County Indigent Health Care Program

Supplemental Security Income & Medicaid Reimbursement Manual

Family Clinical Services
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TEXAS
Health and Human Services

Contents

CIHCP Contact Information

The CIHCP can be contacted via the following methods:

Mailing Address

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Phone

(512) 438-2350 (Austin-area)
8:00 a.m. to 5:00 p.m. Central Time
Monday through Friday

Email

CIHCP@hhs.texas.gov

Websites

CIHCP Services Website

CIHCP Handbook and Forms

Purpose of the Manual

The Texas Health and Human Services Commission's (HHSC) County Indigent Health Care Program (CIHCP), administered by the Family Clinical Services (FCS) Section within the Family Health Services Department, provides this Supplemental Security Income (SSI) and Medicaid Reimbursement Manual to assist counties that are not fully served by public hospitals or hospital districts in filing SSI/Medicaid claims through HHSC for retroactive reimbursement for CIHCP-eligible clients.

The manual provides detailed instructions for counties to process prescription and medical claims that will allow them to maximize reimbursements from Medicaid, when possible. Additionally, the manual provides clarification regarding non-reimbursable claims.

Requirements for Participation

The CIHCP must have a signed Confidentiality Agreement on file from a participating county prior to processing a county's Medicaid reimbursement claims.

The county should complete Form 3087 – Texas Medicaid and Health Care Partnership (TMHP) Confidentiality Agreement – and return to the CIHCP via email at CIHCP@hhs.texas.gov. This agreement must be completed and on file with the CIHCP before any claims are submitted to the program.

Questions regarding the form can be submitted to CIHCP@hhs.texas.gov.

Reimbursement through HHSC is for health care services in which the county paid a Texas Medicaid-enrolled provider.

General Principles

Counties requesting assistance from HHSC/CIHCP should be aware of the following general principles for requesting SSI/Medicaid reimbursement assistance.

- Regardless of Medicaid reimbursement for services, the Texas Health and Safety Code (HSC) Chapter 61 determines the county's responsibilities for services and procedures. Medicaid reimbursement should not interfere with HSC Chapter 61 program requirements.

- For HHSC to process any Medicaid reimbursable claims, the county must follow CIHCP approved payment standards. Questions regarding these standards can be directed to the program at CIHCP@hhs.texas.gov.

- HHSC cannot process claims received after the 95th day from the Medicaid "Add Date."

- HHSC must enter both pharmacy and non-pharmacy claims within 365 days from the date of service.

- The Medicaid reimbursements paid to the county may be a lesser amount than the amount that the county paid to the providers. Medicaid requirements may differ from those of CIHCP.

- HHSC requires immediate notification by the county when a provider reimburses the county on a claim that the county submitted to the HHSC/CIHCP. Counties should consult with providers to clarify filing procedures, when applicable.

- Do not send duplicate claims to be reimbursed by HHSC/CIHCP or by both HHSC/CIHCP and the local provider. If the provider will process the claim, do not send that claim to HHSC/CIHCP. The processing of a duplicate claim by HHSC/CIHCP may require the county to be overpaid and must reimburse HHSC.

- HHSC reserves the right to adjust payments due to overpayments, duplicate payments, and/or other reasons. If there is an adjustment to a previous payment, HHSC will contact the county. The county is responsible for resolving the overpayment in a timely manner.

- The county shall deduct the SSI/Medicaid reimbursement amounts for the reporting month when submitting Form 3072 – Monthly Financial Report.
- For HHSC to process hospital claims, counties must show their calculations on each entry in Block 47 of the UB-04. Claims that do not show their calculations on each entry will be returned to the county for correction.
- Appellants and providers submitting Form 3081 – Appellant/Provider Assignment – must provide the accurate, physical address of the provider in the *Provider Assignment* section. A post office box address is not acceptable.
- HHSC/CIHCP will notify counties regarding payments in a timely manner.

Medicaid Verification Process

HHSC processes reimbursement for a county when the county paid for a health care service through a Texas Medicaid-enrolled provider.

