Complex Approved Scenarios		
Scenario Name	**HHSC ID**	**Description**
Place of Service	C001.001	Review of targeted inpatient hospital claims to verify the claim was billed appropriately in accordance with CMS guidelines and the documentation in the medical record is reflective of the need for inpatient level of care. HMS also verifies that there is a valid physician order for inpatient level of care; if there is no valid physician order, or if the order is ambiguous, the record will be reviewed to determine if there was documentation by a qualified provider to support inpatient level of care was the intended level of service.
DRG Validation	C002.001	For the DRG validation review, a review is conducted to ensure that the critical elements necessary to assign DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, patient discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.
P Herceptin Vial Wastage	C003.001	Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must accurately represent the dosage increment specified in the HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit.
Inpatient Readmission	C004.001	The Centers for Medicare and Medicaid Services (CMS) has identified that readmissions occurring within 30 days to the same acute, general, short-term hospital or hospital system for the same, similar, or related diagnosis have been associated with billing errors, premature discharge, incomplete care and inappropriate readmission. HMS will identify and conduct medical record review of targeted readmission pairs to determine if the readmission was considered clinically related with a reasonable expectation that it could have been prevented with optimal quality of care during the initial hospitalization, or optimal discharge planning and post-discharge follow-up.
Medical Drug – Outpatient Claims	C005.001	Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must accurately represent the dosage increment specified in the HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient, including any appropriately unused portions of drugs and biologicals. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. When billing for unused portions of drugs and biologicals, the use of the modifier JW is required to identify unused portions of drugs and biologicals from single use vials or single use packages that are appropriately discarded. Multi-use vials are not subject to payment for unused portions of drugs or biologicals.

		These rules are further defined in CMS Publication 100-04; Chapter 17, § 10, § 40, and § 100.2.9. Claims billed with medically unlikely billed units will be reviewed to determine the correct number of billable/payable units. Per the Texas Medicaid Manual – Single-Dose Vial Clinician-Administered Drugs Policy, effective July 1st, 2020 providers may bill for and receive reimbursement for unused portions of medications from single-use vials. Reimbursement for unused portions of single-use vials will only be allowed provided the JW modifier is used to identify the discarded amount of drug, the most appropriate vial size is used to minimize discarded amounts of medication, and the exact medication usage/discarded portion is documented appropriately in the medical record.
Medical Drug – Professional Claims	C006.01	Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must accurately represent the dosage increment specified in the HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriately unused portions of drugs and biologicals. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. When billing for unused portions of drugs and biologicals, the use of the modifier JW is required to identify unused portions of drugs and biologicals from single use vials or single use packages that are appropriately discarded. Multi-use vials are not subject to payment for unused portions of drugs or biologicals. These rules are further defined in CMS Publication 100-04; Chapter 17, § 10, § 40, and § 100.2.9. Claims billed with medically unlikely billed units will be reviewed to determine the correct number of billable/payable units. Per the Texas Medicaid Manual – Single-Dose Vial Clinician-Administered Drugs Policy, effective July 1st, 2020 providers may bill for and receive reimbursement for unused portions of medications from single-use vials. Reimbursement for unused portions of single-use vials will only be allowed provided the JW modifier is used to identify the discarded amount of drug, the most appropriate vial size is used to minimize discarded amounts of medication, and the exact medication usage/discarded portion is documented appropriately in the medical record.

Automated Approved Scenarios		
Scenario Name	**HHSC ID**	**Description**
Inpatient Transfer to a Specialty Unit Within the Same Hospital	A001.001	The Texas Medicaid Program does not recognize specialty units within the same hospital as separate entities. Our scenario identifies members who were inpatient and discharged to the same facility, matching on billing and rendering provider, taxonomy and tax identification number, receiving additional DRG payment for same member. Texas Medicaid Provider Procedures Manual, policy 3.7.3.2.2 states: Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Texas Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be submitted as one admission under the provider identifier.
Not a New Patient	A002.001	Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face services from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This edit identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code.
NCCI PTP Table Professional Claims	A003.001	The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to prevent inappropriate payment of services that should not be reported together. One of the NCCI data sets provided is the “column one/column two correct coding edit table”. This table contains service code pairs that generally should not be reported (billed) together. If a provider reports both service codes for the same member on the same day, the service that CMS has indicated as a “column two” code is denied and the “column one” code is eligible for payment. Source: National Correct Coding Initiative Policy Manual – Chapter 1. An overpayment exists when both column one and column two codes are billed and paid. The column two code would be subject to recovery.
Ambulance Transports Overlapping Inpatient Stay	A004.001	When a recipient is classified as an inpatient and is transported, the rendering ambulance transport provider should seek payment from the hospital who has the beneficiary classified as an inpatient. If the rendering ambulance transport provider submits an outpatient claim for the ambulance transport, and is subsequently paid for the claim, the Medicaid payment made to the ambulance transport provider/supplier is likely to be an overpayment. The DRG payment/similar prospective payment system for inpatient services covers all items and non-physician services furnished to inpatients including ambulance transports that Medicaid beneficiaries receive during their inpatient stay. These transports may include transportation of an inpatient by ambulance to and from another facility to receive specialized services not available at the hospital where the beneficiary is classified as an inpatient. Accordingly, ambulance providers/suppliers that render ambulance transport services during an inpatient stay are required to bill the hospital where the beneficiary is an inpatient for that ambulance service. All items

