 is denied as part of 88155. Procedure code 88142 may be reimbursed in addition to 88150 or 88155.

9.4.5 Helicobacter Pylori (H. Pylori)

Procedure codes 83013 and 83014, Helicobacter Pylori, breath test including drug and breath sample collection kit, are a benefit. These codes are considered a clinical lab service. The interpretation/professional component is not separately reimbursed. Procedure code 87338, Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiqualitative, multiple step method, helicobacter pylori, stool, is a benefit of the CSHCN Program. This procedure is not payable on the same date of service to the same provider as procedure codes 83013 and/or 83014. If a gastrointestinal endoscopy is performed within 90 days of the H. Pylori test, procedure codes 43200, 43202, 43234, 43235, and 43239 will be denied. These services can be appealed with submission of medical documentation that supports performance of the endoscopy.

9.4.6 Laboratory Paneling

Laboratory tests generally performed as a part of a laboratory panel on the same day, by the same provider must be billed with the appropriate panel code.

The laboratory tests listed below must be billed as a panel:

- Chemistry tests
- Urinalysis
- Complete blood counts (CBC)

There is no distinction between the methods of testing (whether manual or automated). The test **must** be billed as a panel.

9.4.6.1 Chemistry Tests

The Medicare policy pertaining to laboratory paneling procedures was implemented by the CSHCN Program.

The new organ and disease panel codes 80048, 80050, 80051, 80053, 80061, 80069, 80074, 80076, and 80090 must be used instead of the general multichannel automated panel codes.

The following chemistry tests must be billed individually unless a complete panel is performed on the same day:

Procedure Code	Description
82040	Albumin; serum
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol; serum or whole blood, total
82565	Creatinine; blood
82947	Glucose; quantitative, blood
83718	Lipoprotein, direct measurement, high density cholesterol
84075	Phosphatase, alkaline
84100	Phosphorus inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84443	Thyroid stimulating hormone
84450	Transferase; aspartate amino (AST) (SGOT)
84460	Transferase; alanine amino (ALT) (SGPT)
84478	Triglycerides
84520	Urea nitrogen; quantitative
85022	Hemogram, automated, and manual differential WBC count (CBC)
85025	Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
86644	Antibody, cytomegalovirus (CMV)
86694	Antibody, herpes simplex, nonspecific type test
86705	Hepatitis B core antibody (HbcAb), IgM antibody
86709	Hepatitis A antibody (HAAb) IgM antibody
86762	Antibody, rubella
86777	Antibody, toxoplasma
87340	Hepatitis B surface antigen (HbsAg)
86803	Hepatitis C antibody

9.4.6.2 Complete Blood Counts (CBC)

The codes for a complete blood count [CBC (with or without differential and / or platelet count)] and the individual components are listed below. If only one component is performed, bill the appropriate individual code. If two of the components are performed, use procedure code X7619. If three or more of the components are performed on the same day, they must be combined and billed as procedure code 85022 or 85031. Procedure code X7619 may not be billed on the same day as procedure code 85021, 85022 or 85031.

CBC	Description
85021	Blood count; hemogram, automated (RBC, WBC< HgB, Hct and indices only)

CBC with Differential	Description
85022	Blood count; hemogram, automated, and manual differential WBC count (CBC)
85031	Blood count; hemogram, manual, complete CBC (RBC, WBC, HgB, Hct, differential and indices)

CBC with Differential and Platelet	Description
85023	Blood count; hemogram and platelet count, automated, and manual differential WBC count (CBC)
85024	Blood count; hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)

Components of CBC	Description
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
85008	Blood count; manual blood smear examination without differential parameters
85009	Blood count; differential WBC count, buffy coat
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
85027	Blood count; hemogram and platelet count, automated
85041	Blood count, red blood cell (RBC) only
85048	Blood count; white blood cell (WBC)

If a platelet count (85590 or 85595) is performed on the same day as a CBC, use procedure code 85023, 85024 or 85025. If 85590 or 85595 are billed on the same day as 85023, 85024, 85025, or 85027, then 85590 or 85595 will be denied as part of another procedure.

Platelet estimation (85585) will not be paid when performed on the same day as 85023, 85024, 85025, 85027, 85590, or 85595. Platelet estimation can be billed on the same day of service as 85021, 85022, or 85031.

The following specialized blood counts may be billed in addition to a CBC when performed on the same day:

Procedure Code	Description
84044	Blood count; reticulocyte, manual
85045	Blood count; reticulocyte count, flow cytometry
85046	Blood count, reticulocytes, hemoglobin concentration

Ferritin and Iron Studies

CSHCN may reimburse procedure codes 82728, Ferritin, 83540, Iron, 83550, Iron binding capacity, 84466, Transferrin, 85535, Iron stain (RBC or bone marrow smears), and 85536, Iron stain, peripheral blood. Procedure code 85536 is payable when billed with any of the following diagnoses:

Diagnosis Code	Description
27500	Hemochromatosis
28000	Iron deficiency anemia, secondary to blood loss (chronic)
28010	Iron deficiency anemia, secondary to inadequate dietary iron intake
28080	Other specified iron deficiency anemias
28090	Iron deficiency anemia, unspecified
28100	Pernicious anemia
28110	Other vitamin B12 deficiency anemia
28120	Folate-deficiency anemia
28190	Unspecified deficiency anemia
28240	Thalassemias
28280	Other specified hereditary hemolytic anemias
28290	Hereditary hemolytic anemia, unspecified
28390	Acquired hemolytic anemia, unspecified
28500	Sideroblastic anemia
28521	Anemia in end-stage renal disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic illness
28590	Anemia, unspecified
53600	Achlorhydria
57280	Other sequelae chronic liver disease
57380	Other specified disorders of liver
57390	Unspecified disorder of liver
57930	Other and unspecified postsurgical nonabsorption
57980	Other specified intestinal malabsorption
57990	Unspecified intestinal malabsorption
58500	Chronic renal failure
58600	Renal failure, unspecified
V5600	Extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V5680	Other dialysis

If procedure codes 85535, Iron stain, RBC or bone marrow smears, and 85536, Iron stain, peripheral blood, are billed on the same day, the claim must state clearly that one of the procedures was an iron stain on bone marrow.

If a ferritin and iron procedure are billed on the same day, the ferritin will be denied, and the iron will be paid. Ferritin (82728) and iron (83540) will be payable on the same day with the diagnosis of 27500, Hemochromatosis, 28521, Anemia in ESRD, and/or 585, Chronic renal failure.

9.4.7 Latex Sensitivity Testing

CSHCN will cover radioallergosorbent (RAST) testing for CSHCN clients when used to detect latex sensitivity.

Use procedure code 86003, Allergen specific IGE; quantitative, or semiquantitative, each allergen, when billing for RAST testing.

Requests for RAST testing are covered for the following diagnoses:

Diagnosis Code	Description
59330	Stricture or kinking of ureter
59340	Other ureteric obstruction
59350	Hydroureter
59370–59373	Vesicoureteral reflux
59382	Ureteral fistula
59610	Intestinovesical fistula
59800–59890	Urethral stricture
59910	Urethral fistula
61900–61980	Female genital fistula
61990	Unspecified fistula involving female genital tract
74100–74193	Spina bifida (includes Arnold-Chiari/Chiari II)
75220–75249	Congenital anomalies of genital organs
75261	Hypospadias and epispadias and other penile anomalies, hypospadias
75262	Hypospadias and epispadias and other penile anomalies, epispadias
75263	Hypospadias and epispadias and other penile anomalies, congenital chordee
75270	Indeterminate sex and pseudohermaphroditism
75320	Congenital obstructive defect of renal pelvis and ureter, unspecified obstructive defect of renal pelvis and ureter
75321	Congenital obstructive defect of renal pelvis and ureter, congenital obstructive of ureteropelvic junction
75322	Congenital obstructive defect of renal pelvis and ureter, congenital obstructive of ureterovesical junction
75323	Congenital obstructive defect of renal pelvis and ureter, congenital ureterocele
75329	Congenital obstructive defects of renal pelvis and ureter, other
75340	Other specified anomalies of ureter
75350	Exstrophy of urinary bladder
75360	Atresia and stenosis of urethra and bladder neck
75370	Anomalies of urachus
75380	Other specified anomalies of bladder and urethra

If the physician performs the test in the office, a modifier PO must be used, indicating that the necessary equipment to perform the test is in the office.

9.4.8 Urinalysis

A similar methodology that is used with chemistry tests is applied when two or more components of a urinalysis are performed on the same day and billed separately. The billed services are also denied if not paneled appropriately and must be resubmitted with urinalysis codes 81000, 81001, 81002, or 81003. The following codes are subject to this methodology:

Procedure Code	Description
81000	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated with microscopy
81001	Urinalysis by dipstick or tablet reagent, with microscopy, automated
81002	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated
81003	Urinalysis by dipstick or tablet reagent, without microscopy, automated
81005	Urinalysis, qualitative or semiquantitative except immunoassays
81015	Urinalysis, microscopy only
81020	Urinalysis, two or three glass test
84578	Urobilinogen, urine, qualitative
84583	Urobilinogen, urine, semiqualitative

If procedure code 81015, Urinalysis, microscopic only, is billed in addition to routine urinalysis codes 81000 or 81001, procedure code 81015 is denied as part of 81000 or 81001. If 81015 is billed with urinalysis codes 81002 or 81003, both codes are denied requiring paneling into either 81000 or 81001. If 81015 is billed separately with one or more of the above components on the same day, both 81015 and the other component are denied and should be combined and billed as a urinalysis.

When performing bacterial urine culture with antibiotic sensitivities, use procedure code 87086, Culture, bacterial, urine; qualitative, colony count. The modifier “UA” must be used to indicate the specimen source was urine when billing for laboratory test 82947, Glucose. When blood is the specimen source, no modifier is required. If 82947 is billed with the modifier in addition to procedure code 81000 (Urinalysis), 82947 will be denied as part of 81000.

9.4.9 Repeated Procedures (Modifier 76 or 91)

The use of Modifier 76 and 91 will be limited as follows:

- Modifiers 76 and 91 must not be used when billing the initial procedure. They must be used to indicate the repeated procedure.
- If a repeated procedure performed by the same provider on the same day is billed without Modifier 76 or 91, it is denied as a duplicate procedure
- If more than two services are billed on the same day by the same provider regardless of the use of Modifier 76 or 91, the detail will be denied without documentation of the time the services were rendered
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal
- Modifier 76 or 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline)

Certain procedure codes have been removed from modifiers 76 and 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile, [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal any claims that have been denied for documentation of time. Most procedure codes initially requiring modifiers 76 or 91 will continue to be audited for the 76 and 91 modifiers.

9.4.10 Organ or Disease Panels

Organ panels are specific laboratory studies combined under a problem-oriented classification as an approach to diagnosis. The following list of panels includes all components that must be included to report the panel code. Claims submitted with procedure codes 80002 through 80019 and G0058 through G0060 are denied for incorrect procedure codes.

Panel Code	Description	Panel must include all of the following procedure codes
80048	Basic metabolic panel	82310, 82374, 82435, 82565, 82947, 84132, 84295, and 84520
80050	General health panel	80053, 85022 or 85025, and 84443
80051	Electrolyte panel	82374, 82435, 84132, and 84295
80053	Comprehensive metabolic panel	82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84450, 84460, and 84520
80061	Lipid panel	82465, 83718, and 84478
80069	Renal function panel	82040, 82310, 82374, 82435, 82565, 82947, 84100, 84132, 84295, and 84520
80072	Arthritis panel	84550, 85651, 86255, and 86430
80074	Acute hepatitis panel	86709, 86705, 87340, and 86803
80076	Hepatic function panel	82040, 82247, 82248, 84075, 84155, 84450, and 84460
80090	TORCH antibody panel	86644, 86694, 86762, and 86777

Individual laboratory studies considered a part of a specific panel are denied when billed on the same day as a related panel code billed by the same provider unless modifier 76 or 91 is present.

9.4.11 Reference Labs and Lab Handling Fees

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for laboratory tests. An independent laboratory may only bill CSHCN for tests referred to another laboratory (independent or hospital) if it performs at least one test it is certified to perform and forwards a portion of the same specimen to another laboratory (“reference laboratory”), to have one or more tests performed. In this instance, the referring laboratory may bill for tests it has performed and all tests the “reference laboratory” is to perform on the specimen. When billing, the “YES” box in block 20 of the HCFA-1500 Claim Form must be marked, the name and TPI of the “reference laboratory” where the specimen has been forwarded must be in block 32, and the TPI of the “reference laboratory” must be indicated in block 24K next to each procedure to be performed by the “reference laboratory.”

Important
Only one handling fee may be charged per day, per client, unless specimens are sent to two or more laboratories. This must be documented on the claim.

In both situations, an independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (99001) for collecting and forwarding the specimen to the other laboratory if the specimen is collected by venipuncture or catheterization.

When billing for laboratory services, providers should use the date the specimen was collected as the date of service. If the specimen is sent to a reference laboratory and the client is an inpatient, the hospital is responsible for payment of these services to the reference laboratory.

9.5 Claims Information

Independent laboratory services must be submitted to NHIC-CSHCN in an appropriate electronic format or on a HCFA-1500 Claim Form. Providers may purchase HCFA-1500 Claim Forms from the vendor of their choice; they are not supplied by NHIC. See "Claims Filing Instructions" on page 1-50 for more information on electronic claims submission.

Instructions for correct claims completion are provided below. Blocks not referenced are **not** required for processing by NHIC and may be left blank.

9.5.1 Independent Laboratory HCFA-1500 Claim Form Instructions

The following instructions describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit CSHCN client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. **Hospital to Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. Refer to "Verbal Denials" on page 1-35 for information on verbal denials and the 110-day rule. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of current illness or injury	If the services provided are accident-related, indicate the date of injury of the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and zip code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN. Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech-language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician.
19	Reserved for Local Use	

Block No.	Description	Guidelines
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate – Anesthesiologists use "AA," "AD," "QJ," "QO," or "QQ." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alphanumeric characters (up to 15) in this block are referenced on the Remittance and Status (*R and S*) Report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."

Block No.	Description	Guidelines
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multipage claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient’s home or the provider’s facility, enter name, address, and zip code, or the TPI of the facility where the service was provided. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier’s name, address, zip code, and telephone number	Affix one of the preprinted labels to this block. In lieu of the label, enter the CSHCN TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or by calling 800-568-2413 or 512-514-3000.

9.5.1.1 Independent Laboratory Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Platt, Sylvia J.

3. PATIENT'S BIRTH DATE MM DD YY: 08 03 97 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 942 Hartford Drive

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Comfort STATE: TX

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 78013 TELEPHONE (INCLUDE AREA CODE): 512-555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Stan Levelson, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 9876543-21

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 204 . 00 3. _____ . _____
2. . 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	6	5	85031			1	12 00					Performed in our lab
2	61	01	02	06	01	02	6	5	86812			1	65 00					Refer to 1231231-23
3																		
4																		
5																		
6																		

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 77 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Signature on file

SIGNED DATE 06 09 02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office: 0987654-32

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ABC Laboratory Services
1242 Medical Place
Comfort, TX 78013

PIN# GRP# 0987654-32

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
HCFA 1500 FORM OWCP - 1500 FORM RRB - 1500
INDEPEND

SECTION

10

Medical Nutritional Products and Services

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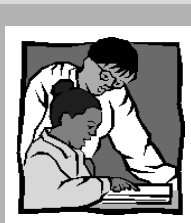
10.1 Enrollment

Providers of medical nutritional products and services must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, and have completed the CSHCN enrollment process and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

10.2 Reimbursement

Medical nutritional products and services are reimbursed according to the lower of the billed amount or the average wholesale price (AWP) per unit according to the prices in the 2000 edition of the *Drug Topics Red Book*, published by Medical Economics Company, Inc., Montvale, New Jersey 07645-1742, on file with the CSHCN Program. For products not listed in the current edition of the *Drug Topics Red Book*, reimbursement is based on the same methodology using the AWP supplied by the manufacturer of the product.



10.3 Benefits and Limitations

10.3.1 Medical Nutritional Products

CSHCN will reimburse medical nutritional products for program eligible clients. Medical nutritional products are those nutritional products that serve as a therapeutic agent for life and health and are part of a treatment regimen. The CSHCN Program will not cover nutritional products for individuals who could be sustained on an age-appropriate diet. Nutritional products are not provided to infants younger than age 12 months unless medical necessity is documented.

10.3.2 Medical Nutrition Services

CSHCN provides coverage for nutritional assessment and counseling to prevent, treat, or minimize the effects of illness, injury, or other impairments.

10.4 Authorization Requirements

Medical Nutritional Products and/or Services may require authorization/prior authorization. Refer to the specific subsection of each service for authorization/prior authorization requirements.

Refer to: "CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services" on page 10-12.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

10.5 Medical Nutritional Products

Medical nutritional products may be reimbursed by CSHCN based on the following criteria:

- The client is program eligible and has a specialized nutritional requirement
- The client's physician documents the nutritional need and identifies the medical nutritional product required by signing an annual authorization request form.
- CSHCN covers the products listed on the CSHCN Medical Nutritional Products Formulary. Refer to the CSHCN Formulary for product codes and description. Requests for medical nutritional products not listed on the formulary must be submitted to the Medical Director of Child Health Policy at the Texas Department of Health (TDH). This includes medical nutritional products (e.g., amino acids) required for the treatment of a specific condition. Reimbursement for medical nutritional products not listed on the formulary is based on the AWP supplied by the manufacturer of the product.

CSHCN Medical Nutritional Products Formulary

Procedure Code	Product
5467X	Acerflex powder, 454 gm each
5149X	Alimentum/iron 960 ml
5349X	Alimentum/iron 240 ml
100NS	Amin-Aid
151NS	Boost 237 ml
5331X	Boost High Protein (Sustacal) 454 gm powder
5099X	Boost High Protein (Sustacal) 237 ml
152NS	Boost High Protein (Sustacal) 946 ml
5471X	Boost Plus (Sustacal Plus) 237 ml
5309X	Boost Pudding (Sustacal gel) 142 gm
153NS	Boost w/fiber (Sustacal w/fiber 237 ml

CSHCN Medical Nutritional Products Formulary	
Procedure Code	**Product**
101NS	Calcilo XD 400 gms
154NS	Casec powder 283 gm
102NS	Citrotein powder 424.8 gms
5256X	Compleat Modified 250 ml
5078X	Compleat Pediatric 250 ml
103NS	Comply 237 ml
104NS	Criticare HN 237 ml
155NS	Duocal 400 gm powder
105NS	Deliver 237 ml
5140X	Enrich (Ensure/fiber) 240ml
5079X	Ensure 240 ml
5080X	Ensure 960 ml
5439X	Ensure Plus 240 ml
156NS	Ensure Plus 960 ml
157NS	Ensure Plus HN 240 ml
5082X	Ensure bottles 8 oz, each
5081X	Ensure powder 420 gms
106NS	Entrition 0.5 1000 ml
107NS	Entrition HN 1000 ml
5001X	Fibersource 250 ml
5006X	Fibersource HN 250 ml
158NS	Forta Shake 470 gms
159NS	Forta Shake 530 gms
108NS	Forta Drink powder 482 gms.
5478X	Glucerna 240 ml
109NS	Glucerna 1000 ml
110NS	Hepatic Aid II Instant Drink powder
160NS	Chocolate
161NS	Custard
162NS	Egg nog
5228X	Impact 250 ml
5084X	Isocal 237 ml
5085X	Isocal 946 ml
111NS	Isocal 355 ml
163NS	Isocal HN 237 ml
5009X	IsoSource 250 ml
5013X	IsoSource HN 250 ml
112NS	Isotein HN powder 82.2 gms
5086X	Jevity 240 ml
5087X	Jevity 960 ml
5393X	Kindercal 237 ml
5241X	Lipisorb 237 ml
5237X	Lipisorb powder 454 gm
5413X	Lofenalac powder 454 gm
5183X	MCT oil 960 ml

CSHCN Medical Nutritional Products Formulary	
Procedure Code	**Product**
5347X	Microlipid 89 ml
113NS	Magnacal Renal 237 ml
114NS	Meritene powder 480 gms
115NS	Meritene powder 2160 gms
116NS	Moducal powder 368 gms
5025X	Neocate powder 400 gm
5028X	Neocate One Plus liquid 237 ml
5029X	Neocate One Plus powder 100 gm
5394X	Next Step Soy powder 340 ml
117NS	Nutra Shake 120ml
164NS	Lemon
165NS	Strawberry
166NS	Vanilla
167NS	Chocolate
118NS	Nutra Shake 180 ml
168NS	Lemon
169NS	Strawberry
170NS	Vanilla
171NS	Chocolate
119NS	Nutra Shake 240 ml
172NS	Lemon
173NS	Strawberry
174NS	Vanilla
175NS	Chocolate
120NS	Nutra Shake Egg Pro 120 ml
121NS	Nutra Shake Egg Pro 240 ml
122NS	Nutra Shake w/fiber 180 ml
123NS	Nutra Shake 99% Lactose free 120 ml, powder 436 gm
124NS	Chocolate 120 ml
125NS	Orange citrus 120 ml
126NS	Orange pineapple 120 ml
127NS	Peach citrus 120 ml
128NS	Strawberry citrus 120 ml
129NS	Chocolate 240 ml
130NS	Strawberry 240 ml
131NS	Vanilla 240 ml
132NS	Nutrament 355 ml
5089X	Nutramigen 390 ml
5090X	Nutramigen 960 ml
5091X	Nutramigen powder 454 gm
5328X	Nutra-Thick 8 oz
5329X	Nutra-Thick single portion pks.
5275X	Nutren 1.0
5276X	Nutren 1.5 250 ml
5277X	Nutren 2.0 250 ml

CSHCN Medical Nutritional Products Formulary	
Procedure Code	**Product**
5036X	Nutren Jr. 250 ml
5848X	Nutren Jr. w/fiber 250 ml
5095X	Osmolite 1000 ml
5093X	Osmolite 240 ml
5094X	Osmolite 960 ml
133NS	Osmolite HN 240 ml
134NS	Osmolite HN 960 ml
135NS	Osmolite HN 1000 ml
5096X	Pediasure 240 ml
5348X	Pediasure/fiber 240 ml
5278X	Peptamen 250 ml
176NS	Peptamen 1000 ml
5395X	Peptamen Jr. 250 ml
136NS	Peptamen Jr. 1000 ml
5390X	Periflex powder 454 gm
5422X	Phenex-1 powder 350 gm
5423X	Phenex-2 powder 325 gm
5030X	Phenylade mix, amino acid blend, powder 454 gm
137NS	Phenylade Bar
5414X	Phenyl-free powder 454 gm
177NS	Phlexy - 10 Bar
178NS	Phlexy - 10 Capsule 200 (not VDP)
179NS	Phlexy - 10 Drink Mix powder 20 gm
5420X	PKU 2 powder 500 gm
5421X	PKU 3 powder 500 gm
5079X	Polycose 126 ml
5098X	Polycose powder 350 gm
5154X	Portagen powder 454 gm
5122X	Pregestimil powder 454 gms
5240X	Product 80056 powder 454 gm
5436X	Product3232A/Diet powder 454gm
5152X	Promod powder 291 gm
138NS	Propac powder 350 mg
180NS	Propeptide 250 ml
181NS	Propeptide for kids 250 ml
5150X	ProViMin powder 150 gm
5120X	Pulmocare 240 ml
5470X	RCF 390 ml
5123X	Reabilan 375 ml
182NS	Reabilan HN 375 ml
5280X	Replete 250 ml
5021X	Resource 237 ml
139NS	Resource Diabetic 240 ml
140NS	Resource Diabetic 1000 ml
141NS	Resource Diabetic 1500 ml

CSHCN Medical Nutritional Products Formulary	
Procedure Code	**Product**
5018X	Resource Just for Kids 237 ml
5354X	Resource Plus 237 ml
142NS	Resource Instant Crystals (powder)
5476X	Scandical 227 gm
5260X	Scandishake powder 510 or 540 gms
183NS	Scandishake powder 85 gm
5391X	Similac PM 60/40 powder 480 gm
5182X	Suplena 240 ml
5331X	Sustacal 454 gm powder (Boost High Protein)
152NS	Sustacal 946 ml (Boost High Protein)
5099X	Sustacal 237 ml (Boost High Protein)
5309X	Sustacal gel 142 gm (Boost Pudding)
153NS	Sustacal w/fiber (Boost w/fiber) 237 ml
5471X	Sustacal Plus 237 ml (Boost Plus)
5100X	Sustacal powder 60 gm
184NS	Thick-it powder, 240 gm each, can
143NS	Thick-it 900 gms
185NS	Tolerex pdr. 80 gm packet, each
144NS	TraumaCal 237 ml
5121X	Twocal HN 240 ml
5121X	Twocal HN 237 ml
146NS	Travasorb HN powder 83.3 gm
147NS	Travasorb MCT powder 89 gm
148NS	Travasorb STD powder 83.3 gm
149NS	Vari-Flavors
5142X	Vital HN powder
150NS	Vivonex flavor packets powder 2.5 gm
5023X	Vivonex Pediatric 48.5 gm
5138X	Vivonex T.E.N. powder 80.4 gm
5417X	XP Analog powder 400 gm
5415X	XP Maxamaid powder 454 gm
5418X	XP Maxamum powder 454 gm

10.5.1 Authorization Requirements

Authorization is required for medical nutritional products. Medical nutritional products may be reimbursed for the following diagnoses:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
140–2089	Malignant neoplasms (cancer)
2701	Phenylketonuria
2770–27701	Cystic fibrosis
3421–34212	Spastic hemiplegia
343–3439	Infantile cerebral palsy

Diagnosis Code	Description
555–5559	Regional enteritis (Crohn's disease)

Submission of an annual prescription documenting the nutritional need and identifying the medical nutritional product(s) requested is not required for clients with the diagnoses listed above.

All other diagnoses require an annual prescription documenting the nutritional need and identifying the medical nutritional product(s) requested. Refer to the "CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services" on page 10-12.

10.6 Medical Nutrition Services

Nutrition assessment and counseling services may be a benefit of CSHCN when:

- Prescribed by a physician
- Documentation supports medical necessity/appropriateness
- Completed by a CSHCN enrolled dietitian licensed by the Texas State Board of Examiners of Dietitians
- Services are provided in the home or office

10.6.1 Authorization requirements

Authorization is not required for the following nutritional counseling services:

- Two nutrition assessments per calendar year
- Four nutrition counseling visits per calendar year

Providers are responsible for maintaining documentation to support medical necessity for nutritional counseling services in the clinical record.

Prior Authorization

Prior authorization is required for visits beyond two assessments and four nutrition counseling visits per calendar year. Requests for additional visits require medical review and must be submitted in writing with documentation to support medical necessity and appropriateness. Complete and submit the "CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services" on page 10-12.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

Use the following codes when requesting prior authorization or submitting claims:

Procedure Code	Description
5294X	Nutrition counseling by licensed dietitian, per hour
5438X	Nutrition assessment by licensed dietitian, per hour

If procedure codes 5438X and 5294X are billed for the same date of service, 5438X will be paid and 5294X will be denied.

10.7 Claims Information

Medical nutritional products and services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim products.

Instructions for proper claims completion are provided in "Medical Nutritional Products and Services HCFA-1500 Claim Form Instructions" on page 10-8. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

10.7.1 Medical Nutritional Products and Services HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident-related, indicate the date of injury or the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.

Block No.	Description	Guidelines
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alpha-numeric characters (up to 15) in this block are referenced on the *R&S* report.

Block No.	Description	Guidelines
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

10.7.1.1 Medical Nutritional Products and Services HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Marberry, Kayla M.

3. PATIENT'S BIRTH DATE (MM DD YY): 08 12 97 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1544 Brittany Trail

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Austin STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 75067 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE (MM DD YY) SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO (MM DD YY)

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jim Smith, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 207907293

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO (MM DD YY)

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 250 . 00 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	09	01	02	09	01	02	1	9	5294X			1	50 75					
2																		
3																		
4																		
5																		
6																		

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 50 75

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Jill Brown

SIGNED DATE 10 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Jill Brown
2010 Main Street
Austin, TX 75067

PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
MEDICAL NUTRITION PRODUCTS AND SERVICES FORM OWCP - 1500 FORM RRB - 1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

10

10.7.1.2 CSHCN Authorization Form for Diapers and Medical Nutritional Products and Services

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6524 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First name:	**Last name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / ZIP:		

Product Information:

CSHCN may approve diapers for a client if the client is incontinent, is over 4 years of age, and has a CSHCN diagnosis approved for diapers. See the *CSHCN Provider Manual* for a list of diagnoses. CSHCN does not require a Medical Necessity Form for medical nutritional products for clients with the diagnosis of cancer, cystic fibrosis, HIV, phenylketonuria, Crohn's disease, infantile cerebral palsy, or spastic hemiplegia. For products, refer to the Medical Nutritional Products and Services section of this manual.

This medical necessity form is for: ❑ Diapers / pull-ups / briefs Height _____
❑ Medical nutritional products Weight _____

Procedure code / Number of diapers needed per month:	
Procedure code / Name of medical nutritional products:	
Number of cans needed per month:	**Can Size:**
Liquid concentrate ❑ **Liquid (ready-to-feed)** ❑ **Powder** ❑ **Other** ❑	

Nutrition Counseling and Assessment Information:

To request prior authorization for: ❑ More than 2 nutrition assessments per calendar year, or
❑ More than 4 nutrition counseling visits per calendar year

Check the appropriate box above, and document medical necessity below.

Attending Physician / Dietitian Information:

Printed or typed name:	
Address / City / ZIP of physician:	**Dietitian:**
Phone number of physician:	**Dietitian:**
Fax number of physician:	**Dietitian:**
Physician's signature: X	**Date:**
Dietitian's signature: X	**Date:**

This form is valid for 12 months from the date signed.

SECTION

11

Orthotics and Prosthetics

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11.2 Reimbursement 11-1
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11.6.1 Orthotics and Prosthetics HCFA-1500 Claim Form Instructions 11-6

11.1 Enrollment

Orthotic and prosthetics providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

11.2 Reimbursement

Orthotic and prosthetic services are reimbursed according to a maximum allowable fee schedule based on Medicare and Medicaid allowable rates. A completed documentation of receipt form must be kept on file.

11.3 Benefits and Limitations

CSHCN may provide coverage for orthotics and prosthetics when medically necessary. Items must be prescribed by a licensed physician or podiatrist (for conditions below the ankle) and supplied by an orthotist or prosthetist who meets CSHCN Program enrollment criteria. Noncustom commercial products may be supplied through a physician's office. Extremity splints and inhibitive casting may be provided by occupational therapists (OTs) or physical therapists (PTs) as appropriate.

Training in the use of an orthotic/prosthetic device for a client who has not worn one previously, has not worn one for a prolonged time period, or is receiving a different type may be reimbursed when provided by a licensed physical or occupational therapist.

11.4 Authorization Requirements

Requests for authorization must be in writing on the "CSHCN Durable Medical Equipment Authorization Request Form" on page 11-10. Modifications of orthotic and prosthetic systems, due to growth or a change in medical status, may be authorized. Repairs needed due to normal wear and tear may be authorized. Additional information may be requested to determine if repairs and modifications are cost effective.

Medical justification is required for replacement of orthoses, if less than six months from the receipt of the initial system, and for prostheses if less than one year from receipt of the initial system.

Refer to: "CSHCN Durable Medical Equipment Authorization Request Form" on page 11-10.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

11.5 Orthotics and Prosthetics

The following list provides examples of orthotics and diagnoses that CSHCN reviews for authorization.

11.5.1 Orthotics

Orthotics	Covered diagnosis / condition
Helmets	Neoplasms of the brain, subarachnoid hemorrhage, subdural hemorrhage, hemophilia, epilepsy (if not well controlled), cerebral palsy (severe)
Spinal orthotics (SO), collars, corsets, body jackets (TLSO, LSO, and LLSO)	Scoliosis, spinal injuries, paraplegia, kyphosis, neurofibromatosis, cerebral palsy, spina bifida, spinal tumor
Hip orthotics (HO)	Dislocated hip, cerebral palsy, spina bifida, congenital deformities of the hip
Thoracic - hip-knee-ankle orthotics (THKAO), parapodium, swivel walker Reciprocating gait orthoses (RGOs)	Spina bifida, spinal injuries, spinal tumor, cerebral palsy, paraplegia Reciprocating gait orthoses may be covered for children with spina bifida or similar functional disabilities. The authorization request must include a statement from the prescribing physician indicating the medical necessity, physical therapy plan, and information that the family is expected to comply with the treatment plan.
Removable shoe insert, UCB (University of California at Berkeley) type	Case-by-case basis using the following criteria to be submitted by the physician: • Client must be 5 years old and • Client must have a valgus deformity and significant congenital pes planus (75461), which is symptomatic for pain, or • Client may have a structural problem that results in significant pes planus, or • Client may have an acute plantar fasciitis, or • Client may have a diagnosis of hemophilia
Hip-knee-ankle-foot orthotics (HKAFO), knee-ankle-foot orthotics (KAFO)	Spina bifida, cerebral palsy, paraplegia, late effects of polio, late effects of CVA, spinal cord lesions, arthrogryposis, club foot, varus deformities of feet, genu varus and genu valgus if growth deformity, arthropathy associated with hematological disorder
Knee orthotics (KO), knee immobilizer	Arthropathy associated with hematological disorders related to lower extremity conditions

Orthotics	Covered diagnosis / condition
Dynamic splints	Case-by-case basis using the following criteria to be submitted by the physician: 1. The patient's condition to be treated with the dynamic splint; 2. The patient's current course of therapy to date, for the condition to be treated. 3. The rationale for the use of the dynamic splint at this time, including: a. Quality of care considerations such as improved outcome, and b. Potential cost effectiveness 4. The likelihood that the family / patient will comply with the use of the dynamic splint.
Ankle-foot orthotics (AFO), plastic or metal	Foot anomalies, cerebral palsy, hemiplegia, spina bifida, club foot, arthrogryposis, arthropathy associated with hematological disorder
Inhibitive casting	Cerebral palsy or any CNS deficit resulting in increased muscle tone in the extremities
Foot orthotics	Foot anomalies, tibial torsion, club foot, varus deformities of feet, cerebral palsy, spina bifida, arthrogyposis, arthritic conditions
Upper extremity orthotics, shoulder, elbow, wrist, hand, finger, mobile arm support	Cerebral palsy, spinal cord injury, brachial plexus lesions, nerve lesions, paralysis, juvenile rheumatoid arthritis, reduction deformities

The following procedure codes are **not** a benefit:

Procedure Code	Description
L3001	Foot, insert, removable, molded to patient model, spenco, each
L3002	Foot, insert, removable, molded to patient model, plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model, silicone gel, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal / metatarsal support, each
L3030	Foot, insert, removable, formed to patient foot, each
L3040	Foot, arch support, removable, premolded, longitudinal, each
L3050	Foot, arch support, removable, premolded, metatarsal, each
L3060	Foot, arch support, removable, premolded, longitudinal / metatarsal, each

11.5.2 Cranial Molding Devices

CSHCN may reimburse for a dynamic orthotic cranioplasty (DOC)™ device or a craniostenosis helmet.

11.5.2.1 Authorization Requirements

Dynamic Orthotic (Cranioplasty DOC™)

A DOC™ device must be **prior** authorized. Requests for the device must be submitted in writing with the following documentation supporting medical necessity and appropriateness:

- Client is between 4 months and 18 months of age
- Client's diagnosis
- Name of the referring physician

- Report from the cleft/craniofacial team evaluation, which includes the following information:
  - The recommendations of the cleft/craniofacial team
  - Determining factors used in recommendation of treatment
  - Any alternative treatment courses that have been followed
- Name of provider of service and the treatment/follow-up schedule

Only CSHCN enrolled orthotists may be authorized for reimbursement.

Dynamic orthotic cranioplasty™ may be approved for diagnosis code 754, Congenital musculoskeletal deformities of skull, face, and jaw.

Use procedure code 5856X, Cranial remolding band, global fee, when submitting claims or requests for authorization for a DOC device.

Craniostenosis Helmets

Use the following procedure codes for craniostenosis helmets:

Procedure Code	Description
L0100	Cranial orthosis (helmet), with or without soft-interface, molded to patient model
L0110	Cranial orthosis (helmet), with or without soft-interface, nonmolded

Craniostenosis helmets require authorization. Craniostenosis helmets may be reimbursed for the following diagnoses, for clients between the age of 4 months and 18 months:

Diagnosis Code	Description
754	Certain congenital musculoskeletal deformities of skull, face, and jaw, plagiocephaly
756	Other congenital anomalies of skull and face bones

11.5.3 Prosthetics

The following are examples of prosthetics and diagnoses that CSHCN reviews for authorization:

Prosthetics	Covered Diagnosis/Condition
Partial foot/foot	Congenital absence, surgical revision or traumatic amputation of lower extremity or hip
Ankle	
Below knee	
Above knee	
Hip disarticulation	
Immediate post surgical	
Hemipelvectomy	
Immediate post surgical	Congenital absence, surgical revision, or traumatic amputation of upper extremity or shoulder
Initial/preparatory prosthetics	
Partial hand	
Wrist disarticulation	
Below elbow	
Elbow disarticulation	
Above elbow	
Shoulder disarticulation	
Myoelectric prosthetics (covered only with physician justification)	Bilateral shoulder disarticulation

The following procedure codes are **not** a benefit:

Procedure Code	Description
L8030	Breast prosthesis, silicone or equal
L8600	Implantable breast prosthesis, silicone or equal
L8614	Cochlear device/system
L8619	Cochlear implant external speech processor, replacement

11.5.4 Eye Prostheses

CSHCN covers eye prostheses that must be authorized for CSHCN clients. The following HCPCS codes are payable to ocularists and should be used when billing for eye prostheses and/or related services:

HCPCS Code	Description
V2623	Prosthetic, eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2629	Prosthetic, eye, other type

There are no specific time limitations on replacement of eye prostheses. A child's eye socket may change size at variable times due to differences in boney growth rate and soft tissue change.

