Appendix E:
Billing

Revised March 2021

Table of Contents

Billing

Enrollment in Texas Medicaid Healthcare Partnership

HHSC is responsible for credentialing each prospective WPO and CWP. HHSC determines the eligibility to enroll as a YES Waiver Provider with Texas Medicaid and Healthcare Partnership (TMHP). TMHP processes all YES Waiver claims and makes payments to providers.

During the credentialing process, HHSC will issue a letter to the applicant entity confirming that permission to enroll with TMHP is granted by HHSC [see POLICY 6000 Comprehensive Waiver Provider General Responsibilities].

Local Mental Health Authority/Local Behavioral Health Authority

An LMHA/LBHA serving as the WPO and/or CWP will bill for YES Waiver services in accordance with [the YES Waiver User Guide].

Wraparound Provider Organization and Comprehensive Waiver Provider

WPO and CWP providers must enter service notes into CMBHS to bill for YES Waiver services and must maintain documentation of service provision for each invoiced amount in the participant's file.

Medicaid billable services will not be reimbursed if:

- The individual who was provided the service did not meet the eligibility requirements.
- The service provided was an integral and inseparable part of another service;
- The service was provided by a person who was not qualified to provide the service in question.
- The service provided was not the type, amount, and duration authorized on the IPC.
- The service provided was not the type, amount, and duration as documented in the Wraparound Plan.
- Two services are provided at the same day and time, except as otherwise indicated by HHSC in YES Waiver policy.

Medicaid Verification

The WPO, and CWP are responsible for verifying a participant's Medicaid benefits at the beginning of each month prior to rendering YES Waiver services. Services delivered to a participant without active Medicaid cannot be reimbursed.

Reimbursement Rate

In accordance with the CWP and WPO agreements with HHSC, the current Waiver service reimbursement rate(s), or any amendment to the rate(s), is payment in full for the provision of Waiver services. More information on reimbursement rates can be found on the HHSC Rate Analysis page at:

https://rad.hhs.texas.gov/long-term-services-supports/youth-empowerment-services-waiver-program-yes.

Additional Charges Prohibited

The WPO and CWP are prohibited from assessing additional charges to a participant, any member of a participant family, or any other party, including a third-party payer, except as permitted by federal and/or state law, rule, regulation, or the Medicaid State Plan.

Non-Reimbursed Services

Services that are not reimbursed include those:

- Not identified on the participants Wraparound Plan.
- Not previously approved on the participant service authorization.
- Exceeding the limits authorized by HHSC.
- Provided on a date in which an active IPC was not in place.
- Provided outside of the participant's Waiver eligibility

State Plan Services

Medicaid providers of State Plan services must submit claims for payment to TMHP, the appropriate MCO, or private insurance, as applicable. The YES Waiver program does not pay claims for State Plan services or for other non-Waiver services.

Payer of Last Resort

Medicaid is the payer of last resort. Any claims that may be covered by a private insurance benefit must be submitted for payment to the private insurance provider prior to submitting the claim to Medicaid; i.e. TMHP or a Medicaid MCO.

Child and Family Team Participation

No two services should be billed at the same time, per Medicaid, with the only exception being specialized therapies. Specialized therapists can bill clinical consultation at the same time ICM is being billed by the Wraparound facilitator. However, the specialized therapist can only bill for **one hour**, regardless of the total meeting time of the CFT meeting.

Community living supports (CLS), family supports, and paraprofessional services team representatives are permitted to be present and to bill for time providing service as part of the CFT meeting, if the participant has an identified need for service(s) at that time. In order to bill for service during the CFT, billing time for Wraparound will need to be suspended. The service provider and Wraparound facilitator are responsible for coordinating billing times.

Billing Errors

If claims were entered and processed twice for the same services, the recoup/payment amount should be remitted directly to TMHP. The contractor will need to complete the TMHP remittance form that includes an address to remit the payment.

When the payment is sent, the contractor will send an email to the contract management unit's inbox MHContracts@hhsc.state.tx.us with a carbon copy (cc) to the YES Waiver Inbox (YESWaiver@hhsc.state.tx.us). The email should include the check number and amount. The contract management unit will verify payment with TMHP for documentation in the contractor's contract file.

Cost Neutrality

Contractors shall stay below the maximum allowable amounts for 100% of authorized services as outlined in the CMS Waiver Application and below the annual participant cost limit as outlined in the CMS YES Waiver application. This shall be measured annually against any service limitations outlined in the manual, and according to the following calculation:

The number of Waiver participants whose paid claims exceed the limitations outlined in the Manual and/or in the CMS YES Waiver Application ÷ by the total number of Waiver Participants served.