		and non-physician services (including ambulance services) furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision typically applies to all hospitals. *nonemergency ambulance transportation of the client during an inpatient hospital stay. Ambulance transport during a client's inpatient stay will not be reimbursed to the ambulance provider.* http://www.tmhp.com/tmppm/tmppm_living_manual_current/vol2_ambulance_services_handbook.pdf 1. Pursuant to section 1903(a)(1) of the Social Security Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Additionally, pursuant to 42 CFR § 433.300(b), the State must refund the Federal share of unallowable overpayments made to Medicaid providers. Additionally, 42 CFR § 433.304 states that an overpayment is the amount that the Medicaid agency paid to a provider in excess of the amount allowable for furnished services. http://www.ecfr.gov/cgi-bin/text-idx?SID=b2201bc2fa14ae238626fefe0f6e6a2a&node=42:4.0.1.1.4&rgn=div5#42:4.0.1.1.4.6.23.6
Office Visits Billed During Inpatient Hospital	A009.001	Office Visit codes should not be billed during an Inpatient Hospital Stay. The appropriate inpatient E/M Visit code needs to be used. Source 1: Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, 30.6.9.1, 30.6.9.2 and 30.6.10 http://www.cms.gov/manuals/downloads/clm104c12.pdf "30.6.10 - Consultation Services Consultation Services versus Other Evaluation and Management (E/M) Visits In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysical Practitioners shall use the CPT codes (99201-99215) depending on the Complexity. Source 3:CPT Professional Edition - Copyright American Medical Association Source 4 HCPCS Level II - Copyright American Medical Association
Correct Coding Add-on Codes	A011.001	The American Medical Association's (AMA) Current Procedural Terminology (CPT) identifies procedure codes that are supplemental to a principal procedure code (Add-On Codes). In most cases these service codes are identified in the CPT manual as "list separately in addition to the code for the primary procedure". In some instances, the primary procedure is identified in the manual and in the others a primary procedure is not specifically addressed. An add-on code is neither a standalone code nor subject to multiple procedure rules since it describes work in addition to the primary procedure. Additional "Add-On" rules may have been added based on State or Plan guidelines. If so the specific regulation may be reviewed at the detailed level.

		Sources: The American Medical Association (AMA), Current Procedural Terminology (CPT) An overpayment exists when an add-on code is billed and paid. The add-on code would be subject to recovery.
Outpatient Duplicates	A013.001	Duplicate payment errors occur when provider's bill carriers multiple times for same patient, same dates of service and are paid for those services.
E&M with Hydration, Drug and Chemotherapy Administration	A014.001	E&M codes are not payable on the same date of service as Hydration, Drug and chemotherapy administration, unless modifier 25 is billed. Query identifies paid claims for E&M services without modifier 25 on the same date of service as drug and chemotherapy administration.
Outpatient Services while Inpatient	A016.001	Outpatient services that are rendered on the date of admission, or within one of the one-day or three-day timeframes indicated by the hospital or an entity that is wholly owned or operated by the hospital, are considered part of the inpatient stay. Outpatient claims submitted for services that are related to the inpatient admission will be denied or recouped if they are submitted with the specified payment window.
DME Rental Exceeding Purchase	A018.001	Texas Medicaid Provider Procedures Manual sets a financial cap on certain durable medical equipment (DME). According to 2.2.2 Durable Medical Equipment and Supplies, "Periodic rental payments are made only for the lesser of either the period of time the equipment is medically necessary, or when the total monthly rental payments equal the reasonable purchase cost for the equipment." The Department places financial caps on certain DME items. These amounts are published through the TMHP Fee Schedule. Fee Schedules - http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx Our review of Medicaid paid claims history suggests that in some cases DME suppliers may have billed Texas Medicaid in excess of published purchase prices. We recommend reviewing such cases to ensure that the supplier is not compensated beyond what the supplier would have received had the equipment been purchased outright. To determine the potential overpayment, HMS will review rental history, compare total reimbursement, and compare to the purchase amount for the corresponding period when the rental began.
Anesthesia Multiple ASA Code Reduction	A019.001	Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement. Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) for administering anesthesia as defined within their individual scope of practice. When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items. When billing for multiple anesthesia services performed on the same day or during the same operative session, the procedure code with the higher RVU should be used. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