A county may check the Medicaid status of an enrolled client by:

- Using the Automated Inquiry System's (AIS) toll-free number (800-925-9126);
- Using the TMHP eligibility verification website;
- Reviewing the Medicaid eligibility letter from the CIHCP-eligible applicant; or,
- Contact HHSC for eligibility details.

A county may verify an active Medicaid pharmacy through the Texas Vendor Drug Program at https://www.txvendordrug.com/providers

Claims Submission Instructions

Counties should follow these general claims submission instructions when submitting information to the HHSC/CIHCP for processing. Counties that do not follow these general instructions may have their claims returned to them for revision and may see processing and reimbursements delayed.

- All claims submitted must be legible, either typed or in blue or black ink. Text should not be cut off, faded, or have anything obstructing fields on forms and supporting documentation.
- All claims must be received by HHSC/CIHCP within the 95-days of the Medicaid "Add Date."
- Pharmacy and non-pharmacy claims must be entered by HHSC within 365 days from the date of service.
- Only claims with dates of service within the Medicaid-eligible time period can be processed.
- Counties should submit one Form 3080 – SSI Appellant Notification for each provider. Each claim must be listed on Form 3080. Counties may submit an additional form if more lines are needed than provided on Form 3080.
- Prescription drug claims and medical claims should be submitted on different forms.
- Claims should be submitted by the county to HHSC/CIHCP for processing when the following have been completed. Failure to follow these steps in this order may result in a claim payment being delayed or denied.
    - Form 3081 – Appellant/Provider Assignment has been signed by the appellant and provider.
    - The provider shall sign Form 3081 on or after the date the appellant signed the form.
    - The county has paid the provider on or after the date that both the appellant and provider signed Form 3081.

Prescription Drug Claims Submission Requirements

Counties should follow the guidance noted when submitting claims for reimbursement for prescription drugs.

- Counties should not request reimbursement for more than three (3) prescription drug claims per appellant per month.
- All claims should be separated on Form 3080 – SSI Appellant Notification.
- Each prescription should be listed on a separate line item on Form 3080. The amount paid for each prescription and date of service should be noted on each line item. Counties should submit as supporting documentation a copy of each prescription drug claim noted on Form 3080.
- Counties should submit a Form 3081 – Appellant/Provider Assignment for each provider that is signed in the order noted under Claims Submission Instructions of this manual.
- The appellant's name (Medicaid client) should be the only name listed on the prescription drug claim.
- Only prescription drugs listed on the Texas Vendor Drug Program website will be processed for payment.
- Prescription drug claims will be paid according to the CIHCP Program Handbook Section 4217 – Prescription Drugs.

Medical Claims Submission Requirements

Counties should follow the guidance noted when submitting claims for reimbursement for medical services.

- All claims should be separated on Form 3080 – SSI Appellant Notification. Do not include claims that have been previously denied or were paid from another source.

- Counties should submit a Form 3081 – Appellant/Provider Assignment for each provider that is signed in the order noted under Claims Submission Instructions of this manual.

- The county should ensure that each claim is on the correct UB-04 or Centers for Medicaid & Medicare Services (CMS) form (UB-04 or CMS-1500) and that each claim includes correct entries. Incorrect entries may delay claims payment or cause claims to be denied.

- The county should ensure that the calculations are completed in their entirety on the UB-04 form. Incorrect calculations may delay claims payment or cause claims to be denied.

Specific Form Requirements

The county should note the specific requirements for each form provided. Questions regarding these requirements should be directed to CIHCP@hhs.texas.gov.

Prescription Drug Claims Form Requirements

The county shall ensure that the following items are completed correctly for each claim. Counties should not submit more than three (3) prescription drugs per month per client.

- Pharmacy information. The pharmacy's full name, physical address, and phone number must be provided. If this information is not printed and clearly legible on the pharmacy's computerized printout, the pharmacist or county are responsible for providing this information clearly on the printout.
- Client information. The client's name should be clearly legible on the computer printout. If this information is not printed and clearly legible on the pharmacy's computerized printout, the pharmacist or county are responsible for providing this information clearly on the printout.
- Prescription information. The prescription's drug name, the prescription drug number, and the 11-digit National Dispensing Code (NDC) number for each prescription drug should be clearly noted on the claim and/or supporting information.