11.5.5 Prescription Shoes and Lifts

CSHCN may authorize prescription shoes (corrective/orthopedic shoes) for CSHCN eligible clients when prescribed by a licensed physician or podiatrist. An approved orthotist may supply shoes. For consideration of coverage, corrective shoes must be:

- Permanently attached to a brace **or**
- Custom modified by an orthotist or orthotist/prosthetist at the direction of the prescribing physician **or**
- Necessary to hold surgical correction or casting (does not have to be attached to a brace); can be authorized up to one year post procedure **or**
- Documented by physician as to specific medical rationale

Note: Lifts for unequal leg length greater than one-half inch will be covered with documentation of medical need.

If the primary diagnosis is 7546, Valgus deformities of the feet, medical justification is required.

Prescription shoes are limited to one pair every three months. Two pairs may be purchased at the same time; however, they cannot be replaced until after six months.

11.5.5.1 Noncovered Items

- Noncorrective shoes, including tennis shoes, even if prescribed by a physician and worn with a removable brace
- Shoe inserts (other than University of California at Berkeley type [UCBs]) when not part of a modified shoe or when shoes are not attached to a brace

11.5.5.2 Authorization Requirements

Authorization requests for payment of prescription shoes must be submitted on the "CSHCN Durable Medical Equipment Authorization Request Form" on page 11-10.

Reimbursement for prescription shoes and lifts is based on HCPCS allowable fees.

11.6 Claims Information

Orthotic and prosthetic services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

11.6.1 Orthotics and Prosthetics HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident related, indicate the date of injury or the accident.

Block No.	Description	Guidelines
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available complete to five digits for each diagnosis observed.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.

Block No.	Description	Guidelines
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alpha-numeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

11.6.1.1 Orthotics and Prosthetics Services HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jimenez, Jorge

3. PATIENT'S BIRTH DATE MM DD YY: 11 23 86 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 563 Lake Ct.

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Pharr STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 75235 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED .....On File..... DATE .....

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

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Joanne Wallace, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 343 . 90 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	1	9	L1960			1	887	35	2				
2																			
3																			
4																			
5																			
6																			

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 887 35

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)
Signature on file
SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Nederland Orthotics
67 Medical Blvd.
Nederlan, TX 77627
214-555-1234
PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
ORTHOTICS AND PROSTHETICS FORM OWCP - 1500 FORM RRB - 1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

11

11.6.1.2 CSHCN Durable Medical Equipment Authorization Request Form

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6524 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

For specialized seating or custom wheelchair purchase requests complete the 6-page CSHCN wheelchair seating evaluation form in addition to this form.

Client Information:

First name:	**Last name:**	**CSHCN #:**	
Date of birth:	**Diagnoses (ICD-9-CM):**		
Address / City / ZIP:			
Client's height:		**Client's weight:**	

Part 1 - The following information must be provided for ALL equipment requests.
Item is to be: Purchased ❑ Modified ❑ Repaired ❑ Rented ❑ Service Date:_____
(Required for rentals)

Description of item(s): _____

_____

_____

Equipment needed for: Lifetime ❑ < 6 months ❑ > 6 months ❑ > 1 year ❑ Other:_____
I certify that the patient's medical condition is such that all equipment requested above is medically necessary.

Physician's signature (required): X_____ **Date signed:**_____
Print or Type Physician's name: X_____
(some items may require additional medical justification)

Part 2 - Must be completed and signed by the VENDOR. The equipment description and pricing information indicated below must be completed. For custom DME requests, attach manufacturer's price sheet(s) for each item.

EQUIPMENT DESCRIPTION:			PRICING INFORMATION:			
Brand name or HCPCS code:	**Model #:**	**Item Description:**	**HCPCS Price:**	**OR**	**Cost / Retail Price**	**CSHCN Price**
			Total:			

DME Provider Information:

DME Provider Name (print or type):
TPI No.:
Phone number:
Fax number:
Address / City / ZIP:
Orthotist / Prosthetist name (print or type):
Signature of DME provider or representative: X
Date:

CSHCN DME Authorization Request Form (continued)

Submit this page (in addition to page 1) if requesting authorization for gait trainers or standers. Include a plan for training caretakers/family on the correct, safe use of the equipment and monitoring the client's need for increases or decreases in time using the equipment at home. Documentation must indicate who will be monitoring home program and providing training.

Client Information:

Client name:	**CSHCN #:**

Additional Information for Gait Trainer Requests:

Child's condition/functional level:	
Is the child expected to be ambulatory and if so, when:	
The time, frequency, and location where the gait trainer will be used:	
The length of time the gait trainer is expected to be needed:	
Growth potential of the equipment:	
Therapist's signature: X	**Print/Type Name:**
Phone number:	**Date:**

Additional Information for Prone or Supine Stander Requests:

Child's condition/functional level:	
Anticipated benefits expected from the stander:	
Frequency and amount of time of the child's standing program (e.g., 45 minutes 3x daily):	
Frequency the stander will be used at home:	
Length of time the stander is expected to be needed (growth potential):	
Therapist's signature: X	**Print/Type Name:**
Phone number:	**Date:**

CSHCN DME Authorization Request Form (continued)

Submit this page (in addition to page 1) if requesting authorization for car seats, bathroom equipment, or hospital cribs/enclosed beds.

Client Information:

Client name:	**CSHCN #:**

Additional Information for Special Needs Car Seat or Travel Restraint Requests:

Postural Control	
Head control _____good _____ fair _____poor	
Trunk control _____good _____fair _____poor	
Equipment requested:	
Gorilla by Snug Seat ❑	**Columbia car seat model #2000 ❑**
Name of certified installer:	
Name of person completing form:	**Phone number:**

Additional Information for Hygiene Equipment Requests:

Equipment requested:	
Is this replacement equipment? No ❑ Yes ❑	
If yes, why can't existing equipment be used?	
Tone: High ❑ Low ❑ Fluctuating ❑ Absent ❑	
Head control: Good ❑ Fair ❑ Poor ❑	**Upper extremity: Good ❑ Fair ❑ Poor ❑**
Trunk control: Good ❑ Fair ❑ Poor ❑	**Lower extremity: Good ❑ Fair ❑ Poor ❑**
Transfers: Dependent ❑ Independent ❑	
Name of person completing form:	**Phone number:**

Additional Information for Hospital Crib/Enclosed Bed Requests:

Medical needs, developmental level, and functional skills:
Describe any other less-restrictive devices that have been used, the length of time used, and why ineffective:
Why a regular child's crib, regular bed, or standard hospital bed cannot be used:
Therapist or doctor's signature: X **Date:**
Print or Type Name:

11.6.1.3 Documentation for Receipt for DME Equipment

This form must be kept in the client's file for all Durable Medical Equipment, Orthotics and Prosthetics, and Prescription Shoes. For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

THIS FORM MUST BE RETAINED BY THE DME PROVIDER. IT SHOULD NOT BE SUBMITTED WITH THE CLAIM.

Client Information:

First name:	**Last name:**
CSHCN #:	
Name of supplier (print or type):	

Equipment Information:

Item	No. Received	Description (include Model # for DME)	Manufacturer's Serial # (for DME only)

I certify that on _____ (mm/dd/yyyy):

The client received the equipment as prescribed by the physician

The equipment has been properly fitted to the client and/or meets the client's needs

The client, the parent or guardian of the client, and/or the primary caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

Print or Type Name: _____

X _____ _____

Signature of client, parent, or client representative — Date signed

Print or Type Name: _____

X _____ _____

Signature of DME supplier — Date signed

THE RECEIVING PARTY AND DME SUPPLIER MUST SIGN AND DATE THIS FORM AT THE TIME THE EQUIPMENT IS ACTUALLY DELIVERED.
Refer to the *CSHCN Provider Manual* for instructions on completing this form.

SECTION

12

Outpatient Physical Therapy and Occupational Therapy

12.1 Enrollment 12-1
12.2 Reimbursement 12-1
12.3 Benefits and Limitations 12-3
12.4 Authorization Requirements 12-3
12.5 Coordination with the Public School System 12-5
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12.6.1 OP and OT HCFA-1500 Claim Form Instructions 12-6
12.6.2 HCFA-1450 (UB-92) Instruction Table 12-11

12.1 Enrollment

To enroll in the CSHCN Services Program, outpatient therapy providers (physical therapy [PT] and occupational therapy [OT]) must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

12.2 Reimbursement

Outpatient therapy services are reimbursed according to a maximum allowable fee schedule.

CSHCN will reimburse therapists and outpatient facilities based on the procedure codes listed on page 12-2. Therapy sessions include the time the therapist is with the client for instance, time spent preparing the client for the session and the time spent completing documentation. Evaluation, re-evaluation, and therapy services may not be billed on the same date of service. Reimbursement of an evaluation is limited to once every six months. Reimbursement for re-evaluation is limited to one per month.

Physical and occupational therapists should use the following procedure codes for authorization and/or claim submission:

Procedure Code for PT	Procedure Code for OT	Description
5068X	5068X	Comprehensive outpatient therapy evaluation, per hour
5380X	5381X	Assessment/re-evaluation
5454X	5455X	Re-evaluation, per session
5836X	5841X	Developmental treatment, initial 30 minutes
5849X	5850X	Developmental treatment, each additional 15 minutes
5852X	5853X	Developmental treatment, more than 1 hour

Outpatient facilities should use the following procedure codes for authorization and/or claim submission:

Procedure Code	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation/occupational therapy evaluation
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97020	Application of a modality to one or more areas; microwave
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, 15 minutes each; therapeutic exercise to develop strength and endurance, range of motion, and flexibility
97112	Therapeutic procedure, one or more areas, 15 minutes each; neuromuscular reduction of movement, balance, coordination, kinesthetic sense, posture, and proprioception
97113	Therapeutic procedure, one or more areas, 15 minutes each; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)

Procedure Code	Description
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97542	Wheelchair management/propulsion training, each 15 minutes
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

12.3 Benefits and Limitations

CSHCN may reimburse medically necessary and appropriate outpatient PT and OT for CSHCN clients. Service must be prescribed by a physician or podiatrist (for conditions below the ankle). PT and OT may be provided through or in a comprehensive outpatient rehabilitation center, a licensed hospital, a physician's office, or the office of an enrolled PT or OT. CSHCN may reimburse for therapists to travel to the patient's community, based on standard CSHCN travel reimbursement policy, when no local therapist is available or when services are provided in the client's home. Use CSHCN local code 100PT, transportation therapist, per mile. PT and OT must be provided by licensed therapists.

12.4 Authorization Requirements

Physical therapy and/or occupational therapy require authorization. Initial evaluations do not require authorization. Treatment plans, not to exceed six months, and requests for extensions require authorization. If the client is of school age, include a copy of the individual educational plan (IEP) or statement from the independent school district that the child is not eligible for the same services through the school.

Refer to: "Request for Initial Outpatient Therapy (Form TP1)" on page 12-18 or "Request for Extension of Outpatient Therapy (2 Pages) (Form TP2)" on page 12-19.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

Physical and/or occupational therapy may be authorized when the child meets the following criteria:

- The child is up to age 3 and measurable progress toward individual treatment goals can reasonably be expected (this may not always indicate physical improvement in the client's condition); **or**
- Child is age 3 or older, not presently eligible for or receiving special education and/or special services during the school year, and has a disabling condition requiring therapy services where measurable progress toward individual treatment goals can reasonably be expected (this may not always indicate physical improvement in the client's condition); **and**

- The child has a developmental anomaly including (but not limited to) the following: cerebral palsy, spina bifida, arthrogryposis, reduction deformities of a limb(s), hydrocephalus, Erb's palsy (brachial plexus palsy), or encephalocele; **or**
- The child has an acute episode of a chronic condition which may include (but is not limited to): Juvenile Rheumatoid Arthritis (JRA), hemophilia, lupus erythematosus, sickle cell crisis (joint pain, swelling and limited range of motion) or cancer; **or**
- The child presents with a new condition which may include (but is not limited to): upper extremity trauma, median or radial nerve lesions, late effects of fractures, burns, spinal cord injury, traumatic brain injury, cerebral embolism, brain tumor, or Guillain Barre Syndrome; **or**
- Child is seen in a specialty clinic for periodic assessment or re-evaluations; **or**
- Child needs short-term therapy related to surgery or casting; **or**
- Child requires training on the use of equipment such as: wheelchairs (powered or manual), orthotics or prosthetics, or other equipment such as ambulation aids (walkers or crutches); **or**

Short-term assistance is needed to instruct child/family in activities of daily living specific to the home environment (such as bathing, toileting, instructions to teach the client, client's parents and caregivers, equipment assessment for braces, wheelchairs, cushions, and so on).

PT/OT services may be authorized as follows:

- Children age birth to 3 years with a developmental anomaly, therapy services may be authorized up to 2 times a week for 6 months (may be extended up to school eligibility without medical review). Requests for a higher frequency of visits per week will require submission of documentation of medical necessity.
- Children age 3 through 21 with a developmental anomaly should be referred to the public school system for services unless ineligible or there is a medically-related therapy issue to address.
- Pre-surgical therapy related to the reason for surgery may be approved up to three times a week for one month.
- Post-surgical therapy directly related to the reason for surgery or for cast removal may be authorized up to five times a week for two months. Post rhizotomy--up to three times a week for one year. After these specified time periods extensions require documentation of medical necessity.
- Therapy addressing an acute episode of a chronic condition (seldom eligible for therapy through the school system) may be authorized up to five times a week for three months. After three months, physician's documentation of continued acute episode is required. After the first six months are authorized, documentation of specific rationale of the need for continued therapy based on the client's chronic diagnosis will need to be submitted.
- New conditions such as: upper extremity trauma, median or radial nerve lesions, late effects of fractures, may have therapy authorized up to five times a week for three months. Extensions after six months require additional documentation of medical necessity.
- New conditions (such as third degree burns) may have therapy authorized up to five times a week for three months and this may be extended up to one year. After one year, documentation of specific rationale of the need for continued therapy must be submitted.
- New conditions such as: spinal cord injury, traumatic brain injury, cerebral embolism, brain tumor, or Guillain Barre Syndrome may have therapy authorized for up to five times a week for the initial three months. This may be extended up to one year.
- Home program monitoring for clients birth to age 3 with: cerebral palsy, spina bifida, arthrogryposis, reduction deformities of limbs, or hydrocephalus may have home program monitoring authorized for up to two times a month for six months.
- Home program monitoring for clients birth to age 21 with: JRA, hemophilia, lupus erythematosus, sickle cell crisis (joint pain/swelling and limited range of motion) may have home program monitoring approved up to one time a month for six months.
- Activities of daily living instructions to teach clients, parents and care-givers for clients age 3 through 21 may be authorized up to three times a week for one month.
- One equipment assessment before receiving the equipment and one assessment after receiving the equipment may be authorized.
- Training for the use of manual wheelchairs may be authorized for up to five times a week for one month.

- Training for the use of powered wheelchairs may be authorized for up to five times a week for one month; then three times a week for two months.
- Training for the use of orthotics/prosthetics (braces/artificial limbs) may be authorized for up to five times a week for one month; then three times a week for two months. Additional requests require documentation of the specific rationale for the medical need for the additional training. Reciprocating gait orthoses (RGOs) may be provided for children with spina bifida or similar functional disability; documentation is required including: a statement from the physician indicating the medical necessity, a coordinated Physical Therapy treatment plan, and documentation that the client/family is expected to comply with the treatment plan. Dynamic splints are provided on a case-by-case basis using the following criteria submitted by the physician:
  - The client's condition to be treated with the dynamic splint.
  - The client's current course of therapy to date, for the condition to be treated.
  - The rationale for the use of the dynamic splint at this time.
  - A therapy treatment plan related to the dynamic splint.
- Training for other equipment (such as walkers or crutches) may be authorized for up to 5 times a week for 1 month.

Refer to: The Addendum to this policy entitled "Occupational Therapy and Physical Therapy Guidelines by Age" for a summary of the above information in chart format.

12.5 Coordination with the Public School System

Children eligible for OT/PT services through the public school system, including extended year services, may not receive supplemental OT/PT through CSHCN. CSHCN covers medically related therapy and cannot supplement related services provided through the public school system. The public school system is responsible for provision of therapy services related to the child's **educational needs** so that they may adequately access provided educational services/programs. A child of any age who has received special education during the school year may be eligible for summer therapy through his or her local school district. A child can receive therapy from both the public school system and CSHCN; however, therapy goals and services will differ because of CSHCN's focus on medically related needs while the school system addresses the child's educational needs. CSHCN does not pay for summer services for **educational goal** attainment of goals since school funding should be available. Children may be eligible for special education services if three years of age or older (visually and/or hearing impaired children are eligible regardless of age).

Any child eligible for special education services **MUST** have a copy of their educational IEP included to request authorization to submit claims for reimbursement of therapy services, to assure there is no duplication of therapy services.

12.6 Claims Information

Outpatient therapy services provided by a physical or occupational therapist must be submitted to CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500 or HCFA-1450 claim form, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

Outpatient therapy services provided by an outpatient facility must be submitted to CSHCN in an approved electronic format or on a HCFA-1450 (UB 92) claim form. Providers may purchase HCFA-1450 claim forms from the vendor of their choice. NHIC does not supply forms.

12.6.1 OP and OT HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident related, indicate the date of injury or the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alphanumeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

12.6.1.1 Occupational Therapists HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rodrigues, Maria L.

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 84 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 Glen Drive

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Webster STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 78212 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....On File.....

14. DATE OF CURRENT MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Phyllis Merrick, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 714 . 31 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	1	9	5381X			1	44	61	1				
2																			
3																			
4																			
5																			
6																			

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 44 61

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Patricia Brown, LPT

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Patricia Brown, OT
911 Medical Blvd.
Bryan, TX 77801

214-555-1234

PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
OCCUPATIONAL THERAPY FORM OWCP - 1500 FORM RRB - 1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

12

12.6.1.2 Physical Therapists HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Gildon, Melinda.

3. PATIENT'S BIRTH DATE MM DD YY: 06 14 93 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 9901 Channing Cross

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Bryan STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 77081 TELEPHONE (INCLUDE AREA CODE): 409-555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: John Martinez, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 767 . 60 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 12345678

24. A DATES OF SERVICE From MM	From DD	From YY	To MM	To DD	To YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	1	9	5380X			1	44	61	1				
2																			
3																			
4																			
5																			
6																			

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 44 61

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Patricia Brown, LPT

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Patricia Brown, LPT
911 Medical Blvd.
Bryan, TX 77801

214-555-1234
PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
PHYSICAL THERAPY FORM OWCP - 1500 FORM RRB - 1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

12.6.2 HCFA-1450 (UB-92) Instruction Table

The instructions describe what information must be entered in each of the block numbers of the HCFA-1450 (UB-92) Claim Form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by NHIC.

Block No.	Description	Guidelines
1	Provider name, address, and telephone number	Affix one of the NHIC preprinted labels to this block. In lieu of the label, enter the hospital name, street, city, state, ZIP code, and telephone number. Preprinted labels may be requested by writing NHIC Provider Enrollment.
3	Patient control number	Optional: any alphanumeric character (limit 16) entered in this Block will be referenced on the *R&S*.
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 331 Home health agency* * Use TOB 331 only. All other TOBs are invalid and will deny.	Enter the three-digit type of bill (TOB) code 1st Digit - Type of Facility 1 Hospital 3 Home health agency 2nd Digit - Bill Classification (Except Clinics and Special Facilities) 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 2nd Digit - Bill Classification (Clinics Only) 1) Rural Health 3) Free Standing 5) Comprehensive Outpatient Rehabilitation Facilities (CORFs) 3rd Digit - Frequency 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim - first claim 3 Interim - continuing claim 4 Interim - last claim 5 Late charge(s) only claim
6	Statement covers period	For inpatient and home health claims, enter the beginning and ending dates of service billed. For inpatient claims, this is usually the dates of admission and discharge.
7	Covered days	For inpatient claims, enter the total days represented on this claim that are to be covered. Usually this is the difference between the admission and discharge dates. In all circumstances the number in this block will be equal to the number of covered accommodation days listed in Block 46.
8	Noncovered days	For inpatient claims, enter the total days represented on this claim that are not covered. The sum of Blocks 7 and 8 must equal the total days billed as reflected in Block 6.
12	Patient name	Enter the patient's last name, first name, and middle initial as printed on the Medical Care Identification.
13	Patient address	Enter the patient's complete address as described (street, city, state, and zip code).
14	Patient birth date	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born.
15	Patient sex	Indicate the patient's sex by entering an "M" or "F."
17	Admission date	Enter numerically the date (MM/DD/YYYY) of admission for inpatient claims; date of service for outpatient claims; start of care (SOC) for home health claims.
18	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for nonpatients (TOB 141), home health claims (TOB 331), RHCs (TOB 711) or FQHCs (TOB 731).

Block No.	Description	Guidelines
19	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 20.)
20	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5) Information not available
21	Discharge hour (required field)	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of “30”), leave the block blank. Code 99 is not acceptable.
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient’s status as of the statement “through” date. 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)

Block No.	Description	Guidelines
23	Medical record number	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
24-30	Condition codes	Enter the two-digit condition code "05" and date the legal claim was filed for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient if this condition is applicable to the claim.
32ab-35ab	Occurrence codes and dates	Enter the appropriate code(s) and date(s). Blocks 54, 61, 62, and 84 must also be completed as required.
36	Occurrence span codes and dates	For inpatient claims, enter code "82" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.
39	Value codes	Accident Hour - For inpatient claims, if the patient was admitted as the result of an accident, enter the time of the accident using military time (00 to 23). Use code 99 if the time is unknown.
42 43	Revenue codes Revenue description	**Inpatient** For inpatient hospital services, enter the description and code for the total charges and each accommodation and ancillary provided. List accommodations first in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is to be used for the accommodation rate. a. Revenue code "001" is for the total charge and must be the last revenue code on the list. **Exception:** Electronic billers must not use revenue code "001." Use of this code will cause the claim billed amount to be doubled. Electronic billers should not put a code in this block. b. **Radiology** - Professional services by a physician must be billed separately by the physician. c. **Laboratory** - If laboratory work is sent out, the name and address or nine-character TPI of the laboratory where the work was forwarded must be entered. d. **Anesthesia** - Professional services by a physician or CRNA must be billed separately by the physician or CRNA. e. **Medical / Surgical Supplies** - Itemize these services provided in the inpatient facility (such as infusion pumps, traction setups, and crutches for inpatient use only). If provided to all admitted patients, admission kits should be billed using revenue code "270." f. Charges for fetal monitoring must be billed using revenue code "732."

Block No.	Description	Guidelines
44	HCPCS/rates	**Inpatient** Enter the accommodation rate per day. **Home Health** Home health agencies must have the appropriate HCPCS procedure code and a description of services rendered for all services billed. Do **not** use revenue codes for billing these services. Enter the date of service numerically (MM/DD/YY) for each service rendered along with the block number of the diagnoses listed in Blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and/or supply must be itemized on the claim form. The UB-92 Claim Form is limited to 27 detail charges. **Outpatient** Outpatient claims must have the appropriate HCPCS code or narrative description. Do **not** use revenue codes for billing these services. Enter the date of service numerically, and the block number of the diagnosis listed in Blocks 67 through 75 corresponding to each procedure. If a procedure corresponds to more than one diagnosis, identify the primary diagnosis. Each service except for medical/surgical and IV supplies and medication must be itemized on the claim by dates of service. For example: a. **Emergency Room** - Bill as "Emergency room" or "Emergency room charge per use." If the client visits the emergency room more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. b. **Operating Room** - Bill as "Operating Room." c. **Recovery Room** - Bill as "Recovery Room" or "Cast Room" as appropriate. d. **Injections** - Must have "Inj. - name of drug; route of administration; the dosage and quantity" or the injection code. e. **Drugs** and **Supplies** - Take-home drugs and supplies are not a benefit of the Medicaid program. Drugs administered in the outpatient setting must be billed with the modifier "SH." The drug description must include the name, strength, and quantity. f. **Radiology** - The description should provide the location and the number of views. As an alternative, identify the HCPCS code. Professional services by a physician must be billed separately by the physician. The license number of the ordering physician must be in Block 83. If the client receives the same radiology procedure more than once in one day, the time must be given for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. g. **Laboratory** - Provide a complete description or use the procedure codes for the laboratory procedures. Professional services by a physician must be billed separately by the physician. Block 83 must have the license number of the ordering physician. If laboratory work is sent out, the name of the test and the name and address or Medicaid number of the laboratory where the work was forwarded must be entered. If the client receives the same laboratory procedure more than once in one day, give the time for each visit. The time of the first visit must be identified in Block 18, using 00 to 23 hours military time (such as 1350 for 1:50 p.m.). Indicate other times on the same line as the procedure code. h. **Nuclear Medicine** - Provide a complete description. i. **Day Surgery** - Day surgery should be billed as an inclusive charge. Services provided in conjunction with the surgery (lab, radiology, anesthesia) should **not** be billed separately. File claims for emergency, unscheduled outpatient surgical procedures with separate charges (lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital's nine-character H045 TPI. **NOTE:** The UB-92 Claim Form is limited to 27 items per outpatient claim. If necessary, IV supplies (Y7112) and central supplies (Y7107) may be combined on the charge detail and considered as single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may **not** be combined on outpatient claims.
45	Service date	Enter the corresponding procedure by dates of service numerically on outpatient claims. Multiple dates of service may not be combined on outpatient claims.
46	Units of service	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in Block 46 should always represent hours spent in observation.

Block No.	Description	Guidelines
47	Total charges	Enter the total charges for each service provided.
48	Noncovered charges	If any of the total charges are noncovered, enter this amount.
51	Medicaid no.	Enter the nine-character TPI.
54	Prior payments	Enter amounts paid by any TPR and complete Blocks 32, 61, 62, and 84 as required.
58	Insured's Name	If other health insurance is involved, enter the insured's name.
60	CSHCN identification number	Enter the patient's nine-digit CSHCN number from their CSHCN identification.
61	Insured group name	Enter the name and address of the other health insurance.
62	Insurance group number	Enter the policy number or group number of the other health insurance.
63	Treatment authorization code	Enter the prior authorization number (PAN) for home health services, freestanding psychiatric facilities, freestanding rehabilitation facilities, and for surgery if one was issued.
65	Employer name	Enter the name of the client's employer if health care might be provided. Complete Block 66.
66	Employer location	Enter the complete address if an employer name is identified in Block 65.
67	Principal diagnosis code	Enter the ICD-9-CM diagnosis code for the principal diagnosis to the highest level of specificity available.
68-75	Other diagnosis codes	Enter the ICD-9-CM diagnosis code to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block.
		A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). **Exception:** A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alpha-fetoprotein.
76	Admitting diagnosis	Enter the ICD-9-CM diagnosis code in Block E indicating the cause of admission or include narrative.
79	Procedure coding method	Enter code "5" for HCPCS or "9" for ICD-9-CM. Code "9" is used only on inpatient hospital billings.
80-81 a, b, c, d, e	Principal and other procedure codes and dates	Enter the ICD-9-CM procedure code for each surgical procedure and the date each was performed.
82	Attending physician ID	For inpatient claims, enter the physician's license number or UPIN of the provider who performed the service/procedure and/or is responsible for the treatment and plan of care in the following format: 11233333 1 Two-digit state indicator (for example, TX for Texas) 2 Licensing board indicator examples B = MD or DO D = Dentist P = Podiatrist C = Chiropractor 3 License number. Example: TXBL1234 If the provider has a temporary license number, enter "TEMPO." Example: TXBTEMPO Procedures are defined as those listed in the ICD-9-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures. For outpatient claims, enter the license number of the physician referring the patient to the hospital.
83 a,b	Other physician ID	For inpatient claims, enter the license number of the provider who performed the principle service/surgical procedure. If same as Block 83, enter that physician's license number or UPIN. For outpatient claims, enter the license number for the following: The ordering physician for all laboratory and radiology services (If a different physician ordered laboratory or radiology services, and enter his license number in Block 82 and enter the referring/attending physician's license number or UPIN in this block.) The designated physician for a limited client when the physician performed or authorized nonemergency care. If the referring physician is a resident, Blocks 82 and 83 must identify the physician who is supervising the resident.

Block No.	Description	Guidelines
84	Remarks	This block is used to explain special situations such as the following: The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. If billing for a private room, the medical necessity must be indicated and signed by the physician. If services are the result of an accident the cause and location of the accident must be entered in this block. The time must be entered in Block 39. If laboratory work is sent out, the name and address or the Medicaid TPI of the facility where the work was forwarded must be entered in this field. If the patient is deceased, enter the date of death. If services were rendered on the date of death, enter the time of death. If the services resulted from a family planning provider's referral, write "Family Planning Referral." If services were provided at another facility, indicate the name and address of the facility where the services were rendered. Enter the date of onset for patients receiving dialysis services.
85	Provider representative signature	The hospital representative must sign their name. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by a hospital representative authorizing this practice.
86	Date bill submitted	Enter the date the bill was signed.

12.6.2.1 Outpatient Facility HCFA-1450 (UB 92) Claim Form

APPROVED OMB NO. 0938-0279

Rehabilitation Health Center 2600 West Drive Texarkana, TX 75503 903-555-1234	2	3 PATIENT CONTROL NO. 12345	4 TYPE OR BILL 131
5 FEDERAL TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH 060102 060102	7 COV.D. / 8 N-C.D. / 9 C-I.D. / 10 L-RD / 11	

12 PATIENT NAME	13 PATIENT ADDRESS	CITY	STATE	ZIP
Freeman, Angela	9504 Dale St., Houston, TX 77057			

14 BIRTH DATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
03241985	F		060102	10					123456								

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM THROUGH	37
a										A
b										B
										C

8	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a					
	b					
	c					
	d					

	42 REV. CO.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
4								
5								
6								
7		Physical Therapy	1-97110	060102	1	45 00		
8								
9								
0								
1								
2								
3			Total Charges			45 00		
4								
5								
6								
7								
8								
9								
0								
1								
2								
3								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	CSHCN	9876543-21					
B							
C							

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P.REL.	60 CERT - SSN - -HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Hearn, Jennifer K.		123456789		
B					
C					

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
123456789			

67 PRIN.DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADMIN. DIAG. CD.	77 E-CODE	78
34210									34210		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	OTHER PHYS. ID
TXBE1234		

a 84 REMARKS

b

c Hemplegia, Spastic

d

85 PROVIDER REPRESENTATIVE	86 DATE
X John Smith, MD	06 01 02

UB - 92 HCFA - 1450
CORFCCP

copy 1

I CERTIFY THAT THE CERTIFICATIONS IN THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

12

12.6.2.2 Request for Initial Outpatient Therapy (Form TP1)

Form TP1 Request for Initial OUTPATIENT THERAPY	
CCP - National Heritage Insurance Company **PO Box 200735** **Austin, TX 78720-0735** **800-846-7470** **CCP FAX: 512-514-4212**	**NHIC-CSHCN** **Children with Special Health Care Needs Services Program** **PO Box 200855** **Austin TX 78720-0855** **800-568-2413 or 512-514-3000** **FAX: 512-514-4222**
Medicaid/CCP Case #	**CSHCN Case #**
Client Name	**DOB**
Client's Address (street, city, ZIP code, county)	**Phone Number**

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No (If yes, attach copy of IEP).

Date of initial evaluation: PT_____ OT_____ SLP_____

COPY OF THE INITIAL EVALUATION MUST BE ATTACHED

ICD-9 code/DIAGNOSIS: _____ Date of onset _____

CATEGORY OF THERAPY BEING REQUESTED:

PT/OT for: ❑ developmental anomalies ❑ pre-surgery* ❑ post-surgery* DATE of surgery_____

❑ cast removal DATE removed_____ ❑ serial casting ❑ acute episode of chronic condition ❑ new condition

❑ specialty clinic ❑ home program ❑ ADL (activities of daily living) ❑ equipment assessment ❑ equipment training;

SPEECH for: ❑ craniofacial ❑ developmental anomalies ❑ new condition ❑ post cochlear implant#

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

____ PT service date(s) FROM_____TO _____ FREQUENCY per week _____per month ____

____ OT service date(s) FROM _____TO _____FREQUENCY per week _____ per month ____

____ SLP service date(s) FROM _____TO _____ FREQUENCY per week _____ per month ____

Print or Type Name

Physician _____ Physician's signature _____ date signed_____

Therapist (PT) _____ Therapist's signature _____ date signed_____

Therapist (OT) _____ Therapist's signature _____ date signed_____

Therapist (SLP) _____ Therapist's signature _____ date signed_____

PROVIDER CONTACT: _____PHONE # (___) _____FAX # (___) _____

PROVIDER'S NAME: _____

BILLING ADDRESS: _____

MEDICAID PROVIDER # _____CSHCN PROVIDER #_____

12.6.2.3 Request for Extension of Outpatient Therapy (2 Pages) (Form TP2)

Form TP2 Request for EXTENSION of OUTPATIENT THERAPY

CCP - National Heritage Insurance Company **PO Box 200735** **Austin, TX 78720-0735** **800-846-7470** **CCP FAX: 512-514-4212**	**NHIC-CSHCN** **Children with Special Health Care Needs Services Program** **PO Box 200855** **Austin TX 78720-0855** **800-568-2413 or 512-514-3000** **FAX: 512-514-4222**
Medicaid / CCP Case #	**CSHCN Case #**
Client Name	**DOB**
Client's Address (street, city, ZIP code, county)	**Phone Number**

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No

Date of initial evaluation: PT_____ OT_____ SLP_____

ICD-9 code / DIAGNOSIS:_____Date of Onset_____

CATEGORY OF THERAPY BEING REQUESTED:

PT / OT for: ❑ developmental anomalies ❑ pre-surgery* ❑ post-surgery* DATE of surgery_____

❑ cast removal DATE removed_____ ❑ serial casting ❑ acute episode of chronic condition ❑ new condition

❑ specialty clinic ❑ home program ❑ ADL (activities of daily living) ❑ equipment assessment ❑ equipment training;

SPEECH for: ❑ craniofacial ❑ developmental anomalies ❑ new condition

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

____ PT service date(s) FROM_____TO _____ FREQUENCY per week _____per month ____

____ OT service date(s) FROM _____TO _____FREQUENCY per week _____ per month____

____ SLP service date(s) FROM _____TO _____ FREQUENCY per week _____ per month____

Print or type name

Physician _____Physician's signature _____date signed_____

Therapist (PT) _____Therapist's signature _____date signed_____

Therapist (OT) _____Therapist's signature _____date signed_____

Therapist (SLP) _____Therapist's signature _____date signed_____

PROVIDER CONTACT: _____PHONE # (__)_____FAX # (__)_____

PROVIDER'S NAME: _____

BILLING ADDRESS: _____

MEDICAID PROVIDER # _____ CIDC 5 digit LOCAL # _____

FORM TP-2 Page 1 of 2

12

–

Medicaid / CCP case #	**CSHCN Case #**
Client Name	**DOB**

CURRENT FUNCTIONAL STATUS: _____

_____

_____

_____

NEW TREATMENT GOALS: _____

_____

_____

_____

PRIOR DATES OF SERVICE from _____ to _____

PRIOR FUNCTIONAL STATUS: _____

_____

_____

_____

PRIOR TREATMENT GOALS: _____

_____

_____

_____

PRIOR TREATMENT PROVIDED: _____

_____

_____

_____

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SECTION

13

Physician

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13.1 Enrollment

13.1.1 Independent Practices

To enroll as a physician (MD and DO) or as a Doctor of Podiatry (DPM) in the CSHCN Program, physicians must be licensed by the licensing board of his or her profession to practice in Texas at the time the service is performed and must have enrolled as a CSHCN provider by completing the required NHIC-CSHCN provider enrollment forms. Physicians must be enrolled in Medicaid before enrolling in CSHCN.

13.1.2 Group Practices

To enroll as a CSHCN provider, a provider group participating in the Medicaid Program must complete an NHIC-CSHCN Provider Enrollment Application. The Medicaid group TPI and performing TPIs for each physician within the group must be included on the application.

If additions or changes occur in the group's enrollment information after the enrollment process is completed, the CSHCN provider group must notify NHIC of the changes.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88).

Refer to: "CLIA Requirements" on page 1-18 for additional information on CLIA.

13.1.3 Group Billing Procedure

To avoid claim denials, group billing providers **must** give the performing TPI on their claims.

13.1.4 Specialty Team/Center

In addition to requiring prior authorization, some services require that both physicians and facilities be approved by TDH-CSHCN as a specialty team/center provider.