Global Surgery	A020.001	Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. The following services are included in the global surgical period: • Preoperative care, including history and physical • Hospital admission work-up • Anesthesia (when administered and monitored by the primary surgeon) • Surgical procedure (intraoperative) • Postoperative follow-up and related services • Complications following the surgical procedure that do not require return trips to the operating room. Texas Medicaid adheres to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows: 0-day Global Period-Reimbursement includes the surgical procedure and all associated services that are provided on the same day. • 10-day Global Period-Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure. • 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure. The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Separate payment is not allowed for evaluation and management (E/M) services, which are within the global period, and are routinely performed by the surgeon or by members of the same group with the same specialty. If it is necessary for the same physician to perform an unrelated E/M service within the global period, one of the following modifiers must be used in order to justify payment: Modifier “-25” (Significant, separately identifiable E/M service by the same physician on the same day of the procedure) Modifier “-24” (Unrelated E/M service by the same physician during a post-operative period) Modifier “-79” (Unrelated procedure or service by the same physician during a post-operative period) Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified non-physician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

Billing Errors_Modifier 57	A021.001	Billing guidelines for Modifier 57 indicate an Evaluation and Management (E/M) service resulted in the initial decision to perform surgery either the day before a major surgery (90 day global) or the day of a major surgery. The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. There are three types of global surgical packages based on the number of post-operative days: 0-day post-operative period (endoscopies and some minor procedures). 10-day post-operative period (other minor procedures). 90-day post-operative period (major procedures). The Medicare Physician Fee Schedule (MPFS) provides information on each procedure code, including the global surgery indicator. The following service is not included in the global surgical payment and may be billed and paid for separately: Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using the modifier "-57" (Decision for Surgery). This visit may be billed separately only for major surgical procedures. The initial evaluation for minor surgical procedures and endoscopies is always included in the global surgery package. The modifier "-57" is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. When the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine pre-operative service and a visit or consultation is not billed in addition to the procedure. [Medicaid] may not pay for an E/M service billed with the CPT modifier "-57" if it was provided on the day of, or the day before, a procedure with a 000- or 010-day global surgical period.
Inpatient Duplicates	A022.001	This concept is to identify duplicate payments made for inpatient claims. The underlying scenario for the duplicate can vary by billing situation. Typically, a duplicate is defined as an erroneous payment made for an already reimbursed service. Our approach is comprehensive and considers multiple data points for the determination of a duplicate service including but not limited to: service dates, procedures, modifiers, member information, provider information, and general claim information such as diagnosis codes.
Professional Duplicates	A023.001	Duplicate claims are where two or more payments have the same date of service or overlapping service dates; recipient, procedure code or drug, quantity, provider type and same provider for pharmacy, professional, institutional, dental or capitation claims.
TX Modifier GZ	A024.001	Modifier GZ describes services or items that are expected to be denied and not reasonable and necessary. Claims billed with Modifier GZ are not covered because they are reasonable and necessary services. According to Texas Medicaid's policy, services or supplies that are not reasonable and necessary are not a covered benefit.

Outpatient Service within 72 hours of admission	A025.001	Outpatient services rendered by the hospital or by an entity wholly-owned or wholly-operated by the hospital within three days (or one-day) of the patient admission, are considered inpatient services. This three-day (or one-day) window applies to diagnostic and non-diagnostic services that are clinically related to the reason for the member's inpatient admission. Outpatient services that were rendered within the specified time frames must be submitted on the inpatient hospital claim and not on an outpatient hospital claim. An outpatient hospital claim for these services will be denied as part of the payment for the inpatient hospital stay. All claims for Children's hospitals where the services were rendered greater than 1 day of the inpatient admission and reimbursed by any methodology other than DRG will be excluded from this concept.
Technical Component while Inpatient	A026.001	While a patient is in the inpatient setting, providers are not allowed to bill the technical component during the inpatient stay. The technical component for any services (procedure codes) are included in the diagnosis-related group (DRG) payment to the hospital/facility. In general, if a procedure is comprised of both a technical and professional component, and is performed on facility/hospital owned equipment, it is necessary for the physician to indicate they are only reporting the professional component, by appending modifier 26 to the procedure code(s) reported. The hospital is responsible for all facility services (the technical component). The CMS Physician Fee Schedule (MPFSDB) PC/TC indicator defines whether a procedure code includes a Technical component, a professional component, both the TC and PC components, or neither (when the concept does not apply). Procedure codes with PC/TC Indicator = 1 (both professional and technical component) with TC modifier and procedure codes with PC/TC Indicator = 3 (technical component only codes) should not be billed, while a patient is in the inpatient setting.

