Medicaid and CHIP Services
COVID-19 Information

The following content was previously published on the MCS COVID-19 web pages. This document was updated May 2023. Use this for reference as needed.

Testing for COVID-19

The below includes initial information on testing for COVID-19. For all information on testing, visit TMHP.com.

Billing Codes

The Centers for Medicare & Medicaid Services (CMS) has issued two new HCPCS codes for use by providers who are testing patients for COVID-19. Providers can submit these codes for dates of service on or after Feb. 4, 2020:

- U0001 – The CDC-developed test kit
- U0002 – A laboratory test that is not the CDC-developed test kit (any technique)

Read the TMHP bulletins issued on March 16 (PDF) and the bulletin issued on June 4 (PDF).

The American Medical Association (AMA) has created a new CPT code for use on or after March 13, 2020:

- 87635 – A laboratory test that is not the CDC-developed test kit (amplified probe technique)

Read the TMHP bulletin issued on June 4 (PDF).

Tests using high-throughput technologies

CMS has issued two new HCPCS codes for lab tests that use high-throughput technologies to test for COVID-19. Providers can submit these codes for dates of service on or after April 14, 2020:

- U0003 – A laboratory test performed using high-throughput technologies that is not the CDC-developed test kit (amplified probe technique)
- U0004 – A laboratory test performed using high-throughput technologies that is not the CDC-developed test kit (any technique)

Read the TMHP bulletin issued on June 4 (PDF).

Tests for COVID-19 Antibody (serologic)

AMA announced one revised CPT code and two new CPT codes that providers can submit for antibody testing for dates of service on or after April 10, 2020:

- 86318 – Multiple infectious agents antibody testing performed using a single-step method immunoassay (Revised - see further information in this TMHP bulletin (PDF))
- 86328 – COVID-19 Antibody testing performed using a single-step method immunoassay
- 86769 – COVID-19 Antibody testing performed using a multiple-step method

Read the TMHP bulletin issued on June 4 (PDF).

Reporting specimen collection

CMS has issued two new HCPCS codes for COVID-19 specimen collection. Laboratories can submit these codes for dates of service on or after March 1, 2020:

- G2023 - Specimen collection, any specimen source (for use by laboratories only)
- G2024 - Specimen collection from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source (for use by laboratories only)

Read the TMHP bulletin issued on June 4 (PDF)

All other providers may continue to bill for the COVID-19 specimen collection using one of these codes:

- 99001 - Handling and/or conveyance of specimen

- 99211 – Established office visit not requiring the presence of a physician

Reimbursement Rates

TMHP has provided reimbursement rate updates for procedure codes related to COVID-19. These rates are effective for the duration of the federal emergency declaration.

Read the TMHP bulletin issued on June 26, 2020 (PDF).

Vaccinations for COVID-19

The below includes information on vaccine administration procedure codes through Jan. 2023. For all information on COVID-19 vaccines and procedure codes, visit TMHP.com.

Vaccine Administration Procedure Codes

Pfizer-BioNTech

On Dec. 11, 2020, in accordance with the FDA's issuance of Emergency Use Authorization for the Pfizer-BioNTech COVID-19 Vaccine, vaccine administration procedure codes 0001A and 0002A are benefits for Texas Medicaid for individuals 16 years of age and older. Vaccine procedure code 91300 is informational only while the vaccine is distributed to providers free of charge.

Read the TMHP bulletin issued on Dec. 14, 2020.

Effective May 10, 2021, coverage was expanded to include individuals 12 years of age and older.

Read the TMHP bulletin issued on May 11, 2021.

Effective Aug. 12, 2021, the FDA issued an amended Emergency Use Authorization for the use of an additional dose of the Pfizer-BioNTech and Moderna COVID-19 vaccines in certain immunocompromised individuals.

Read the TMHP bulletin issued on Aug. 24, 2021.

Effective Sept. 22, 2021, the FDA issued an amended Emergency Use Authorization for vaccine administration code 0004A, the booster dose of the Pfizer-BioNTech COVID-19 vaccine.

Read the TMHP bulletin issued on Oct. 15, 2021.

Effective for dates of service on or after October 29, 2021, in accordance with the U.S. Food and Drug Administration (FDA) Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 vaccine, vaccine

administration procedure codes 0071A and 0072A are benefits of Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program for individuals 5 through 11 years of age.

Read the TMHP bulletin issued on Nov. 18, 2021.

On Nov. 29, 2021, the CDC recommended that everyone age 18 or older should get a booster dose six months after their initial Pfizer-BioNTech or Moderna series or two months after their initial Janssen/Johnson & Johnson vaccine.

Read the TMHP bulletin issued on Dec. 13, 2021.

On Nov. 29, 2021, the CDC recommended that everyone age 18 or older should get a booster dose six months after their initial Pfizer-BioNTech or Moderna series or two months after their initial Janssen/Johnson & Johnson vaccine.

Read the TMHP bulletin issued on Dec. 13, 2021.