Refer to: "Provider Enrollment" on page 1-17 for enrollment procedures on becoming an approved specialty team/center.

- For bone marrow/stem cell transplant services, both the physician and the facility must be specialty team/center approved.
- For cleft/craniofacial surgical procedures, only the physician/dentist must be specialty team approved.
- **If the specialty team/center requirements are not met, all services related to the surgery will be denied.**

Refer to: "Specialty Team/Center" on page 13-60 for more information and a list of specific procedure codes requiring this special designation.

13.2 Reimbursement

Refer to: "Reimbursement" on page 1-22 for more detailed information regarding reimbursement methodologies.

To receive reimbursement, the provider must document in the client's medical record:

- The service
- The date it was rendered
- Any pertinent information about the client's condition that would support the need for the service
- The care that was provided

Note: If a provider bills for an office visit, the client's medical record must contain documentation for that date of service regarding the client's complaint and any physician orders. If the visit is a follow-up office visit, then the client's progress relating to the previous condition must be documented for the date of service billed. If billing

for a hospital visit, whether it is a routine hospital visit or other type of hospital visit, documentation of that visit must be part of the client's medical record and must be written in the physician's orders or the client's progress notes.

13.2.1 General Medical Record Documentation Requirements

NHIC-CSHCN routinely performs a retrospective review of all providers. This review may include comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

Note: This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.

Requirement	Mandatory / Desirable
All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.	Mandatory
Each page of the medical record documents the patient's name and CSHCN identification number.	Mandatory
Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.	Mandatory
The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. The AMA's Current Procedural Terminology (CPT) descriptors of key / contributory components with level of service descriptions are used to evaluate the selection of levels of service.	Mandatory
Necessary follow-up visits specify time of return by at least the week or month.	Mandatory
The history and physical documents the presenting complaint with appropriate subjective and objective information.	Mandatory
The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need for the services.	Mandatory
Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.	Mandatory
Unresolved problems are noted in the record.	Mandatory
Immunizations are noted in the record as "complete" or "up-to-date."	Desirable
Personal data includes address, employer, home / work telephone numbers, sex, marital status, and emergency contacts.	Desirable

Most physician services are reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM).

For information on anesthesia services that are reimbursed according to relative value units, refer to "Anesthesiology" on page 13-4.

CSHCN will limit reimbursement for those physician's services furnished in hospital outpatient settings that are ordinarily furnished in physician's offices. The limit for each service is determined by establishing a charge base for each professional service and multiplying the charge base by 0.60. The charge base for a service is the TMRM fee for similar routine services furnished by family practitioners in the office.

This provision applies to those procedures performed in the outpatient department of the hospital (for example, clinics and emergency situations). If the eligible client is seen in the outpatient department of the hospital in an emergency situation, the condition that created the emergency must be documented on the claim form. The following is a list of those services excluded from this limitation:

- Surgical services that are covered ambulatory surgical center services
- Anesthesiology and radiology services

- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention must reasonably be expected to result in one of the following:
  - Placing the client's health in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

13.3 Benefits and Limitations

13.3.1 Aerosol Treatments / Inhalation Therapy

CSHCN will reimburse aerosol therapy for any covered diagnosis or related condition. On physician claims, nebulizers and metered-dose inhalers must be coded as follows: 94640, Nonpressurized inhalation treatment for acute airway obstruction.

13.3.1.1 Pentamidine Aerosol Treatment

CSHCN covers procedure codes 94642, J2545, and Z1612, Pentamidine, aerosol, for the treatment of pneumocystis carinii in clients with HIV disease, diagnosis code 042.

13.3.2 Allergy Services

Allergy testing is paid on a per-test basis. Providers must bill for these services indicating the number of tests provided in the units field of the HCFA-1500 Claim Form. If the number of tests is not indicated in this field, payment will be made for one test only.

Antibiotic desensitization is the only allergy service that is payable by the CSHCN Program. CSHCN may reimburse antibiotic desensitization evaluation and treatment for CSHCN clients with cystic fibrosis and human immunodeficiency virus (HIV) disease. Any other diagnosis requires medical justification. The following is a list of payable allergy services:

Procedure Code	Description
95010	Percutaneous tests, (scratch) with drugs, bios, venom; immediate type reaction, specify number of tests
95015	Intracutaneous tests, with drugs, bios, venom; immediate type reaction, specify number of tests
95180	Rapid desensitization procedure, each hour (e. g., insulin, penicillin, horse serum)

13.3.3 Anesthesiology

Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT-4 anesthesia code in block 24D of the HCFA-1500 Claim Form)
- Physician administering anesthesia (modifiers must be used to designate this)
- Time, in minutes
- Appropriate modifier

Base units for anesthesia represent the relative value units (RVUs) for the procedures performed. When multiple procedures are performed, the base units represent the procedure with the highest RVUs.

Time units are added to the base units. Time in minutes is divided by either 15 or 30 minutes depending on the modifier billed with the exception of the AD modifier (see below). A modifier must be used on all claims.

Modifier	Description	Time Divided by 15 minutes	% Reductions of Base Units
2X	(NHIC) CRNA medically directed	N/A	N/A
AA	(HCFA) Anesthesia services performed personally by anesthesiologist	15 min.	0 percent
AD	(HCFA) Medical supervision by a physician: more than four concurrent anesthesia procedures	Total time units for claims will be one	10 percent
QJ	(NHIC) Medically directed by a physician: two concurrent procedures	30 min.	10 percent
QO	(NHIC) Medically directed by a physician: three concurrent procedures	30 min.	40 percent
QQ	(NHIC) Medically directed by a physician: four concurrent procedures	30 min.	40 percent
QX	(HCFA) CRNA service with medical direction by physician	N/A	N/A
QZ	(HCFA) CRNA service without medical direction by a physician	N/A	N/A

Total units (as determined by the above guidelines) are multiplied by the conversion factor of $15.55.

13.3.3.1 Services Incidental to Surgery and/or Anesthesia

The following procedures are not payable when billed with a surgical/anesthesia service:

Procedure Code	Description
36010	Introduction of catheter, superior or inferior vena cava
36420	Venipuncture, cutdown; under age 1 year
36425	Venipuncture, cutdown; age 1 or over
36430	Transfusion, blood or blood components
36440	Push transfusion, blood, 2 years or under
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion; cutdown
82800	Gases, blood, pH only
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)
82805	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); with O2 saturation, by direct measurement, except pulse oximetry
82810	Gases, blood, O2 saturation only, by direct measurement, except pulse oximetry
82820	Hemoglobin-oxygen affinity (pO2 for 50% hemoglobin saturation with oxygen)
93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization
93562	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
94656	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day
94657	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; subsequent days

Procedure Code	Description
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple
94681	Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted
94690	Oxygen uptake, expired gas analysis; rest indirect (separate procedure)
94770	Carbon dioxide, expired gas determination by infrared analyzer
99231-99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of the three key components
99291	Critical care, evaluation and management of the unstable critically ill or unstable critically injured patient, requiring the constant attendance of the physician; first hour
99292	Critical care, evaluation and management of the unstable critically ill or unstable critically injured patient, requiring the constant attendance of the physician; each additional 30 minutes (List separately in addition to code for primary service)
Z9084	Intravenous therapy - IV therapy (not including chemotherapy)

Multiple surgical procedures billed on the same day by the same provider will be subject to the multiple surgery guidelines. Placement of a central venous catheter will be denied as part of another procedure billed on the same day when billed with insertion of intra-aortic balloon assist device through the femoral artery, open approach (33970).

Providers must code the procedures in block 24D of the HCFA-1500 Claim Form with a valid CPT-4 anesthesia code. The following procedure codes are valid anesthesia procedure codes in addition to those listed in CPT-4 and must be used when appropriate:

Procedure Code	Description
0094X	Anesthesia for pelvic exam
0095X	Anesthesia for bone marrow transplant
00103	Anesthesia for reconstructive procedures of eyelid (e.g., blepharoplasty, ptosis surgery)
00147	Anesthesia for iridectomy
X7010	Induction of anesthesia only (anesthesiologist only)

If procedure code 01996, Daily management of epidural or subarachnoid drug administration, is used, it must be reported as medical rather than anesthesia.

13.3.3.2 Base Units

Base units represent the relative value units (RVUs) for the anesthesia procedure performed. The uniform relative value guide used by NHIC-CSHCN to reimburse anesthesia services is one developed by the Texas Medicare carrier.

Refer to: Medicare's Physician Newsletters for the CPT anesthesia codes and corresponding base units assigned to each code.

13.3.3.3 Time Units

CPT-4 Definition: "Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision."

Time, in minutes, indicated on the claim will be divided by 15 or 30 minute increments based on the modifier indicated. This determines the time units that are used in the payment formula. Total time units for the AD modifier is one.

The "BILLED QTY" (quantity) field on the *R and S* reflects only the number of units NHIC processed for time. The RVUs assigned for the procedure code are not reflected in the "BILLED QTY" field but can be determined by subtracting the units allowed for time from the total units paid.

13.3.3.4 Reimbursement

To determine the total number of units payable, NHIC adds the number of RVUs assigned to the appropriate procedure code and the units allowed for the time.

Reimbursement for anesthesia services is determined by a calculation using the number of base units associated with the anesthesia procedure plus the quantity billed (anesthesia time units) multiplied by the TMRM conversion factor for physicians.

Services provided by a CRNA are reimbursed by TDH-CSHCN. For information on enrollment or claims filing, contact TDH-CSHCN at 800-252-8023.

The following procedure codes are payable to a physician, in addition to an anesthesia procedure or service:

Procedure Code	Description
99100	Anesthesia for patient of extreme age, under one year or over 70
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency conditions defined as existing when delay in treatment of the patient would lead to a significant increase in threat to life or body part

13.3.3.5 Regional Anesthesia (Epidural, Nerve Block, Spinal)

Local, regional, or general anesthesia provided by the surgeon is not a separately payable benefit of the CSHCN Program when performed by the operating surgeon. If anesthesia services are provided and the CPT modifier “47” is used, the services will be included in the global fee for the surgical procedure(s).

13.3.4 Hearing Services

CSHCN covers audiological testing for clients not covered through the Program for Amplification for Children of Texas (PACT) in the Bureau of Children’s Health. Payment may be made to physicians to test clients whose hearing is found to be suspect on the routine screening, whether or not hearing is found to be impaired.

A basic comprehensive audiometry (92557) is covered and includes the following tests:

Procedure Code	Description
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry; threshold only
92556	Speech audiometry; threshold and discrimination
92557	Comprehensive audiometry threshold evaluation and speech recognition
92560	Bekesy audiometry; screening
92562	Loudness balance test, alternate binaural or monaural

If three or more of the above procedures are performed on the same day, they must be billed as 92557. Any combination of three or more tests billed separately on the same day as basic audiometry will be denied. Providers may not bill any of the above tests on the same day as 92557.

The following additional tests are also covered by CSHCN:

Procedure Code	Description
92561	Bekesy audiometry; diagnostic
92563	Tone decay test
92564	Short Increment Sensitivity Index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92571	Filtered speech test
92572	Staggered spondaic word test (SSW)
92573	Lombard test
92575	Sensorineural acuity level test
92576	Synthetic sentence identification test (SSI)
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92585	Brainstem evoked response recording [evoked response (EEG) audiometry]
92589	Central auditory function test(s) (specify)

Procedure codes 92571, 92572, and 92576 will not be paid if billed by the same provider on the same day as 92589.

CSHCN covers hearing aids and related services (92590 through 92596) or amplification devices through the Program for Amplication for Children in Texas (PACT) for clients under 21 years of age. Hearing aids for clients 21 years of age and older will be reimbursed at the current PACT reimbursement rates for the prescribed hearing aid.

13.3.5 Blood Factor Products

CSHCN reimburses for blood factor products and related pharmaceuticals for program-eligible clients with diagnoses 28600 through 28640.

Reimbursement for blood factor products will be the lower of the billed price or the United States Public Health Service (USPHS) price in effect on the date of service plus a dispensing fee of $0.04 per unit or (per microgram for factor VIIa).

Blood factor products require authorization. The physician's prescription must accompany the CSHCN authorization form for hemophilia blood factor products (refer to "CSHCN Authorization Form for Hemophilia Blood Factor Products" on page 8-43). When obtaining authorization or submitting claims, products must be identified by product name and manufacturer or by National Drug Code (NDC), and the following HCPCS codes should be used:

Procedure Code	Description
J7190	Factor VIII (antihemophilic factor [human]), per IU
J7191	Factor VIII (porcine)
J7192	Factor VIII (antihemophilic factor [recombinant]), per IU
J7193	Factor IX (antihemophilic factor, purified, nonrecombinant) per IU

Procedure Code	Description
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7198	Anti-Inhibitor, per IU
J7199	Hemophilia clotting factor, not otherwise classified
Q0187	Factor VIIa (coagulation factor, recombinant) per 1.2 mg

Whether provided in a hospital outpatient facility, in a physician's office, or in the client's home, all ancillary services such as infusion supplies, administration, and home delivery expenses are included in reimbursement for the product as described above.

Medical review is required for approval of blood factor products for any diagnosis other than 28600 through 28640 with the exception of procedure code Q0187, Factor VIIa, Coagulation factor, recombinant, per 1.2 mg which is only payable for diagnoses 28600 through 28610. Procedure codes J7193 and J7195 are payable only for diagnosis code 28610.

When submitting claims where the dispensed units are more than 999, submit a quantity of "1" and indicate the specific number of units provided on the claim form.

13.3.6 Cancer Screening

The following procedure codes are a covered benefit of the CSHCN Program:

Procedure Code	Description
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
G0103	Prostate cancer screening; prostate specific antigen test (PSA) total
G0104	Colorectal cancer screening; flexible sigmoidoscopy
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
G0122	Colorectal cancer screening; barium enema

13.3.6.1 Colorectal Cancer Screening

Screening colonoscopy is recommended once every 24 months for individuals at high risk for colorectal cancer. High-risk individuals include people with **one or more** of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or adenomatous polyposis
- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of colorectal cancer
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis

A screening colonoscopy may be covered for the following diagnoses:

Diagnosis Code	Description
V1005	Personal history of malignant neoplasm of the large intestine
V1006	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
V1600	Family history of malignant neoplasm of gastrointestinal tract
V1850	Family history of certain other specific conditions, digestive disorders
55500	Regional enteritis of small intestine
55510	Regional enteritis of large intestine
55520	Regional enteritis of small intestine with large intestine
55590	Regional enteritis of unspecified site
55600	Ulcerative (chronic) enterocolitis
55610	Ulcerative ileocolitis
55620	Ulcerative (chronic) proctitis
55630	Ulcerative (chronic) proctosigmoiditis
55680	Other ulcerative colitis
55690	Ulcerative colitis, unspecified
55820	Toxic gastroenteritis and colitis
55890	Other and unspecified noninfectious gastroenteritis and colitis

13.3.7 Chemotherapy

Chemotherapy services are a covered benefit of the CSHCN Program when provided personally by a physician or under the supervision of a physician.

Note: Authorization is **not** required by the physician or outpatient facility for chemotherapy administration when performed in the outpatient facility.

When chemotherapy is administered in the physician's office, the physician may be reimbursed by using the appropriate CPT-4 Codes 96400 through 96410, 96420 through 96422, 96440 through 96542, and/or 96549. The following chemotherapy codes are **not** a benefit: 96412, 96414, 96423, 96425, and 96545.

The chemotherapeutic agents should be billed separately, including the name of the drug and actual amount administered for correct reimbursement.

Chemotherapy administration and injection codes 96400 through 96410, 96420, 96440 through 96524, and/or 96549 include charges for IV solutions (such as saline, dextrose and water, Ringer's solution, etc.), IV equipment (administration sets, needles, extension tubing, etc.), and time spent in administering the drugs and subsequent observation of the patient.

Procedure codes 96440, 96445, and 96450 include payment for the surgical procedure; separate reimbursement for the surgical code is not allowed. These codes require the direct supervision of the physician.

Note: Evaluation and management services are payable in addition to 96440, 96445, and 96450.

Prolonged infusion of chemotherapeutic agents are reimbursed as follows:

Reimbursement of Prolonged Infusion of Chemotherapeutic Agents		
First Hour	96410	Chemotherapy administration, intravenous; infusion technique, up to one hour
	96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour

The following chemotherapy codes are **not** a benefit of the CSHCN Program:

Procedure Code	Description
96412	Chemotherapy administration, intravenous; infusion technique, one to eight hours, each additional hour
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than eight hours), requiring the use of portable or implantable pump
96423	Chemotherapy administration, intra-arterial; infusion technique, one to eight hours, each additional hour
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours), requiring the use of portable or implantable pump

Chemotherapy injection code 96545, Provision of chemotherapy agent, is **not** a benefit of the CSHCN Program.

Chemotherapeutic drugs and other injections given in the course of chemotherapy are reimbursed using the appropriate HCPCS code.

Chemotherapy planning program is reimbursed with HCPCS code Z9615. No other patient contact code will be reimbursed on the same day.

Chemotherapy administration by push technique (96408 and 96420) and by infusion technique (96410 and 96422) will be allowed on the same day. Only one intravenous push administration (96408) and only one intra-arterial push administration (96420) will be allowed per day, regardless of whether separate drugs are given.

Procedure code 6235X, Implantation, revision, or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump, without laminectomy, may be billed when related to the administration of chemotherapy. This code is payable to physicians in the inpatient and outpatient settings. No separate payment is made for the catheter or implantable pump.

13.3.8 Consultations

A consultation is defined as rendering an opinion for evaluation and/or management of a patient. Claims must indicate the name and address or a valid CSHCN TPI of the referring physician.

Office and outpatient consultations (outpatient hospital or ambulatory facility) are coded 99241 through 99245. The medical decision complexity and examination detail determines which code must be used in the office (POS 1) or as an outpatient (POS 5).

Consultation procedure codes 99241 through 99245, 99251 through 99263, and 99271 through 99275 are denied if billed by the performing surgeon or anesthesiologist within the postoperative care days.

Note: Initial and follow-up inpatient consultations may be billed in POS 3 (inpatient hospital).

A consultation initiated by a client and/or family and not requested by a physician is reported as an office visit using codes 99201 through 99215, or as a confirmatory consultation, using codes 99271 through 99275.

The assumption of the total or specific care of a client from one physician to another does not constitute a consultation.

One initial inpatient consultation (99251 through 99255) is allowed per hospitalization per provider with up to three follow-up inpatient consultations (99261 through 99263) within a 30-day period, if needed to complete the initial consultation, or a new evaluation is requested by the attending physician. If another initial inpatient consultation is billed during this time period, it is changed to the appropriate follow-up consultation code. Any follow-up consultations beyond the 30-day period are changed to the appropriate inpatient evaluation and management code.

13.3.9 Echoencephalography

The following diagnosis codes are only payable for procedure code 76506, Echoencephalography:

Diagnosis Code	Description
01300–01386	Tuberculosis of meninges and central nervous system
17000	Malignant neoplasm of bone and articular cartilage
19010	Malignant neoplasm of eye; orbit
19100–19190	Malignant neoplasm of brain
19200–19210	Malignant neoplasm of other and unspecified parts of nervous system; cranial nerves and cerebral meninges
19430	Malignant neoplasm of pituitary gland and craniopharyngeal duct
19830–19850 19889	Secondary malignant neoplasm of other unspecified sites
21300	Benign neoplasm of bone and articular cartilage
22500–22520	Benign neoplasm of brain and other parts of nervous system
22700	Benign neoplasm of other endocrine glands and related structures
23400–23480	Carcinoma in situ of other and unspecified sites
23750–23760 23790	Neoplasm of uncertain behavior of endocrine glands and nervous system
23800–23880	Neoplasm of uncertain behavior of other and unspecified sites and tissues
23960–23970	Brain neoplasm/endocrine/nerve neoplasm
32400–32490	Intracranial and intraspinal abscess
32500	Phlebitis and thrombophlebitis of intracranial venous sinuses
33110–33190	Other cerebral degeneration
34800	Cerebral cysts
34820	Benign intracranial hypertension
34840	Compression of brain
34850	Cerebral edema
37700–37775	Disorders of optic nerve and visual pathways
43000	Subarachnoid hemorrhage
43100	Intracerebral hemorrhage
43200-43290	Other unspecified intracranial hemorrhage
43400-43491	Occlusion of cerebral arteries
43600	Acute, but ill-defined, cerebrovascular disease
43710	Other generalized ischemic cerebrovascular disease
43730	Cerebral aneurysm, nonruptured
74100–74103	Spina bifida
74200-74240	Other congenital anomalies of nervous system
74781	Anomalies of cerebrovascular system
76780	Other specified birth trauma
77210–77214	Fetal and neonatal intraventricular hemorrhage
77220	Fetal and neonatal subarachnoid hemorrhage
77900	Convulsions in newborn
78031–78039	Convulsions
77970	Periventricular leukomalacia

13.3.9.1 Intraoperative Echography

Procedure code 76986, Echography, intraoperative, is no longer denied as “Service is not a benefit.” The code is part of a surgical procedure and is denied as “This charge is included in the surgical/anesthesia fee.”

13.3.9.2 Ambulatory Electroencephalogram

CSHCN covers ambulatory electroencephalographic monitoring for eligible clients with the following diagnoses:

Diagnosis Code	Description
33320	Myoclonus
34500–34501	Generalized nonconvulsive epilepsy
34510–34511	Generalized convulsive epilepsy
34520	Petit mal status
34530	Grand mal status
34540–34541	Partial epilepsy, with impairment of consciousness
34550–34551	Partial epilepsy, without mention of impairment of consciousness
34560–34561	Infantile spasms
34570–34571	Epilepsia partialis continua
34580–34581	Other forms of epilepsy
34590–34591	Epilepsy, unspecified
V1085	Personal history of malignant neoplasm of brain
V1086	Personal history of malignant neoplasm of nervous system
V1240	Personal history of disorders of nervous system and sense organs
V1241	Benign neoplasm of the brain
V1249	Other disorders of nervous system and sense organs
V1360	History of congenital malformation
V1369	Congenital malformations, other
V7649	Special screening for malignant neoplasms, other sites
V7680	Special screening for malignant neoplasms, other neoplasm
V7681	Special screening for malignant neoplasms, nervous system
V7689	Special screening for malignant neoplasms, other neoplasm
V800	Special screening for neurological conditions

The following procedure codes must be used when billing for ambulatory electroencephalograms:

Procedure Code	Description
95950	Monitoring for identification and lateralization of cerebral seizure focus; electroencephalographic (8 channel EEG) recording and interpretation, each 24 hours
95951	Monitoring for (localization) of cerebral seizure focus cable or radio, 16 or more channel telemetry; combined electroencephalographic (EEG) and video recording and interpretation, each 24 hours (for example, for presurgical localization)
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG; electroencephalographic (EEG) recording and interpretation, each 24 hours
95956	Monitoring for localization of cerebral focus by cable or radio, 16 or more channel telemetry; electroencephalographic (EEG) recording and interpretation, each 24 hours

If more than one of the above procedure codes are billed on the same day, the most inclusive code will be paid and all other codes will be denied.

Ambulatory electroencephalograms are limited to two for each physician for the same client per six months.

13.3.10 Emergency Services

An emergency medical condition is defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that if not immediately treated must reasonably be expected to result in one of the following:

- Placing the client's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

13.3.10.1 After-Hours Charges

The following codes are payable to an office-based physician in addition to the appropriate evaluation and management code for providing services in the emergency room (POS 5) or office (POS 1) after routine hours.

Procedure Code	Description
99050	Services requested after office hours in addition to basic service (office only)
99052	Services requested between 10 p.m. and 8 a.m. in addition to basic service (office or emergency department)
99054	Services requested on Sundays and holidays in addition to basic service (office or emergency department)
99056	Services provided at the request of patient in a location other than physician's office which are normally provided in the office (emergency department only)

13.3.10.2 Emergency Room Services

Physicians treating patients in the emergency room must use procedure codes 99281 through 99285 when providing emergency care. Nonemergency care must be billed with procedure codes 99201 through 99205 for new patients and 99211 through 1-99215 for established patients.

The above codes are the appropriate codes for the physician who is attending to a patient in an outpatient observation room setting for less than six hours. Document the time for multiple visits in block 24K of the HCFA-1500 Claim Form.

13.3.10.3 Observation Room Services

Physician outpatient hospital observation room service is for professional services for a period of more than six hours but less than a 24-hour period regardless of the hour of the initial contact, whether or not the patient remains under physician care past midnight.

Note: Physicians may bill codes 99218, 99219, and 99220 for the outpatient observation period of greater than 6 hours but less than 24 hours.

Emergency department visits (99281 through 99285) and emergency department/office inconvenience or after-hours charges (99052 through 99056) will be denied the same day as physician outpatient hospital observation room service (99218 through 99219 and 99220) when billed by the same provider.

When patient status changes from observation to inpatient, the date of inpatient admission is the date the patient was first placed on observation status. This rule **always** applies, regardless of the length of time the patient was in observation (fewer than 24 hours) or whether the physician's order to formally admit the patient was the following day. Charges are to be billed as specified in "Outpatient Services" in the Hospital section.

The following observation codes are a benefit of the CSHCN Services Program:

Procedure Code	Description
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

The following limitations apply to these codes:

- If 99234 through 99236 are billed on the same day by the same provider as initial observation care codes (99218 through 99220), 99234 through 99236 are denied.
- If a hospital admission (99221 through 99223) is billed on the same day by the same provider as outpatient hospital observation (99234 through 99236), the observation is denied.
- If 99234 through 99236 are billed on the same day by the same provider as prolonged detention (99354 through 99355), the prolonged detention is denied.
- If 99234 through 99236 are billed on the same day by the same provider as a subsequent hospital visit (99231 through 99233), the subsequent visit is denied.
- If 99234 through 99236 are billed on the same day by the same provider as a consultation, the consult is denied.
- Codes 99234 through 99236 are not payable on the same day as 99238 through 99239.
- Codes 99234 through 99236 are subject to the global surgical fee pre/post care days assigned to certain surgical procedures.

13.3.10.4 Prolonged Physician Services

Physicians may bill for prolonged physician services in the emergency room when a patient requires the presence of a physician. When billing for prolonged physician services, the following procedure codes must be used:

Procedure codes 99354 through 99357: Reported when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting.

Procedure codes 99354 and 99356: Must be used to report the first hour of prolonged service and will be limited to one per day. Each additional 30 minutes must be reported using procedure codes 99355 and 99357 and will be limited to three units, or one and one-half hours per day. Prolonged services of fewer than 15 minutes in duration must not be reported separately.

Procedure codes 99354 through 99355: Procedure codes 99354 through 99355 are limited to the office (POS 1) and outpatient (POS 5) settings. Evaluation and management services performed in the office (99201 through 99215) or in the emergency department (99281 through 99285) may be reported in addition to prolonged physician services. Physician outpatient observation (99218

through 99220 and 99234 through 99236) billed on the same day as prolonged services by the same provider will be denied. Prolonged physician services billed on the same day as critical care (99291, 99292) will be denied.

Procedure codes 99356 and 99357: Procedure codes 99356 and 99357 are limited to the inpatient (POS 3) setting. Prolonged service may be paid on the same day as an initial hospital visit (99221 through 99223), subsequent hospital visit (99231 through 99233), or initial neonatal intensive care visit (99295). Prolonged services and newborn resuscitation (99440) will be denied when billed on the same day as subsequent neonatal intensive care (99296 through 99297) by the same provider. Procedure codes 99354 through 99357 will be denied when billed on the same day as critical care services (99291 through 99292) by the same provider.

Note: Prolonged physician service without direct (face-to-face) patient contact (99358 through 99359), physician standby service (99360) and physician supervision of a patient under care of a home health agency (99374 through 99375) are **not** benefits of the CSHCN Program.

13.3.11 Evaluation and Management Codes

Evaluation and management (E/M) codes are used to report client contacts/visits. When billing for these services, select the code that will describe the extent of history and physical examination and the complexity of the medical decision making involved. Refer to the current version of the AMA CPT-4 for appropriate E/M codes with descriptions.

13.3.12 Gastrostomy Devices

CSHCN reimburses for low-profile gastrostomy devices when prescribed by a physician and documentation supports medical necessity. The following devices may be covered:

Procedure Code	Description
5234X	Gastrostomy device, obturated, mushroom type (Button, Stomate, Bard, Gastro-Port)
5235X	Gastrostomy kit, nonobturated, balloon type (MIC-KEY, Pee-Wee)

Nonobturated gastrostomy devices may be payable to physicians, pharmacies, medical suppliers, and home health agencies. Obturated gastrostomy devices may be reimbursed only to physicians. Two devices may be reimbursed per calendar year. Related supplies and equipment will be reimbursed according to the expendable supplies and durable medical equipment policy.

13.3.13 Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen is a mode of therapy involving exposure of the body to oxygen under pressure greater than one atmosphere. Such treatment is performed in specially constructed hyperbaric chambers which may hold one or several patients. Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, this use of oxygen is not considered hyperbaric oxygen treatment in itself.

Requests for HBO are covered for the following diagnoses:

Diagnosis Code	Description
0383	Septicemia due to anaerobes
0400	Gas gangrene
52689	Osteoradionecrosis
68600	Other local infection of skin and subcutaneous tissue, pyoderma unspecified
68601	Other local infection of skin and subcutaneous tissue, pyoderma gangrenosum
68609	Other local infection of skin and subcutaneous tissue, other pyoderma
7070–7079	Chronic ulcers of the skin

Diagnosis Code	Description
73010–73019	Chronic refractory osteomyelitis
7854	Gangrene
9064–9069	Late effects of crushing and burns
9092	Late effects of radiation
990	Effects of radiation, unspecified
9964	Mechanical complication of internal orthopedic device, implant and graft
99652	Mechanical complication due to graft of other tissue, NEC
99660–99662	Infection and inflammatory reaction due to internal prosthetic device, implant and graft

Physicians billing for the professional component of HBO therapy should use procedure code 99183, Physician attendance/supervision of hyperbaric oxygen therapy, per session.

Note: Procedure code 99183 is limited to one per day.

Outpatient hospitals billing for HBO are reimbursed with the following CPT-4 procedure codes:

Procedure Code	Description
Z9112	Initial hour of hyperbaric oxygen (HBO) therapy (technical component)
Z9113	Hyperbaric oxygen therapy (technical component); each additional half hour

Note: HBO is limited to one initial and three subsequent therapies per day.

Procedure code G0167, Hyperbaric oxygen treatment not requiring physician attendance, per treatment session, is considered to be included in the charge of procedure code Z9112 and Z9113, and is **not** a covered benefit.

13.3.14 Injection Administration Billed by a Physician

Injection administration billed by a physician will be reimbursed separately from the medication. Injection administration must be billed using the following procedure code: 90782, Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular. Procedure code 90782 will be limited to one per day unless documentation clearly indicates that the medications must not be mixed. Injection administration (90782) will be paid in addition to an evaluation and management or consultation visit. This ensures that each injection will receive one administration fee regardless of the dosage.

13.3.14.1 Botulinum Toxin (Type A)

Providers should bill procedure code J0585, Injection, botulinum, toxin type A, per unit. Botulinum toxin, type A may be covered for the following diagnoses:

Diagnosis Code	Description
34211	Spastic hemiplegia and hemiparesis affecting dominant side
34212	Spastic hemiplegia and hemiparesis affecting nondominant side
34300	Congenital diplegia
34310	Congenital hemiplegia
34320	Congenital quadriplegia
34330	Congenital monoplegia
34340	Infantile hemiplegia
34380	Cerebral palsy NEC
34390	Cerebral palsy NOS

Authorization and medical review is required for all other diagnoses. Documentation for consideration of other diagnoses must include diagnosis, clinical course, clinical history, and other treatments with an explanation of ineffective results. This documentation must be submitted to NHIC-CSHCN with an authorization request or included with the claim.

13.3.14.2 Cidofovir (Vistide)

CSHCN coverage for Cidofovir is limited to the treatment of CMV retinitis in patients with HIV/AIDS. Use procedure code J0740, Cidofovir, 375 mg.

13.3.14.3 Denileukin Diftitox (Ontak)

CSHCN coverage for Denileukin Diftitox is limited to treatment of mycosis, fungoides, diagnosis code 20210 and Sezary's disease, diagnosis code 20220. Providers should use procedure code J9160, Injection, Deniluekin Diftitox, 300 mcg, vial.

13.3.14.4 Docetaxel (Taxotere)

CSHCN coverage for Docetaxel is limited. Providers should use procedure code, J9170, Docetaxel, 20 mg. Docetaxel may be covered for the following diagnoses:

Diagnosis Code	Description
1620	Malignant neoplasm of trachea, bronchus, and lung; trachea
1622	Main bronchus
1623	Upper lobe, bronchus or lung
1624	Middle lobe, bronchus or lung
1625	Lower lobe, bronchus or lung
1628	Other parts of bronchus or lung
1629	Bronchus and lung, unspecified
17400–17590	Malignant neoplasm of the breast
18300	Malignant neoplasm of the ovary and other uterine adnexa
19700–19720	Secondary malignant neoplasm of respiratory and digestive system
19770	Malignant neoplasm of liver, specified as secondary
19820–19830	Secondary malignant neoplasm of skin; brain and spinal cord
19850	Secondary malignant neoplasm of bone and bone marrow
19860	Secondary malignant neoplasm of ovary
19881	Secondary malignant neoplasm of breast
19889	Secondary malignant neoplasm, other

13.3.14.5 Epirubicin Hydrochloride (Ellence)

Procedure code J9180, is a covered benefit of the CSHCN Program. This procedure code is limited to diagnoses 17400 through 17590, malignant neoplasm of male or female breast.

13.3.14.6 Epoprostenol (Flolan)

Procedure code J1325, Epoprostenol, 0.5mg (Flolan), is a covered benefit of the CSHCN Program. This procedure code is limited to diagnosis 41600, Primary pulmonary hypertension only.

13.3.14.7 Erythropoietin Alfa (EPO)

The following diagnoses are payable for erythropoietin:

Diagnosis Code	Description
04200	Human immunodeficiency virus infection
20300–20301	Multiple myeloma and immunoproliferative neoplasms
23870	Neoplasm of uncertain behavior, other lymphatic and hematopoietic tissues
27330	Macroglobulinemia
28000–28590	Anemias (refer to 2002 ICD-9-CM for exact descriptions)
40300	Hypertensive renal disease malignant, without mention of renal failure
40301	Hypertensive renal disease malignant, with renal failure
40310	Hypertensive renal disease benign, without mention of renal failure
40311	Hypertensive renal disease benign, with renal failure
40390	Hypertensive renal disease unspecified, without mention of renal failure
40391	Hypertensive renal disease unspecified, with renal failure
40402	Hypertensive heart and renal disease malignant, with renal failure
40403	Hypertensive heart and renal disease malignant, with congestive heart failure and renal failure
40412	Hypertensive heart and renal disease benign, with renal failure
40413	Hypertensive heart and renal disease benign, with congestive heart failure and renal failure
40492	Hypertensive heart and renal disease unspecified, with renal failure
40493	Hypertensive heart and renal disease unspecified, with congestive heart failure and renal failure
58600	Renal failure, unspecified
71400	Rheumatoid arthritis
99811	Hemorrhage complicating a procedure
V5810	Encounter for other and unspecified procedures and aftercare, chemotherapy

When billing for EPO, use the following procedure codes, with a covered diagnosis:

Procedure Code	Description
Q0136	EPO (for non-ESRD use), per 1,000 units
Q9920–Q9936	EPO per 1,000 units, at patient HCT of 36 or less

Procedure codes Q9937 through Q9940, EPO, per 1,000 units, at patient HCT of 37 or above, are not payable for EPO.

EPO coverage is limited to three injections per seven days. For example, if a client with end-stage renal disease has a hematocrit of 34 percent and is given 5,000 units of EPO, bill a quantity of five, using code Q9934. The client may receive three payable injections per seven days.

13.3.14.8 Gamma Globulin / Immune Globulin

The following diagnoses are currently payable for codes J1460 through J1561 and J1563, Z1048, 1046X, Gamma globulin, and 1048X, Sandoglobulin:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
27900	Hypogammaglobulinemia, unspecified
27901–27906	Primary immunodeficiencies
27909	Deficiency of humoral immunity
27910–27913	Deficiency of cell-mediated immunity
27919	Other, deficiency of cell-mediated immunity
27920–27940	Immune deficiency
28730	Primary thrombocytopenia
58500	Chronic renal failure
58600	Renal failure, unspecified

13.3.14.9 Granisetron Hydrochloride (Kytril)

CSHCN coverage for Granisetron Hydrochloride is limited to the treatment for encounter of radiotherapy and chemotherapy, diagnosis codes V5800 through V5810. The quantity used must appear on the claim. Providers should use procedure code J1626, Injection, Granisetron Hydrochloride, 100 mcg.

13.3.14.10 Ibutilide Fumarate (Corvet)

Procedure code J1742, Ibutilide fumarate, 1mg, is a covered benefit of the CSHCN Program. This procedure code is covered for the following diagnoses only:

Diagnosis Code	Description
42731	Atrial fibrillation
42732	Atrial flutter

13.3.14.11 Infliximab (Remicade)

CSHCN coverage for Infliximab (Remicade) is limited to the treatment of regional enteritis, large and/or small intestine, intestinal fistula and anal fistula, rheumatoid arthritis and other inflammatory polyarthropathies diagnosis codes 55500 through 55590, 56510, 56981, and 71400 through 71430. Providers should use procedure code J1745, Injection, Inflximab, 10 mg.