Only prescription drugs listed on the Texas Vendor Drug Program website will be processed for reimbursement. Any related supplies needed to administer the prescription drug are not eligible for reimbursement.

If a client has more than three prescription drug claims listed on Form 3080, only the three most expensive claims will be processed for payment. Any missing information or information not clearly listed may delay processing of the claim or cause the claim to be denied.

CMS-1500 Form Claims Requirements

The county shall ensure that the following items are completed correctly on the CMS-1500 form for each claim.

- Block #2 must list the client/patient's full name
- Block #5 must list the client/patient's full mailing address.
- Block #17 must list all the following:
    - The ordering physician's name for laboratory services and/or radiology services;
    - The referring physician/performing surgeon's name for services provided in an ambulatory surgical center; or,
    - The referring physician's name for consultation services.
- Block #17-B must list the National Provider Identifier (NPI) for the physician/surgeon listed in Block #17.
- Block #21 must list at least one diagnosis code.
- Block #24-A must have only one date per line billed. Multiple dates or date ranges should not be noted in block #24a.
- Block #24-A must have the National Drug Code (NDC) qualifier of N4, followed by an 11-digit NDC number for physician-administered prescription drug procedure code.
- Block #24-B must have the correct place of service. If the patient is registered at a hospital, the place of service must indicate inpatient or outpatient status at the time of service. (See Appendix A: Place of Service Codes for more information.)
- Block #24-D must have procedure codes. Modifiers may be necessary. Anesthesia claims require modifiers and the number of minutes. (Minutes are usually placed in the Block #24 area.)
- Block #24-E must have the diagnosis line-item reference. Enter the line-item reference for each service or procedure as it relates to each ICD-10-CM or

International Classification of Diseases, Tenth Revision, Clinical Modification diagnosis code identified in Block #21.

- Block #24-F must have the full charge.
- Block #24-G must have the number of days or units.
- Block #31 must be appropriately signed and dated.
    - A handwritten signature or signature stamp of the provider or authorized representative is acceptable.
    - "Signature on File" statement for claims prepared by computer billing services or office-based computer services.
- Block #32 must be completed if the place of service in Block #24-B is anywhere other than the home or provider's facility.
- Block #33 must have the Texas Medicaid Program billing provider name, address, phone number, NPI, and Texas Provider Identifier (TPI).
- Write the Medicaid payment rate for each Current Procedural Terminology (CPT) code listed and the per unit amount next to the rate (e.g., 10 units at the Medicaid payment rate of $155.50 = $15.50/unit).

UB-04 Outpatient Hospital Claims Requirements

The county shall ensure that the following items are completed correctly on the UB-04 Outpatient Hospital Claims Form for each claim.

- Block #1 must have the provider's name, address, and phone number.
- Block #4 must have a three-digit type of bill code.
- Block #8-B must have the client/patient's name.
- Block #9 must have the client/patient's address.
- Block #12 must have the date of service.

- Block #13 must have the admission hour. (Admission hour is the time of treatment for outpatient claims.)
- Block #14 must have the type of admission code.
- Block #15 must have the source of admission code.
- Block #17 must have the patient status code.
- Block #42 must have the revenue code.
- Block #43 must have a description of the services.
- Block #43 must have the National Drug Code (NDC) qualifier of N4, followed by an 11-digit NDC number for physician-administered prescription drug procedure code.
- Block #44 may need a Healthcare Common Procedure Code (HCPC) if warranted by the revenue code.
- Block #45 must have the date(s) of service.
- Block #46 must have the number of units of service.
- Block #47 must have complete charges. The charges must have the appropriate calculations completed by the county in Block 48 and divided by the number of units.
- Block #67-A through #67-Q must have at least one ICD-10-CM diagnosis code.
- Block #76 through #79 must have the applicable physician information including the NPI.
- Ensure that the Medicaid rate is written on the claim (e.g., 40%)
- Ensure that the total amount paid is written on the claim and that the calculations for each procedure reflect this total.

Example:

Total Billed Amount:	$500.00
Medicaid Rate:	40%

Amount Paid:	$200.00

UB-04 Inpatient Hospital Claims Requirements

The county shall ensure that the following items are completed correctly on the UB-04 Inpatient Hospital Claims Form for each claim.