Effective Jan. 3, 2022, the Pfizer-BioNTech COVID-19 vaccine, COVID-19 vaccine administration code 0004A (the booster dose of the Pfizer-BioNTech COVID-19 vaccine) is now a benefit of Medicaid and CHIP for individuals 12 years of age and older.

Read the TMHP bulletin issued on Jan. 25, 2022.

Effective Jan. 3, 2022, COVID-19 vaccine administration code 0073A is a benefit of Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program for the administration of the third (additional) dose of the Pfizer-BioNTech COVID-19 vaccine for children 5 through 11 years of age.

Read the TMHP bulletin issued on Feb. 3, 2022.

Effective Jan. 3, 2022, COVID-19 vaccine administration codes 0051A, 0052A, 0053A, and 0054A are a benefit of Medicaid, HTW, the Family Planning Program (FPP), and the CSHCN Services Program for the

administration of the first, second, third (additional), and booster doses, respectively, of the tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine for individuals 12 years of age and older.

Read the TMHP bulletin issued on March 1, 2022.

On May 17, 2022, the FDA amended the Emergency Use Authorization for the Pfizer-BioNTech COVID-19 vaccine single booster dose for individuals 5 years through 11 years of age at least 5 months after completion of the primary series with the Pfizer-BioNTech COVID-19 vaccine.

Read the TMHP bulletin issued on May 25, 2022.

Effective May 17, 2022, COVID-19 vaccine administration code 0074A is a benefit of Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program for the administration of the booster dose of the Pfizer-BioNTech COVID-19 vaccine for individuals five years through 11 years of age.

Read the TMHP bulletin issued on June 3, 2022.

Effective June 17, 2022, COVID-19 vaccine administration procedure codes 0081A, 0082A, 0083A, 0111A, 0112A, and 0113A are benefits of Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on July 29, 2022.

Effective Aug. 31, 2022, HHSC will cover the new bivalent Pfizer-BioNTech COVID-19 booster vaccine as a payable pharmacy benefit.

Read the TMHP bulletin issued on Sept. 16, 2022.

Effective Aug. 31, 2022, in accordance with the U.S. Food and Drug Administration’s emergency use authorization, COVID-19 vaccine administration codes 0124A and 0134A are benefits of Medicaid, Healthy Texas Women (HTW), the Family Planning Program (FPP), and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on Sept. 23, 2022.

Effective Oct. 12, 2022, in accordance with the U.S. Food and Drug Administration's amended Emergency Use Authorization, COVID-19 vaccine administration codes 0144A and 0154A are benefits of Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on Oct. 31, 2022.

Effective Dec. 8, 2022, per the U.S. Food and Drug Administration's amended Emergency Use Authorizations, COVID-19 vaccine administration codes 0164A (Moderna) and 0173A (Pfizer-BioNTech) are benefits of Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program for administration of the Moderna COVID-19 bivalent booster vaccine to individuals 6 months through 5 years of age and the Pfizer-BioNTech COVID-19 bivalent booster vaccine to individuals 6 months through 4 years of age.

Read the TMHP bulletin issued on Jan. 19, 2023.

Moderna

On Dec. 18, 2020, in accordance with the FDA's issuance of Emergency Use Authorization for the Moderna COVID 19 Vaccine, vaccine administration procedure codes 0011A and 0012A are benefits for Medicaid, Healthy Texas Women, Family Planning Program and the Children with Special Health Care Needs Services Program for individuals who are 18 years of age and older. Vaccine procedure code 91301 is informational only while the vaccine is distributed to providers free of charge.

Read the TMHP bulletin issued on Dec. 18, 2020.

Effective Aug. 12, 2021, the FDA issued an amended Emergency Use Authorization for the use of an additional dose of the Pfizer-BioNTech and Moderna COVID-19 vaccines in certain immunocompromised individuals.

Read the TMHP bulletin issued on Aug. 24, 2021.

Effective Oct. 20, 2021, the FDA issued amended Emergency Use Authorizations for vaccine administration codes 0034A and 0064A, the booster doses of the Janssen/Johnson & Johnson and Moderna COVID-19 vaccines, respectively.

Read the TMHP bulletin issued on Nov. 15, 2021.

On Nov. 29, 2021, the CDC recommended that everyone age 18 or older should get a booster dose six months after their initial Pfizer-BioNTech or Moderna series or two months after their initial Janssen/Johnson & Johnson vaccine.

Read the TMHP bulletin issued on Dec. 13, 2021.

On May 13, 2022, HHSC added formulary coverage for a new booster dose-only formulation of the Moderna COVID-19 vaccine for individuals 18 years of age or older. This formulation is authorized under the Emergency Use Authorization.

Read the TMHP bulletin issued on May 25, 2022.

Effective March 29, 2022, COVID-19 vaccine administration code 0094A is a benefit of Medicaid, (HTW), the Family Planning Program (FPP), and the Children with Special Health Care Needs (CSHCN) Services Program for the administration of the booster dose of the Moderna COVID-19 vaccine to individuals 18 years of age or older.

Read the TMHP bulletin issued on June 2, 2022.

Effective June 17, 2022, in accordance with the Food and Drug Administration's issuance of updated age restrictions for the emergency use authorization for the Moderna COVID-19 vaccine, coverage of vaccine administration procedure codes 0011A, 0012A, and 0013A have been expanded.