13.3.14.12 Linezolid (Zyvox)

Linezolid is a covered benefit of the CSHCN Program when provided in an inpatient setting (POS 3). Providers should use procedure code J2020 when billing for this injection. The oral form of this medication is covered through the Vendor Drug Program.

13.3.14.13 Lioresal (Baclofen)

Procedure codes J0475, Injection, Baclofen, 1 ampule, 10 mg/20 ml, and J0476, Injection, Baclofen, 50 mcg, for intrathecal trial, are covered benefits of the CSHCN Program. Authorization is required for 6235X, Implantation, revision, or repositioning of intrathecal or epidural catheter for implantable infusion pump, without laminectomy, when related to the intrathecal administration of Baclofen. Separate payment for the device is not covered for the physician or the hospital.

13.3.14.14 Porfimer Sodium (Photofrin)

Porfimer sodium is a covered benefit of the CSHCN Services Program. Providers should use procedure code J9600, Porfimer sodium, 75 mg. Porfimer sodium is payable for the following diagnoses:

Diagnosis Code	Description
15000	Malignant neoplasm of cervical esophagus
15010	Malignant neoplasm of thoracic esophagus
15020	Malignant neoplasm of abdominal esophagus
15030	Malignant neoplasm of upper third of esophagus
15040	Malignant neoplasm of middle third of esophagus
15050	Malignant neoplasm of lower third of esophagus
15080	Malignant neoplasm of contiguous or overlapping sites of esophagus whose point of origin cannot be determined
15090	Malignant neoplasm of esophagus, unspecified
19780	Secondary malignant neoplasm of other digestive organs and spleen

13.3.14.15 Rituximab (Rituxan)

Rituximab is a benefit of the CSHCN Program. Providers should use procedure code J9310, Injection, Rituximab, 100 mg.

13.3.14.16 Sumatriptan Succinate (Imitrex)

CSHCN coverage for procedure code J3030, Injection, sumatriptan succinate, 6 mg, is limited to treatment of classical migraines. Use diagnosis code 34600, Classical migraine.

13.3.14.17 Topotecan HCL (Hycamtin)

CSHCN coverage for topotecan is limited to treatment of metastatic ovarian cancer after failure of initial or subsequent chemotherapy, and malignant neoplasm of trachea, bronchus, and lung. Use procedure code J9350, Topotecan, 4mg.

13.3.14.18 Trastuzumab (Herceptin)

CSHCN coverage for trastuzumab is limited to the treatment of breast cancer, diagnosis codes 17400 through 17590. Providers should use procedure code J9355, Injection, Transtuzumab, intravenous, per 10 mg.

13.3.14.19 Valrubicin (Valstar)

CSHCN coverage for valrubicin is limited to the treatment of cancer of the bladder, diagnosis code 23370. Providers should use procedure code J9357, Valrubicin, intravesical use, 200 mg vial.

13.3.15 Injections and Oral Medications

Oral medication should be used in preference to injectable medication in the office and outpatient hospital unless one of the following circumstances applies:

- No acceptable oral equivalent is available
- Injectable medication is the standard treatment of choice
- The oral route is contraindicated
- The patient has a temperature over 102°F (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly
- The patient has demonstrated non-compliance with orally prescribed medication (documented on the claim and in the medical record)
- Previously attempted oral medication regimens have proven ineffective as supported by the medical record
- An emergency situation occurs

Claims submitted for antibiotic or steroid injections billed in a physician's office (POS 1) or in the outpatient hospital (POS 5) must include one of the following modifiers:

Modifier	Description
6A	Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available.
6B	The patient has a temperature over 102°F (documented on the claim) and a high blood level of antibiotic is needed quickly.
OC	Injection is medically necessary as the oral route is contraindicated, or an acceptable oral equivalent is not available.
ET	Emergency treatment. (This must be used to document an emergency situation.)
JI	This injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.

13.3.16 Immunizations

The CSHCN Services Program pays for immunizations administered to program eligible children. CSHCN encourages all providers to take advantage of opportunities to review and update the immunization status of children.

The Texas Department of Health (TDH) will supply vaccines free of charge to any provider enrolled in the Texas Vaccines for Children Program (TVFC). The provider will need to obtain the vaccine from the local health department/district or TDH regional office. Providers may bill a $3 administration fee per vaccine administered on a HCFA-1500 Claim Form with their appropriate CSHCN TPI.

If the CSHCN client is immunized during an initial or follow-up office visit that was for a medical condition, the visit will be reimbursed in addition to the immunization administration fee when an appropriate medical diagnosis is referenced in block 24D of the claim form. If the CSHCN child presents for **immunizations only**, an office visit must not be billed in addition to the immunization administration code, and the diagnosis code must reference immunizations only (V03 through V06).

The following are the appropriate procedure codes for vaccine administration:

Immunization	Procedure Code	Immunization	Procedure Code
DTP #1	5701X	eIPV #1	5723X
DTP #2	5702X	eIPV #2	5724X
DTP #3	5703X	eIPV #3	5725X
DTP #4	5704X	eIPV #4	5713X
DTP #5	5705X	HibCV #1	5716X
DTaP #1	5711X	HibCV #2	5717X
DTaP #2	5712X	HibCV #3	5718X
DT (Child)/Td (Adult) #1	5706X	HibCV #4	5719X
DT (Child)/Td (Adult) #2	5707X	HEPT B #1	5729X
DT (Child)/Td (Adult) #3	5708X	HEPT B #2	5730X
DT (Child)/Td (Adult) #4	5709X	HEPT B #3	5731X
DT (Child)/Td (Adult) #5	5710X	MMR #1	5726X
DTP/HIB #1	5732X	MMR #2	5727X
DTP/HIB #2	5733X	Varicella	5743X
DTP/HIB #3	5734X	DTaP #1	5745X
DTP/HIB #4	5735X	DTaP #2	5746X
Td #1	5736X	DTaP #3	5747X

Immunization	Procedure Code	Immunization	Procedure Code
Hepatitis A	5741X	DTaP #4	5748X
OPV #1	5720X	DTaP #5	5749X
OPV #2	5721X	OPV #5	5715X
OPV #3	5722X	Pneumococcal conjugate vaccine	5498X
OPV #4	5714X		

Procedure code 5498X, Administration of pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use, is a payable benefit of the CSHCN Program.

CSHCN pays for the following immunization codes for program eligible clients, which include an administration fee, when the provider has purchased the vaccine:

Procedure Code	Description
90633	Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule, for intramuscular use
90634	Hepatitis A vaccine, pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
90669	Pneumococcal conjugate vaccine, polyvalent for children less than five years, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use
90701	Diphtheria and tetanus toxoids and whole cell pertussis vaccine (DPT), for intramuscular use
90702	Diphtheria and tetanus toxoids (DT), for intramuscular use
90703	Tetanus toxoid, for intramuscular or jet injection use
90704	Mumps virus vaccine, live, for subcutaneous or jet injection use
90705	Measles virus vaccine, live, attenuated, for subcutaneous or jet injection use
90706	Rubella virus vaccine, live, for subcutaneous or jet injection use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
90708	Measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90709	Rubella and mumps virus vaccine, live, for subcutaneous use
90712	Poliovirus vaccine, live, oral [any type(s)]
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use
90716	Varicella vaccine, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) absorbed, for use in individuals seven years of age or older, for intramuscular or jet injection use
90719	Diphtheria toxoid, for intramuscular use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis (DTP) and Haemophilus influenza B (HIB) vaccine (DPT-HIB), for intramuscular use
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and haemophilus influenza B vaccine (DTaP-HIB), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23 valent, adult or immunosuppressed patient dosage, polyvalent, for subcutaneous or intramuscular use
90744	Hepatitis B vaccine; pediatric/adolescent dosage, for intramuscular use
90746	Hepatitis B vaccine; adult dosage, for intramuscular use
90747	Hepatitis B vaccine; dialysis or immunosuppressed patient dosage, for intramuscular use

The following immunization codes are **not** a benefit of the CSHCN Services Program:

Procedure Code	Description
90714	Typhoid vaccine
90717	Yellow fever vaccine, for subcutaneous use
90725	Cholera, for injectable use
90726	Rabies vaccine
90727	Plague vaccine, for intramuscular or jet injection use
90728	BCG vaccine

13.3.16.1 Influenza Vaccine

Effective for dates of service on or after April 1, 1999, when billing for influenza virus vaccine, use procedure codes 90657, 90658, and 90659. (See “Immunizations” on page 13-22 for descriptions.)

Influenza vaccine is recommended for the following individuals:

- Clients with chronic medical conditions
- Children and teenagers 6 months to 18 years old on long-term aspirin therapy, who are susceptible to the development of Reye’s syndrome
- Women who are more than three months pregnant during the influenza season

Influenza is most common from December to April. Administration of the vaccine is suggested between September and mid-November. Influenza vaccine can be given at the same time as other vaccines, including the pneumonococcal vaccine, but should be given in a different area of the body.

13.3.16.2 Hepatitis A Immunizations

Administration of Hepatitis A vaccine should be billed using procedure code 5741X. Hepatitis A vaccine is not a routine childhood immunization, and provision is made based on medical necessity and documented need of the community. The vaccine is not licensed for use in children under 2 years of age. The vaccine consists of a primary dose, followed by a booster dose at least six months later. Providers should refer to the vaccine package insert for questions about prescribing information. Hepatitis A is provided at no cost by the Texas Department of Health (TDH) and the Texas Vaccines for Children Program. Providers should contact their local or regional health department to see if they are in an area with documented need and to obtain the vaccine.

13.3.16.3 Hepatitis B Immunizations

Your local health department provides coverage for Hepatitis B vaccines for infants up to 12 months of age and high-risk newborns. Physicians examining newborns should order the initial dose of this vaccine. Hospitals need to notify the parent and/or guardian that this immunization was administered and provide information regarding the timing of the second dose at 1 or 2 months of age. The vaccine for these preventive immunizations may be obtained free of charge from your local health department/district or TDH regional office.

For clients not covered by the Texas Vaccines for Children Program, the CSHCN Program covers hepatitis B vaccine (90744, 90746, and 90747) for patients who are at high risk for contracting the disease, including patients suffering from chronic immunosuppressant conditions that may or may not require multiple blood transfusions/products as part of ongoing therapy. Hepatitis B vaccine is medically necessary for patients who are exposed to hepatitis B. (HBIG is also required for exposed patients.)

13.3.16.4 Pneumococcal Polysaccharide Vaccine

Pneumococcal polysaccharide vaccines (PPV) are limited to once per lifetime, per client, except for those clients identified below. Use procedure code 1-90732.

Revaccination is recommended after six years (**not every** six years) for the following high-risk individuals:

- People age 65 and older who received their first dose when younger than 65, if five or more years have passed since that dose (for example, received 14-valent vaccine)
- People with the following conditions:
  - Damaged spleen or no spleen (asplenic)
  - Sickle cell disease
  - HIV infection or AIDS
  - Cancer, leukemia, lymphoma, multiple myeloma
  - Kidney failure
  - Nephrotic syndrome
  - Organ or kidney transplant clients
  - Taking immunosuppressants (chemotherapy or long term steroids)

Children 10 years and younger may receive a second dose three years after the first dose. Those older than 10 may receive a second dose five years after the first dose. Currently, revaccination following a second dose is **not** a benefit.

Note: PPV is not recommended for children less than two years of age.

13.3.17 Laboratory Services

Benefits are provided for professional and technical services ordered by a physician and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client's medical record as medically necessary and referenced to an appropriate diagnosis. CSHCN does not reimburse baseline or screening laboratory studies.

Providers who perform both the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component. Providers who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, will be denied. Claims will be paid based on the order they are received. For example, if a claim is received for the total component and NHIC has already made payment for the technical and/or interpretation component for the same procedure, same dates of services, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

If a physician performs more than 100 laboratory tests per year for other providers in a laboratory, the lab must be certified by Medicare and the provider must enroll as an independent laboratory with NHIC. A physician laboratory is defined as one that is owned by the physician, is located in the office area, and is the laboratory in which the physician performs or personally supervises laboratory tests on a daily basis. Personal supervision is defined as the physician being present in the building where the services are performed.

Physicians may only bill for laboratory tests that are actually provided in their office. **If a specimen is obtained by venipuncture or catheterization and forwarded to an outside laboratory, the physician may only bill a lab handling fee (99000).** The lab handling fee covers the expense of obtaining the specimen and packaging it to be sent to a reference laboratory. Providers may be reimbursed one lab handling fee a day, per client, unless multiple specimens are obtained and sent to different laboratories. When billing for a lab handling fee, the physician must document that a specimen was sent to a reference laboratory in block 20 and indicate the reference laboratory name and address or CSHCN TPI in block 32 of the HCFA-1500 Claim Form. The physician is required to forward the client's name, address, CSHCN number, and diagnosis with the specimen to the reference laboratory so the laboratory may bill the CSHCN Program for its services. When billing for laboratory services, providers should use the date the specimen was collected as the date of service. If the specimen is sent to a reference laboratory and the client is an inpatient, the hospital is responsible for payment of these services to the reference laboratory.

Interpretation of laboratory tests for patients is considered part of the physician's professional services (hospital, office, or emergency room visits) and must not be billed separately.

Refer to: "Laboratory Paneling" on page 9-8 for detailed processing instructions on paneling laboratory tests.

Clinical pathology services furnished to inpatients and outpatients by physicians are not reimbursable by the CSHCN Program. Anatomical pathology services to hospital patients continue to be allowed for CSHCN reimbursement.

If a physician is personally involved in a clinical pathology procedure, a clinical pathology consultation may be billed using one of the following codes:

Procedure Code	Description
80500	Clinical Pathology Consult – Limited
80502	Clinical Pathology Consult – Comprehensive

To be considered for payment, all clinical pathology consults must meet all the following criteria:

- Be requested by the patient's attending physician
- Relate to a test result that lies outside the normal or expected range in view of the condition of the patient
- Result in a narrative report included in the patient's medical record that documents direct physician contact with the patient
- Require the exercise of medical judgment by the physician performing the consult

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments of 1998 (CLIA). Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: "CLIA Requirements" on page 1-18 for additional information on CLIA.

The new organ or disease panels include the following codes:

80048 – Basic metabolic panel includes:	
Calcium	82310
Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Potassium	84132
Sodium	84295
Urea nitrogen (BUN)	84520

80050 – General health panel includes:	
Comprehensive metabolic panel	80053
Thyroid stimulating hormone (TSH)	84443
Hemogram, automated and manual differential WBC count (CBC)	85022
Hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	85025

80051 – Electrolyte panel includes:	
Carbon dioxide	82374
Chloride	82435
Potassium	84132
Sodium	84295

80053 – Comprehensive metabolic panel includes:	
Albumin	82040
Bilirubin total	82247
Calcium	82310
Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Phosphatase, alkaline	84075
Potassium	84132
Protein, total	84155
Sodium	84295
Transferase, aspartate amino (AST) (SGOT)	84450
Transferase, alanine amino (ALT) (SGPT)	84460
Urea nitrogen (BUN)	84520

80061 – Lipid panel includes:	
Cholesterol, serum, total	82465
Lipoprotein, direct measurement, high density (HDL) cholesterol	83718
Triglycerides	84478

80069 – Renal function panel includes:	
Albumin	82040
Calcium	82310
Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Phosphorus, inorganic	84100
Potassium	84132
Sodium	84295
Urea nitrogen (BUN)	84520

80074 – Acute hepatitis panel includes:	
Hepatitis B core antibody (HbcAb), IgM antibody	86705
Hepatitis A antibody (HAAb), IgM antibody	86709
Hepatitis C antibody	86803
Hepatitis B surface antigen (HbsAg)	87340

80076 – Hepatic function panel includes:	
Albumin	82040
Bilirubin, total	82247
Bilirubin, direct	82248
Phosphatase, alkaline	84075
Protein, total	84155

80076 – Hepatic function panel includes:	
Transferase, aspartate amino (AST) (SGOT)	84450
Transferase, alanine amino (ALT) (SGPT)	84460

80090 – TORCH antibody panel includes:	
Antibody, cytomegalo virus (CMV)	86644
Antibody, herpes simplex, nonspecific type test	86694
Antibody, toxoplasma	86777
Antibody, rubella	87672

13.3.17.1 Complete Blood Counts (CBC)

The codes for a complete blood count [CBC (with or without differential and/or platelet count)] and the individual components are listed below. If only one component is performed, bill the appropriate individual code. If two of the components are performed, use procedure code X7619. Procedure code X7619 is any two/same day: RBC/WBC/HGB/HCT/indices/comp WBC diff/partial WBC diff/RBC morphology/PLT test. If three or more of the components are performed on the same day, they must be combined and billed as procedure code 85022 or 85031. Procedure code X7619 may not be billed on the same day as procedure code 85021, Blood count; hemogram, automated (RBC, WBC, HgB, Hct and indices only), 85022, or 85031.

CBC with Differential	Description
85022	Blood count; hemogram, automated, and manual differential WBC count (CBC)
85031	Blood count; hemogram, manual, complete CBC (RBC, WBC, HgB, Hct, differential and indices)

CBC with Differential and Platelet	Description
85023	Blood count; hemogram and platelet count, automated, and manual differential WBC count (CBC)
85024	Blood count; hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)

Components of CBC	Description
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
85008	Blood count; manual blood smear examination without differential parameters
85009	Blood count; differential WBC count, buffy coat
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
85027	Blood count; hemogram and platelet count, automated
85041	Blood count, red blood cell (RBC) only
85048	Blood count; white blood cell (WBC)

If a platelet count (85590 or 85595) is performed on the same day as a CBC, use procedure code 85023, 85024 or 85025. If 85590 or 85595 are billed on the same day as 85023, 85024, 85025, or 85027, then 85590 or 85595 will be denied as part of another procedure.

Platelet estimation (85585) will not be paid when performed on the same day as 85023, 85024, 85025, 85027, 85590, or 85595. Platelet estimation can be billed on the same day of service as 85021, 85022, or 85031.

The following specialized blood counts may be billed in addition to a CBC when performed on the same day:

Procedure Code	Description
84044	Blood count; reticulocyte, manual
85045	Blood count; reticulocyte count, flow cytometry
85046	Blood count, reticulocytes, hemoglobin concentration

13.3.17.2 Cytogenetics Testing

Genetic testing is limited to diagnoses 20280 through 20298, Lymphomas, and 20400 through 20891, Leukemia. The following procedure codes are payable for the above diagnoses only:

Procedure Code	Description
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (e.g., diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88264	Chromosome analysis; analyze 20-25 cells
88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivates and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (e.g., for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells
88291	Cytogenetics and molecular cytogenetics; interpretation and report

The cytogenetics procedure codes are divided into three tables. The tables are detailed below.

Table A: Procedure Codes for Tissue Culture

Procedure Code	Description
88230	Tissue culture for non-neoplastic disorders; lymphocyte
88233	Tissue culture for chromosome analysis; skin or other solid tissue biopsy
88237	Tissue culture for neoplastic disorders; bone marrow blood cells
88239	Tissue culture for neoplastic disorders; solid tumor

Table B: Procedure Codes for Chromosome Analysis

Procedure Code	Description
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE) 20-25 cells
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (e.g., for ataxia telangiectasia, Fanconi anemia, Fragile X)
88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (e.g., Diepoxybutane, mitomycin C, ionizing radiation, UV radiation)
88261	Chromosome analysis; count 5 cells, 1 karyotype with banding
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding
88264	Chromosome analysis; analyze 20-25 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	Chromosome analysis; additional specialized banding technique (e.g., NOR, C-banding)

Table C: Procedure Codes for Molecular Cytogenetics

Procedure Code	Description
88271	Molecular cytogenetics; DNA probe, each (e.g., FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (e.g., for derivates and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (e.g., for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells

Each provider may be paid one culture procedure (Table A) and one chromosome analysis procedure (Table B) for the same client on the same day. Each client is limited to six culture procedures (Table A) and six chromosome analysis procedures (Table B) per 365 days. Each client is limited to one molecular cytogenetics procedure (Table C) per 365 days.

The procedures listed in Tables A and C may be reimbursed when billed together for the same date of service. The most comprehensive procedure per table will be reimbursed; the others will be denied as “part of.”

In Table B, **only one procedure code may be reimbursed** for each of the following subcategories. The other procedure codes will be denied as “part of.”

- 88245, 88248, and 88249 (when billed together, only one of these procedure codes will be reimbursed)
- 88261 through 88264
- 88280 and 88283

13.3.17.3 Cytopathology Studies – Gynecological, Pap Smears

Pap smear is a benefit of the CSHCN Program for early detection of cancer.

Procurement and handling of the pap smear are considered part of the evaluation and management of the client and are not reimbursed separately. Physicians interpreting a cytopathology specimen (pap smear) must report the place of service according to where the cytopathology specimen is interpreted: POS 1 (in office), POS 3 (inpatient), POS 5 (outpatient), POS 6 (independent lab).

- Procedure codes 88142, 88143, 88145 through 88154, and 88164 through 88167 are benefits of CSHCN. They must be used to report gynecological cytopathology tests. Their reimbursement is limited to pathologists (MDs and DOs) and laboratories (CLIA-certified to provide pathology services).
- The interpretation portion of any gynecological cytopathology test must be reported using procedure code 88141. It is inappropriate to use procedure codes 88142, 88143, 88145 through 88154, and 88164 through 88167 to bill for the interpretation. Procedure code 88141 remains a benefit. Its reimbursement is restricted to laboratories and pathologists. It is reimbursed in addition to cytopathology procedure codes (88142, 88143, 88145 through 88154, and 88164 through 88167).

The following procedure codes are payable for cytopathology services:

Procedure Code	Description
88142	Cytopathology, cervical or vaginal, (any reporting system); collected in preservative fluid, automated thin layer preparation, manual screening under physician supervision (ThinPrep)
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening under physician supervision
88145	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system, under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system, with manual rescreening, under physician supervision
88150	Cytopathology, slides, cervical or vaginal, manual screening under physician supervision
88152	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88164	Cytopathology, slides, cervical or vaginal, (the Bethesda system); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal, (the Bethesda system); with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal, (the Bethesda system); with manual screening and computer-assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal, (the Bethesda system); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

Procedure code 88141, Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service), is reimbursed to a physician only. It will be denied when billed by a pathologist in conjunction with the total component for cytopathology procedures (codes 88142 through 88155 or 88164 through 88167.

Procedure code 88155, Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index) (list separately in addition to code[s] for other technical and interpretation services), is a benefit but is **not** reimbursed when billed in addition to the cytopathology procedure codes 88142 through 88154 and 88164 through 88167.

Procedure code 88144, Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening under physician supervision, is not a benefit since the procedure it describes has not been FDA approved.

13.3.17.4 Cytopathology Studies – Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine are considered part of the evaluation and management of the client and are not reimbursed separately. Interpretation of cytopathology studies is reimbursed to pathologists and laboratories (CLIA-certified to provide pathology services). Providers must bill using procedure codes 88160, 88161, and 88162.

- Procedure codes 88160 and/or 88161 are not reimbursed when billed with procedure code 88162. Procedure codes 88160 and/or 88161 are denied as part of 88162.
- Procedure code 88160 is not reimbursed when billed with procedure code 88161. Procedure code 88160 is denied as part of procedure code 88161.

Procedure Code	Description
88160	Cytopathology, smears, any other source; screening and interpretation
88161	Cytopathology, smears, any other source; preparation, screening and interpretation
88162	Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains

- Reimbursement for procedure codes 88160 through 88162 is limited to pathologists (MD and DO) and laboratories (CLIA-certified to provide pathology services).

13.3.17.5 Ferritin and Iron Studies

CSHCN may reimburse procedure codes 82728, Ferritin, 83540, Iron, 83550, Iron binding capacity, 84466, Transferrin, 85535, Iron stain (RBC or bone marrow smears), and 85536, Iron stain, peripheral blood. Procedure code 85536 is payable when billed with any of the following diagnoses:

Diagnosis Code	Description
27500	Hemochromatosis
28000	Iron deficiency anemia, secondary to blood loss (chronic)
28010	Iron deficiency anemia, secondary to inadequate dietary iron intake
28080	Other specified iron deficiency anemias
28090	Iron deficiency anemia, unspecified
28100	Pernicious anemia
28110	Other vitamin B12 deficiency anemia
28120	Folate-deficiency anemia
28190	Unspecified deficiency anemia
28240	Thalassemias
28280	Other specified hereditary hemolytic anemias
28290	Hereditary hemolytic anemia, unspecified
28390	Acquired hemolytic anemia, unspecified
28500	Sideroblastic anemia
28521	Anemia in end-stage renal disease
28522	Anemia in neoplastic disease
28529	Anemia of other chronic illness
28590	Anemia, unspecified
53600	Achlorhydria

Diagnosis Code	Description
57280	Other sequelae chronic liver disease
57380	Other specified disorders of liver
57390	Unspecified disorder of liver
57930	Other and unspecified postsurgical nonabsorption
57980	Other specified intestinal malabsorption
57990	Unspecified intestinal malabsorption
58500	Chronic renal failure
58600	Renal failure, unspecifiedRenal failure, unspecified
V5600	Extracorporeal dialysis
V5631	Encounter for adequacy testing for hemodialysis
V5632	Encounter for adequacy testing for peritoneal dialysis
V5680	Other dialysis

If procedure codes 85535, Iron stain, RBC or bone marrow smears, and 85536, Iron stain, peripheral blood, are billed on the same day, the claim must state clearly that one of the procedures was an iron stain on bone marrow.

If a ferritin and iron procedure are billed on the same day, the ferritin will be denied, and the iron will be paid. Procedure code 82728, Ferritin, and 83540, Iron, will be payable on the same day with the diagnosis of 27500, Hemochromatosis, 28521, Anemia in ESRD, and/or 585, Chronic renal failure.

13.3.17.6 Helicobacter Pylori (H. Pylori)

Procedure codes 83013 and 83014, Helicobacter Pylori, breath test including drug and breath sample collection kit, are a benefit. These codes are considered a clinical lab service. Procedure code 87338, Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiqualitative, multiple step method, helicobacter pylori, stool, is a benefit of the CSHCN Program. This procedure is not payable on the same date of service to the same provider as procedure codes 83013 and/or 83014. If a gastrointestinal endoscopy is performed within 90 days of the H. Pylori test, procedure codes 43200, 43202, 43234, 43235, and 43239 will be denied. These services may be appealed with submission of medical documentation that supports performance of the endoscopy.

13.3.17.7 Latex Sensitivity Testing

CSHCN will cover radioallergosorbent (RAST) testing for CSHCN clients when used to detect latex sensitivity.

Use procedure code 86003, Allergen specific IGE; quantitative, or semi-quantitative, each allergen, when billing for RAST testing.

Requests for RAST testing are covered for the following diagnoses:

Diagnosis Code	Description
59330	Stricture or kinking of ureter
59340	Other ureteric obstruction
59350	Hydroureter
59370–59373	Vesicoureteral reflux
59382	Ureteral fistula
59610	Intestinovesical fistula
59800–59890	Urethral stricture
59910	Urethral fistula
61900–61980	Female genital fistula

Diagnosis Code	Description
61990	Unspecified fistula involving female genital tract
74100–74193	Spina bifida (includes Arnold-Chiari/Chiari II)
75220–75249	Congenital anomalies of genital organs
75261	Hypospadias and epispadias and other penile anomalies, hypospadias
75262	Hypospadias and epispadias and other penile anomalies, epispadias
75263	Hypospadias and epispadias and other penile anomalies, congenital chordee
75270	Indeterminate sex and pseudohermaphroditism
75320	Congenital obstructive defect of renal pelvis and ureter, unspecified obstructive defect of renal pelvis and ureter
75321	Congenital obstructive defect of renal pelvis and ureter, congenital obstruction of ureteropelvic junction
75322	Congenital obstructive defect of renal pelvis and ureter, congenital obstruction of ureterovesical junction
75323	Congenital obstructive defect of renal pelvis and ureter, congenital ureterocele
75329	Congenital obstructive defect of renal pelvis and ureter, other
75340	Other specified anomalies of ureter
75350	Exstrophy of urinary bladder
75360	Atresia and stenosis of urethra and bladder neck
75370	Anomalies of urachus
75380	Other specified anomalies of bladder and urethra

If the physician performs the test in the office, add modifier PO, indicating that the necessary equipment to perform the test is in the office.

13.3.17.8 Urinalysis

A similar methodology that is used with chemistry tests is applied when two or more components of a urinalysis are performed on the same day and billed separately. The billed services are also denied if not paneled appropriately and must be resubmitted with urinalysis codes 81000, 81001, 81002, or 81003. The following codes are subject to this methodology:

Procedure Code	Description
81000	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated with microscopy
81001	Urinalysis by dipstick or tablet reagent, with microscopy, automated
81002	Urinalysis by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated
81003	Urinalysis by dipstick or tablet reagent, without microscopy, automated
81005	Urinalysis, qualitative or semiquantitative except immunoassays
81015	Urinalysis, microscopy only
81020	Urinalysis, two or three glass test
84578	Urobilinogen, urine, qualitative
84583	Urobilinogen, urine; semiquantitative

If procedure code 81015, Urinalysis, microscopic only, is billed in addition to routine urinalysis codes 81000 or 81001, procedure code 81015 is denied as part of 81000 or 81001. If 81015 is billed with urinalysis codes 81002 or 81003, both codes are denied requiring paneling into either 81000 or 81001. If 81015 is billed separately with one or more of the above components on the same day, both 81015 and the other component are denied and should be combined and billed as a urinalysis.

When performing bacterial urine culture with antibiotic sensitivities, use procedure code 87086, Culture, bacterial, urine; qualitative, colony count. The modifier “UA” must be used to indicate the specimen source was urine when billing for laboratory test 82947, Glucose. When blood is the specimen source, no modifier is required. If 82947 is billed with the modifier in addition to procedure code 81000, Urinalysis, 82947 will be denied as part of 81000.

13.3.18 New Patient Visits

A new patient is defined as a patient who is new to the physician and whose medical and administrative records need to be established.

Payment of new patient visits is limited to one every two years, per patient, per provider. An established patient is defined as a patient whose medical and administrative records are available to the physician. A new patient visit in the office (POS 1) or home (POS 2) will be changed to an established patient visit if history shows that the same physician has previously furnished a medical service, a surgical service, or a consultation within two years.

13.3.19 Ophthalmology

Eye exam with refraction codes are used when the doctor is evaluating a patient with ocular disease, 92002 through 92014.

The following ophthalmological components are payable only if billed alone, and not in conjunction with a complete eye examination: 92020, 92060, and 92100.

The following special ophthalmological services are payable in addition to general ophthalmological services: 92018, 92019, 92081 through 92083, 92120, 92140, and Z9539.

Office visits and ophthalmological medical examinations will be paid in addition to the following ophthalmoscopy and specialized ophthalmological services.

13.3.19.1 Procedure Codes

Procedure Code	Description
92225	Ophthalmoscopy, extended, with retinal drawing (i.e., melanoma), with interpretation and report; initial
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report
92265	Needle oculoelectromyography, one or more extra ocular muscles, one or both eyes, with interpretation and report
92226	Ophthalmoscopy, extended, with retinal drawing (i.e., melanoma), with interpretation and report; subsequent
92250	Fundus photography with interpretation and report
92270	Electro-oculography with interpretation and report
92285	External ocular photography with interpretation and report for documentation of medical progress
92230	Fluorescein angioscopy with interpretation and report
92260	Ophthalmodynamometry
92275	Electroretinography with interpretation and report
92287	Special anterior segment photo with interpretation and report; with fluorescein angiography

Procedure codes 92225, 92226, 92230, and 92235 are considered by CSHCN as unilateral codes and can be paid a quantity of two if both left and right eyes are evaluated.

Unless specifically designated by CPT-4 as being a unilateral code, all ophthalmological services listed above are considered bilateral and must not be billed as quantity of two.

13.3.19.2 Intraocular Lenses

Note: CSHCN will not reimburse physicians who supply IOLs to ambulatory surgical centers or hospital ambulatory surgical centers; payment for the IOL is included in the facility fee.

Ophthalmologists who perform cataract extractions and intraocular lens (IOL) implants in their office are reimbursed for the lens. The provider must submit a copy of the manufacturer's invoice for the IOL with the claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (minus any discount) plus a handling fee not to exceed 5 percent of the acquisition cost.

13.3.20 Osteopathic Manipulative Treatment (OMT)

OMT performed by a provider licensed to perform OMT is a covered benefit for acute situations which may include an acute musculoskeletal condition, an acute exacerbation of a chronic condition, or acute treatment following procedures/surgery. The acute modifier "AT" must be submitted with the claim for payment to be made.

The following procedure codes are payable for OMTs to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and viscera regions:

Procedure Code	Description
9726X	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist), performed by physician; one area
9726Y	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist), performed by physician; each additional area
98925	Osteopathic manipulative treatment (OMT); one to two body regions involved
98926	Osteopathic manipulative treatment (OMT); three to four body regions involved
98927	Osteopathic manipulative treatment (OMT); five to six body regions involved
98928	Osteopathic manipulative treatment (OMT); seven to eight body regions involved
98929	Osteopathic manipulative treatment (OMT); nine to ten body regions involved

Procedure codes 9726X through 9726Y billed on the same day by the same provider as 98925 through 98929 will be denied as part of another procedure on the same day.

When multiples of procedure codes 98925 through 98929 are billed on the same day by the same provider, the most inclusive code will be paid and the others denied.

If a physician bills an initial or subsequent care visit on the same day, it may be paid in addition to the OMT on that day. A physician may bill OMT in the outpatient hospital (POS 5) setting.

13.3.21 Personal Supervision Versus Direct Supervision

Physician services include reasonable and medically necessary services ordered and performed by a physician or under the personal supervision of a physician that are within the scope of practice of their profession as defined by state law. The physician must examine the client, make a diagnosis, establish a plan of care, and document these tasks on the appropriate client medical records before submitting claims. If such documentation is not present in the appropriate medical record, then any payment may be recouped. The services are covered if provided in the office, client's home, hospital, or elsewhere.

To be payable by CSHCN, the services must be personally performed by the physician or by a qualified person working under the personal supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided. In instances where one physician is taking call for another physician, the services provided must be billed by the performing physician.

NHIC-CSHCN may make payments to a physician for CSHCN covered services provided by another physician acting as his or her substitute. Such substitution arrangements may be either informal reciprocal arrangements of 14 days or fewer, or long-term arrangements (up to 90 days) involving per diem or fee-for-time compensation.

The substituting physician is not required to enroll with CSHCN. The name and address of the substituting physician are not required to be documented on the claim.

If you are billing for a substitute physician, the modifier “Q5” or “Q6” must follow the procedure code in block 24D for services provided by the substituting physician.

If the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of their client in a teaching setting as an approved and accredited training program by the appropriate accreditation agencies, the physician’s services are covered. For major surgical procedures and other complex and dangerous procedures or situations, the attending physician must be physically present during the procedure or situation to provide personal and identifiable direction. If personal and identifiable direction is not provided or is not appropriately documented, any payment for services may be recouped.

The attending physician must demonstrate that personal and identifiable direction was provided within the following criteria:

- Reviewing the client’s history and physical examination and personally examining the client within a reasonable period after the client’s admission and before the client’s discharge
- Confirming or revising the client’s diagnosis
- Determining the course of treatment to be followed
- Ensuring that any supervision needed by the interns or residents is provided
- Entering in the client’s medical record, appropriate daily documentation of the tasks identified above, before submitting the claim

13.3.22 Physical Therapy (PT) Services

Physical therapy (PT) performed by a physician or physical therapist is a covered benefit of the CSHCN Program.

Refer to: “Outpatient Physical Therapy and Occupational Therapy” on page 12-1 for more information about PT services.

CSHCN will consider reimbursement to physicians for therapy services performed in their office for program eligible clients.

Physical medicine is the use of one or more modalities applied to produce therapeutic changes to biological tissue. The PT codes 97012 through 97799 may generally be used to bill for these services.

13.3.22.1 Physical Therapy Codes

Procedure Code	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97020	Application of a modality to one or more areas; microwave
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy
97026	Application of a modality to one or more areas; infrared

Procedure Code	Description
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, and percussion)
97139	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g., mobilization, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
9725X	Myofascial release/soft tissue mobilization, one or more regions
97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	Physical performance test or measurement (such as, musculoskeletal, functional capacity), with written report, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

Exclusion of any CPT code does not necessarily mean the code is not a benefit.

13.3.23 Podiatry

Podiatrists (DPM) enrolled as CSHCN providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their licensure as a DPM and when such procedures would also be reimbursable to a physician (MD or DO) under the CSHCN Program.

Use procedure codes G0127, 11055 through 11057, and 11719, when billing for podiatric services. These procedure codes are limited to one service every six months, per client.

13.3.23.1 Nerve Conduction Studies

Doctors of Podiatry may be reimbursed for nerve conduction studies. Nerve conduction studies must be billed using the following procedure codes:

Procedure Code	Description
95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
95904	Nerve conduction, amplitude velocity and/or latency study; sensory, each nerve, mixed
95934	H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle
95936	H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus

Procedure codes 95900 and/or 95904 will be reimbursed at the full amount allowed for the first nerve study and at half fee for each additional study regardless of the number of studies.