Waiver participants must have an IPC at a cost within the cost ceiling. For Waiver participants with needs that exceed the cost limit, HHSC has a process to ensure their needs are met. The process includes examining third party resources or

institutional services. Third party resources are examined during the CFT meeting that occurs when a Waiver participant is enrolled in the program, during each subsequent CFT meeting, and as the Waiver participant approaches the cost limit. If a Waiver participant's needs exceed the cost limit, the CFT will explore a referral for other services or institutional settings.

Waiver participants will be informed of their rights and given the opportunity to request a Fair Hearing if HHSC proposes to terminate their Waiver eligibility.

Notification to HHSC

A representative from the WPO must notify HHSC when nearing the cost neutrality limit.

Electronic Visit Verification (EVV)

YES Comprehensive Waiver Providers must comply with 1 TAC 354, Subchapter O (relating to Electronic Visit Verification) for in-home respite. See HHSC's Electronic Visit Verification website for more information:

https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification.

Billing: Adaptive Aids and Supports

Billable Aids and Supports

A provider can submit a claim for reimbursement for AA&S for services provided and within the approved limits of an authorized IPC. Billable AA&S must meet all policy and procedure standards [see POLICY 9000.1 Billing: Adaptive Aids and Supports]. There is a separate process for AA&S requests that must be followed before these services are provided and claims submitted.

Non-Billable Aids and Supports

A provider cannot bill Medicaid for AA&S above approved limits on the authorized IPC or for AA&S that do not meet YES Waiver policy standards and procedures [see POLICY 9000.1 Billing: Adaptive Aids and Supports].

Associated Fees

For LAR

A provider can submit a claim for reimbursement for entry, registration, or other applicable fee(s) to pay for a LAR to accompany a participant in order to facilitate a Waiver service on behalf of the service is required for participant participation.

For Provider

A provider cannot bill Medicaid for entry, registration, or other applicable fee(s) to pay for a provider to facilitate a Waiver service for the participant, as these fees are included in the provider's pay rate.

Payment Rate

The payment rate for an AA&S is dependent upon the direct and associated costs for the approved service.

Annual Limit

There is a combined limit of $5,000 for minor home modifications and AA&S, per 365-day IPC period. The amount approved cannot exceed the annual cost limit.

Bids

HHSC requires a CWP to obtain three bids for any AA&S costing $500 or more.

Required Documentation

In order to properly bill for the provision of AA&S, a provider must provide:

- a receipt of purchase;
- documentation of a good faith effort to obtain multiple bids, when applicable;
- participant name;
- start and stop time of the service, if applicable;
- service name and description, if applicable;
- service location, if applicable;
- specific skill(s) received and method used to train participant in skill(s), and participant's response to use of AA&S;
- verified use of the AA&S;
- an invoice or receipt for the purchase of the material(s), in compliance with Waiver policies and procedures;
- proof that at least three bids or prices were solicited for AA&S costing
- $500 or more; and
- proof of completed health and safety and background checks.

NOTE: See the YES Waiver User Guide for instructions on requesting AA&S services.

Requisition Fee

HHSC directly reimburses the CWP for the requisition fee associated with the total cost of securing each identified support purchased, in accordance with the following:

Cost of Service	Payment Rate
Under $500	10% of cost
$500–$999.99	$54.03
$1,000–$1,499.99	$92.85
$1,500–$1,999.99	$105.66
$2,000–$2,499.99	$118.86
$2,500–$2,999.99	$134.21
$3,000–$3,499.99	$140.81
$3,500–$3,999.99	$147.02
$4,000–$4,499.99	$153.62
$4,500–$4,999.99	$160.22
$5,000	$168.96

Reimbursement of Service Rate

HHSC directly reimburses the CWP for the total cost, per identified support. If the AA&S was subcontracted, the CWP must reimburse the subcontractor the total cost.

Billing: Community Living Supports

Unit Designation and Payment Rate

The unit designation for CLS is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant face-to-face.

Bachelor's degree and master's degree level CLS clinicians are paid at the same rate per unit. See the HHSC Rate Analysis page for current reimbursement amounts for YES Waiver services:

https://rad.hhs.texas.gov/long-term-services-supports/youth-empowerment-services-waiver-program-yes.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and must be included on the Wraparound Plan and authorized on the Individual Plan of Care (IPC).

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

Required Documentation

In order to properly bill for the provision of CLS service(s), a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Employment Assistance

Unit Designation and Payment Rate

The unit designation for employment assistance is 15 minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant face-to-face.

Employment assistance services are paid at the rate of $6.52 per unit.

Availability of Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

In order to properly bill for the provision of employment assistance services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Family Supports

Unit Designation and Payment Rate

The unit designation for family supports is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant face-to-face.

Family support services are paid at the rate of $6.25 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

Required Documentation

In order to properly bill for the provision of family support services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Minor Home Modification

Payment Rate

The payment rate for minor home modifications is dependent upon the direct and associated costs for the type of modification chosen.

Annual Limit

There is a combined limit of $5,000 for minor home modifications and AA&S per 365-day IPC period.