Read the TMHP bulletin issued on July 11, 2022.

Effective for dates of service on or after June 17, 2022, in accordance with the U.S. Food and Drug Administration amendment to the Emergency Use Authorization, COVID-19 vaccine administration codes 0091A, 0092A, and 0093A are benefits of Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program for the administration of the Moderna COVID-19 vaccine to individuals 6 through 11 years of age.

Read the TMHP bulletin issued on July 28, 2022.

Effective for dates of service on or after June 17, 2022, COVID-19 vaccine administration procedure codes 0081A, 0082A, 0083A, 0111A, 0112A, and 0113A are benefits of Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on July 29, 2022.

Effective March 29, 2022, reimbursement rates for COVID-19 administration procedure code 0094A (Moderna COVID-19 Vaccine (Blue Cap) 50MCG/0.5ML Administration – Booster) will be implemented for Texas Medicaid, Healthy Texas Women (HTW), Family Planning Program (FPP), and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on Aug. 9, 2022.

Effective Aug. 31, 2022, HHSC will cover the new bivalent Moderna COVID-19 booster vaccine as a payable pharmacy benefit.

Read the TMHP bulletin issued on Sept. 16, 2022.

Effective Aug. 31, 2022, in accordance with the U.S. Food and Drug Administration's emergency use authorization, COVID-19 vaccine administration codes 0124A and 0134A are benefits of Medicaid, Healthy Texas Women (HTW), the Family Planning Program (FPP), and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on Sept. 23, 2022.

Effective Oct. 12, 2022, in accordance with the U.S. Food and Drug Administration's amended Emergency Use Authorization, COVID-19 vaccine administration codes 0144A and 0154A are benefits of Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on Oct. 31, 2022.

Effective Dec. 8, 2022, per the U.S. Food and Drug Administration's amended Emergency Use Authorizations, COVID-19 vaccine administration codes 0164A (Moderna) and 0173A (Pfizer-BioNTech) are benefits of Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program for administration of the Moderna COVID-19 bivalent booster vaccine to individuals 6 months through 5 years of age and the Pfizer-BioNTech COVID-19 bivalent booster vaccine to individuals 6 months through 4 years of age.

Read the TMHP bulletin issued on Jan. 19, 2023.

Janssen/Johnson & Johnson

On Feb. 27, 2021, in accordance with the FDA's issuance of Emergency Use Authorization for the Janssen COVID 19 Vaccine, vaccine administration procedure code 0031A is a benefit for Medicaid, Healthy Texas Women, Family Planning Program and the Children with Special Health Care Needs Services Program for individuals 18 years of age and older. Vaccine procedure code 91303 is informational only while the vaccine is distributed to providers free of charge.

Read the TMHP bulletin issued on Feb. 27, 2021.

Effective Oct. 20, 2021, the FDA issued amended Emergency Use Authorizations for vaccine administration codes 0034A and 0064A, the booster doses of the Janssen/Johnson & Johnson and Moderna COVID-19 vaccines, respectively.

Read the TMHP bulletin issued on Nov. 15, 2021.

On Nov. 29, 2021, the CDC recommended that everyone age 18 or older should get a booster dose six months after their initial Pfizer-BioNTech or Moderna series or two months after their initial Janssen/Johnson & Johnson vaccine.

Read the TMHP bulletin issued on Dec. 13, 2021.

Novavax

Effective July 13, 2022, in accordance with the U.S. Food and Drug Administration's Emergency Use Authorization, COVID-19 vaccine administration codes 0041A and 0042A are benefits of Medicaid, Healthy Texas Women (HTW), the Family Planning Program (FPP), and the Children with Special Health Care Needs (CSHCN) Services Program for the administration of the first and second dose of the primary series of the Novavax COVID-19 vaccine to individuals 18 years of age and older.

Read the TMHP bulletin issued on Aug. 3, 2022.

Effective Aug. 19, 2022, the age range for COVID-19 vaccine administration codes 0041A and 0042A has changed from 18 years of age or older to 12 years of age or older.

Read the TMHP bulletin issued on Sept. 13, 2022.

Effective Oct. 19, 2022, in accordance with the U.S. Food and Drug Administration's amended emergency use authorization, COVID-19 vaccine administration code 0044A is now a benefit of Medicaid, Healthy Texas Women (HTW), the Family Planning Program (FPP), and the Children with Special Health Care Needs (CSHCN) Services Program for the administration of the Novavax booster dose to individuals 18 years of age or older.

Read the TMHP bulletin issued on Nov. 7, 2022.

In-home Vaccination

Effective June 8, 2021, COVID-19 vaccine administration add-on procedure code M0201 is now a benefit of Medicaid. Procedure code M0201 is an add-on procedure code for use when a COVID-19 vaccine is administered in the

home setting and is the only service provided in the same home on the same date.

Read the TMHP bulletin issued on Sept. 16, 2021.

Beginning Feb. 10, 2022, for dates of service on or after Oct. 29, 2021, COVID-19 vaccine administration add-on procedure code M0201 is a benefit for clients 5 years of age or older for Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program.