Procedure codes 95903, 95934, and 95936 will be reimbursed at the full amount allowed when performed with procedure codes 95900 and/or 95904. This is in addition to the reimbursement for the codes 95900 and 95904.

13.3.24 Radiology Services

In compliance with regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This regulation does not affect radiology services performed by the physician or others under his personal supervision in his office. The radiology equipment must be owned by that physician and be located **in the physician's office**. If the physician is a member of a clinic that owns and operates radiology facilities, he or she may bill for these services.

However, if the physician practices independently and shares space in a medical complex where radiology facilities are located, he or she may not bill for these services even if he or she owns or shares ownership of the facility, unless he or she personally supervises and is responsible for the daily operation of the facilities.

If a physician owns radiology equipment and performs studies in his or her office but has a radiologist come to the office to perform the interpretations, the physician may bill for all services connected with the study and reimburse the radiologist for an interpretation or the physician may bill for the technical component and allow the interpreting physician to bill separately for an interpretation. When billing for services in an inpatient or outpatient hospital setting, radiologists may only bill the professional interpretation of procedures.

A separate charge for an x-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall workup and treatment of the client.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist is **not** billing for the professional component of x-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid and the other provider denied.

Providers who perform the technical service and interpretation must bill for the total component. Providers who perform only the technical service must bill for the technical component. Providers who perform only the interpretation must bill for the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, will be denied. Claims will be paid based on the order they were received. For example, if a claim is received for the total component and NHIC has already made payment for the technical and/or interpretation component for the same procedure, same dates of service, same

client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components.

Radiologists are required to identify the referring provider by full name and address or CSHCN TPI in block 17 of the HCFA-1500 Claim Form. As with all procedures billed to the CSHCN Program, baseline screening and/or comparison studies are **not** a benefit.

Abdominal flat plates (AFP) or kidneys, ureters, bladder, (KUB) codes 74000, 74010, and 74020 are frequently taken as preliminary x-rays before other, more complicated x-ray procedures. If a physician bills separately for an AFP or KUB and more complicated procedures, the charges are combined and the more complex procedure may be paid. If, however, the **claim specifically states the AFP or KUB was done first,** and the results required further x-rays, each procedure may be paid separately.

Oral preparations for x-rays (for example, Oragrafin, X-prep, Neloid) are included in the charge for the x-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radioactive materials used in the performance of specialized x-ray procedures may be paid.

Osteolyte is a type of radionuclide and must be coded as 78990, Provision of diagnostic radiopharmaceutical(s).

13.3.24.1 Cardiac Blood Pool Imaging

Cardiac blood pool imaging (78472, 78473, 78481, 78483, 78494, and 78496) is a covered benefit for the CSHCN Program.

13.3.24.2 Computerized Axial Tomography (CAT) Scan

Scout views and reconstruction are considered part of any CAT scan. Procedure codes 76375, Coronal, sagittal, multiplanar, oblique, three-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging or other tomographic modality, and 76380, Computerized tomography limited or localized follow-up study, are denied when billed on the same day as any other CAT scan. Procedure codes 76375 and 76380 are paid if billed as an independent procedure.

Freestanding facilities may bill for CAT scans. The radiologist or neurologist who then reads the scan may bill for interpretation only. In addition, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill for interpretation.

13.3.24.3 Low Osmolar Contrast Material (LOCM)

Low osmolar contrast material used with intrathecal, intra-arterial, and/or intravenous radiological procedures may be reimbursed separately when medically indicated for clients with, but not limited to, the following high-risk conditions:

- History of allergic reaction to contrast material, with the exception of a heat or flushing sensation or a single episode of nausea or vomiting
- History of asthma
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension
- Generalized severe debilitation
- Sickle cell disease

The LOCM is reimbursed as a drug furnished as incidental to a physician's service limited to services performed in the office (POS 1), freestanding radiation centers (POS 5), and outpatient facilities (POS 5).

Radiological procedures which specify "with contrast" include payment for **high** osmolar contrast material and no additional payment is made for **low** osmolar contrast material. When using **low** osmolar contrast material for procedures, bill the codes which specify "without contrast." The **low** osmolar contrast material must be billed separately and will be reimbursed as outlined above.

The following local codes should be used when billing for low osmolar contrast material:

Procedure Code	Description
1173Y	Isovue 200, 50 ml
1179Y	Isovue 300, 50 ml
1180Y	Isovue 300, 100 ml
1170Y	Omnipaque 240, 50 ml
1174Y	Omnipaque 300, 50 ml
1175Y	Omnipaque 300, 100 ml
1176Y	Omnipaque 350, 100 ml
1171Y	Optiray 240, 50 ml
1172Y	Optiray 240, 100 ml
1177Y	Optiray 320, 50 ml
1178Y	Optiray 320, 100 ml

All other low osmolar contrast media will be reimbursed using the following procedure codes:

Procedure Code	Description
A4644	Supply of low osmolar contrast material (100-199 mgs of iodine)
A4645	Supply of low osmolar contrast material (200-299 mgs of iodine)
A4646	Supply of low osmolar contrast material (300-399 mgs of iodine)

Specific products currently available should be billed as follows:

Procedure Code	Description
A4644	Omnipaque 140 and 180
A4644	Optiray 160
A4645	Omnipaque 210 and 240
A4646	Hexabrix
A4646	Optiray 320
A4645	Optiray 240
A4645	Isovue 200
A4646	Omnipaque 300 and 350
A4646	Isovue 300 and 370

When submitting a claim for procedure codes A4644 through A4646, the name of the drug and the number of ccs or mls used must be indicated. If the drug and volume is not indicated, procedure codes A4644 through A4646 will be denied with message 384, “Medication charges must indicate the name of the drug, route of administration and the dosage.”

13.3.24.4 Magnetic Resonance Angiography (MRA)

Magnetic resonance angiography is a technique which allows noninvasive visualization and study of blood vessels through either two-dimensional or three-dimensional image reconstruction. The CSHCN Program reimburses MRA procedures of the head and neck for program eligible clients with specific diagnoses. The use of MRA in other areas of the body is considered investigational and will not be covered by CSHCN.

Payment for MRA of the head and/or neck is limited to the following diagnoses:

Diagnosis Code	Description
43000	Subarachnoid hemorrhage
43100	Intracerebral hemorrhage
43200	Nontraumatic extradural hemorrhage
43210	Subdural hemorrhage
43290	Intracranial hemorrhage NOS
43400	Cerebral thrombosis without mention of cerebral infarction
43401	Cerebral thrombosis with cerebral infarction
43410	Cerebral embolism without mention of cerebral infarction
43411	Cerebral embolism with cerebral infarction
43490	Cerebral artery occlusion, unspecified, without mention of cerebral infarction
43491	Cerebral artery occlusion, unspecified with cerebral infarction
43600	Acute but ill-defined cerebrovascular diseases
43730	Nonruptured cerebral aneurysm
43800	Late effects of cerebrovascular disease
43810	Late effects of cerebrovascular disease, speech and language deficits, unspecified
43811	Late effects of cerebrovascular disease, speech and language deficits, aphasia
43812	Late effects of cerebrovascular disease, speech and language deficits, dysphasia
43819	Late effects of cerebrovascular disease, other speech and language deficits
43820	Late effects of cerebrovascular disease, hemiplegia affecting unspecified side
43821	Late effects of cerebrovascular disease, hemiplegia affecting dominant side
43822	Late effects of cerebrovascular disease, hemiplegia affecting non-dominant side
43830	Late effects of cerebrovascular disease, monoplegia of upper limb affecting unspecified side
43831	Late effects of cerebrovascular disease, monoplegia of upper limb affecting dominant side
43832	Late effects of cerebrovascular disease, monoplegia of upper limb affecting non-dominant side
43840	Late effects of cerebrovascular disease, monoplegia of lower limb affecting unspecified side
43841	Late effects of cerebrovascular disease, monoplegia of lower limb affecting dominant side
43842	Late effects of cerebrovascular disease, monoplegia of lower limb affecting non-dominant side
43850	Late effects of cerebrovascular disease, other paralytic syndrome affecting unspecified side
43851	Late effects of cerebrovascular disease, other paralytic syndrome affecting dominant side
43852	Late effects of cerebrovascular disease, other paralytic syndrome affecting non-dominant side
43853	Other paralytic syndrome, bilateral
43881	Other late effect of cerebrovascular disease, apraxia
43882	Other late effect of cerebrovascular disease, dysphagia
43889	Other late effect of cerebrovascular disease
43890	Unspecified late effects of cerebrovascular disease

The following procedure codes must be used when submitting a claim for MRA of the head and/or neck with or without contrast material(s):

Procedure Code	Description
70544	Magnetic resonance angiography, head; without contrast material(s)
70545	Magnetic resonance angiography, head; with contrast material(s)
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s)
70547	Magnetic resonance angiography, neck; without contrast material(s)
70548	Magnetic resonance angiography, neck; with contrast material(s)
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s)

13.3.24.5 Magnetic Resonance Imaging (MRI)

Magnetic resonance imaging (MRI) is a noninvasive nuclear procedure for imaging tissues of high fat and water content that are poorly seen with other radiologic techniques. The CSHCN Program covers MRI procedures for specific diagnoses. **MRI procedures do not require authorization.** MRI procedures with appropriate diagnosis codes are as follows:

Procedure Code	Description		
70336	MRI, temporomandibular joint, TMJ		
Diagnosis Codes – Payable for procedure code listed above			
17000–17010	90920	V1060–V1069	V7110
19850	99000	V1071–V1079	V7642
21300–21310	V1001–V1002	V1081–V1082	
23770–23772	V1022	V1340	

Procedure Code	Description		
70540	MRI, orbit, face and neck		
Diagnosis Codes – Payable for procedure code listed above			
17000–17010	23770–23772	V1071–V1079	V1240–V1249
17100	90920	V1081–V1082	V7110
19010	99000	V1084	V7642
19500	V1001–V1002	V1087	
19850	V1022	V1089	
21300–21310	V1060–V1069		

Procedure Code	Description		
70551	MRI, brain; without contrast		
70552	MRI, brain; with contrast		
70553	MRI, brain; without contrast, followed by contrast, and further sequences		
Diagnosis Codes – Payable for procedure codes listed above			
19100–19190	25320–25330	43730	V1020–V1029
19200–19210	25370	71000	V1030
19430–19440	32400	74100–74103	V1040–V1049
19830–19840	32600	74200	V1050–V1059
22500–22520	33140	74230–74240	V1060–V1069

Diagnosis Codes – Payable for procedure codes listed above			
22730–22740	34800	74781	V1071–V1079
23700–23710	43000	90920	V1081–V1089
23750–23760	43100	99000	V1369
23770–23772	43200–43290	V1000–V1009	V7110
23960	43600	V1011–V1012	V8000

Procedure Code	Description
72141	MRI, spinal canal and contents, cervical; without contrast
72142	MRI, spinal canal and contents, cervical; with contrast
72156	MRI, spinal canal and contents, cervical; without contrast, followed by contrast and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17020	33600–33690	90920	V1060–V1069
19220–19230	72110	95200–95209	V1071–V1079
19830–19850	72120	95280	V1081–V1089
21320	72150–72170	99000	V1340
21390	74100–74101	V1000–V1009	V1369
22530–22540	74190–74191	V1011–V1012	V7110
23750–23760	74230	V1020–V1029	V8000
23770–23772	74251–74259	V1030	V8210
32410	80605–80609	V1040–V1049	
32600	80615–80619	V1050–V1059	

Procedure Code	Description
72146	MRI, spinal canal and contents, thoracic; without contrast
72147	MRI, spinal canal and contents, thoracic; with contrast
72157	MRI, spinal canal and contents, thoracic; without contrast, followed by contrast and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17020	33600–33690	80630–80639	V1050–V1059
19220–19230	72120	90920	V1060–V1069
19830–19850	72141	95210–95219	V1071–V1079
21320	72150–72170	95280	V1081–V1089
21390	74100	99000	V1340
22530–22540	74102	V1000–V1009	V1369
23750–23760	74190	V1011–V1012	V7110
23770–23772	74192	V1020–V1029	V8000
32410	74251–74259	V1030	
32600	80620–80629	V1040–V1049	

Procedure Code	Description
72148	MRI, spinal canal and contents, lumbar; without contrast
72149	MRI, spinal canal and contents, lumbar; with contrast
72158	MRI, spinal canal and contents, lumbar; without contrast, followed by contrast and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17020	32600	74251–74259	V1050–V1059
19220–19230	33600–33690	80640–80670	V1060–V1069
19830–19850	72130	90920	V1071–V1079
21320	72142	95220–95280	V1081–V1089
21390	72150–72170	99000	V1340
22530–22540	74100	V1000–V1009	V1369
23750–23760	74103	V1011–V1012	V7110
23770–23772	74190	V1030	V8000
32410	74193	V1040–V1049	

Procedure Code	Description
72195	MRI, pelvis; without contrast material(s)
72196	MRI, pelvis; with contrast material(s)
72197	MRI, pelvis; without contrast material(s), followed by contrast material(s) and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17060	21360	90920	V1040–V1049
17160	21390	99000	V1050–V1059
18500	23340	V1000–V1009	V1060–V1069
19530	23770–23772	V1011–V1012	V1071–V1089
19850	73210	V1020–V1029	V7110
23650	73342–73395	V1030	V7680–V7690

Procedure Code	Description
73218	MRI, upper extremity, other than joint; without contrast material(s)
73219	MRI, upper extremity, other than joint; with contrast material(s)
73220	MRI, upper extremity other than joint; without contrast material(s) followed bycontrast material(s) and further sequences
73221	MRI, any joint of upper extremity; without contrast material(s)
73222	MRI, any joint of upper extremity; with contrast material(s)
73223	MRI, any joint of upper extremity; without contrast material(s) followed by contrast material(s) and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17040–17050	21340–21350	73341–73395	V1089
17120	21390	90920	V1340
19540	23770–23772	99000	V7110
19850	73230	V1081–V1082	V8000

Procedure Code	Description
73718	MRI, lower extremity, other than joint; without contrast material(s)
73719	MRI, lower extremity, other than joint; with contrast material(s)
73720	MRI, upper extremity other than joint; without contrast material(s) followed bycontrast material(s) and further sequences
73721	MRI, any joint of upper extremity; without contrast material(s)
73722	MRI, any joint of lower extremity; with contrast material(s)
73723	MRI, any joint of lower extremity; without contrast material(s) followed by contrast material(s) and further sequences

Diagnosis Codes – Payable for procedure codes listed above			
17070–17080	21360–21390	73342–73344	V1089
17130	23770–23772	90920–73395	V1340
19550	73210	99000	V7110
19850	73240–73250	V1081–V1082	V8000

A freestanding MRI facility may bill for the technical portion only. The radiologist or neurologist who then reads the MRI may bill for interpretation only. In addition, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill for interpretation.

13.3.24.6 Positron Emission Tomography

The CSHCN Program covers positron emission tomography (PET), as part of the diagnostic workup for those clients with uncontrolled complex partial seizures. The intent of the PET must be to locate and document a seizure focus in preparation for possible anterior temporal lobectomy surgery. All requests for coverage require medical review. Procedure code 78608, Brain imaging, positron emission tomography, metabolic imaging, must be used when requesting PET.

Payment for PET is limited to the following diagnoses:

Diagnosis Code	Description
34540	Partial epilepsy with impairment of consciousness, without mention of intractable epilepsy
34541	Partial epilepsy with impairment of consciousness, with intractable epilepsy

13.3.25 Radiation Therapy

Radiation therapy performed in physician's offices, hospitals (in or outpatient), and freestanding radiation facilities must be billed using the following guidelines for POS and procedure codes for each provider type.

13.3.25.1 Freestanding Radiation Therapy Facilities / Outpatient Facilities

Freestanding radiation therapy facilities and outpatient hospitals will be reimbursed only for the technical component for services rendered in POS 5 for the following services:

Clinical Brachytherapy

Procedure Code	Description
77781	Remote afterloading high intensity brachytherapy; 1 to 4 source positions or catheters
77782	Remote afterloading high intensity brachytherapy; 5 to 8 source positions or catheters
77783	Remote afterloading high intensity brachytherapy; 9 to 12 source positions or catheters
77784	Remote afterloading high intensity brachytherapy; over 12 source positions or catheters
77799	Unlisted procedure, clinical brachytherapy

Clinical Treatment Planning

Procedure Code	Description
77280	Therapeutic radiology simulation aided field setting; simple
77285	Therapeutic radiology simulation aided field setting; intermediate
77290	Therapeutic radiology simulation aided field setting; complex
77295	Theraputic radiology simulation aided field setting; three dimensional

Procedure code 77295 is payable once per day.

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

Procedure Code	Description
77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment, only when prescribed by the treating physician
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest).
77310	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)
77315	Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77326	Brachytherapy isodose calculation; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
77327	Brachytherapy isodose calculation; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328	Brachytherapy isodose calculation; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)
77332	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds, or casts)
77520	Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment set-up and verification images
77523	Proton beam delivery to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment set-up and verification images
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices

Procedure codes 77305, 77310, and 77315 will be denied when billed on the same day as procedure code 77295.

Radiation Treatment Delivery/Port Films

Procedure Code	Description
77401	Radiation treatment delivery, superficial and/or ortho voltage
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6 – 10 MeV
77404	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11 – 19 MeV
77406	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or Greater
77407	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6 – 10 MeV
77409	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11 – 19 MeV
77411	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or Greater

Procedure Code	Description
77412	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (for example, electron or neutrons); up to 5 MeV
77413	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (for example, electron or neutrons); 6 – 10 MeV
77414	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (for example, electron or neutrons); 11 – 19 MeV
77416	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (for example, electron or neutrons); 20 MeV or Greater
77417	Therapeutic radiology port film(s)

13.3.25.2 Professional Services

The following procedure codes are payable as professional components only for services performed in POS 3 or 5 and as total components for services performed in POS 1.

Clinical Brachytherapy

Procedure Code	Description
77750	Infusion or instillation of radioelement solution
77761	Intracavitary radioelement application; simple
77762	Intracavitary radioelement application; intermediate
77763	Intracavitary radioelement application; complex
77776	Interstitial radioelement application; simple
77777	Interstitial radioelement application; intermediate
77778	Interstitial radioelement application; complex
77781	Remote afterloading high intensity brachytherapy; 1 to 4 source positions or catheters
77782	Remote afterloading high intensity brachytherapy; 5 to 8 source positions or catheters
77783	Remote afterloading high intensity brachytherapy; 9 to 12 source positions or catheters
77784	Remote afterloading high intensity brachytherapy; over 12 source positions or catheters
77789	Surface application of radioelement
77799	Unlisted procedure, clinical brachytherapy

Only the technical component is payable to physicians for the following services when rendered in a facility recognized by CSHCN as a radiation treatment center (POS 1) or in the physician's office (POS 1).

Clinical Treatment Management

Procedure Code	Description
77427	Radiation treatment magnetic, five treatments
77431	Radiation therapy management with complete course of therapy consisting of one or two fractions only

Procedure code 77427 represents a full week of therapy. Bill this code once a week using the first date of therapy within that week. Additional documentation listing the date and time for each fraction administered is required and will be reviewed manually for coverage. Radiation treatment, magnetic is reported in units of five fractions of treatment sessions, regardless of the actual time period in which the services are furnished. These services need not be furnished on consecutive days.

Multiple fractions represented on two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days.

The professional component is payable for services rendered in a freestanding radiation therapy facility (POS 5), outpatient hospital (POS 5), and inpatient hospital (POS 3). Physicians billing for patient services rendered in a facility recognized by CSHCN (CIDC) as a radiation treatment center (POS 1) or their offices (POS 1) will be reimbursed for total components.

Clinical Treatment Planning

Procedure Code	Description
77261	Therapeutic radiology treatment planning; simple
77262	Therapeutic radiology treatment planning; intermediate
77263	Therapeutic radiology treatment planning; complex
77295	Therapeutic radiology simulation-aided field setting; three dimensional

Procedure Code	Description
77280	Therapeutic radiology simulation aided field setting; simple
77285	Therapeutic radiology simulation aided field setting; intermediate
77290	Therapeutic radiology simulation aided field setting; complex
77299	Unlisted procedure, therapeutic radiology clinical treatment planning

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

Procedure Code	Description
77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment, only when prescribed by the treating physician
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)
77310	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single are of interest)
77315	Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77326	Brachytherapy isodose calculation; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
77327	Brachytherapy isodose calculation; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328	Brachytherapy isodose calculation; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachy therapy, over 12 sources)
77332	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds, or casts)
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices
77520	Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment set-up and verification images
77523	Proton beam delivery to one or two treatment areas, two or more ports, two or more custom blocks, and two or more compensators, with treatment set-up and verification images

13.3.25.3 Radioisotope Therapy

Procedure Code	Description
Y9311	P32 (Phosphorus)
Y9312	RA-RN (Radium - Radon)
Y9313	CS (Cesium)
Y9314	I131 (Iodine)
Y9315	Radioisotope, Other

The following services are **not** benefits of the CSHCN Program:

Procedure Code	Description
77321	Special teletherapy port plan, particles, semi-body, total body
77331	Special dosimetry (for example, TLD, microdosimetry) (specify), only when prescribed by the treating physician
77336	Continuing medical radiation physics consultation in support of therapeutic radiologist, including continuing quality assurance reported per week of therapy
77370	Special medical radiation physics consultation
77431	Radiation therapy management with complete course of therapy consisting of one or two fractions only
77470	Special treatment procedure (for example, total body irradiation, semi-body irradiation, per oral, vaginal cone irradiation)
77499	Unlisted procedure, therapeutic radiology treatment management
77600–77620	Hyperthermia
77790	Supervision, handling, loading of radioelement

The following services will be allowed once per day unless documentation submitted with an appeal supports the need for the service to be provided more than once: therapeutic radiation treatment planning, therapeutic radiology simulation-aided field setting, teletherapy, brachytherapy isodose calculation, treatment devices, intracavity radioelement application, interstitial radioelement application, remote afterloading high intensity brachytherapy, radiation treatment delivery, localization, and radioisotope therapy.

Clinical brachytherapy services (77750 through 77799) include admission to the hospital and daily care. Initial and subsequent hospital care will be denied on the same day that clinical brachytherapy services are billed.

A consultation on the same day as clinical treatment planning and clinical brachytherapy is included in the therapeutic radiology procedure.

Laboratory and diagnostic radiological services provided in an office (POS 1) will be reimbursed to physicians as a total component. Freestanding radiation therapy facilities will also be reimbursed for the total component for these services in POS 5. Injectable medications given during the course of therapy in any setting will be reimbursed separately.

Normal follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be paid on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

No separate payment will be made for any of the following procedure codes provided on the same day as radiation therapy by the same provider:

Procedure Codes		
16000–16030	99052–99054	99241–99245
36425	99211–99215	99281–99285

Procedure Codes		
53670	99183	Z9112–Z9113
53675		

13.3.25.4 Strontium-89

CSHCN coverage for strontium-89 is limited to a total of 10 mci intravenously injected every 90 days for any provider. Use procedure code 9-A9600, Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mci.

Reimbursement will be limited to hospital facilities, free-standing radiation treatment centers (POS 5), and the office setting (POS 1). Strontium-89 provided in the inpatient setting (POS 3) is part of the TEFRA reimbursement, and no separate payment will be made.

Coverage of A9600 is limited to the following diagnosis codes:

Diagnosis Code	Description
17400	Malignant neoplasm of female breast; nipple and areola
17410	Malignant neoplasm of female breast; central portion
17420	Malignant neoplasm of female breast; upper-inner quadrant
17430	Malignant neoplasm of female breast; lower-inner quadrant
17440	Malignant neoplasm of female breast; upper-outer quadrant
17450	Malignant neoplasm of female breast; lower-outer quadrant
17460	Malignant neoplasm of female breast; axillary tail
17480	Malignant neoplasm of female breast; other specified sites
17490	Malignant neoplasm of female breast; breast (female), unspecified
17500	Malignant neoplasm of male breast; nipple and areola
17590	Malignant neoplasm of male breast; other and unspecified sites
18500	Malignant neoplasm, prostate
19850	Secondary malignant neoplasm bone

The quantity used, per mci, must appear on the claim.

13.3.26 Referrals to Other Providers

When a CSHCN provider refers a CSHCN client to another provider for further treatment or services, the provider must forward notification of the client's eligibility and CSHCN number. The provider to whom the client is referred must advise the client whether he or she accepts CSHCN clients.

13.3.27 Surgery

13.3.27.1 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure.

13.3.27.2 Assistant Surgeons

Assistant surgeons are reimbursed 16 percent of the listed fee for the surgical procedure performed.

CSHCN policy states that an assistant surgeon will not be paid in a hospital classified by Medicaid as a teaching facility with an approved graduate training program in the performing physician's specialty. These claims will only be paid if one of the following modifiers is present on the claim:

Modifier	Description
82	No qualified resident was available
8A	There were exceptional medical circumstances, such as an emergency or life threatening situation, requiring immediate attention
8B	The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of one of his patients
8C	The surgical procedure was complex and required a team of physicians

All claims for assistant surgeon's services must include in block 32 of the HCFA-1500 Claim Form the name and address or CSHCN TPI of the hospital in which the surgery was performed.

If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

"I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to review."

A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed. Full payment is allowed for the surgery, and the assistant surgical procedure is paid at half the allowed amount as an assistant (16 percent of the listed fee for the surgical procedure performed). Surgical procedures that do not ordinarily require the services of an assistant will be denied when billed with a type of service 8 (assistant surgery).

13.3.27.3 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of "1" for each code. For all procedures, modifiers LT (left side), and RT (right side) must be used as appropriate.

Bilateral procedures performed on separate limbs are paid the full allowance for the major procedure and half the allowance for subsequent procedures performed on the same day when medically justified.

13.3.27.4 Bone Growth Stimulators

CSHCN will reimburse for internal and external bone growth stimulation for clients with the following diagnoses:

Diagnosis Code	Description
73310	Pathologic fracture, unspecified site
73311	Pathologic fracture of the humerus
73312	Pathologic fracture of the distal radius and ulna
73313	Pathologic fracture of the vertebrae
73314	Pathologic fracture of the neck of the femur
73315	Pathologic fracture of other specified part of the femur
73316	Pathologic fracture of the tibia and fibula
73319	Pathologic fracture of other specified site

Diagnosis Code	Description
73381	Malunion of fracture
73382	Nonunion of fracture
73393	Stress fracture of tibia or fibula
90520	Late effect of fracture of upper extremities
90540	Late effect of fracture of lower extremities

Physicians may be reimbursed for implantation of an internal bone growth stimulator. Use procedure code, 20975, Electrical stimulation to aid bone healing; invasive. The implanted device is part of the hospital reimbursement.

CSHCN does not reimburse physicians for noninvasive bone growth stimulation (CPT code 20974).

13.3.27.5 Casting

CSHCN will pay for the application of casts, splinting, and strapping in addition to an evaluation and management code when no surgery is performed. If casting, splinting, strapping, or traction is billed the same day as surgery, it is considered part of the surgical procedure.

Note: Supplies used for casting, splinting, and strapping are **NOT** reimbursed separately.

Clubfoot casting is covered for the following diagnoses:

Diagnosis Code			
73671	75459	75469	75471
75450–75453	75460–75462	75470	75479

The following procedure codes must be used when submitting claims for clubfoot casting:

Procedure Code	Description
29450	Application of clubfoot cast with molding or manipulation, long or short leg
29750	Wedging of clubfoot casting

The following procedure codes should be used when billing for casting, splinting or strapping services:

Body and upper extremity casts:

Procedure Code	Description
29000	Application of halo type body cast
29010	Application of Risser jacket, localizer, body; only
29015	Application of Risser jacket, localizer, body; including head
29020	Application of turnbuckle jacket, body; only
29025	Application of turnbuckle jacket, body; including head
29035	Application of body cast, shoulder to hips
29040	Application of body cast, shoulder to hips; including head (Minerva type)
29044	Application of body cast, shoulder to hips; including one thigh
29046	Application of body cast, shoulder to hips; including both thighs
29049	Application; plaster figure-of-eight

Procedure Code	Description
29055	Application; shoulder spica
29058	Application; plaster Velpeau
29065	Application; shoulder to hand (long arm)
29075	Application; elbow to finger (short arm)
29085	Application; hand and lower forearm (gauntlet)

Body and upper extremity splints:

Procedure Code	Description
29105	Application of long arm splint (shoulder to hand)
29125	Application of short arm splint (forearm to hand); static
29126	Application of short arm splint (forearm to hand); dynamic
29130	Application of finger splint; static
29131	Application of finger splint; dynamic

Body and upper extremity strapping:

Procedure Code	Description
29200	Strapping; thorax
29220	Strapping; lower back
29240	Strapping; shoulder (e.g. Velpeau)
29260	Strapping; elbow to wrist
29280	Strapping; hand to finger

Lower extremity casts:

Procedure Code	Description
29305	Application of hip spica cast; one leg
29325	Application of hip spica cast; one and one-half spica or both legs (for hip spica - body - cast, including thighs only, see: 29046)
29345	Application of long leg cast (thigh to toes)
29355	Application of long leg cast (thigh to toes); walker or ambulatory type
29358	Application of long leg cast brace
29365	Application of cylinder cast (thigh to ankle)
29405	Application of short leg cast (below knee to toes)
29425	Application of short leg cast (below knee to toes); walker or ambulatory type
29435	Application of patellar tendon bearing (PTB) cast
29440	Adding walker to previously applied cast
29445	Application of rigid total contact leg cast

Lower extremity splints:

Procedure Code	Description
29505	Application of long leg splint (thigh to ankle or toes)
29515	Application of short leg splint (calf to foot)

Lower extremity strapping:

Procedure Code	Description
29520	Strapping; hip
29530	Strapping; knee
29540	Strapping; ankle
29550	Strapping; toes

Cast removal or repair:

Procedure Code	Description
29700	Removal or bivalving: gauntlet, boot or body cast
29705	Removal or bivalving; full arm or full leg cast
29710	Removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.
29715	Removal or bivalving; turnbuckle jacket
29720	Repair of spica, body cast or jacket
29730	Windowing of cast
29740	Wedging of cast (except clubfoot casts)

13.3.27.6 Circumcision

CSHCN will reimburse providers for performing a circumcision for conditions that require intermittent catheterization.

The following list of procedure codes are to be used when requesting authorization or billing for circumcisions:

Procedure Code	Description
54150	Circumcision, using clamp or other device; newborn
54152	Circumcision, using clamp or other device; except newborn
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn

Note: Routine circumcision of a newborn without an accompanying medical condition is not a benefit of CSHCN.

13.3.27.7 Cosurgery

The CSHCN Program does **not** reimburse for team surgery. Cosurgery is a benefit of the CSHCN Program.

Cosurgery occurs when two surgeons, usually with different specialties/skills, perform surgery on the same patient during the same operative session. The additional surgeon in a “cosurgeon” situation is not acting as an assistant surgeon but has a comparable role with the other physician.

Authorization is not specifically required for procedures using cosurgeons although all other authorization requirements must be met. Prior authorization must be obtained for those procedures completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in "Specialty Team/Center" on page 13-60.

When billing for cosurgery, each surgeon must bill the appropriate CPT code(s) and the following modifier, 62–Two surgeons: two surgeons perform the specific procedure(s).

Each surgeon will receive 58 percent of the highest paying procedure and 29 percent of any secondary procedure. Additional payment will not be made for an assistant surgeon.

Claims submitted without the cosurgery modifier "62" will not be considered cosurgery. Reimbursement for these claims will be determined by other surgery reimbursement methodology.

Note: Each surgeon that performs cosurgery should bill the appropriate CPT procedure code for the specific surgery that he/she has performed.

13.3.27.8 Extracorporeal Shock Wave Lithotripsy

Extracorporeal Shock Wave Lithotripsy (ESWL) (procedure code 50590) is a covered benefit for renal stones that cause hydronephrosis (diagnosis codes 59100, 59200, 59210, 59290). All claims received for ESWL must include this information.

13.3.27.9 Global Fees

The CSHCN Program reimburses surgeons and anesthesiologists based on a global fee concept. This concept means that the fee paid for the surgical procedure includes routine preoperative care and varying amounts of postoperative care based on the complexity of the procedure.

Major and extensive surgical procedures (for example, repair of transposition of the great arteries) include all routine care pertaining to the surgery three days preoperatively, including admissions and consultations, and all routine postoperative care for six weeks, in any place of service.

Post-operative complications necessitating readmission to the hospital during the post-operative package of service may be reimbursed outside the package of service upon appeal to NHIC-CSHCN. Documentation of the medical appropriateness of the protracted medical stay is required with submission of the appeal.

Simple diagnostic (such as needle biopsy) and minor surgical procedures (for example, thoracentesis) do not include any preoperative or postoperative care restrictions. These surgeries are identified in CPT by an asterisk (*) to the right of the code. If the procedure is performed in an inpatient hospital setting, a visit is not paid on the same day. If performed in the office or home, visits are reimbursed in addition to the surgical procedure.

All supplies (trays, dressings, local anesthetics) are considered part of the surgical procedure and must not be billed separately to CSHCN or the client.

13.3.27.10 Multiple Surgeries

CSHCN payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the major procedure, (for example, the highest paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- When a surgical procedure and a biopsy on the same organ or structure are done on the same day, the procedures will be combined and paid as the appropriate code.

13.3.27.11 Office Procedures

Certain surgical procedures have been identified as more appropriately performed in the office setting rather than as outpatient hospital, ambulatory surgical center, or inpatient hospital procedures. The following list of surgical procedure codes must be billed in POS 1 (physician's office). When the following procedures are performed in a place of service other than the office (POS 1), the

medical necessity and/or special circumstances must be documented on the claim. These surgical procedures will be evaluated on a retrospective basis which could result in recoupment and adjustment of the original claim payment.

Procedure Code	Description
11400	Excision, benign lesion, except skin tag; trunk, arms, or legs; 0.5 cm or less
11401	Excision, benign lesion, except skin tag; trunk, arms, or legs; 0.6 to 1.0 cm
11402	Excision, benign lesion, except skin tag; trunk, arms, or legs; 1.1 to 2.0 cm
11403	Excision, benign lesion, except skin tag; trunk, arms, or legs; 2.1 to 3.0 cm
11404	Excision, benign lesion, except skin tag; trunk, arms, or legs; 3.1 to 4.0 cm
11420	Excision, benign lesion, except skin tag; scalp, neck, hands, feet, or genitalia; 0.5 cm or less
11421	Excision, benign lesion, except skin tag; scalp, neck, hands, feet, or genitalia; 0.6 to 1.0 cm
11422	Excision, benign lesion, except skin tag; scalp, neck, hands, feet, or genitalia; 1.1 to 2.0 cm
11423	Excision, benign lesion, except skin tag; scalp, neck, hands, feet, or genitalia; 2.1 to 3.0 cm
11440	Excision, other benign lesion, except skin tag; face, ears, eyelids, nose, lips, or mucous membrane; 0.5 cm or less
11441	Excision, other benign lesion, except skin tag; face, ears, eyelids, nose, lips, or mucous membrane; 0.6 to 1.0 cm
11442	Excision, other benign lesion, except skin tag; face, ears, eyelids, nose, lips, or mucous membrane; 1.1 to 2.0 cm
11443	Excision, other benign lesion, except skin tag; face, ears, eyelids, nose, lips, or mucous membrane; 2.1 to 3.0 cm
11444	Excision, other benign lesion, except skin tag; face, ears, eyelids, nose, lips, or mucous membrane; 3.1 to 4.0 cm
11600	Excision, malignant lesion; trunk, arms, or legs; 0.5 cm or less
11601	Excision, malignant lesion; trunk, arms, or legs; 0.6 to 1.0 cm
11602	Excision, malignant lesion; trunk, arms, or legs; 1.1 to 2.0 cm
11603	Excision, malignant lesion; trunk, arms, or legs; 2.1 to 3.0 cm
11604	Excision, malignant lesion; trunk, arms, or legs; 3.1 to 4.0 cm
11620	Excision, malignant lesion; scalp, neck, hands, feet, or genitalia; 0.5 cm or less
11621	Excision, malignant lesion; scalp, neck, hands, feet, or genitalia; 0.6 to 1.0 cm
11622	Excision, malignant lesion; scalp, neck, hands, feet, or genitalia; 1.1 to 2.0 cm
11623	Excision, malignant lesion; scalp, neck, hands, feet, or genitalia; 2.1 to 3.0 cm
11624	Excision, malignant lesion; scalp, neck, hands, feet, or genitalia; 3.1 to 4.0 cm
11640	Excision, malignant lesion; face, ears, eyelids, nose, or lips; 0.5 cm or less
11641	Excision, malignant lesion; face, ears, eyelids, nose, or lips; 0.6 to 1.0 cm
11642	Excision, malignant lesion; face, ears, eyelids, nose, or lips; 1.1 to 2.0 cm
11643	Excision, malignant lesion; face, ears, eyelids, nose, or lips; 2.1 to 3.0 cm
11644	Excision, malignant lesion; face, ears, eyelids, nose, or lips; 3.1 to 4.0 cm
28010	Tenotomy, percutaneous, toe, single tendon
28011	Tenotomy, percutaneous, toe, multiple tendons
31505	Laryngoscopy, indirect (separate procedure), diagnostic
41100	Biopsy, tongue, anterior two-thirds
53600	Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent

Procedure Code	Description
53620	Dilation of urethral stricture by passage of filiform and follower, male; initial
53621	Dilation of urethral stricture by passage of filiform and follower, male; subsequent
53660	Dilation of female urethra including suppository and/or instillation; initial
53661	Dilation of female urethra including suppository and/or instillation; subsequent
54060	Destruction of lesion, penis, simple; surgical excision

13.3.27.12 Second Opinions

CSHCN Program benefits include payment to physicians when a CSHCN client requests a second opinion regarding surgery. The claim must be coded with the appropriate office or hospital visit code, and the notation “Client Initiated Second Opinion” must be noted in block 24D of the HCFA-1500 Claim Form.