E/M Services Billed with Modifier 59	A027.001	The CPT Manual defines modifier 59 as a Distinct Procedural Service. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Modifier 59 should not be appended to an E/M (Evaluation and Management) service. To report a separate and distinct E/M service with a non E/M service performed on the same date the procedure code should be billed with modifier 25. This concept will identify claims where modifier 59 was appended to an E/M service incorrectly, which resulted in an overpayment.
TX Emergency Room Compliance	A028.001	Use of CPT code 99285 requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: 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) are of high severity and pose an immediate significant threat to life or physiologic function. An extensive review was led by HMS' Chief Medical Officer Dr. Gary Call, VP of Clinical Policy Dr. Tim Garrett, and other clinical team members on all ICD-10 diagnosis codes in order to create a list of codes reflecting the lack of potential for level 5 emergency room applicability. HMS' approach limits reviews to only professional claims where all diagnosis codes billed are present on that diagnosis code list. In addition to the previously stated criteria, we add additional claim history exclusions to further eliminate the chance of a level 5 billing being appropriate. The diagnosis list is HMS intellectual property and considered proprietary, so all information for the algorithm/edit cannot be shared. However, a brief overview has been provided to substantiate the quality of the review. HMS will review the member's relevant claim history. This member history criteria is built into the algorithm, but manual review is also performed during implementation for quality control. This claim history review spans the three days before and after the service date(s) of the 99285 ER service. If any of the following occurrences are in the client's history for the applicable time period the claim will not be considered for review, that criteria includes, but is not limited to: o Ambulance Services o Any Inpatient Admission

		○ Any Surgical Procedure ○ Observation Services ○ Any Revenue Code Indicating Trauma ○ Any Revenue Code Indicating a Cardiology Service ○ Specifically the 480-489 Range An example of a valid overpaid claim is a level 5 ER visit 99285 billed with only diagnosis code (R51) for headache and the claim was not eliminated for a client history exclusion. In this example, a single diagnosis of headache does not present the medical complexity, high decision-making criteria, and potential threat to life to warrant a level 5 (99285) coding. *This concept will only include the Professional claims billed with the level 5 procedure code (99285).
Independent Labs During Inpatient	A031.001	This concept will identify professional Independent Lab claims with a place of service 81 and CPT codes 80000-89999 that were billed while the patient was in an Inpatient setting. Claims that are submitted for an inpatient stay should include all related services and are paid for within the DRG payment. The laboratory codes should not be billed separately according to Texas policy. Laboratory services are included in an Inpatient Stay and not reimbursed separately. The following services are included in an Inpatient Stay and not reimbursed separately: • Whole blood and packed red blood cells. Inpatient services include whole blood and packed red blood cells that are reasonable and necessary for treatment of illness or injury. Whole blood and packed red blood cells that are available without cost are not reimbursed by Texas Medicaid. • Laboratory, radiology, and pathology services. Inpatient services include all medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology services.

Inappropriate Services Billed with a Telehealth Visit	A032.001	This concept will identify claims submitted for Telehealth visits that have been billed with an inappropriate service. Telehealth services are a benefit of Texas Medicaid and is defined as health-care services, other than telemedicine medical services, delivered by a licensed health professional. Billing for services such as injections, labs, x-rays and surgery would not be appropriate when the member is not in the provider's office to receive the service. An overpayment occurs when the telehealth visit is billed with an inappropriate service that the patient was not in the office to receive. Telehealth Modifiers: 95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System GT - Via interactive audio and video telecommunication systems GQ – Via asynchronous telecommunications system G0 – Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke.
Excessive Inpatient Consultations	A033.001	This concept will identify professional claims where CPT codes 99251-99255 were inappropriately billed more than once during the inpatient hospital stay. The code(s) 99251-99255 are used to bill for consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one initial inpatient consultation (99251-99255) is allowed for each hospitalization within a 30-day period. Subsequent consultations billed as initial consultations will be denied and should be billed with a more appropriate code. Excessive consultations codes billed during the 30-day period, are billed inappropriately and may result in an overpayment. Code Description: 99251- Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit. 99252 - Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care

		professionals, 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) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit. 99253 – Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit. 99254- Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit. 99255-Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.