Read the TMHP bulletin issued on Feb. 22, 2022.

Federally Qualified Centers and Rural Health Clinics

Effective March 23, 2021, Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers may be reimbursed for COVID-19 vaccine administration services rendered in the office, outpatient hospital, and other location settings.

Read the TMHP bulletin issued on April 19, 2021.

Other

On June 23, 2022, the Texas Medicaid & Healthcare Partnership (TMHP) implemented the second quarter 2022 Healthcare Common Procedure Coding System additions, which include new COVID-19 procedure codes.

Read the TMHP bulletin issued on Aug. 17, 2022.

Becoming a COVID-19 Vaccinator

The Department of State Health Services (DSHS) recruits providers to serve as COVID-19 vaccinators.

Interested providers should visit the Provider Vaccine Information webpage on the DSHS website.

Treatment services

CMS issued a fact sheet for COVID-19 treatment services covered by Medicaid here.

For information on coding related to COVID-19 diagnosis refer to the following TMHP bulletins:

- New COVID-19 Diagnosis Code U071 to Be a Benefit of Texas Medicaid and the CSHCN Services Program Effective April 1, 2020
- Grouper Version 37.1 for Dates of Discharge on or after April 1, 2020

For information on the testing and treatment of the uninsured for COVID-19 see the resources section of this page.

Medicaid and CHIP Flexibilities

In response to the federal public health emergency (PHE), which was declared Jan. 31, 2020, and ended May 11, 2023, HHSC implemented certain flexibilities for managed care organizations (MCOs) and dental maintenance organizations (DMOs), providers and members. Information about these flexibilities including guidance, when they set to expire and which became permanent implementation, was issued through various communication channels. Effective with the end of the PHE, HHSC has ended many temporary flexibilities related to the COVID-19 pandemic.

Appeals and Fair Hearings

Appeals

The extended time frame of 90 days for members, legally authorized representatives, or authorized representatives to request an MCO internal appeal ended on March 31, 2023. The normal timeframe is 60 days.

Fair Hearings

The below extended timeframes that were allowed for fair hearings ended on May 11, 2023:

- Number of days to request a fair hearing was extended to 150 days. The normal timeframe is 120 days.
- Number of days HHSC has to make a fair hearing determination was extended to 120 days. The normal timeframe is 60-90 days from the date HHSC receives a request for a fair hearing.

CHIP Co-Payments

Medical office visit co-payments were waived for all CHIP members for services provided from March 13, 2020, through the end of the federal public health emergency, May 11, 2023. HHSC will reinstate co-pays for CHIP medical office visits on May 12, 2023. The reinstatement of medical office visit co-pays does not apply to:

- COVID-19-related office visits for COVID-19 vaccines, testing, and treatment, including preventative therapies and treatment of post-COVID conditions (long-haul COVID-19), and treatment of health conditions that may seriously complicate the treatment of COVID-19 during the period when a patient is diagnosed with or is presumed to have COVID-19.
- Mental health and substance use disorder outpatient office visits. Co-pays have been permanently removed for mental health and substance use disorder outpatient office visits to comply with federal regulations.

Co-payments are not required for covered services delivered via telemedicine or telehealth to CHIP members.

Provider Reimbursement

The member's MCO will reimburse the provider the full rate for the service, including what would have been paid by the member through cost-sharing. Providers must attest that the medical office visit and/or COVID-19 co-payment was not collected by using the attestation form and submitting an invoice to the appropriate MCO or by submitting a detailed claim that includes the co-payment amount of each claim transaction for services provided in which co-payments were not collected. MCOs have 30 calendar days to pay an invoice received from a provider.

Electronic Visit Verification Policy Updates

Existing EVV Providers

HHSC is issuing temporary EVV policies (PDF) in response to COVID-19. The temporary policies are effective March 21, 2020 through December 31, 2020 unless noted in the PDF. The temporary policies will not be extended after Dec. 31, 2020.

For dates of service beginning on Jan. 1, 2021, EVV claims matching with denials will resume, and claims will no longer receive an EVV07 match code in the EVV Portal.

Program providers:

- Must ensure a matching EVV visit transaction is accepted in the EVV Portal before billing the claim, or the claim will be denied.
- Will no longer have 180 days to complete visit maintenance.
- Should continue to follow the Best Practices for Temporary Policies for COVID-19 to avoid recoupments for claims with dates of service from March 21, 2020 to Dec. 31, 2020.

Face to Face Visits: Managed Care

Extended enrollment MDCP and STAR+PLUS HCBS

To ensure members do not experience a gap in services due to the temporary suspension of face to face service coordination visits for COVID-19, HHSC extended enrollment in the Medically Dependent Children's Program (MDCP) and STAR+PLUS Home and Community Based Services (HCBS) for members with an ISP expiring from April 2020 through December 2020 for 12 months from the original ISP end date.

Service Coordination Visits

Effective immediately MCOs may allow service coordination visits to be completed in person when requested by the member receiving services. Telehealth should be the primary modality for service coordination visits if in-person is not feasible. Beginning Sept. 1, 2021, MCOs must offer service coordination visits in person when requested by the member receiving services.