13.3.27.13 Septoplasty

CSHCN will reimburse septoplasty for the following diagnoses:

Diagnosis Code			
14000	17300	21630	73800–73810
14030	17330	23000	74483
14050–14090	19100–19190	23200	74900–74925
14500–14580	19430–19440	23510	75026
14700–14790	19500	23590	75029
16000–16090	19600	23770–23772	75400
17000	21200	27700–27701	90500
17200	21300	52400–52410	94130–94159
17230	21600	52890	94700

Use procedure code 30520, Septoplasty or submucous resection with or without cartilage scoring, contouring/or replacement with graft when billing for septoplasty.

13.3.27.14 Tonsillectomies, Adenoidectomies, Myringotomies

Requests for tonsillectomies, adenoidectomies, and myringotomies are covered for the following diagnoses:

Diagnosis Code	Description
21200–21210	Benign neoplasm of nasal cavities, middle ear, and accessory sinuses/larynx
21230	Benign neoplasm of bronchus and lung
38300–38322	Acute/chronic mastoiditis Acute/chronic petrositis
38332	Recurrent cholesteatoma of postmastoidectomy cavity
38502–38503	Tympanosclerosis involving tympanic membrane ear ossicles, and middle ear
38521–38524	Other acquired abnormality of ear ossicles
38530–38533	Cholesteatoma of middle ear and mastoid
52400–52406	Major anomalies of jaw size
52409	Other specified anomaly
74400–74409	Anomalies of ear causing impairment of hearing
74483	Macrostomia

Diagnosis Code	Description
74900–74925	Cleft palate and cleft lip
75026	Other specified anomalies of mouth
75029	Other specified anomalies of pharynx
75400	Certain congenital musculoskeletal deformities of skull, face, and jaw
75600	Other congenital musculoskeletal anomalies of skull, and face bones

Use the following procedure codes when billing for tonsillectomies, adenoidectomies, and/or myringotomies:

Procedure Code	Description
42820	Tonsillectomy and adenoidectomy, under age 12
42821	Tonsillectomy and adenoidectomy, age 12 or older
42825	Tonsillectomy, primary or secondary; under age 12
42826	Tonsillectomy, primary or secondary, age 12 or older
42830	Adenoidectomy, primary; under age 12
42831	Adenoidectomy, primary; age 12 or over
42835	Adenoidectomy, secondary; under age 12
42836	Adenoidectomy; secondary; age 12 or over
69420	Myringotomy including aspiration and/or eustachian tube inflation
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia
X2998	Adenoidectomy and bilateral myringotomy with insertion of tubes

13.3.27.15 Unlisted Surgical Procedure Code Considerations

Unlisted surgical procedure codes are commonly used when a matching description of a procedure performed cannot be found within the HCPCS procedure coding system. These unlisted procedure codes always end with “99” (for example, 37799, Unlisted procedure, vascular surgery).

Every effort should be made to find and use a procedure code which best matches the surgery performed. If an unlisted procedure code is used, the following items must be sent in with your claim:

- A complete description of all procedures performed
- An operative report of procedures

Remember to verify if a procedure requires authorization. Refer to “NHIC-CSHCN Authorization Requirements” on page 1-15 for authorization requirements and “Specialty Team/Center” on page 13-60 for specific information on procedures which must be performed by an approved specialty team/center. Filing your claim correctly the first time will help ensure your claim is processed in a timely manner.

13.3.27.16 Vitrasert Ganciclovir Implant

Procedure code 67027, Implantation of intravitreal drug delivery system, which includes concomitant removal of vitreous, is a covered benefit for the diagnosis of 36320, Chorioretinitis, unspecified. Include medical documentation that supports the diagnosis of cytomegalovirus retinitis when submitting a request for authorization and/or a claim for this service. If a vitrectomy and implantation of implant are billed on the same day by the same provider, the insertion code is paid and the vitrectomy code payment is denied as part of the other service.

13.4 Authorization Requirements

Authorization is a condition for reimbursement; it is not a guarantee of payment. It is the responsibility of each provider to check the client's CSHCN card at the time each service is provided to verify eligibility. Any service provided while the client is not eligible cannot be reimbursed by NHIC, and the responsibility for payment for services is determined by private arrangements made between the provider and the client. All claims filing deadlines must be met.

Prior authorization must be obtained before performing the following services:

- Anterior lobectomies for complex partial seizures
- Bone marrow/stem cell transplants
- Cleft/craniofacial surgical procedures
- Inpatient admissions
- Inpatient dental surgical procedures, as specified in "Dental" on page 3-1
- Inpatient rehabilitation admissions
- Reduction mammoplasties
- Rhizotomies

Authorization requests for other services requiring authorization must be received by NHIC within the 90-day authorization deadline. This 90-day deadline is for all services requiring authorization (not **prior** authorization), including extensions and emergency situations.

Authorization requests received after the authorization deadline will be denied.

All requests for authorizations must be submitted in writing. See "CSHCN Surgery Authorization Form" on page 13-71 for a sample of the Surgery Authorization Request Form to be completed and returned with your written request.

Physicians performing surgery in the inpatient setting do not need to obtain authorization unless the procedure is listed in "Services Requiring Physician Prior Authorization" on page 13-61.

Incomplete prior authorization requests will be denied, and will be considered only if received before the service is provided. Requests to extend the deadline will not be considered except in cases of retroactive eligibility.

Exception: Authorization cannot be given if the client does not have CSHCN eligibility when the request is received by NHIC-CSHCN. All claims must meet the 90-day filing deadline.

Providers may fax their authorization requests to 512-514-4222. This fax is for authorization requests only.

Authorization must be requested for the following services:

- Hospital ambulatory surgery (outpatient hospital day surgery, not including surgeries under "Prior Authorization")
- Freestanding ambulatory surgery (not including surgeries under "Prior Authorization")
- Therapeutic Apheresis

13.4.1 Specialty Team/Center

In addition to requiring prior authorization, some services require that both physicians and facilities be approved by TDH-CSHCN as a specialty team/center provider.

- For bone marrow/stem cell transplant services, both the physician and the facility must be specialty team/center approved.
- For cleft/craniofacial surgical procedures, only the physician/dentist must be specialty team approved.
- **If specialty Team/Center requirements are not met, all services related to the surgery will be denied.**

13.4.2 Services Requiring Physician Prior Authorization

The following procedures require that prior authorization be approved before services are rendered.

13.4.2.1 Anterior Temporal Lobectomy for Complex Partial Seizures

Anterior temporal lobectomies are covered for diagnoses 34540 through 34541. The following must be included with the request for **prior** authorization:

- Indicate whether a diagnostic workup has been performed before anterior temporal lobectomy.
- Document medical treatment regimens tried to date.
- Document the drug treatment regimens (name drugs) that have been increased to maximum acceptable levels without ability to control seizure activity.
- Document that seizures have temporal focus.

Procedure code 61538 must be used for anterior temporal lobectomies.

13.4.2.2 Bone Marrow/Stem Cell Transplants

Bone marrow/stem cell transplants must be prior authorized. Services must be provided in a CSHCN-approved bone marrow/stem cell transplant center and performed by an approved specialty team provider. For enrollment as an authorized specialty team or center, see "Provider Enrollment" on page 1-17.

Providers may fax prior authorization requests to 512-514-4222.

Refer to: "CSHCN Surgery Authorization Form" on page 13-71.

The following additional information must be submitted with the prior authorization request:

- Indicate if the client is diagnosed with CML in blast crisis
- Specify the type of transplant being performed:
  - _____ Allogeneic
  - _____ Matched related
  - _____ Matched nonrelated
  - _____ Autologous
  - _____ Other (specify) _____
- Indicate status of client:
  - _____ 1st remission
  - _____ 2nd remission
  - _____ Relapse
  - _____ Other (specify) _____

CSHCN will review requests for prior authorization of bone marrow transplants for program eligible clients with the following specified CSHCN covered medical conditions:

Diagnosis Code	Type of Transplant	Medical Condition
14000–20890	Autologous only	Neuroblastoma stage D
20100–20198	Autologous and Allogeneic	Hodgkin's lymphoma
20280	Autologous and Allogeneic	Non-Hodgkin's lymphoma
20400	Autologous and Allogeneic	Acute lymphoblastic leukemia (ALL)
20500	Autologous and Allogeneic	Acute non-lymphoblastic leukemia (ANLL) Acute myelogenous leukemia (AML)
20510	Allogeneic only	Chronic myelogenous leukemia (CML) (excluding CML in blast crisis)

13.4.2.3 Facility Reimbursement

A maximum amount of $200,000 per client is reimbursed for a transplant hospitalization. All hospital charges for patient care (inpatient hospital only) during the time of the hospital stay will be applied to the $200,000 limit. Transplant protocols that require multiple infusions, stem cell support, stem cell rescue, and/or multiple inpatient admissions may be reimbursed up to the maximum of $200,000.

An additional 60-day limitation of hospital days begins the day of hospital admission for the transplant.

Transplant protocols that require multiple infusions, stem cell support, stem cell rescue, and/or multiple inpatient admissions are subject to the 60-day inpatient limitation beginning on the day of the hospital admission for the initial transplant procedure.

Bone marrow/stem cell transplant patients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge for the bone marrow transplant event. This includes reimbursement for antirejection drugs. Donor costs also may be reimbursed by CSHCN. Donor costs will not be considered by CSHCN when another third party resource is available to reimburse the transplant.

Note: Donor costs must be included on the client's inpatient hospital claim for the transplant.

13.4.2.4 Physician Reimbursement

Physicians are reimbursed the lower of the billed amount or the amount allowed by the Texas Medicaid Program.

If approved, a letter with the authorization number will be sent to the physician (when applicable) and to the hospital where the surgery/service will be performed. This authorization number must be placed in block 23 of the HCFA-1500 Claim Form.

Note: An additional 60-day limitation of hospital days begins the date of hospital admission for an approved bone marrow transplant.

When the procedures are performed on an emergency basis (refer to "Emergency Services" on page 13-14 for definition of emergency), deadlines and requirements supporting documentation (for example, the admitting history and physical, pathology, and consultation reports) must accompany the claim.

The following specific procedures must be prior authorized and performed by an approved specialty team at an approved center:

Procedure Code	Description
38230	Bone marrow harvesting for transplantation
38231	Blood-derived peripheral stem cell harvesting for transplantation per collection
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic
38241	Bone marrow transplantation; autologous

13.4.2.5 Cleft / Craniofacial and Oral Surgery Procedures

The following procedures must be prior authorized and performed by an approved specialty team:

Procedure Code	Description
21076	Impression and custom preparation; surgical obturator prosthesis
21077	Orbital prosthesis
21079–21110	Prosthesis introduction or removal
21120–21180	Repair, revision or reconstruction
21182–21235	Repair, revision or reconstruction
21244–21247	Repair, revision or reconstruction
21255–21296	Repair, revision or reconstruction
21299	Unlisted craniofacial and maxillofacial procedures
21497	Interdental wiring, other than fracture
30400–30462	Repair (nose)
40527	Excision of lip, full thickness
40650–40761	Repair (cheiloplasty)
42145	Palatopharyngoplasty
42200–42281	Repair (palate, uvula)
61550–61559	Craniectomy or craniotomy
62115–62117	Reduction of craniomegalic skull
67950	Canthoplasty
67961–67975	Reconstruction of eyelid

13.4.2.6 Reduction Mammoplasty

Reduction mammoplasties to equalize breast size are considered cosmetic and are not covered by the CSHCN Program.

Medically necessary reduction Mammoplasty, procedure code 19318, requires prior authorization by the CSHCN medical director, and may be authorized only when documentation supports the need for reduction mammoplasty and its association with the client's covered diagnosis.

Requests that do not contain the required information are considered incomplete and are denied. Surgeons are required to include the following information in their letter of medical necessity requesting **prior** authorization:

- Client's name and CSHCN number
- Complete history and physical, including height, weight, and breast size
- Description of functional debility caused by the condition
- Preoperative photographs (both front and side views)
- Description of past treatments and outcomes
- Number of grams of tissue to be removed from each side
- Requesting surgeon's nine-character CSHCN TPI
- Name and address of facility where services will be performed and CSHCN TPI

All the above must be submitted under the requesting surgeon's signature. When submitting for prior authorization, requests **must** be sent to the CSHCN medical director. Mail prior authorization requests for reduction mammoplasty for clients to:

TDH-CSHCN Services
ATTN: Medical Director
1100 West 34th Street
Austin TX 78756-3179

13.4.2.7 Rhizotomy

Rhizotomies are covered for diagnoses 34300 through 34390, and 34480 through 34489.

Indication whether or not the client has spastic cerebral palsy with no athetosis (has underlying muscle strength) must be included with the request for **prior** authorization

The following procedures must be **prior** authorized, but do not have to be performed in a specialty center:

Procedure Code	Description
63185	Laminectomy for rhizotomy; one or two segments
63190	Laminectomy for rhizotomy; more than two segments
64622	Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar or sacral, single level
64623	Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar or sacral, each additional level (list separately in addition to code for primary procedure)
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (list separately in addition to code for primary procedure) (use 64627 in conjunction with 64626)

13.4.3 Telemedicine Services

CSHCN may reimburse physicians and advanced practice nurses (APNs) for consultations and follow-up visits at hub sites, and for evaluation and management services at remote sites via telemedicine using face-to-face interactive video communication. The hub site provider may be reimbursed whether or not there is a billing provider at the remote site.

13.4.3.1 Benefit / Limitations

Physician / APN consultations and follow-up visits, and physician / APN remote site office visits delivered via telemedicine are included as a benefit of the CSHCN Program. Services available through telemedicine are not new services to the CSHCN Program. The costs of equipment or telecommunication should not be billed separately and will not be reimbursed. Emergency room care, critical care, nursing facility care, domiciliary care, home care, preventive care and newborn care services are not approved telemedicine services. Consultative, but not routine, inpatient care, is included as a telemedicine service.

13.4.3.2 Authorization Requirements

Authorization is not required for telemedicine care.

13.4.3.3 Reimbursement

Providers should submit claims with the appropriate CPT-4 code and the GT modifier in the first modifier field. If the GQ modified is used to describe the asynchronous telecommunications system it should be in the second modifier field, and the GT modifier must be in the first field.

The following Evaluation and Management codes (from CPT-4) will be considered for reimbursement for telemedicine services:

Consultation at HUB site	Evaluation and Management Code
Office Consultations	99241–99245
Confirmatory consultations	99271–99275
Inpatient consultations	99251–99255

Follow-up care at HUB site	Evaluation and Management Code
Office or other outpatient services, new patient	99201–99205
Office or other outpatient services, established patient	99211–99215
Follow-up inpatient consultation	99261–99263

Evaluation and management services at remote site	Evaluation and Management Code
Office or other outpatient services, new patient	99201–99205
Office or other outpatient services, established patient	99211–99215
Hospital care	99221–99233

Reimbursement is the same for visits performed via telemedicine as for those performed in person. Reimbursement is the lower of the billed amount or the amount allowed by the Texas Medicaid Program.

Claims for APN services should be submitted to:

TDH-CSHCN
1100 West 49th Street
Austin TX 78756-3179

Claims for physician services should be submitted to:

NHIC-CSHCN
PO Box 200855
Austin TX 78720-0855

13.5 Therapeutic Apheresis

Therapeutic apheresis requires authorization. Reimbursement for procedure code 36520, Therapeutic apheresis; plasma and/or cell exchange, is limited to the following diagnoses:

Diagnosis Code	Description
20300, 23860	Multiple myeloma Plasmacytoma, NOS
7100	Systemic lupus erythematosus
7140–7142	Rheumatoid arthritis

Apheresis is denied for all other diagnoses. Other diagnoses can be reviewed on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the hospital's reimbursement and is not paid separately.

13.6 Claims Information

Physician services must be submitted to NHIC-CSHCN in approved electronic format or on a HCFA-1500 Claim Form. Providers may purchase HCFA-1500 Claim Forms from the vendor of their choice; NHIC does not supply the forms. See "Claims Filing Instructions" on page 1-50 for more information on claims submission.

When completing a HCFA-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided in the following table. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

13.6.1 Physician HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no.	Enter the patient's nine-digit CSHCN client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. **Hospital to Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. Refer "Verbal Denials" on page 1-35 for more information on verbal denials and the 110-day rule. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of current illness or injury	If the services provided are accident-related, indicate the date of injury or the accident.

Block No.	Description	Guidelines
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and zip code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN. Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Services provided to a client in a nursing facility (SNF, ICF, or ECF) must identify the attending physician. Laboratory and radiology services must identify the ordering physician. Speech-language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate – Anesthesiologists use "AA," "AD," "QJ," "QO," or "QQ." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.

Block No.	Description	Guidelines
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed).
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alpha-numeric characters (up to 15) in this block are referenced on the Remittance and Status (*R and S*) Report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and zip code, or the TPI of the facility where the service was provided. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, zip code, and telephone number	Affix one of the preprinted labels to this block. In lieu of the label, enter the CSHCN TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or by calling 800-568-2413 or 512-514-3000.

13.6.1.1 Physician (Anesthesiologist) HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Stirney, Brenda K.

3. PATIENT'S BIRTH DATE (MM DD YY): 01 04 97 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1200 N. Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Bay City STATE: TX

ZIP CODE: 12345 TELEPHONE (INCLUDE AREA CODE): 123-555-1234

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY: STATE:

ZIP CODE: TELEPHONE (INCLUDE AREA CODE):

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX: M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): ☐ YES ☒ NO

b. AUTO ACCIDENT? ☐ YES ☒ NO

c. OTHER ACCIDENT? ☐ YES ☒ NO

10d. RESERVED FOR LOCAL USE:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. INSURED'S BIRTH DATE (MM DD YY) SEX: M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN OR PROGRAM NAME:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....On File.....

14. DATE OF CURRENT (MM DD YY) ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO (MM DD YY)

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. ID NUMBER OF REFERRING PHYSICIAN: CID110099

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO (MM DD YY)

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 162 . 90 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

	24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	3	7	00520	AA	1		500 00	1				123456789
2									Time: 53	minutes								
3																		
4																		
5																		
6																		

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 500 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Susan Johnson, MD

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Doctor's Hospital
3321 Medical Drive
Bay City, TX 77414

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Susan Johnson, M.D.
438 Norlins Way
Bay City, TX 77414

PIN# GRP# CID000999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
ANESTHESIOLOGIST FORM OWCP - 1500 FORM RRB - 1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

13

13.6.1.2 Doctor of Dentistry Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Sanches, Donna K.

3. PATIENT'S BIRTH DATE MM DD YY: 06 14 97 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 8001 Austin Place

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: East STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 72342 TELEPHONE (INCLUDE AREA CODE): 817-555-1234

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Jeff Jones, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 9876543-21

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 208 . 00
2. 522 50
3. _____ . _____
4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 999011997

24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06	01	02	06	01	02	1	2	41850			2	52 94	1				1357924-68
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 52 94

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

John Brown, DDS

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
John Brown, DDS
1414 Green St.
East, Texas 72341

PIN# GRP# 1234567-89

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
HCFA 1500 FORM OWCP - 1500 FORM RRB - 1500
DENTAL

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

13.6.1.3 CSHCN Surgery Authorization Form

CSHCN Surgery Authorization Request Form

Submit to CSHCN Authorization Department, 12545 Riata Vista Circle, Austin, TX 78727 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, option 2#.

Client Information:

First name:	**Last Name:**	**CSHCN #:**
Date of birth:	**Diagnoses (ICD-9-CM):**	
Address / City / Zip:		

Procedure Information:

Surgical Procedure(s) Requested (CPT Codes):	
Anticipated Date of Surgery:	
Facility Name / CSHCN TPI:	
Inpatient Surgery? ❑Yes ❑No	**Outpatient Surgery?** ❑Yes ❑No
Surgeon Name / CSHCN TPI:	

Freestanding Surgical Center Information:

If freestanding surgical center, indicate patient's physical status (ASA level) below:

_____ASA I / P1 NORMAL HEALTHY PATIENT
_____ASA II / P2 PATIENT WITH MILD SYSTEMIC DISEASE

Please note: If the patient's physical status is P3, P4, P5, or P6 services may not be authorized in a freestanding surgical center (see descriptions below).

ASA III / P3.....PATIENT WITH SEVERE SYSTEMIC DISEASE

ASA IV / P4.....PATIENT WITH SEVERE SYSTEMIC DISEASE THAT IS A CONSTANT THREAT TO LIFE

ASA V / P5.....MORIBUND PATIENT WHO IS NOT EXPECTED TO SURVIVE WITHOUT THE OPERATION

ASA VI / P6.....DECLARED BRAIN-DEAD PATIENT WHOSE ORGANS ARE BEING REMOVED FOR DONOR PURPOSES

Other Insurance Info: (check each that apply)	❑None ❑Yes	If Yes: ❑Private ❑Medicare ❑Medicaid

Please include additional information as applicable (documentation for procedures, medical necessity, etc.). For the procedures rhizotomy, craniectomy for anterior temporal lobectomy, and bone marrow / stem cell transplant, see the provider manual for specific criteria needed to accompany the request for each of these.

Signature of Provider:	**Date:**
Print or Type Provider Name:	**Phone Number:**
Provider Address / City / Zip:	**FAX Number**
CSHCN TPI:	**Contact Name:**

13.6.1.4 Hemophilia Blood Factor Products Authorization Form

CSHCN Authorization Form for Hemophilia Blood Factor Products

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin, TX 78727-6524 or FAX to 512-514-4222

For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

Client Information:

First Name:	Last Name:
CSHCN #:	DOB:
Diagnoses (ICD-9-CM):	
Address/City/State/ZIP:	

Provider Information:

Name (print or type):	TPI #:
Phone #:	FAX #:
Address/City/State/ZIP:	
Contact name:	Provider Signature:

Prescribing Physician's Name: _____ **Telephone Number:** _____

Product Information:

Product Name/Manufacturer:	
National Drug Code (NDC):	
HCPCS Code:	Quantity (per I.U.):

SECTION

14

Respiratory Equipment

14.1 Enrollment 14-1
14.2 Reimbursement 14-1
14.3 Benefits and Limitations 14-2
14.4 Authorization 14-2
14.5 Modifier Requirements 14-3
14.6 Claims Information 14-3
14.6.1 DME HCFA-1500 Claim Form Instructions 14-4

14.1 Enrollment

DME providers must be enrolled and active in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, and have completed the CSHCN enrollment process and comply with all applicable state laws and requirements.

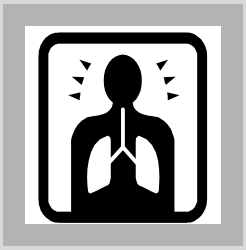
Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number or will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their R&S report.

14.2 Reimbursement

Respiratory equipment reimburses the lower of the billed amount or the amount allowed by the Centers for Medicare and Medicaid Services (CMS), if available, or the Texas Medicaid Program.

Repairs of respiratory equipment are reimbursed at list price of the part plus labor.

The provider must agree to accept CSHCN's reimbursement as "payment in full." Repairs are reimbursed at list price of part plus labor time. Use Medicaid local code 5806X, Labor for repair or modification to existing equipment, per hour, when requesting authorization and/or claim submission. Providers must have a client or their representative complete the "Documentation of Receipt Form" found in "CSHCN Documentation of Receipt for DME Equipment" on page 14-11 when the equipment is delivered. The date of delivery on the Documentation of Receipt Form is the date of service which should appear on the claim. The provider should retain this form; do not submit it with the claim.



14.3 Benefits and Limitations

CSHCN may reimburse the rental or purchase of medically necessary and appropriate respiratory equipment. The item must be prescribed by a licensed physician, and be covered by CSHCN.

Equipment may be rented or purchased depending on the cost effectiveness of the action requested. In general, equipment will be purchased if it will be needed for more than six months. CSHCN will purchase only new, unused equipment.

Repairs will be considered if the item was purchased by CSHCN, or is an item obtained from another source that is on the CSHCN approved list. The repair must be cost-effective when compared to the replacement cost.

Exception: Oxygen concentrators are rented not purchased due to high maintenance costs and need for frequent repairs.

14.4 Authorization

Respiratory equipment requires authorization. Requests for authorization must be submitted in writing and must include documentation of medical necessity. Refer to the "CSHCN Durable Medical Equipment Authorization Request Form" on page 14-8.

Note: Fax transmittal confirmations will not be accepted as proof of timely authorization submission.

CSHCN considers requests for coverage for the following types of respiratory equipment:

- Oxygen equipment and supplies:
  - Rental of stationary gaseous oxygen cylinders. Stands, carts, regulators, and carrying cases are included in the rental price.
  - Rental or purchase of portable gaseous oxygen cylinders. Stands, carts, regulators, and carrying cases are included in the rental/purchase price.
  - Rental of liquid oxygen systems. Stands, regulators, oxygen conservers, and carrying cases are included in the rental price.
  - Rental of oxygen concentrators. A back-up cylinder of gaseous oxygen is required and is included in the rental price.
  - Purchase of liquid or gaseous oxygen contents or refills
  - Purchase of oxygen humidification devices, such as a "Cascade" device
  - Purchase of liquid oxygen systems
  - Purchase or rental of oximeters
  - Rental of apnea monitors
- Inhalation therapy equipment:
  - Intermittent Positive Pressure Breathing (IPPB) machines (IPPB machines will be rented only)
  - Rental or purchase of suction equipment
  - Rental or purchase of percussors
  - Purchase of a "Flutter" valve
- Miscellaneous equipment:
  - Purchase or rental of medical grade or "heavy duty" air compressors
  - Purchase or rental of Continuous Positive Airway Pressure (CPAP) machines
  - Purchase or rental of Bilevel Positive Airway Pressure (BiPAP) machines
  - Purchase or rental of immersion heaters
  - Requests for rental/purchase of duplicate items to be used in two different locations
  - Requests to replace items purchased within the last two years
  - Ventilators

- Nebulizer
  Nebulizers do not require authorization for clients for the following diagnoses:

Diagnosis Code	Description
27700–27701	Cystic fibrosis
49300–49392	Asthma
74500–74570	Bulbus cordis anomalies and anomalies of cardiac septal closure
74590	Unspecified defect of septal closure
74600–74650 74670–74730	Other congenital anomalies of heart
74741–74749	Anomalies of great veins

- Ultrasonic nebulizer
  Authorization is not required for the purchase of an ultrasonic nebulizer for the following diagnoses:

Diagnosis Code	Description
27700	Cystic fibrosis, without mention of meconium ileus
27701	Cystic fibrosis, with meconium ileus
042	human immunodeficiency virus

Requests for an ultrasonic nebulizer that do not meet the criteria specified above require prior authorization. Written documentation of medical necessity and specific rationale for the need for an ultrasonic nebulizer must be submitted with the prior authorization request.
Respiratory equipment that is **not** covered by CSHCN:

- Room air vaporizers or humidifiers
- Rental of substitute equipment when a purchased item that is under warranty is being repaired
- Air filtering systems
- Specialized vacuum cleaners
- Air conditioners
- Dehumidifiers

14.5 Modifier Requirements

For durable medical equipment procedures, use one of the following modifiers:

Modifier	Description
Y4	(Medicare) Purchase – New Equipment (DME)
Z6	Medicare (DME) Rental Equipment

14.6 Claims Information

DME services must be submitted to NHIC-CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the provider of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, because information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

14.6.1 DME HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident related, indicate the date of injury or the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in Block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related must to be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alphanumeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file, a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

14.6.1.1 Respiratory Equipment HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Williams, Sarah M.

3. PATIENT'S BIRTH DATE MM DD YY: 08 12 97 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1201 Carning Place

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Plano STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 75432 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

b. AUTO ACCIDENT? ☐ YES ☒ NO

c. OTHER ACCIDENT? ☐ YES ☒ NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Paul Burnes, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 907 . 00 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	01	02	2	J	E0570			1	150 00	1				
2																		
3																		
4																		
5																		
6																		

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 120 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

David Patton

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
General Supply Company
1902 Bunker Hill
Hillsboro, TX 74932

PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
DURABLE MEDICAL EQUIPMENT FORM OWCP - 1500 FORM RRB - 1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

14

14.6.1.2 CSHCN Durable Medical Equipment Authorization Request Form

Submit to NHIC-CSHCN Authorization Department
12545 Riata Vista Circle, Austin TX 78727-6404 or FAX to: 512-514-4222
For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

For specialized seating or custom wheelchair purchase requests complete the 6-page CSHCN wheelchair seating evaluation form in addition to this form.

Client Information:

First name:	**Last name:**	**CSHCN #:**	
Date of birth:	**Diagnoses (ICD-9-CM):**		
Address / City / ZIP:			
Client's height:		**Client's weight:**	

Part 1 - The following information must be provided for ALL equipment requests.
Item is to be: Purchased ❑ Modified ❑ Repaired ❑ Rented ❑ Service Date:_____
(Required for rentals)

Description of item(s): _____

_____

_____

Equipment needed for: Lifetime ❑ < 6 months ❑ > 6 months ❑ > 1 year ❑ Other:_____
I certify that the patient's medical condition is such that all equipment requested above is medically necessary.

Physician's signature (required): X_____ **Date signed:**_____
Print or Type Physician's name: X_____
(some items may require additional medical justification)

Part 2 - Must be completed and signed by the VENDOR. The equipment description and pricing information indicated below must be completed. For custom DME requests, attach manufacturer's price sheet(s) for each item.

EQUIPMENT DESCRIPTION:			PRICING INFORMATION:			
Brand name or HCPCS code:	**Model #:**	**Item Description:**	**HCPCS Price:**	**OR**	**Cost / Retail Price**	**CSHCN Price**
			Total:			

DME Provider Information:

DME Provider Name (print or type):
TPI No.:
Phone number:
Fax number:
Address / City / ZIP:
Orthotist / Prosthetist name (print or type):
Signature of DME provider or representative: X
Date:

CSHCN DME Authorization Request Form (continued)

Submit this page (in addition to page 1) if requesting authorization for gait trainers or standers. Include a plan for training caretakers/family on the correct, safe use of the equipment and monitoring the client's need for increases or decreases in time using the equipment at home. Documentation must indicate who will be monitoring home program and providing training.

Client Information:

Client name:	**CSHCN #:**

Additional Information for Gait Trainer Requests:

Child's condition/functional level:	
Is the child expected to be ambulatory and if so, when:	
The time, frequency, and location where the gait trainer will be used:	
The length of time the gait trainer is expected to be needed:	
Growth potential of the equipment:	
Therapist's signature: X	**Print/Type Name:**
Phone number:	**Date:**

Additional Information for Prone or Supine Stander Requests:

Child's condition/functional level:	
Anticipated benefits expected from the stander:	
Frequency and amount of time of the child's standing program (e.g., 45 minutes 3x daily):	
Frequency the stander will be used at home:	
Length of time the stander is expected to be needed (growth potential):	
Therapist's signature: X	**Print/Type Name:**
Phone number:	**Date:**

CSHCN DME Authorization Request Form (continued)

Submit this page (in addition to page 1) if requesting authorization for car seats, bathroom equipment, or hospital cribs/enclosed beds.

Client Information:

Client name:	**CSHCN #:**

Additional Information for Special Needs Car Seat or Travel Restraint Requests:

Postural Control	
Head control _____good _____ fair _____poor	
Trunk control _____good _____fair _____poor	
Equipment requested:	
Gorilla by Snug Seat ❑	**Columbia car seat model #2000 ❑**
Name of certified installer:	
Name of person completing form:	**Phone number:**

Additional Information for Hygiene Equipment Requests:

Equipment requested:	
Is this replacement equipment? No ❑ Yes ❑	
If yes, why can't existing equipment be used?	
Tone: High ❑ Low ❑ Fluctuating ❑ Absent ❑	
Head control: Good ❑ Fair ❑ Poor ❑	**Upper extremity: Good ❑ Fair ❑ Poor ❑**
Trunk control: Good ❑ Fair ❑ Poor ❑	**Lower extremity: Good ❑ Fair ❑ Poor ❑**
Transfers: Dependent ❑ Independent ❑	
Name of person completing form:	**Phone number:**

Additional Information for Hospital Crib/Enclosed Bed Requests:

Medical needs, developmental level, and functional skills:	
Describe any other less-restrictive devices that have been used, the length of time used, and why ineffective:	
Why a regular child's crib, regular bed, or standard hospital bed cannot be used:	
Therapist or doctor's signature: X	**Date:**
Print or Type Name:	

14.6.1.3 CSHCN Documentation of Receipt for DME Equipment

This form must be kept in the client's file for all Durable Medical Equipment, Orthotics and Prosthetics, and Prescription Shoes. For help completing this form call CSHCN Customer Service at 800-568-2413 or 512-514-3000, select option 2#.

THIS FORM MUST BE RETAINED BY THE DME PROVIDER. IT SHOULD NOT BE SUBMITTED WITH THE CLAIM.

Client Information:

First name:	**Last name:**
CSHCN #:	
Name of supplier (print or type):	

Equipment Information:

Item	No. Received	Description (include Model # for DME)	Manufacturer's Serial # (for DME only)

I certify that on _____ (mm/dd/yyyy):

The client received the equipment as prescribed by the physician

The equipment has been properly fitted to the client and/or meets the client's needs

The client, the parent or guardian of the client, and/or the primary caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.

Print or Type Name: _____

X _____ _____

Signature of client, parent, or client representative — Date signed

Print or Type Name: _____

X _____ _____

Signature of DME supplier — Date signed

THE RECEIVING PARTY AND DME SUPPLIER MUST SIGN AND DATE THIS FORM AT THE TIME THE EQUIPMENT IS ACTUALLY DELIVERED.
Refer to the *CSHCN Provider Manual* for instructions on completing this form.

SECTION

15

Speech Language Pathology Services

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15.1 Enrollment

To enroll in the CSHCN Services Program, Speech Language Pathology (SLP) providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

15.2 Reimbursement

Outpatient therapy services are reimbursed according to a maximum allowable fee schedule.

CSHCN will reimburse therapists and outpatient facilities based on the procedure codes listed below. Therapy sessions include the time the therapist is with the client for instance, time spent preparing the client for the session and the time spent completing documentation. Evaluation, re-evaluation, and therapy services may not be billed on the same date of service. Reimbursement of an evaluation is limited to once every six months. Reimbursement for re-evaluation is limited to one per month.

Use the following procedure codes for authorization and/or claim submission:

Procedure Code for SLP	Description
5068X	Comprehensive outpatient therapy evaluation, per hour
5382X	SLP evaluation, per session
5385X	Assistive technology (equipment training), per session

Procedure Code for SLP	Description
5456X	SLP re-evaluation, per session
5846X	SLP developmental treatment, initial 30 minutes
5847X	SLP group treatment, per session
5851X	SLP developmental treatment, each additional 15 minutes
5854X	SLP developmental treatment, session, more than 1 hour

15.3 Benefits and Limitations

Speech Language Pathology services (SLP) for a client must be medically necessary and prescribed by a physician and provided by a speech-language pathologist licensed by the State of Texas.

CSHCN Program coverage of Speech Language Pathology services may be limited to certain conditions, by type of service, by age, by the client's medical status, and whether the client is eligible for services for which a school district is legally responsible. Speech-language services may be benefits when provided to clients experiencing speech-language difficulty because of a disease or trauma, developmental delay, oral motor problem, or congenital anomaly.

15.4 Authorization Requirements

Speech Language Pathology services must be authorized.

Speech Language Pathology services may be authorized if the patient:

- Meets other program criteria, **and**
- Has cleft lip/palate or other craniofacial anomaly, **or**
- Has dysphagia/swallowing disorder, **or**
- Meets Speech Language Pathology guidelines as detailed below.

CSHCN may authorize and reimburse for speech language pathology services for dysphagia/swallowing disorders, cleft palate, or other craniofacial anomalies whether or not the patient is school-age and in special education.

Children who have a condition other than cleft palate or craniofacial anomaly may be eligible to receive services if they have a voice articulation and/or expressive/receptive language disorder, and if they are expected to make measurable progress toward their individual SLP treatment goals.

The initial evaluation does not require authorization. Treatment plans, not to exceed six months, and requests for extensions require authorization. Authorization requests must be received in writing by NHIC. If the client is school age, include a copy of the individual educational plan (IEP) or statement from the independent school district that the child is not eligible for the same services through the school.