- Block #1 must have the provider's full name, address, and phone number.
- Block #3-B must have the medical record number.
- Block #4 must have the three-digit type of bill code.
- Block #6 must have the beginning and ending date of service.
- Block #8-B must have the client/patient's name.
- Block #9 must have the client/patient's address.
- Block #12 must have the admission date.
- Block #13 must have the admission hour.
- Block #14 must have the type of admission code.
- Block #15 must have the source of admission code.
- Block #16 must have the discharge hour.
- Block #17 must have the patient status code.
- Block #42 must have the revenue codes.
- Block #43 must have the description of the charges.
- Block #46 must have the number of units of service.
- Block #47 must have the charges. The charges must have the appropriate calculations completed by the county in Block #48 and divided by the number of units.
- Block #67-A through #67-Q must have at least one ICD-10-CM diagnosis code.

- Block #69 must have the admitting diagnosis code.
- Blocks #74 through #74-E must have the principal and other procedure codes and dates. The provider must enter the ICD-10-CM procedure code for each surgical procedure and the date each procedure was performed.
- Blocks #76 through 79 must have the applicable physician information including the physician's NPI.

Ensure that the total amount paid is written on the claim and that the calculations for each procedure reflect this total. Incorrect calculations may delay payment of the claim or cause the claim to be denied.

Exclusions and Limitations on Reimbursement

The following services/procedures cannot be processed by HHSC for claims reimbursement:

- Mammography
- Skilled nursing facility services
- Hospital lab procedures
- Rural health care clinics
- Date(s) of service outside Medicaid eligibility dates

The following limitations are in place for processing claims for Medicaid reimbursement.

- Lab services will be filed only for physician and independent labs.
- If anesthesia, surgery, and assistant surgery claims are submitted for the same date(s) of service for the same client, it is possible that only one of the procedures will be reimbursed.
- Outpatient hospital claims for physical therapy and/or occupational therapy require modifiers.
- A FQHC is reimbursed by the CPT code rate.
- Outpatient hospital services with surgical procedures that were not an emergency are reimbursed at the ambulatory surgical center rate.
- HHSC cannot process an anesthesia claim without an anesthesia modifier and a state-defined modifier of U1 or U2.

HHSC/CIHCP Review and Process

Upon receipt of the claims (forms and any required supporting documentation), the CIHCP claims specialist will:

- Verify the Medicaid eligibility dates, correct forms and form completion, and any additional program requirements.
- Ensure that general principles and submission requirements noted in this manual have been appropriately followed.
- Process the individual claims or communicate with the county for any additional information or clarifications that may be needed.

Prescription Drug Claims Processing

Upon receipt of the claims (forms and any required supporting documentation), the CIHCP claims specialist will:

- Verify all claims requirements;
- Compute reimbursement amount to the county;
- Apply state payment procedures;
- Send reimbursement notification to the county; and,
- Comptroller reimburses the county for expenses.

Medical Claims Processing

Upon receipt of the claims (forms and any required supporting documentation), the CIHCP claims specialist will:

- Verify all claims requirements;
- Enter claims information and submit through the claims portal. HHSC receives a *Remittance and Status* (R&S) *Report* indicating payment status from the claims portal;
- Reconcile claims;
- Apply state payment procedures;

- Send reimbursement notification letter to the county. When all the claims in the case have been reconciled, the word “Complete” will be on the notification letter.; and,
- Comptroller reimburses the county for expenses.