For all members, including those with levels of care and ISPs that have been extended, MCOs and MMPs must continue to conduct service coordination and service planning telephonic or telehealth visits to ensure members are receiving needed services.

MCOs and MMPs are required to conduct the same number of contractually required annual outreach contacts, at this time. This applies to facility and community members.

All MCOs and MMPs may use telehealth or telephonic processes to:

- Coordinate discharge planning for members transitioning from hospitals.
- Conduct joint meetings with Local Intellectual and Developmental Disability Authorities (LIDDAs), Case Management Agencies and Direct Service Agencies.

- Allow providers to provide mental health targeted case management services.
- Conduct Screening and Assessment Instruments (SAIs) and Individual Service Plans (ISPs) for STAR Kids members not in the Medically Dependent Children's Program (MDCP).

Telehealth Assessments

STAR+PLUS HCBS and MDCP interest list releases were suspended beginning in April 2020. STAR+PLUS HCBS interest list releases resumed in February 2021. MDCP interest list releases resumed in October 2021.

Effective immediately MCOs may to conduct initial MDCP and STAR+PLUS HCBS waiver assessments in person when requested by the member. Telehealth should be the primary modality for the assessments if in-person is not feasible. Telephone may only be used as a last resort.

Beginning September 1, 2021 MCOs must offer waiver assessments in person when requested by the member.

This guidance is for the following groups

- Individuals who were released from STAR+PLUS HCBS or MDCP interest lists prior to the interest list release suspension.
- STAR+PLUS HCBS releases beginning in February 2021.

MCOs must start conducting level of care reassessments via telehealth for members with ISPs expiring December 30, 2020 and moving forward. Telephone may only be used as a last resort. ISPs that would have expired through December 31, 2020 have been extended for 12 months. Even if the reassessment results in a denial, eligibility for the waiver will be maintained through the length of the pandemic to comply with maintenance of eligibility requirements in H.R. 6201.

MCOs and MMPs will process a change in condition, including submission of a medical necessity level of care (MNLOC) or screening and assessment

instrument (SAI), when it is identified there is a change in the member's service needs.

Nursing facility MDS authorization extensions

HHSC extended nursing facility minimum data set (MDS) assessment authorizations by 90 days for those expiring from April 2020 to May 9, 2021. Effective May 10, 2021, MDS assessments will no longer be extended.

Read the TMHP bulletin posted on Aug. 6, 2020..

FMSA Orientations

HHSC directed STAR, STAR Health, STAR Kids, and STAR+PLUS MCOs to allow FMSAs to suspend providing face-to-face orientations for CDS employers through January 31, 2022. Employer orientations scheduled through the end of January 2022 will be virtual or by telephone.

Effective February 1, 2022, FMSAs can permanently conduct new employer orientation virtually (i.e. audio-visual) in addition to allowing in-person orientations, based on member preference.

Face to Face Visits: IDD Waivers and Other Services

Eligibility extensions

To ensure members do not experience a gap in services due to the temporary suspension of face to face service coordination visits for COVID-19, HHSC is extending Intellectual Disability/Related Condition (ID/RC) assessments and individual plans of care (IPC) through December 30, 2020. HHSC will not automatically renew IPCs and ID/RC assessments expiring on or after December 31, 2020. This guidance is for individuals who are enrolled in the following programs:

- Community Living Assistance and Support (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services Program (HCS)
- Texas Home Living (TxHmL)

As a reminder, electronic signatures are allowed in accordance with TAC Chapter 49.305 (j). Additional guidance related to COVID-19 allowances can be found in the information letters below.

For reference:

HCS and TxHmL: IL 2020-45 (PDF)

CLASS and DBMD: IL 2020-46 (PDF)

FMSA Orientations

FMSAs may suspend providing face-to-face orientations for CDS employers through January 31, 2022. Employer orientations scheduled through January 2022 will be virtual or by telephone.

Effective February 1, 2022, FMSAs can permanently conduct new employer orientation virtually (i.e. audio-visual) in addition to allowing in-person orientations, based on member preference.

Service Coordination Visits

Effective immediately MCOs may allow service coordination visits to be completed in person when requested by the member receiving services for the following groups:

- Fee-for-service Medicaid 1915(c) waiver case managers and service coordinators for Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL), Deaf-Blind with Multiple Disabilities (DBMD) and Home and Community-based Services (HCS)
- General Revenue service coordinators
- Community First Choice service coordinators
- Preadmission Screening and Resident Review (PASRR) habilitation coordinators

Telehealth should be the primary modality for service coordination visits if in-person is not feasible. Beginning Sept. 1, 2021, MCOs must offer service coordination visits in person when requested by the member receiving services.

Supervisory Visits

Community Attendant Services, Family Care, and Primary Home Care providers may suspend face to face supervisory visits and instead conduct interdisciplinary team (IDT) meetings by telephone or by video (virtually)- through August 22, 2021. Beginning August 23, 2021 face to face visits will be required.