Authorizations may be granted for:

- SLP evaluation – Only one is allowed for payment per six months, without authorization or written documentation of medical necessity. An evaluation will not be reimbursed on the same day as treatment.
- SLP re-evaluation (may only be reimbursed once per month)
- SLP evaluation of swallowing and oral function for feeding
- Sessions that do not exceed one hour in length
- Treatment plans (not to exceed six months), and extensions
- The Speech Language Pathologist may assist a dentist, radiologist, orthodontist, or surgeon with diagnostic procedures based on the diagnostic procedure's schedule as set by the dentist, radiologist, orthodontist, or surgeon.

- Treatment of new conditions may last up to five times a week for three months beginning no later than one year after date of onset. Based on need, this can be extended for up to one year (after one year, refer to medical review). Examples of new conditions include (but are not limited to) traumatic brain injury, brain tumor, stroke, brain embolism, and other new conditions that affect voice, articulation, and/or expressive/receptive language.
- One equipment assessment for augmentative communication devices/systems or other communication technology may be authorized prior to getting the equipment through purchase or rental arrangement. Time for the adjustment of the ACD will be included as part of the therapy session.
- Training sessions in the use of technology, including augmentative communication devices/systems and their required adjustments/modifications, may be approved for up to five times a week for a period of one month after receipt of the device/new technology and then three times a week for two months. Additional requests require medical review.
- In children up to three years of age, no more than twice a week for developmental conditions including (but not limited to) cleft palate, cerebral palsy, or significant hearing loss when there is a voice, articulation, or expressive/receptive language disorder, or with a swallowing dysfunction and/or oral dysfunction for feeding. This may be extended without medical review upon receipt of the Request for Extension of Therapy Services (TP-2) form. For children age 3 up to 21 years, refer to public school for services, unless ineligible, or child has a new condition. Requests for a frequency rate greater than two times a week will require medical review.

Exceptions to the limitations listed may be made when appropriate and after medical review.

Note: When group therapy is authorized in addition to individual therapy, weekly limits may not be extended.

Speech language pathology services may be authorized following cochlear implant surgery as follows:

- For nonschool-based treatment after a cochlear implant, SLP treatment may be scheduled up to five times a week for three months beginning four to six weeks postoperatively. This can be extended based on medical need for up to one year (after one year, refer to medical review for requests for continuation of the five times a week frequency).
- Up to three times a week, for the second and third years after cochlear implant placement (after the third year postoperatively), refer to medical review for requests for extension of treatment.

If the child is receiving these services through a school-based therapist, CSHCN will not duplicate these services but can provide additional therapy if the school is unable to provide therapy at the required/recommended frequency. For example, if the school is providing therapy three times a week, CSHCN can provide additional outpatient therapy services two times a week during the first year postcochlear implant.

Refer to: The addendum to this policy entitled “Speech Therapy Guidelines by Age” for a summary of the above information in chart format.

15.5 Coordination with the Public School System

Children eligible for SLP services through the public school system, including extended year services, may not receive supplemental SLP services through CSHCN. CSHCN covers medically related therapy and cannot supplement related services provided through the public school system. The public school system is responsible for provision of therapy services related to the child’s educational needs so that they may adequately access provided educational services/programs. A child of any age who has received special education during the school year may be eligible for summer therapy through his or her local school district. A child can receive therapy from both the public school system and CSHCN; however, therapy goals and services will differ because of CSHCN’s focus on medically related needs while the school system addresses the child’s educational needs. CSHCN does not pay for summer services for educational goal attainment of SLP goals since school funding should be available. However, because of the special medical needs of children with cleft palate, cochlear implants or craniofacial anomalies, some SLP services are covered by CSHCN even if the child is eligible for speech therapy for educational needs through the public school system. Children age 3 or older may be eligible for special education services (visually and/or hearing impaired children are eligible regardless of age).

Any child eligible for special education services **must** have a copy of their educational IEP included to request authorization to submit claims for reimbursement of therapy services, to assure there is no duplication of therapy services.

15.6 Claims Information

Outpatient therapy services must be submitted to CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

15.6.1 SLP HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident related, indicate the date of injury or the accident.
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.

Block No.	Description	Guidelines
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alphanumeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.

Block No.	Description	Guidelines
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

15.6.1.1 Speech Language Pathologists HCFA-1500 Example Claim

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Huges, Amanda J.

3. PATIENT'S BIRTH DATE MM DD YY: 06 15 89 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 506 Unterhall Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: Terrell STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 78218 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Karen Belman, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 749 . 23 3. _____ . _____
2. 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06	01	02	06	01	02	1	9	5382X			1	40 85	1				
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 40 85

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Jay Masters

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Jay Masters
1402 Silver Blvd.
Terrell, TX 75160

214-555-1234

PIN# GRP# 987654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
SPEECH LANGUAGE PATHOLOGY FORM OWCP - 1500 FORM RRB - 1500

15.6.1.2 Request for Initial Outpatient Therapy (Form TP1)

Form TP1 Request for Initial OUTPATIENT THERAPY	
CCP - National Heritage Insurance Company PO Box 200735 Austin, TX 78720-0735 800-846-7470 CCP FAX: 512-514-4212	NHIC-CSHCN Children with Special Health Care Needs Services Program PO Box 200855 Austin TX 78720-0855 800-568-2413 or 512-514-3000 FAX: 512-514-4222
Medicaid/CCP Case #	CSHCN Case #
Client Name	DOB
Client's Address (street, city, ZIP code, county)	Phone Number

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No (If yes, attach copy of IEP).

Date of initial evaluation: PT_____ OT_____ SLP_____

COPY OF THE INITIAL EVALUATION MUST BE ATTACHED

ICD-9 code/DIAGNOSIS: _____ Date of onset _____

CATEGORY OF THERAPY BEING REQUESTED:

PT/OT for: ❑ developmental anomalies ❑ pre-surgery* ❑ post-surgery* DATE of surgery_____

❑ cast removal DATE removed_____ ❑ serial casting ❑ acute episode of chronic condition ❑ new condition

❑ specialty clinic ❑ home program ❑ ADL (activities of daily living) ❑ equipment assessment ❑ equipment training;

SPEECH for: ❑ craniofacial ❑ developmental anomalies ❑ new condition ❑ post cochlear implant#

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

____ PT service date(s) FROM_____TO _____ FREQUENCY per week _____per month ____

____ OT service date(s) FROM _____TO _____FREQUENCY per week _____ per month ____

____ SLP service date(s) FROM _____TO _____ FREQUENCY per week _____ per month ____

Print or Type Name

Physician _____ Physician's signature _____ date signed_____

Therapist (PT) _____ Therapist's signature _____ date signed_____

Therapist (OT) _____ Therapist's signature _____ date signed_____

Therapist (SLP) _____ Therapist's signature _____ date signed_____

PROVIDER CONTACT: _____PHONE # (___)_____ FAX # (__)_____

PROVIDER'S NAME: _____

BILLING ADDRESS: _____

MEDICAID PROVIDER # _____CSHCN PROVIDER #_____

15

15.6.1.3 Request for Extension of Outpatient Therapy (2 Pages) (Form TP2)

Form TP2 Request for EXTENSION of OUTPATIENT THERAPY	
CCP - National Heritage Insurance Company **PO Box 200735** **Austin, TX 78720-0735** **800-846-7470** **CCP FAX: 512-514-4212**	**NHIC-CSHCN** **Children with Special Health Care Needs Services Program** **PO Box 200855** **Austin TX 78720-0855** **800-568-2413 or 512-514-3000** **FAX: 512-514-4222**
Medicaid/CCP Case #	**CSHCN Case #**
Client Name	**DOB**
Client's Address (street, city, ZIP code, county)	**Phone Number**

HAS THE CHILD RECEIVED THERAPY IN THE LAST YEAR FROM THE PUBLIC SCHOOL SYSTEM? ❑ Yes ❑ No

Date of initial evaluation: PT_____ OT_____ SLP_____

ICD-9 code/DIAGNOSIS:_____Date of Onset_____

CATEGORY OF THERAPY BEING REQUESTED:

PT/OT for: ❑ developmental anomalies ❑ pre-surgery* ❑ post-surgery* DATE of surgery_____

❑ cast removal DATE removed_____ ❑ serial casting ❑ acute episode of chronic condition ❑ new condition

❑ specialty clinic ❑ home program ❑ ADL (activities of daily living) ❑ equipment assessment ❑ equipment training;

SPEECH for: ❑ craniofacial ❑ developmental anomalies ❑ new condition

CHECK SERVICE REQUESTED, INDICATE THE DATE(S) OF SERVICE AND FREQUENCY PER WEEK OR MONTH:
(Dates of service cannot exceed six months. If possible, end requested date of service on the last day of the month.)

____ PT service date(s) FROM_____TO _____ FREQUENCY per week _____per month ____

____ OT service date(s) FROM _____TO _____FREQUENCY per week _____ per month____

____ SLP service date(s) FROM _____TO _____ FREQUENCY per week _____ per month____

Print or type name

Physician _____Physician's signature _____date signed_____

Therapist (PT) _____Therapist's signature _____date signed_____

Therapist (OT) _____Therapist's signature _____date signed_____

Therapist (SLP) _____Therapist's signature _____date signed_____

PROVIDER CONTACT: _____PHONE # (__)_____FAX # (__)_____

PROVIDER'S NAME: _____

BILLING ADDRESS: _____

MEDICAID PROVIDER # _____ CIDC 5 digit LOCAL # _____

FORM TP-2 Page 1 of 2

Medicaid / CCP case #	**CSHCN Case #**
Client Name	**DOB**

CURRENT FUNCTIONAL STATUS: _____

_____

_____

_____

NEW TREATMENT GOALS: _____

_____

_____

_____

PRIOR DATES OF SERVICE from _____ to _____

PRIOR FUNCTIONAL STATUS: _____

_____

_____

_____

PRIOR TREATMENT GOALS: _____

_____

_____

_____

PRIOR TREATMENT PROVIDED: _____

_____

_____

_____

FORM TP-2 Page 2 of 2

SECTION

16

Total Parenteral Nutrition (TPN) / Hyperalimentation

16.1 Enrollment 16-1
16.2 Reimbursement 16-1
16.3 Benefits and Limitations 16-1
16.4 Claims Information 16-2
16.4.1 Total Parenteral Nutrition (TPN) / Hyperalimentation HCFA-1500 Claim Form Instructions 16-2

16.1 Enrollment

TPN / Hyperalimentation providers must be enrolled and active in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

Note: If no claims are submitted for 12 months, the nine-digit CSHCN provider or TPI number will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *R&S* report.

16.2 Reimbursement

TPN / Hyperalimentation services are reimbursed according to a maximum allowable fee that is based on the Medicaid maximum allowable rate. Reimbursement for procedure code Z9812, Hyperalimentation, includes all costs such as the solution itself including additives, durable medical equipment (DME) for therapy, related TPN supplies, and nursing services for the administration.

16.3 Benefits and Limitations

The CSHCN Program may reimburse for total parenteral nutrition (TPN) and hyperalimentation for home and outpatient therapy for the following diagnoses:

Diagnosis Code	Description
042	Human immunodeficiency virus (HIV) disease
140–2089	Malignant neoplasm (cancer)
27700–27701	Cystic fibrosis
5550–5559	Regional enteritis (Crohn's Disease)

All other diagnoses require submission of documentation to support medical necessity.

16.4 Claims Information

TPN/hyperalimentation services must be submitted to NHIC CSHCN in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice; NHIC does not supply the forms.

When completing a HCFA-1500, all pertinent information must be included on the claim, because information is not keyed from attachments. Superbills or itemized statements are not accepted as claim supplements.

Instructions for proper claims completion are provided below. Blocks that are not referenced are not required for processing by NHIC and may be left blank.

16.4.1 Total Parenteral Nutrition (TPN)/Hyperalimentation HCFA-1500 Claim Form Instructions

The instructions below describe what information must be entered in each of the block numbers of the HCFA-1500 Claim Form. **Block numbers not referenced in the table may be left blank**. **They are not required for claim processing by NHIC**.

Block No.	Description	Guidelines
1a	Insured's ID no. (for program checked above, include all letters)	Enter the patient's nine-digit client number.
2	Patient's name	Enter the patient's last name, first name, and middle initial.
3	Patient's date of birth Patient's sex	Enter numerically the month, day, and year (MM/DD/YY) the client was born. Indicate the patient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (street, city, state, and ZIP code).
9	Other insured's name	For special situations, use this space to provide additional information. Other uses include, but are not limited to the following: If the patient is deceased, enter the date of death. If the services were rendered on the date of death, indicate the time of death. If the patient has chronic renal disease, enter the date of onset of dialysis treatments. **Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility.
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in block 11, "Other Health Insurance Coverage."
11	Other health insurance coverage	If another insurance resource has made payment, write "(Name) Insurance Company paid $(Amount) on (Date)." If another insurance resource has been billed and denied the claim, write "(Name) Insurance Company denied claim on (Date)." Attach a copy of the denial letter or form to the claim. If the patient has health, accident, or other insurance policies or is covered by private or government benefit system which may pay in full or in part for the services billed on this form, enter all pertinent information available. If the patient is enrolled in Medicare, enter the patient's Health Insurance Claim (HIC) number from the Medicare Identification Card. The notation of "DENIED" indicates the third party resource denied the claim.
12	Patient or authorized person's signature	Providers are encouraged to obtain the patient's signature on claim forms; however, NHIC will process the claim without the signature of the patient. The patient's signature authorizes the release of the medical information on the claim.
14	Date of injury	If the services provided are accident related, indicate the date of injury or the accident.

Block No.	Description	Guidelines
17 and 17a	Name of referring physician or other source	Enter the complete name, address, and ZIP code and/or the TPI or (UPIN in block 17a) in the following situations: Electronic billers should enter the six-digit Medicare number or UPIN Clinical pathology consultations to hospital inpatients or outpatients must identify the attending physician. Consultation services must identify the referring physician. Laboratory and radiology services must identify the ordering physician. Speech language therapy must identify the ordering physician. Physical therapy must identify the ordering physician. Occupational therapy must identify the ordering physician. In-home hyperalimentation services must identify the ordering physician.
19	Reserved for Local Use	**Multiple Transfers** Indicate that the claim is part of a multiple transfer and provide the other client's complete name and nine-digit CSHCN number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
20	Was laboratory work performed outside your office?	Check the appropriate box. The information is not required to process claims, but it may be requested for retrospective review. If "YES," enter the name and address or TPI number of the facility that performed the service in block 32. CSHCN regulations require a provider bill only for those laboratory services that he or she actually performed. Any services performed outside of the provider's office must be billed by the performing laboratory or radiology center.
21	Diagnosis or nature of illness or injury	Enter the ICD-9-CM diagnosis code to the highest level of specificity available.
23	Prior authorization no. (PAN)	Enter the prior authorization or authorization number (PAN) issued by NHIC if applicable.
24A	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If more than one date of service is for a single procedure, each date must be given (such as "03/16, 17, 18/02"). **Electronic Billers** CSHCN does not accept multiple (to-from) dates on a single line detail. Bill only one date per line. **"To" dates of service are not used on electronic claims.**
24B	Place of service (POS)	Select the appropriate place of service (POS) code for each service. If the patient is registered at a hospital, the POS must indicate inpatient or outpatient status at the time of service. **Ambulance** The place of service for all ambulance transfers will be the destination.
24D	Fully describe procedures, medical services, or supplies furnished for each date given	Enter the appropriate procedure codes for all procedures/services billed. If a procedure code is not available, enter a concise description. Give complete information for: **Injections** – Provide a breakdown of each injection and separate the charge for an injection from the office visit charge. Indicate the name of the drug, strength, and dosage; and the necessity for the injection by using one of the modifiers. **Sutures** – Indicate number of sutures, length, and location of laceration. **Laboratory** – Indicate the specific type of laboratory procedure. **X-ray** – Indicate the number of views and type. When unusual or extenuating circumstances occur, give a brief medical report. **Ambulance** – The pick-up point and destination must be indicated on the claim form. **Anesthesiologists** – Enter the appropriate CPT-4 anesthesia procedure code for all procedures billed. If the anesthesia is given for more than one procedure, identify all procedures performed and indicate what is considered the major procedure. A breakdown of charges is not necessary. Enter the time in minutes. Enter one of the following modifiers as appropriate - Anesthesiologists use "AA," "AD," "QJ," "QO," "QQ," or "QS." Use modifiers (for example, acute, left, right) to describe services.

Block No.	Description	Guidelines
24E	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to each ICD-9-CM diagnosis code identified in block 21. If a procedure is related to more than one diagnosis, the primary diagnosis the procedure is related to must be the one identified. Do not enter more than one reference per procedure. This could result in denial of the service.
24F	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24G	Days or units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed.)
24K	Other	The space is used to provide additional information such as pertinent comments that may explain an unusual procedure. It also is used to identify laboratory tests sent outside the provider's office when a laboratory handling fee is billed in addition to laboratory tests. Members of a group practice (except pathology and renal dialysis groups) must identify the TPI of the doctor/clinic within the group who performed the service. The number that identifies the doctor/clinic as a member of that group practice should not appear in block 33 and must not be used to bill the CSHCN Program. The HCFA-1500 Claim Form is designed to list six line items in block 24. If more than six line items are billed, a provider attaches additional forms.
26	Patient's account number	Optional – Any alphanumeric characters (up to 15) in this block are referenced on the *R&S* report.
27	Accept assignment	Not optional – All providers of CSHCN services must accept assignment to receive payment. Providers must check "YES." Electronic billers must submit a "Y."
28	Total charge	Enter the total of separate charges for each page of the claim. Enter the total of all pages on last claim if filing a multi-page claim.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
30	Balance due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of physician or supplier	The physician/supplier or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
32	Name and address of facility where services rendered	If services were provided in a place other than the patient's home or the provider's facility, enter name, address, and ZIP code, or the TPI of the facility where the service was provided. For ambulance transfers if the destination is a hospital, enter the name and address, and the TPI of the facility. For laboratory specimens sent to an outside laboratory for additional testing, the complete name and address or the TPI of the outside laboratory should be entered. The laboratory should bill the CSHCN Program for the services performed.
33	Physician or supplier's name, address, ZIP code, and telephone number	Enter the TPI, provider name, street, city, state, ZIP code, and telephone number. Preprinted labels are requested by writing NHIC Provider Enrollment or calling 800-568-2413 or 512-514-3000.

16.4.1.1 TPN HCFA-1500 Claim Form Example

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☒ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1.a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 912345600

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jefferson, Martha

3. PATIENT'S BIRTH DATE MM DD YY: 09 27 93 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 5668 Marlin Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: San Antonio STATE: TX

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ Employed ☐ Full-time Student ☐ Part-time Student ☐

CITY STATE

ZIP CODE: 77718 TELEPHONE (INCLUDE AREA CODE)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S BIRTH DATE MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN OR PROGRAM NAME

d. INSURANCE PLAN OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes**, return to and complete item 9a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED .....On File..... DATE .....

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

SIGNED .....

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dan Smith, M.D.

17a. ID NUMBER OF REFERRING PHYSICIAN: 123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 042
2.
3. _____ . _____
4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E DIAGNOSIS CODE	F $ CHARGES		G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	06	01	02	06	04	02	2	1	Z9812			1	580	00	4				
2																			
3																			
4																			
5																			
6																			

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 12345678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 580 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are a part thereof)

Carl Smith

SIGNED DATE 06 10 02

32. NAME AND ADDRESS OF FACULTY WHERE SERVICES WERE RENDERED (If other than home or office

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Hyperalimentation Supply
2081 West Street.
San Antonio, TX 77711

210-555-1234

PIN# GRP# 987654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA - 1500 (12-90)
TOTAL PARENTERAL NUTRITION/HYPERALIMENTATION FORM OWCP - 1500 FORM RRB - 1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

16

SECTION

17

Transportation of Remains of Deceased Clients

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17.2 Reimbursement 17-1
17.3 Benefits and Limitations 17-1
17.4 Claims Information 17-2

17.1 Enrollment

Providers who transport the remains of a deceased client must have a valid provider agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

17.2 Reimbursement

Transportation of remains is reimbursed according to a maximum allowable fee schedule. Providers should use the following procedure codes when submitting a claim for services:

Procedure Code	Description
100FH	First call
200FH	Embalming
300FH	Mileage, per mile
400FH	Container

17.3 Benefits and Limitations

CSHCN provides coverage for the costs of transporting the remains of a client who expires in an approved facility (including nonbilling facilities) while receiving services if the facility is not in the family's city of residence. Transportation costs of the parent or other responsible person accompanying the remains may also be paid.

CSHCN will consider the following services for reimbursement.

- **First Call Charge –** This includes the removal of the body, by the funeral home, from the facility in which the client expired.
- **Air Transportation –** Transportation costs by the funeral home to the airport, cost of an airtray provided by the funeral home, and cost of airline transportation for the body and accompanying parent or other responsible person may all be paid.

- **Land Transportation –** If the body is being transported over land, one-way mileage will be paid based on the State Mileage Guide. It is common for the body to be transported on a cot, however, CSHCN will pay for a container/coffin (not a casket) if one is used. It is legal in Texas for the family to transport the body themselves. If they elect to do this, CSHCN will reimburse the family or a third party on the family's behalf at the standard CSHCN mileage rate for a one-way trip.
- **Rail Transportation –** If the body is transported by rail, CSHCN may pay the cost of transportation by the funeral home to the station and the cost of a container provided by the funeral home. The cost of rail transportation for the body and accompanying parent or other responsible person may also be paid.
- **Bus Transportation –** It is not common practice for bodies to be transported by bus.
- **Embalming –** State law requires a body to be refrigerated between 34–40 degrees, or embalmed within 24 hours of death. Airlines and rail systems require embalming. However, depending on distance, a body can be transported over land without being embalmed.

17.4 Claims Information

Contact CSHCN at 800-568-2413 for assistance obtaining and completing claims for transportation of remains of deceased clients.

17.4.0.1 Transportation of the Remains of Deceased Clients Reimbursement Request Form

Children with Special Health Care Needs (CSHCN)
Transportation of the Remains of Deceased Clients Reimbursement Request Form

Niños con Necesidades Médicas Especiales (CSHCN)
Solicitud para el reembolso del gasto de transportación de un difunto

Dates Billed: ___/___/__ **to** ___/___/___
Periodo que se está cobrando: del ___/___/___ al ___/___/___

Client Case Number: _____
Núm. de caso del cliente: _____

Client Name: _____
Nombre del cliente: _____

Client DOB: ___/___/___
F.D.N. del cliente: ___/___/___

Please describe what you are requesting to be reimbursed for - include mode of transportation:
Por favor, describa lo que quiere se le reembolse (inclusive, el tipo de transportación):

_____
_____
_____

Estimated one way mileage (if driving): _____
Cantidad aproximada de millas por viaje de ida (si manejó): _____

City starting from: _____
Ciudad de partida: _____

City & State (not payable beyond the Texas border) ending at: _____
Ciudad a donde llegó: _____

Number of attached receipts: _____
Número de recibos adjuntos: _____

Total amount requested (if known): $_____
Cantidad total que solicita: $ _____

I certify that the information on this form is correct, that I have paid in advance for these costs or traveled as described above as a result of transporting the deceased client. I am requesting reimbursement for the transportation cost(s) that were incurred for the above mentioned deceased CSHCN eligible client, and I certify that I am financially unable to pay for these costs without CSHCN assistance.

Yo certifico que la información de este formulario es correcta, que he pagado por adelantado estos gastos o que he viajado como se describió anteriormente para trasladar al difunto cliente. Solicito reembolso por los gastos de transportación incurridos debido al cliente difunto mencionado anteriormente elegible para CSHCN y certifico que económicamente no puedo pagar estos gastos sin la ayuda de CSHCN.

Parent/Guardian Signature: _____
Firma del padre o tutor: _____

Date: _____
Fecha: _____

The following information is required for payment (please print):
La siguiente información se necesita para el pago (por favor, escriba en letra de molde):

Pay to: _____
Hágase pagadero a: _____

Relationship to client _____
Parentesco con el cliente: _____

Address: _____
Dirección: _____

City, State, Zip: _____
Ciudad, Estado, ZIP: _____

Phone number: _____
Número de teléfono: _____

Please paper clip a copy of all of the receipts for above request to the back of this form (do not staple).
Haga el favor de adjuntar (no grapar) detrás de este formulario una copia de todos los recibos para la solicitud mencionada.

Mail to: (Envíe a):
NHIC-CSHCN
PO Box 200855
Austin, TX 78720-0855

FOR NHIC USE ONLY *(SOLAMENTE PARA EL USO DE NHIC)*
MICR #:_____
Amt pd.: $_____
Initials: _____

SECTION

18

TexMedNet General Information

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18.1 CSHCN Billing Features

Texas Medicaid Network (TexMedNet) was developed and implemented to improve Medicaid and CSHCN billing.

TexMedNet is available to all CSHCN providers. Contact the TexMedNet Help Desk at 888-863-3638 or 512-514-4150 for more information.

This system pays claims faster, more accurately, and with less effort from providers' office staff. TexMedNet offers the following services:

- Electronic funds transfer (EFT)
- Electronic eligibility verification
- Electronic claims submission
- Electronic claims status inquiry
- Electronic *Remittance and Status Report* (*ER&S*)
- Electronic appeals submission
- Bulletin board system (BBS)

TexMedNet uses the following technology:

- ANSI X12, updated NSF and UB-92 formats for batch transactions
- EDIFACT for interactive transactions
- TDHconnect for a Windows-based solution that can be used in your personal computer
- Electronic data interchange (EDI) through bulletin board systems using standard asynchronous telecommunications

18.2 Accessing TexMedNet

Business organizations (for example, billing organizations, vendors and clearinghouses) communicate with TexMedNet using their computer systems. Electronic data interchange (EDI) standards, approved by the health care industry, are mapped to CSHCN requirements to facilitate open access. Industry standards for telecommunications are also used.

All TexMedNet electronic services may also be accessed by using TDHconnect. TDHconnect is a Windows-based software application available through NHIC. This software enables personal computers to access TexMedNet.

18.3 Getting Started

As a result of the 76th legislature, House Bill 2085 recommends that all Texas Medicaid service providers receive payment by Electronic Funds Transfer (EFT). All providers are strongly encouraged to participate in EFT. EFT does not require software and you can enroll today, see "Electronic Funds Transfer Agreement" on page 18-18. Instructions for ordering **EFT enrollment forms** are in "Ordering Forms" below. Complete the EFT form, include a deposit slip or canceled check, and mail the items to:

NHIC
ATTN: Provider Enrollment
12545 Riata Vista Circle
Austin TX 78727-6524
FAX: 512-514-4214

18.3.1 First Step

If you are a paper biller, determine whether you will be using a vendor or TDHconnect. Vendors generally give different levels of support depending on your needs and often supply a medical management system to further enhance office operations. They also address both commercial and government claims. A list of certified vendors who offer TexMedNet services can be found on the Bulletin Board System (BBS) under the General Library (Certvendor.txt).

TDHconnect, a Windows-based software, is also available for claims processing. Instructions for requesting the **TDHconnect Order Form** are in "Ordering Forms" below.

18.3.2 Second Step

If you use a vendor, they will guide you through implementation. If they have distributed software to you, you will generally need a TexMedNet User ID. Instructions on requesting a **TexMedNet User ID** are in "Ordering Forms" below.

If requesting TDHconnect, a Quick Reference Guide will be sent with the TDHconnect software to guide you through installation. An online manual is also built into TDHconnect and will instruct you on its use.

18.4 Ordering Forms

18.4.1 The Electronic Funds Transfer Form

Fax a request labeled "EFT Enrollment Form" and the following to 512-514-4214:

- Organization name
- Contact name, telephone number, and address
- Contact fax number

18.4.2 Electronic Remittance and Status Report Form, ECS Agreement

Fax a request labeled "ERS Enrollment Form" or "ECS Agreement Form" and the following information to 512-514-4228 or 512-514-4230:

- Organization name
- Contact name, telephone number, and address
- Fax number
- Primary TPI
- Number of billing TPIs

18.4.3 TDHconnect Order Form, TexMedNet User ID Form

1) Contact your vendor representative, or
2) Fax the following information to 512-514-4228 or 512-514-4230:
    - Name of requested form
    - Organization name
    - Contact name and telephone number
    - Fax number, or
3) Download through the TexMedNet BBS from the TexMedNet library. The BBS telephone number is 512-514-4895. The User ID is any month, January through October. The password is NHIC.

18.5 Vendor Implementation

The following are guidelines that the vendor may refer to when implementing TexMedNet:

18.5.1 Step 1

Establish which services you will offer.

18.5.2 Step 2

Download format specification documentation. This documentation contains all information you will need to begin testing for production except your IDs. Specification documentation is available through the TexMedNet Bulletin Board System in the DOCSPECS library. The TexMedNet BBS number is 512-514-4895. Use any month, January through October, as the User ID and NHIC as the password. Once you have begun testing you will receive your own User ID.

18.5.3 Step 3

Documentation specification questions can be sent to the TexMedNet e-mail address VENDCLAIM or contact your NHIC vendor representative. Your e-mail should contain the following:

- Organization name
- Contact name and telephone number
- Fax number
- Best time of day to contact you
- Type of service (for example, eligibility, appeals)
- Type of format
- Questions

The e-mail address will be accessed by NHIC specification experts at 10 a.m. each working day. A specifications expert will call the indicated contact person within 24 hours after receiving the e-mail. Telephone communication from you should take place through NHIC Provider Automation or your NHIC Representative. This enables specification experts to best utilize their time in answering your questions.

18.5.4 Step 4

Request an ECMS and TexMedNet ID by faxing the following information to 512-514-4228 or 512-514-4230. You will receive the IDs within two weeks.

- TexMedNet ID request
- Organization name
- Address
- City/State/ZIP
- Contact name and telephone number
- Fax number

- Tax ID
- Type of services you will be supporting (for example, Eligibility, Appeals)
- Type of format used for claims submission (for example, NSF, UB92, ANSI X12 837)
- Listing of billing TPIs that will use this service

Indicate if you will be distributing software for these TPIs or if your organization will process the transactions.

18.5.5 Step 5

TexMedNet features a self-test system. Vendors may self-test or ask for the assistance of NHIC. Vendors are encouraged to contact NHIC for testing assistance. The following steps should be followed for assisted testing:

- Limit test files size to 10 transactions
- Transmit the test file to the Production BBS using a test indicator within the transaction
- Within 24 hours after sending the file to the Production BBS, please send the information below to the appropriate TexMedNet e-mail address:

Note: Access the TexMedNet BBS by dialing 512-514-4895.

- Include the following in the text of the e-mail message:
    - Company name
    - Contact name
    - Contact telephone Number
    - ECMS ID
- After saving the e-mail message, select the “attach” capability to upload the test file to the e-mail

E-mail addresses for testing:

E-mail Addresses	
VENDCLAIM	Claims
VENDELIG	Eligibility
VENDAPPEL	Appeals

The test reviewer acknowledges your mail and contacts you. You should download and review your responses before this contact.

18.5.6 Step 6

Reminder: Telephone communication from you should take place through your NHIC Vendor Representative or TexMedNet e-mail. This will enable test reviewers to fully utilize their time in expediting your test.

Within 24 hours of submitting your first test, your name, and the service you are testing will be added to the list supplied to providers requesting vendor status. When you have completed testing, your status will be changed to Production. The testing process outlined above adds you to the Vendor Status Report distributed to providers.

TexMedNet Help Desk 888-863-3638 or 512-514-4150

18.6 Vendor Certification

NHIC offers vendors, billing services, and clearinghouses the opportunity to become a certified submitter of TexMedNet claims. Certified TexMedNet submitters will be highlighted on the list distributed to providers looking for TexMedNet services. The certification process also assures providers that their services meet all the standards expected by the Texas Department of Health and the National Heritage Insurance Company.

The benefit to you, the vendors with whom NHIC interfaces, is realized through increased visibility to our providers. By providers calling in about one of the following, their organization's name will be provided to CSHCN providers, with special notation that your services exceed the minimum requirements established with the TexMedNet system.

NHIC will automatically disseminate this list of vendors to **providers**:

- Requesting information about electronic billing
- Dissatisfied with their existing capabilities for electronic claim submission
- Requesting support for electronic data interchange (EDI) where the current vendor's qualification falls below the expectations established by the qualification criteria

18.7 Bulletin Board System (BBS)

The TexMedNet Bulletin Board System (BBS) furnishes electronic mail (e-mail) and library capabilities. The following are some examples of what you will find in the BBS library:

Library	Description
APPEALS	Library for uploading appeals
BANNERPG	CSHCN banner pages
DOCSPECS	Vendor specifications
FEESCHED	Medicaid reimbursement fees
GENERAL	General information
REFFILES	Library for reference files
TXMEDNET	Overview of TexMedNet

18.7.1 Accessing the BBS

For initial access to the TexMedNet BBS, follow the procedures listed below. When you begin implementing TexMedNet services, you are assigned your own user identification.

- Use a communications software package (TDHconnect comes with a communications software package).
- Dial the TexMedNet BBS at 512-514-4895. Type your User ID and press Enter. (Your initial User ID is any month, January through October.)
- Type your password at the prompt and press Enter. (Your initial password is NHIC.)
- The system will prompt you for the remaining selections.

18.8 Electronic Eligibility Verification

Electronic eligibility verification is a method of accessing CSHCN eligibility information using a personal computer. Eligibility information can be accessed by a business organization bridging directly into TexMedNet or by using the TDHconnect application, the free Windows-based software available from NHIC.

You can submit an eligibility verification inquiry either by client identification number, or by entering two of the following three items: name, date of birth, or social security number. City, county, state, or ZIP code are optional search fields available on each request to help further identify the CSHCN client, if needed. The response displays detailed information about the following client eligibility aspects, when applicable:

- CSHCN
- Medicaid
- Medicare
- Limited
- Authorization or prior authorization

- Other insurance
- Medicaid managed care
- Benefit limitations, furnishing last service dates on dental and screening services

18.8.1 Advantages to Electronic Eligibility Verification

- Inquiries can be submitted using your personal computer
- Inquiries for eligibility information are possible 24 hours a day, 7 days a week
- The TexMedNet system receives file updates from the Texas Department of Human Services (TDHS) each business day ensuring access to up-to-date information
- Span dates can be entered for a 31-day period for each request
- Interactive requests (single transactions) receive a response within 15 seconds
- Batch requests (multiple transactions) receive a response within 24 hours
- A report for users to print or download is generated for batch responses
- Users are able to download or print interactive responses

18.8.2 Access to Electronic Eligibility Verification

Eligibility verification is available to business organizations (e.g., billing organizations, vendors and clearinghouses) interfacing directly with TexMedNet or through TDHconnect.

Refer to the Getting Started section of the TexMedNet packet for implementation information. For all other information call the TexMedNet Help Desk at 888-863-3638 or 512-514-4150.

Electronic data interchange (EDI) standards approved by the health care industry, are used and mapped to CSHCN requirements to facilitate open access. Upon completion, Texas-specific formats are available for download from the TexMedNet BBS. Industry standards for telecommunications are also used. Electronic batch submission responses are deposited to the submitter's TexMedNet Production BBS mail box. The following formats are used for electronic eligibility:

Formats	
Interactive Inquiry and Response	EDIFACT
Batch Inquiry	ANSI ASC X12 270
Batch Response	ANSI ASC X12 271

18.9 Electronic Claims Submission

TexMedNet electronic claims submission is designed to pay CSHCN claims quicker and with less effort from provider office staff. It is a system structured to accept both interactive (single claim) and batch (multiple claims) claim submission. TexMedNet electronic claims submission can be accessed by a provider or business organization bridging directly into TexMedNet or by using TDHconnect, the free Windows-based software available from NHIC.

Claims are submitted to a front-end processor that contains approximately 250 edits. A warning message is returned if front-end edits detect an error for interactive claims. The submitter of a batch receives an electronic file deposited to their TexMedNet Production BBS mail box reporting accepted and rejected claims within a batch. Ten header and ten detail level errors can be returned per claim. Interactive submission has a front-end response within 15 seconds. Batched claims receive a front-end response within 24 hours.

18.9.1 Advantages of Electronic Claim Submission

Example: Two examples of front-end edits are verifying patient eligibility and confirming that other insurance does not exist.

- Approximately 250 front-end edits enable error identification, correction and resubmission of problem claims in a timely manner thereby potentially increasing cash flow by increasing the number of first-pass clean claims forwarded to the final processing cycle
- Claims can be submitted 24 hours a day, 7 days a week
- Claims can be submitted interactively or in batches
- Claims receive an ICN during front-end processing, helping to meet filing deadlines
- The number of attachments required is reduced, enabling more claims to be processed electronically
- A comprehensive processing approach has been incorporated into the system, allowing a single point of entry into the system for all Title XIX and CSHCN claims. Medicare and BCBS claims can also be submitted through TexMedNet.

18.9.2 Access to Electronic Claim Submission

Refer to: A sample “TexMedNet Response Report Prototype – Accepted Claims” on page 18-12 and “TexMedNet Response Report Prototype – Rejected Claims” on page 18-13.

TexMedNet electronic CSHCN claim submission is available to business organizations (for example, billing organizations, vendors and clearinghouses) interfacing directly with TexMedNet. Contact your business organizations to determine their availability.

Refer to the Getting Started section of the TexMedNet packet for implementation information. For all other information contact the TexMedNet Help Desk at 888-863-3638 or 512-514-4150.