Appendix

A. Place of Service Codes (Block 24 on CMS-1500)

1-Digit Numeric Codes (for Paper Billers)	Place of Service	2-Digit Numeric Codes (for Electronic Billers)
1	Office	11, 15, 50, 60, 65, 71, 72
2	Home	12
3	Hospital (Inpatient)	21, 51, 52, 55, 56, 61
4	Skilled Nursing Facility (SNF) Intermediate Care Facility (ICF) Intermediate Care Facility for Mentally Retarded (ICF-MR)	31, 32, 54
5	Hospital (Outpatient)	22, 23, 24, 62
6	Independent Lab	81
7	Birthing Center	25
8	Extended Care Facility	33
9	Other Location	03, 04, 05, 06, 07, 08, 26, 34, 41, 42, 53, 99
Indicate destination using above codes	Destination of Ambulance	Indicate destination using above codes

B. Type of Bill Codes (Block 4 of UB-04)

111 – Inpatient Hospital
131 – Outpatient Hospital
141 – Non-patient (laboratory or radiology charges)
731 – Federally Qualified Health Center (FQHC)

C. Claims Forms (Depending on Service Provided)

CMS-1500	UB-04
Advanced Practice Nurse	Ambulatory Surgical Center, Hospital-based
Ambulatory Surgical Center, Freestanding	Federally Qualified Health Center (FQHC)
Anesthetist	Hospital, Inpatient
Certified Nurse Midwife (CNM)	Hospital, Outpatient
Certified Registered Nurse Anesthetist (CRNA)	
Counseling (LCSW, LMFT, LPC, or Ph.D.)	
Durable Medical Equipment (DME)	
Federally Qualified Health Center (FQHC)	
Independent Laboratory	
Physician	

D. Claims Processing Tips

CIHCP recipients can later become Medicaid eligible. It is important that each CMS-1500 form and UB-04 form submitted has the correct Medicaid codes.

To ensure correct codes, ask each provider to bill the county as if the provider were billing Medicaid manually (i.e., paper billing).

The major reasons for non-entry of claims are:

- Incomplete claims and/or required forms; or,
- Incomplete NPI. The NPI must have ten (10) digits.
  (Check with the provider for their correct Medicaid NPI billing number, if needed.)

E. Calculations

Below are helpful hints for processing calculations for outpatient hospital claims paid by percent, inpatient hospital claims paid by percent, and inpatient hospital claims paid by a Diagnosis-Related Group (DRG).

Outpatient Hospital Claim by Percent

- Multiply each entry in Block 47 by the percent rate. Write the result in Block 48.
- Divide the amount by the number of service units. Write the result in Block 46.

Inpatient Hospital Claim Paid by Percent

- Multiply each entry in Block 47 by the percent rate. Write the result in Block 48.
- Divide this amount by the number of service units. Write the result in Block 46.

Inpatient Hospital Claim Paid by DRG

- Divide the DRG amount by the total billed amount to come up with a percent.

- Multiply each entry in Block 47 by the percent from Step 1. Write the result in Block 48.
- Divide this amount by the number of service units. Write the result in Block 46.

F. HHSC/CIHCP Internal SSI Medicaid Audit

Below are steps that HHSC/CIHCP staff will be conducting for counties that engage with the program for assistance with processing SSI/Medicaid claims.

- The HHSC/CIHCP will be conducting random quarterly internal audits of cases submitted by counties for SSI Medicaid Reimbursement.
- All counties submitting claims for SSI/Medicaid reimbursement will be reviewed at least once per fiscal year.
- Claims will be audited for correct payment methodologies and Medicaid reimbursement procedures outlined in this manual.
- Counties are responsible for all repayments identified through the audit.
- Failure to comply with HHSC audit procedures may result in HHSC's determination to not file claim reimbursements for the county.
- Counties with high percentage errors identified through the internal audit will be required to fulfill additional requirements prior to claims processing. Requirements are listed below:
    - Level 1 – The county will be required to submit payment formulas for all claims in the next three cases submitted to HHSC for reimbursement. HHSC/CIHCP will review the payment formulas for errors.
    - Level 2 – The county will be required to re-calculate all payments submitted to and paid by CIHCP for the prior two quarters and refund any overpayments to the appropriate entity.
    - Level 3 – The county will be disqualified from the SSI/Medicaid Reimbursement process for six months.

G. Forms

The following CIHCP forms must be used in processing reimbursement claims through HHSC for SSI/Medicaid Reimbursement

- Form 3080 – SSI Appellant Notification
- Form 3081 – Appellant/Provider Assignment
- Form 3087 – TMHP Confidentiality Agreement

All forms for the CIHCP can be found online with the CIHCP Program Handbook and Forms.