For reference:

IL 2020-16 (PDF)

In-Home Service Delivery

Home health agencies and certified providers of long-term services and supports (LTSS) delivered through either a Medicaid waiver or state plan program are required to have backup plans in place. These plans include provisions for when an in-home care provider cannot work because they are sick.

If a backup plan is not currently in place, providers must work with clients or their legally authorized representatives (LARs) to develop one.

- Providers in managed care may need to coordinate with members' service coordinators to ensure backup plans are comprehensive.
- Providers employed by an individual using the Consumer Directed Services (CDS) option should work with their CDS employer, MCO, program service coordinators or case managers to develop a backup plan.

Medicine, Supplies, and Durable Medical Equipment

Delivery of Durable Medical Equipment

Guidelines on waiving signature requirements for Durable Medical Equipment (DME) are outlined in this TMHP Bulletin (PDF). This is effective through December 31, 2021.

Beginning with dates of service on or after January 1, 2022, this flexibility will end, and the client or guardian signature requirement for the DME Certification and Receipt Form will resume.

Drug Shortages

Visit the Vendor Drug Program website for any temporary changes made to the preferred drug list due to reported drug shortages.

Providers should complete the Drug Shortage Notification (HHS Form 1315) to inform HHSC of potential shortages impacting prescribing choice or pharmacy claim processing.

Extra Medicine or Supplies

On March 19, 2020, the Texas State Board of Pharmacy authorized pharmacists in Texas to dispense up to a 30-day supply of medication (other than a schedule II-controlled substance) for patients in Texas in the event a prescriber cannot be reached in response to the state of disaster declaration for COVID-19. Beginning August 1, 2021 pharmacies will no longer provide early refills.

Prior Authorizations

Extensions to Existing Prior Authorizations

To help ensure continuity of care during the COVID-19 response, HHSC has directed MCOs and MMPs to extend for 90 days existing prior authorizations and service authorizations that require recertification and are set to expire through December 31, 2020, after which time the 90-day prior authorization extensions will come to an end.

This extension does not apply to current authorizations for one-time services or pharmacy PAs. For example, a single non-emergency ambulance trip would not be extended, but a recurrent non-emergency ambulance authorization for dialysis would be extended.

This extension applies to all state plan services requiring recertification, including acute care and long-term services and supports such as personal assistance services, personal care services, community first choice, private duty nursing, physical, occupational and speech therapies, and day activity and health services. This extension also applies to clinician administered drugs (CADs), when clinically appropriate.

Read the TMHP bulletin posted on April 9 for more details.

New and Initial Prior Authorizations

HHSC has directed TMHP to move forward with processing new and initial prior authorization (PA) requests, including recertification requests, by relaxing document submission timeframes for providers if they are unable to provide certain required documentation through December 31, 2021.

Beginning with dates of service January 1, 2022 and after, all pre-COVID prior authorization timeframe and submission requirements will resume as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM).

This guidance applies to all state plan services, including acute care and long-term services and supports such as personal assistance services, personal care services, Community First Choice, private duty nursing, day

activity and health services, and durable medical equipment and supplies. Medical necessity-related documentation of clinical records to demonstrate patient status and progress specific to some services is still required.

Providers must submit the appropriate PA forms for requesting services, including the procedure and diagnosis codes, applicable modifiers, dates of service, and numerical quantities for services requested.

Read the TMHP bulletin posted on Oct. 25, 2021 (PDF) for more details.

Provider Enrollment

Expedited Enrollment

Providers may use the Public Health Emergency Enrollment Application until July 31, 2021. Beginning August 1, 2021 providers must return to the normal enrollment application process.

Read the TMHP bulletin posted on April 1, 2020..

Fingerprinting Exemptions

Effective September 1, 2021, the Public Health Enrollment exemptions for the submission of proof of fingerprinting and undergoing pre-enrollment and post-enrollment site visits will end. Providers that require proof of fingerprinting and pre and post site visits will no longer be exempt from these requirements.

Off-Site Facility Application

In response to the COVID-19 PHE, hospitals that have received approval from HHSC via the Health and Human Services COVID-19 Off-Site Facility Application can add alternate physical addresses for temporary off-site facilities. This guidance will remain in effect until the end of the PHE.

Read the TMHP bulletin posted on April 20, 2020.

Revalidation Changes

Effective May 11, 2023, HHSC will end the flexibility of extended Medicaid provider revalidation dates that were implemented during the COVID-19 PHE.

Read the TMHP bulletin posted on March 10, 2023.

School and Health Related Services

Beginning July 1, 2021, SHARS providers will no longer get the Certification of Funds (COF) letter through email in addition to the mailed letter.

Read the TMHP Bulletin posted on June 14, 2021.

Effective for dates of service on or after October 1, 2022, School Health and Related Services (SHARS) benefits will change for Texas Medicaid.

Read the TMHP bulletin posted on Aug. 18, 2022.

Teleservices

Medicaid and CHIP health plans have flexibility to provide teleservices, including in a member's home.

In addition, many fee-for-service policies have been updated to allow teleservices. Please see the Medicaid and CHIP Teleservices webpage and the Texas Medicaid Provider Procedures Manual for additional information.