Electronic data interchange (EDI) standards, approved by the health care industry, are used and mapped to CSHCN requirements to facilitate open access. Industry standards for telecommunications are also used. Electronic batch submission responses are deposited to the submitter’s TexMedNet Production BBS mail box. It is the submitter’s responsibility to download the response file after each claim submission and to reformat the file in a report readable format. NHIC Batch Number is required on every page of the response report. The following formats are used for TexMedNet electronic claim submission:

Formats			
Interactive claim/ response		Internal	
Batch submission	ANSI ASC X12 837	NSF	UB92
Batch claim status notification	ANSI ASC X12 277	Internal	Internal
Batch functional acknowledgment	ANSI ASC X12 997		

18.10 Online Claim Status Inquiry

Online Claim Status Inquiry is a method of accessing CSHCN claim history using a personal computer. You can access Claim Status Inquiry by using the TDHconnect application, a free Windows-based software available from NHIC.

You will have access to paid, suspended, and denied claim information, for a 24-month period, on CSHCN claims submitted under billing TPIs assigned to your organization. You can make inquiries at the provider, client, or claim level.

18.10.1 Advantages to Online Claim Status Inquiry

- You can use the time you would have spent making inquiries over the telephone to more effectively serve your clients
- You can access CSHCN claims any time
- You can cross-reference explanation of benefits (EOB) and explanation of pending status (EOPS) files for more timely research
- You can download or print information

18.10.2 Access to Online Claim Status Inquiry

TDHconnect acts as the security gate for claim status inquiry, so all access will take place through TDHconnect.

Refer to the Getting Started section of the TexMedNet packet for implementation information. For all other information contact the TexMedNet Help Desk at 888-863-3638 or 512-514-4150.

18.11 Online Appeal Submission

Online appeal submission is a method of submitting CSHCN appeals using the personal computer (PC). An appeal is a request for reconsideration of a previously dispositioned claim. The online appeals feature can be accessed by a business organization bridging directly into TexMedNet or by using TDHconnect, the free Windows-based software available from NHIC.

18.11.1 Advantages to Online Appeal Submission

Using online appeal submission provides the following advantages to the users:

- Increased accuracy of appeals filed to potentially improve cash flow
- Print and download capabilities help maintain audit trails
- Appeal submission windows can be automatically populated by electronic remittance and status report information, thereby reducing data entry time

18.11.2 Access to Online Appeal Submission

TexMedNet online appeal submission is available to business organizations (for example, billing organizations, vendors and clearinghouses) interfacing directly with TexMedNet or through TDHconnect.

Refer to the Getting Started section of the TexMedNet packet for implementation information. For any other information contact the TexMedNet Help Desk at 888-863-3638 or 512-514-4150.

Because no national standards exist, a proprietary format will be used for submitting TexMedNet appeals. Texas specific formats are available for download from the TexMedNet BBS.

18.12 Electronic Remittance and Status Report

The TexMedNet Electronic Remittance and Status (ER and S) Report is deposited to the receiver's TexMedNet Production BBS mail box each Monday by 6 a.m. The report can be accessed by a business organization bridging directly into TexMedNet or by using TDHconnect, the free Windows-based software available from NHIC.

Explanation of benefits (EOB) and explanation of pending status (EOPS) reference files are available through the TexMedNet Bulletin Board System.

18.12.1 Advantages of Electronic Remittance and Status Reports

The following productivity improvements are gained by using TexMedNet electronic remittance and status reports:

- Increase accuracy of input
- Decrease employee time spent on input
- Increase paper storage capacity
- Improve research capabilities
- Facilitate timely reconciliation
- Easily create reports

18.12.2 Access to Electronic Remittance and Status Reports

TexMedNet electronic remittance and status reports are available to business organizations (for example, billing organizations, vendors, and clearinghouses) interfacing directly with TexMedNet and through TDHconnect.

Refer to the Getting Started section of the TexMedNet packet for implementation information. For all other information contact the TexMedNet Help Desk at 888-863-3638 or 512-514-4150 or fax a request to 512-514-4230 or 512-514-4228.

Electronic data interchange (EDI) standards approved by the health care industry, are used and mapped to CSHCN requirements to facilitate open access. Upon completion, Texas-specific formats are available for download from the TexMedNet BBS. Industry standards for telecommunications are also used. The electronic remittance and status report will be deposited to the receiver's TexMedNet Production BBS mail box.

Testing takes place using a production ER and S. This is initiated by having a provider enroll for the ER and S feature. Formats used for TexMedNet electronic remittance and status reports are:

Formats	
Claim payment advice	ANSI ASC X12 835
Claim status notification	ANSI ASC X12 277

18.12.3 Enrollment Procedures

The Electronic Remittance and Status Report Form and ECS Agreement can be requested by faxing the following to 512-514-4228 or 512-514-4230:

- ERS Enrollment Form
- Organization name
- Contact name
- Fax number
- Contact telephone number

To enroll for the ER and S feature, providers must submit a completed enrollment form to NHIC. NHIC processes the form within five working days after receipt.

18.13 Electronic Funds Transfer

Electronic funds transfer (EFT) is a method for directly depositing funds into a designated bank account. When you enroll, NHIC deposits funds from your approved claims directly into your designated bank account. Transactions transmitted through EFT contain descriptive information to help reconcile your bank account.

18.13.1 Advantages of EFT

- Stop payments are no longer necessary because no paper is involved in the transaction process.
- Payment theft is less likely to occur because the process is handled electronically rather than by paper.
- Deposited funds are available for withdrawal the Wednesday morning following the completed financial cycle. When a bank holiday occurs during the week, deposits are available on Thursday.
- Upon deposit, your bank considers the transaction immediately collected. No float is attached to EFT deposits for CSHCN funds.
- NHIC includes provider and remittance and status numbers with each transaction submitted. If your bank's processing software captures and displays the information, both numbers would appear on your banking statement.

18.13.2 Enrollment Procedures

The Electronic Funds Transfer Form can be requested by faxing the following information to 512-514-4214:

- EFT Enrollment Form
- Organization name
- Contact name
- Address
- Contact telephone number
- Contact fax number

To enroll for the EFT feature, providers must submit a completed enrollment form to NHIC. A voided check or copy of a deposit slip must be attached to the enrollment form. One form should be filled out for each billing TPI, including an original signature of the provider.

Within five working days after receipt, NHIC will process the form. NHIC then issues a prenotification transaction during the next cycle directly to your bank account. This transaction serves as a check-point to verify EFT is working correctly.

If your bank returns the prenotification without errors, you will begin receiving EFT transactions with the third cycle following the enrollment form processing. Until you begin receiving EFT transactions, you will continue to receive paper checks. If you change bank accounts, a new enrollment form must be submitted to Provider Enrollment. The prenotification process is repeated and, once completed, the EFT transaction is deposited to your new bank account.

18.13.3 Forms

18.13.3.1 TexMedNet Response Report Prototype – Accepted Claims

TexMedNet Response Report Prototype
Accepted Claims

File: 0928376.z06 Batch ID: A4309678
Batch Number: 39 Page: 0165

Provider: 123456789

PCN	From Date Of Service	Billed Amt	Recipient#	ICN
900005430	01/01/2000			268876576543543
900004350	12/12/1999			284758697047836
900006540	01/05/2000			426353454758667

File Totals

Total Claims	59	Total Billed Amount	$234,857.43
Total Rejected Claims	3	Total Billed Accepted	$204,336.99
Total Accepted Claims	56	Total Billed Rejected	$ 30,520.44

18.13.3.2 TexMedNet Response Report Prototype – Rejected Claims

TexMedNet Response Report Prototype
Rejected Claims

File: 0928376.z06 Batch ID: A4309678
Batch Number: 39 Page: 0165

Provider: 123456789

PCN	From Date Of Service	Billed Amt	Client#
Detail# Code	Description		
900005430	01/01/00		876548279
04 N0180	Combination of Procedure Code and Modifier 1 or 2 TPI or claim form is invalid.		
07 N0185	The client's Sex is invalid for this procedure.		
900004350	12/12/00		951244867
03 N0021	Service requires a Referring TPI for processing		
07 N0034	Procedure is not payable on non-emergency claims.		
900006540	01/05/00		15452160
N0004	Client information (name, date of birth or sex) does not match the PCN on NHIC Eligibility file.		
02 N0185	The client's Sex is invalid for this procedure.		

File Totals

Total Claims	59	Total Billed Amount	$234,857.43
Total Rejected Claims	3	Total Billed Accepted	$204,336.99
Total Accepted Claims	56	Total Billed Rejected	$ 30,520.44

18.13.3.3 Electronic Billing Research Request Fax Form

For the TexMedNet System only:

To: NHIC Electronic Data Interchange (EDI)
Fax# 512-514-4228 or 512-514-4230 Attention: _____

Your name: _____ Phone number: _____ Fax number:_____
CSHCN TPI _____
Name of billing service/clearinghouse _____

The following information is required for research to be completed by the NHIC EDI department. If you are unsure of the answers please call your billing service, clearinghouse, vendor or the TexMedNet Help Desk at 512-514-4150 or 888-863-3638.

Do you or your billing service/clearinghouse submit directly to NHIC _____ or to Blue Cross Blue Shield _____?

If transmission was direct to NHIC with TDHconnect, Clearinghouse, Billing Service or Vendor:
Are you questioning the entire batch _____ or specific claims ____?

Entire Batch and Specific Claims:
TexMedNet Production Id: _____
Transmission number(s) _____ Date of transmission _____
(Please make sure you attach the Transmittal Reports)
(If you are using a billing service, vendor or clearinghouse please obtain the transmission number from them)
TPI _____ Number of claims in batch _____ Billed Amount _____
(List additional batches on a separate sheet)
For Specific Claims only:
Attach a separate sheet with the Client's #, Date of Service, Billed Amount, and TPI.

If transmission was to Blue Cross Blue Shield:
Are you questioning the entire batch: ___ or specific claims ___?

Entire Batch and Specific Claims:
NHIC Assigned Batch ID(s) _____ Date of transmission _____
TPI _____ Number of claims in batch ____ Billed Amount _____
(Please make sure you attach the Transmittal Reports)
Specific Claims Only:
Attach a separate sheet with the Client's #, Date of Service, Billed Amount, and TPI.

Comments: _____
_____
_____
_____
_____
_____
_____

18.13.3.4 National Heritage Insurance Company Electronic Remittance and Status (ER&S) Request Agreement

NOTE: If the **PROVIDER** is dialing the BBS to download the ER&S, fill out BLOCK 1 and BLOCK 3. In BLOCK 3, check Option 1. If a **BUSINESS ORGANIZATION OTHER THAN THE PROVIDER** is dialing the BBS to download the ER&S, fill out BLOCK 1, BLOCK 2 and BLOCK 3. In BLOCK 3, check Option 2.

BLOCK 1		
Provider Name	Provider Phone No.	Provider Tax ID No.
Provider Contact Name (If other than provider)	Provider Contact Phone Number	
Provider's Physical Address	CSHCN Nine-Character Billing TPI	

Fill in Block 2 ONLY if the information is different than Block 1:

BLOCK 2	
Name of Business Organization to Receive ER&S	Business Organization Phone Number
Business Organization Contact Name	Business Organization Contact Phone Number
Business Organization Address	Business Organization Tax ID Number

Note: Indicate location to receive Remittance and Status (R&S) information (check box 1 or 2):
Indicate format preference for receiving Remittance and Status (R&S) information (check box 3 or 4):

BLOCK 3		For NHIC use only
_____	1. Electronic R&S sent to provider's electronic mailbox with no change to the paper R&S destination.	M N Q **1** _ _
_____	2. Electronic R&S sent to business organizations' (identified in block 2 of this form) electronic mailbox with no change to the paper R&S destination.	M N Q **1** _ **1**
_____	3. Electronic R&S to be received using NHIC software (TDHconnect), **OR**	TXMEDNET
_____	4. Electronic R&S to be received using anything other than NHIC software (TDHconnect).	TXSMPROV

Please include the TexMedNet Production ID below:

_____ (9 digits) This TexMedNet Production ID is the electronic mailbox ID to be used in downloading ER&S files.

I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

I (we) understand that paper-formatted R&S information will continue to be sent to my (our) accounting address as maintained at NHIC until I (we) submit an Electronic R&S Certification Request form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature _____ Date _____

Title _____ Internet ID (if applicable) _____

Please return this form to:

National Heritage Insurance Company
Electronic Data Interchange Department
12545 Riata Vista Circle, Second Floor
Austin TX 78727-6524
Tel: 888-863-3638
Fax: 512-514-4230 or 512-514-4228

18.13.3.5 National Heritage Insurance Company Electronic Remittance and Status (ER&S) Production Verification or Change Request Agreement

NOTE: If the **PROVIDER** is dialing the BBS to download the ER&S, fill out BLOCK 1 and BLOCK 3. In BLOCK 3, check Option 1. If a **BUSINESS ORGANIZATION OTHER THAN THE PROVIDER** is dialing the BBS to download the ER&S, fill out BLOCK 1, BLOCK 2, and BLOCK 3. In BLOCK 3, check Option 2 or Option 4.

Please change the TexMedNet Production ID FROM: _____ TO: _____ (9 digits)

BLOCK 1		
Provider Name	Provider Phone No.	Provider Tax ID No.
Provider Contact Name (If other than provider)	Provider Contact Phone Number	
Provider's Physical Address	CSHCN Nine-Character Billing TPI	

Fill in Block 2 ONLY if different than Block 1:

BLOCK 2	
Name of Business Organization to Receive ER&S	Business Organization Phone Number
Business Organization Contact Name	Business Organization Contact Phone Number
Business Organization Address	Business Organization Tax ID Number

Indicate format preference for receiving Remittance and Status (R&S) information (check one space only):

BLOCK 3		
_____	1. Paper R&S.	For NHIC use only
_____	2. Electronic R&S sent to provider's electronic mailbox, no paper R&S sent.	M N Q **1** **1** _
_____	3. Electronic R&S sent to business organizations' (identified in block 2 of this form) electronic mailbox, no paper R&S sent.	M N Q 1 1 1
_____	4. Electronic R&S sent to provider's electronic mailbox with no change to the paper R&S destination.	M N Q **1** _ _
_____	5. Electronic R&S sent to business organization's(identified in block 2 of this form) electronic mailbox with no change to the paper R&S destination.	M N Q **1** _ **1**

This TexMedNet Production ID is the electronic mailbox ID to be used in downloading ER&S files.

I (we) request to receive R&S information in the format indicated above. If I (we) want to receive only Electronic R&S information, I (we) accept responsibility for interpretation of data. I (we) ensure our system has been sufficiently tested to ensure reliable interpretation of Electronic R&S information. I (we) authorize R&S information be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with my (our) receipt of Electronic R&S information.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature _____ Date _____

Title _____ Internet ID (if applicable) _____

Please return this form to:

National Heritage Insurance Company
Provider Automation Department
12545 Riata Vista Circle, Second Floor
Austin TX 78727-6524

Input By _____ Input Date_____

ECMS Mailbox ID_____

18.13.3.6 TDHconnect Order Form

TDHconnect is the software owned by the Texas Department of Health for interfacing into the TexMedNet system. You will be able to use Eligibility, Claim Submission, Claim Status Inquiry, Remittance and Status Report, Appeals, TexMedNet Email and access the TexMedNet BBS using this software. The system requirements for TDHconnect are listed on the bottom of this page. You should acquire the hardware and software before ordering TDHconnect. This form should be faxed to 512-514-4228. You should receive your software and User ID's within three weeks of our receipt of the form. A Quick Reference Guide will be enclosed with your software supplying basic TDHconnect instructions. TDHconnect has an internal manual accessed through the Help function within the software. The Help file contains all information necessary for the operation of TDHconnect. Many providers have already implemented the software using the Help file. However, if you find that you need further assistance, workshop style classes will be available in the coming months. Instructions for registration are on the reverse side of this form.

Fill out one TDHconnect Order Form for your location. If you have multiple TPIs, list those you will use on TDHconnect. Please send a separate attachment listing all billing TPIs if there are more than seven.

Organization Name			
CSHCN TPI(s)			
Contact Name			
Contact Phone			
Address			
City/ST/Zip			

TDHconnect Software and Hardware Requirements

The following are the **minimum** and **recommended** PC requirements:

Minimum TDHconnect 2.0 Hardware	Recommended TDHconnect 2.0 Hardware
PC with a Pentium class processor	PC with a Pentium 200 MHz or higher processor
Modem that supports 9600 bps	Modem that supports 28800 bps
CD-ROM drive	CD-ROM drive
100 MB hard disk space for installation with 50 MB hard disk space per user, per year for database	100 MB hard disk space for installation with 50 MB hard disk space per user, per year for database
800x600 VGA (monitor resolution), 256 colors	800x600 VGA (monitor resolution), 256 colors
Minimum TDHconnect 2.0 Operating System	**Recommended TDHconnect 2.0 Operating System**
Important: The following minimum and recommended hardware and software requirements apply only to the needs of TDHconnect version 2.0. **NOTE**: To run other software on your desktop with TDHconnect version 2.0, you should consider the additional RAM requirements of the other software and set up your PC accordingly.	
Microsoft Windows 95 operating system and 16 MB of RAM	Microsoft Windows 95 operating system and 48 MB of RAM
Microsoft Windows 98 operating system and 24 MB of RAM	Microsoft Windows 98 operating system and 64 MB of RAM
Microsoft Windows ME operating system and 32 MB of RAM	Microsoft Windows ME operating system and 64 MB of RAM
Minimum TDHconnect 2.0 Operating System	**Recommended TDHconnect 2.0 Operating System**
Microsoft Windows NT 4.0 with Service Pack 5 operating system and 24 MB of RAM	Microsoft Windows NT 4.0 with Service Pack 5 operating system and 64 MB of RAM
Microsoft Windows 2000 Professional operating system and 64 MB of RAM	Microsoft Windows 2000 Professional operating system and 128 MB of RAM
Important: Three times the current database size of free disk space will be required if you convert an old database to TDHconnect 2.0.	
Microsoft Internet Explorer 4.0.1 with Service Pack 2. (Internet Explorer 5.0 is included on the TDHconnect 2.0 installation CD-ROM.)	Microsoft Internet Explorer 5.0 (included on the TDHconnect 2.0 installation CD-ROM)
Adobe Acrobat Reader 4.0	Adobe Acrobat Reader 4.05 (installed with TDHconnect 2.0)

18.13.3.7 Electronic Funds Transfer Agreement

National Heritage Insurance Company
Electronic Funds Transfer
Authorization Agreement

NOTE: Complete all sections below and attach a voided check or a photocopy of your deposit slip. Enter one TPI per form.

Type Of Authorization _____**NEW** _____**CHANGE**

Provider Name	**CSHCN 9-Character Billing TPI**
Provider Accounting Address	**Provider Phone No.**

Bank Name	**ABA / Transit No.**
Bank Phone No.	**Account No.**
Bank Address	**Type Account (check one)**
	Checking _____ Saving _____

I (we) hereby authorize National Heritage Insurance Company to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am (are) responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Department of Health (TDH) or its health insuring contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature _____ Date _____

Title _____ Internet ID (if applicable) _____

_____ _____

Contact Name _____ Contact Phone No. _____

Print Provider Name_____

Please return this form to:

NHIC
ATTN: Provider Enrollment Department
PO Box 200795
Austin TX 78720-0795

Input By _____ **Date**_____

18.13.3.8 Enrolling in the Electronic Funds Transfer Program

NHIC
ATTN: Provider Enrollment Department
PO Box 200795
Austin TX 78720-0795

Electronic Funds Transfer (EFT) is a payment method that deposits funds for claims approved for payment directly into a provider's bank account. These funds can be credited to either checking or savings accounts, provided the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account**.

The following items are specific to EFT:

- EFT funds are available to providers when banks open on Wednesday mornings (Thursday, in the event of a bank holiday).
- Applications will be processed within five working days of receipt.
- Prenotification to the bank takes place on the cycle following the application processing.
- Ten days after prenotification, future deposits are received electronically.
- The *Remittance and Status (R&S) Report* furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated *R &S* reports are cross-referenced by both TPI and *R&S* number.
- The availability of *R&S* reports is unaffected by EFT, and they continue to arrive in the same manner and time frame as currently received.

NHIC provides the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. The effective date for EFT under the CSHCN Program is Wednesday (or Thursday) of each week.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit, and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customers' needs.
>
> In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date."

To enroll in the EFT Program, the provider should complete the Electronic Funds Transfer Authorization Agreement. **A voided check or a photocopy of your deposit slip must be returned with the agreement to the NHIC address indicated on the form.**

AIS User's Guide

A.1 Hours of Operation A-1
A.2 NHIC-CSHCN AIS Instructions A-1

Reminder: The provider's AIS code is printed on page 1 of their weekly Remittance and Status (*R and S*) Report.

Dialing 800-568-2413 or 512-514-3000 gives you access to the CSHCN Automated Inquiry System (AIS) and NHIC-CSHCN Customer Service.

This telephone number offers the following information and services:

- Client eligibility
- Claims status
- CSHCN check status (for claims paid by NHIC)
- Customer service connection

A.1 Hours of Operation

Claim status, client eligibility, and check amount information is available from the CSHCN-AIS line at 800-568-2413 or 512-514-3000.

- Eligibility information is available 24 hours a day, seven days a week.
- All other information is available 6 a.m. to 6 p.m. CST, Monday through Friday.

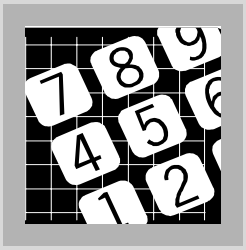
A.2 NHIC-CSHCN AIS Instructions

CSHCN AIS prompts you to enter your 9-character CSHCN Texas Provider Identifier (TPI) number. Use the following instructions to obtain information:

If your CSHCN TPI is 15000999, enter *15000999, followed by the pound (#) button.

For claim status:

- Press 1 and the (#) sign.
- Enter the CSHCN client number.
- Enter the earliest date of service or admission date on the claim as MMDDYY.
- Enter the exact billed amount on the claim, without decimal.
- Press 2 and the (#) sign on paid or denied claims to hear EOB messages.



For client eligibility and add date:

- Press 2 and the (#) sign.
- Enter the CSHCN client number or the Social Security No. and Date of Birth. Enter date of birth as MMDDCCYY.
- Enter date of service as MMDDYY.

Note: CSHCN AIS eligibility information does not include diagnosis information. Check the eligibility card for the client's eligible diagnoses.

For check amount:

- Press 3 and the (#) sign.

The AIS telephone number is a toll-free call. Dial 800-568-2413 or 512-514-3000.

Refer to the title page of your *R and S* report for the precoded CSHCN AIS TPI.

NAID

B.1 NHIC Acronyms and Initials Dictionary

AB	Aid to the Blind
ABC	Any Baby Can (non-profit organization)
ABD	Aged, Blind, and Disabled
ADA	Americans with Disabilities Act
A/EEG	Ambulatory Electroencephalogram
AFDC	Aid to Families with Dependent Children
AFDC-UP	AFDC Unemployed Parent Program
AFP	Abdominal Flat Plates
AG	Office of the State Attorney General
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
ALL	Acute Lymphoblastic Leukemia
ALS	Advanced Life Support
AMA	American Medical Association
AML	Acute Myelogenous Leukemia
ANB	Aid to the Needy Blind
ANLL	Acute Non-Lymphoblastic Leukemia
APN	Advanced Practice Nurse
A/R	Accounts Receivable
ARC	AIDS Related Complex
ASC	Ambulatory Surgical Center
ASHA	American Speech and Hearing Association
ASR	Ancillary Services Review
AZT	Azidothymidine - formerly AZT now Zidovudine (Retrovir)
BBS	Bulletin Board System
BCBS	Blue Cross Blue Shield
BENE	Beneficiary, i.e., recipient, client
BLS	Basic Life Support
CAN	Community Action Network
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARE	Client Assessment Review and Evaluation
CARTS	Case Action Request Tracking System

CBC	Complete Blood Count
CCAD	Community Care for the Aged and Disabled
CCH	Commerce Clearinghouse Guide
CCN	Cash Control Number
CCP	Comprehensive Care Program
CCPD	Continuous Cycling Peritoneal Dialysis
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Comprehensive Health Centers
CIHCP	County Indigent Health Care Program
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMI	Case Mix Index
CML	Civil Monetary Law or Chronic Myelogenous Leukemia
CMPL	Civil Monetary Penalty Law
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse-Midwife
COB	Close of Business or Coordination of Benefits
COINS	Coinsurance
COM	Computer-Output Microfilm
COMPAS	(Texas) Computerized Medicaid Claims Processing Assessment System
COPPER	Computer Post-Pay Evaluation Reporting System
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAS	Claims Processing Assessment System
CPI	Consumer Price Index
CPR	Customary, Prevailing, and Reasonable Method
CPS	Child Protective Services
CPT- 4	Current Procedural Terminology (in Physicians' CPT), 4th Edition
CPVT	Claims Processing Validation Team
CRCP	Certified Respiratory Care Practitioner
CRD	Chronic Renal Disease
CRNA	Certified Registered Nurse Anesthetist
CRT	Cathode Ray Tube
CST	Central Standard Time
CSHCN	Children with Special Health Care Needs
CT	Claim Type or Computerized Axial Tomography Scan (also 'Cat Scan")
CY	Calendar Year
DAHS	Day Activity and Health Services
db	Decibel
DBA	Doing Business As (name)
DC	Doctor of Chiropractic Medicine
DDM	Denver Development Materials
DDS or DMD	Doctor of Dentistry
DEA	Drug Enforcement Agency
DEFRA	Deficit Reduction Act of 1984
DEO	Data Entry Online
DHHS	Department of Health and Human Services (cf. HHS)
DHS	Department of Human Services
DISPRO	Disproportionate Share Hospital
DME	Durable Medical Equipment
DO	Doctor of Osteopathy
DOB	Date of Birth
DOS	Date of Service
DPM	Podiatrist/Doctor of Podiatric Medicine
DRG	Diagnosis Related Group
DTaP	Diphtheria, Tetanus, Acellular Pertussis
DT	Diphtheria, Tetanus (child)
DTP/HIB	Diphtheria, Tetanus, Pertussis/Haemophilus influenza type B
DTP	Diphtheria, Tetanus, Pertussis
DUR	Drug Use Review (Program)
D/W	Distilled Water
ECA	Emergency Care Attendant
ECF	Extended Care Facility
ECI	Early Childhood Intervention (Program)
ECS	Electronic Claims Submission
ECMS	Electronic Commerce Management System
EDC	Estimated Date of Confinement
EDI	Electronic Data Interchange
EDS	Electronic Data Systems Corporation
EFT	Electronic Funds Transfer
eIPV	Enhanced Inactivated Polio Vaccine
ELAs	Eligible Legalized Aliens
E/M	Evaluation and Management (Services)
EOB	Explanation of Benefits
EOM	End Of Month
EOMB	Explanation of Medicare Benefits
EOPS	Explanation of Pending Status
EP	Erythrocyte Protoporphyrin
EPO	Erythropoietin Alfa
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment, see also Texas Health Steps (THSteps)
ER&S	Electronic Remittance and Status
ESRD	End-stage Renal Disease
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FHS	Family Health Services
FHSP	Family Health Services Program
FL	Form Locators
FP	Family Planning, Family Practitioner or Family Physician

FPIL	Federal Poverty Income Limit
FQHC	Federally Qualified Health Center
FSY	Fee Screen Year
FY	Fiscal Year
GB&PO	Governor's Budget and Planning Office
GIS	Geographic Information System
HA	Hearing Aids
HAASC	Hospital-Affiliated Ambulatory Surgical Center
HASC	Hospital Ambulatory Surgical Center
HB	House Bill
HBP	Hospital-Based Physician
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HCS	Home and Community-Based Services
HEPT B	Hepatitis B
HHA	Home Health Aide or Home Health Agency
HHS	(Department of) Health and Human Services
HibCV	Haemophilus influenzae type b conjugate vaccine
HIC	Health Insurance Claim (number)
HIO	Health Insuring Organization
HIV	Human Immunodeficiency Virus
HLD	Handicapping Labio-Lingual Deviation
HMO	Health Maintenance Organization
HUMR	Hospital Utilization Master Reporting (System)
ICD-9-CM	International Classification of Diseases Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility (see also SNF and ECF)
ICFMR	Intermediate Care Facility for the Mentally Retarded
ICN	Internal Control Number (in "15-digit CSHCN ICN")
IEP	Individual Education Plan
IH	Inpatient Hospital (Claim)
IHC	Indigent Health Care (Unit)
IHFSP	In-Home and Family Support Program
IOL	Intraocular Lens
IP	Inpatient Hospital
IPA	Individual Practice Association
IPC	Information Processing Center
IPD	Intermittent Peritoneal Dialysis
IPV	Inactivated Polio Vaccine
IUD	Intrauterine Device
JOBS	Job Opportunities and Basic Skills (Program)
LAR	Legislative Appropriation Request
LBB	Legislative Budget Board
LCL	Lowest Charge Level
LMSW	Licensed Master Social Worker
LOCM	Low Osmolar Contrast Material
LOS	Length of Stay
LTC	Long Term Care
LVN/LPN	Licensed Vocational or Licensed Practical Nurse
MAO	Medical Assistance Only
MAPPER	Maintaining and Preparing/Producing Executive Reports
MARS	Management and Administrative Reporting Subsystem
MCAC	Medical Care Advisory Committee
MCAIS	Managed Care Automated Inquiry System
MCL	Most Comfortable Levels
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MD	Doctor of Medicine
MDC	Major Diagnostic Category
MEDICAID	Texas Medical Assistance Program
MEI	Medicare Economic Index
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MHMR	Mental Health and Mental Retardation
MHR	Mental Health Rehabilitative (Provider)
MIHIA	Maternal and Infant Health Improvement Act
MIS	Management Information System
MLOS	Mean Length of Stay
MMIS	Medicaid Management Information System
MMR	Measles, Mumps, Rubella
MMWR	Morbidity and Mortality Weekly Report
MNC	Medically Needy Clearinghouse
MNIL	Medically Needy Income Limit
MNP	Medically Needy Program
MQC II	Medicaid Quality Control
MQMB	Medicaid Qualified Medicare Beneficiary
MR	Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRP	Medical Recipient Profile (in "MRP File)
MRUS	Medical Resource Utilization System
MSAFP	Maternal Serum Alfa-fetoprotein
MSAM	Multi-Keyed Sequential Access Method
MSC	Maternity Service Clinics
MTP	Medical Transportation Program
NAIS	NHIC Automated Inquiry System
NCQA	National Committee for Quality Assurance
NEAT	NHIC Edit/Audit Tracking
NEC	Not Elsewhere Classified
NHIC	National Heritage Insurance Company
NOC	Not Otherwise Classified
NR	Non-Reactive
N/S	Normal Saline

NSF	National Standard Format
NTAG	National Technical Advisory Group
NUBC	National Uniform Billing Committee
OAA	Old Age Assistance (Program)
OASDI	Old Age, Survivors, and Disability Insurance
OB	Obstetrics
OBRA	Omnibus Budget Reconciliation Act
OH	Outpatient Hospital (Claim)
OI	Other Insurance
OIG	Office of the Inspector General
OMT	Osteopathic Manipulation Treatment
OO	Operative Outpatient
OPO	Organ Procurement Organization
OPV	Oral Polio Vaccine
OSHA	Occupational Safety and Health Adm.
OTC	Over-The-Counter (Drugs)
OTIS	Online Terminal Information System
PA	Physician's Authorization OR Prior Authorization, depending on the audience; OR, also, Public Assistance OR, Physician Assistant
PACT	Program for Amplification for Children of Texas (Hearing Aids/Services)
PAN	Prior Authorization Number
PARE	Profiling Assistance for Recipient Evaluation
PASARR	Preadmission (MH/MR) Screening and Annual Resident Review
PBQuiet	Speech Discrimination Ability
PCCM	Primary Care Case Management (Program)
PCN	Program Case Number
PCP	Personal or Primary Care Physician, Pneumocystis Carinii Pneumonia
PDI	Payment Division Increments or Indicators
PDQ	Denver Pre-Screening Developmental Questionnaire (cf. TPSI, DDST, and DDST-R)
PE	Presumptive Eligibility
PHC	Primary Home Care
PHP	Prepaid Health Plans
PHS	Purchased Health Services (Section)
PIP	Personal Injury Protection
PKU	Phenylketonuria (part of neonatal screen)
PL	Public Law
PMPM	Per Member Per Month [Capitation (or premium) payments]
POS	Place of Service
PPAC	Physician Payment Advisory Committee
PPO	Preferred Provider Organization
PPRA	Postpayment Review and Analysis
PPRM	Profile/Pricing Review Meeting
PPS	Prospective Payment System
PRO	Peer Review Organization
PT	Patient Transfer Modifier or Proficiency Test or Physical Therapy
PTD	Permanent and Totally Disabled (Program)
PWE	Primary Wage Earner
PWI	Pregnant Women and Infants Program
QA	Quality Assurance
QAP	Quality Assurance Programs
QARI	Quality Assurance Reform Initiative
QA/UR	Quality Assurance/Utilization Review
QC	Quality Control
QMB	Qualified Medicare Beneficiary
R&S	Remittance and Status report
RA	Remittance Advice
RBRVS	Resource-Based Relative Value Scale
RCC	Ratio of Cost to Charges
RCM	Recipient Control Master (in "RCM File")
RCP	Respiratory Care Practitioner
RECON	Reconciliation or Reconsideration
RIMS	Referral Identification Monitoring System
RN	Registered Nurse
ROUTS	Referred Out System
RPR	Rapid Plasma Reagin
RPT	Registered Physical Therapist
RSDI	Retirement Survivors Disability Insurance
RSR	Risk Stabilization Reserve
RVS	Relative Value Study
RVUs	Relative Value Units
RW	Relative Weight
SAS	Statistical Analysis System
SAT	Speech Awareness Thresholds
SAVE	Systematic Alien Verification for Entitlements (Program)
SAVERR	System for Application, Verification, Eligibility, Reports, and Referrals
SB	Senate Bill
SCC	System Control Codes (in "SCC File")
SDA	Standard Dollar Amounts
SDX	State Data Exchange
SED	Systems Engineer Development
SFY	State Fiscal Year (September 1 - August 31)
SHARS	School Health and Related Services
SID	Surface Identification
SLIAG	State Legalization Impact Assistance Grant
SMIB	Supplemental Medical Insurance Benefits
SNF	Skilled Nursing Facility (see also ICF and ECF)
SNV	Skilled Nursing Visit also known as SNC, RN visit, or LVN visit
SOC	Start of Care (concerning Home Health claims)

SPSS	Statistical Package for the Social Services
SRT	Speech Reception Thresholds
SSA	Social Security Administration
SSI	Supplemental Security Income (Program)
STAG	States' Technical Advisory Group
STAR	State of Texas Access Reform (in "LoneSTAR Health Initiative")
STARS	Systems Tracking and Referral System
STAT FILE	Statistical File
TAC	Texas Administrative Code
TARS	Texas Automated Recovery System
TCADA	Texas Commission on Alcohol and Drug Abuse
TCB	Texas Commission for the Blind
Td	Tetanus-diphtheria (adult)
TDCI	Texas Drug Code Index
TDH	Texas Department of Health
TDHS	Texas Department of Human Services
TMHMR	Texas Department of Mental Health and Mental Retardation
TEA	Texas Education Agency
TEFRA	Tax Equity and Fiscal Responsibility Act (of 1982)
TexMedNet	Texas Medicaid Network
THA	Texas Hospital Association
THSteps-CCP	Texas Health Steps (formerly EPSDT-CCP) Comprehensive Care Program
TID	Tooth Identification Number
TMA	Texas Medical Association
TMAC	Texas Maximum Allowable Cost (Program)
TMF	Texas Medical Foundation
TMIS	Texas Medicaid Information System
TMMIS	Texas Medicaid Management Information System
TMQC	Texas Medicaid Quality Control
TMRM	Texas Medicaid Reimbursement Methodology
TMRP	Texas Medical Review Program
TNA	Texas Nurses Association
TOB	Type of Bill
TOPPS	Triple Option Product Processing System
TORCH	Toxoplasmosis, Other Agents, Rubella, Cylomegalovirus, and Herpes Simplex (Congenital Perinatal Infection)
TP	Type Program
TPI	Texas Provider Identifier
TPL	Third Party Liability
TPN	Total Parenteral Nutrition (i.e., Hyperalimentation)
TPR	Third Party Resources
TPSI	Texas Pre-School Screening Inventory (for hearing; cf. PDQ, DDST, and DDST-R)
TUP	Total Units Paid
UB-92	Uniform Bill-92 (HCFA-1450)
UCR	Usual, Customary, and Reasonable
UPIN	Universal Provider Identification Number
UR	Utilization Review
URO	Utilization Review Organization
USC	U.S. Code
USDHHS	U.S. Department of Health and Human Services
VAN	Value Added Networks
VIN	Vendor Identification Number (Tax I.D. Number)
WAN	Wide Area Network (linking TDHS to the initiative site offices)
WIC	Women, Infants, and Children (special supplemental food program)
XPCN	Cross-reference Program case Number
YTD	Year-To-Date

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