For an overview of updates, read the TMHP bulletin posted on July 15, 2022.

Behavioral Health Services

Effective September 1, 2022, some behavioral health services delivered by synchronous audiovisual or synchronous telephone (audio-only) technology will become benefits of Texas Medicaid.

Read the TMHP bulletin posted on July 15, 2022.

Case Management for Children and Pregnant Women

Effective September 1, 2022, case management benefits for children and pregnant women will change for Texas Medicaid.

Read the TMHP bulletin posted on July 18, 2022.

The Texas Health and Human Services Commission (HHSC) is updating the direction and providing clarification related to COVID-19 flexibilities for Case Management for Children and Pregnant Women (CPW) services and guidance on National Correct Coding Initiative (NCCI) practices for CPW claims.

Read the TMHP bulletin posted Jan. 17, 2023.

Early Childhood Intervention Program

Effective September 1, 2022, benefit information for the Early Childhood Intervention (ECI) program will be updated to identify services that will remain permanent benefits when delivered through telehealth.

Read the TMHP bulletin posted on July 15, 2022.

Federally Qualified Health Centers

To help ensure continuity of care during the COVID-19 response, HHSC will reimburse Federally Qualified Health Centers (FQHCs) as telemedicine (physician-delivered) and telehealth (non-physician-delivered) service distant site providers.

Read the TMHP bulletin posted on April 20, 2020.

Effective December 1, 2020, FQHCs may be reimbursed as telemedicine and telehealth distant site provider as permanent policy change.

Healthy Texas Women (HTW)

Effective September 1, 2022, benefit information for the Healthy Texas Women (HTW) program will be updated to identify services that will remain permanent benefits when delivered through telemedicine and telehealth.

Read the TMHP bulletin posted on July 15, 2022.

Effective May 12, 2023, HHSC will authorize Healthy Texas Women (HTW) providers to submit claims for reimbursement for telephone (audio-only) established patient office visits for non-behavioral health (non-BH) services specified in the below article.

Read the TMHP bulletin posted on April 13, 2023.

Effective with the end of the federal public health emergency (PHE) on May 11, 2023, HHSC will end the temporary Healthy Texas Women (HTW) flexibility that has allowed for telephone (audio-only) medical (physician-delivered) evaluation and management (E/M) services.

Read the TMHP bulletin posted on April 13, 2023.

Hospice Services

Effective November 9, 2021 Medicaid hospice providers must resume face-to-face reassessments, as required in the 40 TAC Section 30.14(e)(1), Certification of Terminal Illness and Record Maintenance.

Read the HHSC IL (PDF) posted on Sept. 13, 2021 for more information.

Medical Nutrition Counseling

Effective September 1, 2022, procedure code S9470, when billed with modifier 93, may be authorized for delivery through synchronous telephone (audio-only) technology during a declaration of a state of disaster if clinically appropriate and safe, as determined by the provider and agreed upon by the person receiving the services.

Read the TMHP bulletin posted on July 15, 2022.

Non-Behavioral Health Services

Effective May 12, 2023, providers may submit claims for reimbursement for telephone (audio-only) established patient office visits for non-behavioral health (non-BH) services specified in the below article and per their licensing board and professional guidelines.

Read the TMHP bulletin posted on April 13, 2023.

Effective with the end of the federal public health emergency (PHE) on May 11, 2023, (HHSC will end the temporary flexibility that has allowed for telephone (audio-only) medical (physician-delivered) evaluation and management (E/M) services.

Read the TMHP bulletin posted on April 13, 2023.

Nursing Services for CLASS, DBMD, HCS and TxHML

During the COVID-19 pandemic, flexibilities were put in place to allow nursing assessments to be provided by telehealth (synchronous audio-visual technology). Certain parts of this flexibility were made permanent effective May 1, 2022, while other parts ended on May 11, 2023.

Read the HHSC alert posted on April 28, 2022.

Physical Therapy (PT), Occupational Therapy *(OT), Speech Therapy (ST)*

Effective September 1, 2022, the Texas Health and Human Services Commission (HHSC) will transition certain COVID-19 flexibilities to permanent guidance in line with House Bill (H.B.) 4 (87th Legislature, Regular Session, 2019). This will include some physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services delivered by synchronous audiovisual technology for adults and children.

Read the TMHP bulletin posted on July 15, 2022.

Physician Evaluation and Management

Effective for dates of service on or after September 1, 2022, synchronous audiovisual technology telemedicine delivery for physician evaluation and management for general family planning, antenatal, and postnatal services may be a benefit of Texas Medicaid.

Read the TMHP bulletin posted on July 15, 2022.

Rural Health Clinics

Effective April 1, 2022, rural health clinic (RHC) providers performing patient-site telemedicine services may be reimbursed for the facility fee (procedure code Q3014) as an add-on procedure code.

Read the TMHP bulletin posted Feb. 28, 2022.

School Health and Related Services (SHARS)

Effective for dates of service on or after October 1, 2022, School Health and Related Services (SHARS) benefits will change for Texas Medicaid.

Read the TMHP bulletin posted on Aug. 18, 2022.

Texas Health Steps

On September 1, 2022, the Texas Medicaid & Healthcare Partnership (TMHP) will update the Texas Medicaid Provider Procedures Manual, Children's Services Handbook with synchronous audiovisual and synchronous telephone (audio-only) technology criteria to allow telemedicine and telehealth services

for Texas Health Steps preventive care medical checkups during a declaration of a state of disaster.

Read the TMHP bulletin posted on July 17, 2022.

Temporary Change on Living in Same Home Prohibitions

HHSC temporarily lifted the prohibition on service providers of respite and CFC PAS/HAB from living in the same home as the person receiving Home and Community-based Services and Texas Home Living program services. This guidance remained in effect until the end of the PHE.

More information about temporary changes to this policy is available in the provider alert issued on June 14, 2022.

Texas Health Steps Checkups

Effective May 11, 2023, HHSC will end the flexibility to allow remote delivery of certain components of medical checkups for children over 24 months of age (i.e., starting after the "24 month" checkup). Because some of these requirements, like immunizations and physical exams, require an in-person visit, providers must follow-up with their patients to ensure completion of any components within 6 months of the telemedicine visit.

Read the TMHP bulletin posted on April 27, 2022.

Upgrades for STAR+PLUS Members Who Left a Nursing Facility Without HCBS in Place

To comply with federal requirements, the following flexibility will remain in place until Aug. 31, 2023.

HHSC is allowing STAR+PLUS MCOs and MMPs to use the existing process for requesting upgrades to STAR+PLUS HCBS for members who exited a nursing facility (NF) through Aug. 31, 2023. MCOs and MMPs are currently identifying and informing eligible members of the option to upgrade and conducting the STAR+PLUS HCBS Program medical necessity/level of care (MN/LOC) assessment for program eligibility.

Providers should direct STAR+PLUS and MMP members who were discharged from a NF on or after March 18, 2020, through Aug. 31, 2023, currently do not reside in a NF, and still have NF Medicaid to their MCOs for more information about the option to upgrade to STAR+PLUS HCBS.

Medicaid CHIP COVID-19 Information Sessions

For older handouts and recordings, email Medicaid CHIP.

- May 2023
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- April 2023
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- March 2023
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Feb. 2023
    - Medicaid CHIP COVID-19 Information (PDF)
        - The linked PDF above was updated after the Stakeholder recording to reflect more current member numbers for redetermination.
    - Medicaid CHIP COVID-19 Information Recording | Email us for transcripts.
- Jan. 2023
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Dec. 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Nov. 2022

    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Oct. 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Sept. 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- July 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- June 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- May 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- April 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- March 2022
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    - Medicaid CHIP COVID-19 Information Recording
- Feb. 2022

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- Jan. 2022
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Dec. 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Nov. 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Oct. 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Sept. 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- Aug. 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- July 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- June 2021

    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording
- May 2021
    - Medicaid CHIP COVID-19 Information (PDF)
    - Medicaid CHIP COVID-19 Information Recording

Resources

Section 1135 Waiver Flexibilities - Texas Coronavirus Disease 2019 (Initial Request) | Medicaid

- Section 1135 Waiver Flexibilities - Texas Coronavirus Disease 2019 (Second & Third Request) | Medicaid
- Section 1135 Waiver Flexibilities - Texas Coronavirus Disease 2019 (Fourth Request) | Medicaid
- Section 1135 Waiver Flexibilities - Texas Coronavirus Disease 2019 (Fifth Request) | Medicaid

1115 THTQIP Appendix K: Coronavirus Disease 2019 (COVID-19): Section 1115 Demonstrations | Medicaid (search by state for all Texas approval letters and approved Appendix K)

1915(c) Appendix K: Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers | Medicaid (search by state for all Texas approval letters and approved Appendix K)

CARES ACT Provider Relief Fund - Medicaid and CHIP Distribution

The U.S. Department of Health and Human Services (HHS) expects to distribute $15 billion to eligible Medicaid and CHIP providers that have not yet received a payment from the Provider Relief Fund General Distribution allocation. HHS has indicated the payment to each eligible provider will be at least 2 percent of reported gross revenue from patient care. The deadline to apply has been extended to September 13, 2020.

HHS also plans to allow certain Medicare providers who experienced challenges in the Phase 1 Medicare General Distribution application period a second opportunity to receive funding. This includes Medicare providers who missed the opportunity to apply for additional funding from the $20 billion portion of the $50 billion Phase 1 Medicare General Distribution and Medicare providers and provider practices who experienced a change of ownership in 2020.

More information is available on the Cares Act Provider Relief Fund webpage.

Reimbursement for COVID-19 testing and treatment of the uninsured

On April 22, 2020, the federal Health Resources and Services Administration (HRSA) launched a new COVID-19 uninsured program to support reimbursement to providers and facilities for testing and treatment of the uninsured.

The program includes testing and treatment provided on or after February 4, 2020 and began accepting claims May 6, 2020.

More information is available on the HRSA website.