Availability of Units

The availability of minor home modifications varies, depending upon the recommendations of the CFT and the Wraparound Plan, in consideration of the annual cost limit.

Non-Billable Modifications

A provider cannot bill Medicaid for room and board, normal household expenses, or items not related to the improvement of the participant's disability.

Bids

HHSC requires a CWP to obtain three bids for any modification costing $500 or more.

Required Documentation

In order to properly bill for minor home modifications, a provider must provide:

- a receipt of purchase; and
- documentation of a good faith effort to obtain multiple bids, when applicable.
- documentation verifying installation, completion of modification, or delivery of goods.

Requisition Fee

HHSC directly reimburses the CWP for the requisition fee associated with the total cost of each identified modification, in accordance with the following:

Cost of Service	Payment Rate
Under $500	10% of cost
$500–$999.99	$80.04
$1,000–$1,499.99	$118.86
$1,500–$1,999.99	$131.67
$2,000–$2,499.99	$163.89
$2,500–$2,999.99	$196.50
$3,000–$3,499.99	$227.19
$3,500–$3,999.99	$258.27
$4,000–$4,499.99	$284.28
$4,500–$4,999.99	$309.90
$5,000	$335.91

Reimbursement of Service Rate

HHSC directly reimburses the CWP for the total cost, per identified modification. If the modification was subcontracted, the CWP must reimburse the subcontractor the total cost.

Billing: Non-Medical Transportation

Unit Designation and Payment Rate

The unit designation for non-medical transportation is one mile. One mile is billed as one unit. In order to bill for a unit, it must be provided to the participant face-to-face.

Mileage incurred prior to picking the participant up or after dropping the participant off to access Waiver services are not units and cannot be billed.

Non-medical transportation is paid at the rate of $0.55 per unit.

Limitations

Payment for non-medical transportation is limited to the costs of transporting a participant to and from Waiver services included in the service authorization, or to access other activities and/or resources identified in the service authorization.

Whenever possible, members of the participant's family, neighbors, friends, or community agencies which can provide non-medical transportation at no cost must be utilized prior to requesting it through the Waiver.

When costs for transportation are included in the provider rate for another Waiver service the participant is receiving at the same time, non-medical transportation will not be reimbursed separately as a Waiver service.

Non-medical transportation cannot be provided at the same time as:

- Community Living Supports;
- Supported Employment;
- Employment Assistance; or
- Paraprofessional Services.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

Providers are required to maintain a transportation log documenting the use of this service. The log may be requested during quality management audits. A template is

available on the YES Waiver website. In order to properly bill for the provision of non-medical transportation, a provider must document:

- date of contact;
- mileage, including start and stop time; and
- direct service provider's printed name, signature, and credentials.

Rounding Mileage

Mileage is rounded to the nearest whole mile, in accordance with the following:

Mileage	Round
.01–.49	Down
.50–.99	Up

Reimbursement and Negotiation Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Paraprofessional Services

Unit Designation and Payment Rate

The unit designation for paraprofessional services is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant face-to-face.

Paraprofessional services are paid at the rate of $6.15 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

Required Documentation

In order to properly bill for the provision of paraprofessional services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Pre-Engagement Services

Unit Designation and Payment Rate

Reimbursement for Pre-Engagement services is only authorized for the LMHA/LBHA.

The unit designation for pre-engagement services is hourly. One hour is billed as one unit. Pre-engagement services are permitted to be billed a maximum of **16 hours.**

Pre-engagement services are paid at the rate of $15.85 per unit.

Pre-Engagement Services are not billed by submitting a DSHS form b13 and a YES-PE Invoice. This is a manual process and is not processed through CMBHS. LMHA/LBHA's should contact their program liaison for additional guidance on submitting documentation for this service.

Billing: Respite Services

Billing: Respite – In Home

Unit Designation and Payment Rate

The unit designation for in-home respite services is 15-minutes. One hour is billed as four units. In order to bill for a unit, the unit must be provided to the participant face-to-face.

In-home respite services are paid at the rate of $5.22 per unit, and for one-to-one care of a single individual at the specified time.

Incremental Billing

HHSC permits out-of-home camp respite services to be billed in 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	1.0
30	2.0
45	3.0
60	4.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of in-home respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan; and

- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Camp

Unit Designation and Payment Rate

The unit designation for out-of-home camp respite services is a 15-minute unit rate. One hour is billed as four units. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Out-of-home camp respite services are paid at the rate of $2.46 per unit.

Incremental Billing

HHSC permits out-of-home camp respite services to be billed in 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	1.0
30	2.0
45	3.0
60	4.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of out-of-home camp respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Licensed Childcare Center

Unit Designation and Payment Rate

The unit designation for out-of-home LCCC respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

LCCC respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $5.32 per unit.

School Age

LCCC respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $5.17 per unit.

Incremental Billing

HHSC permits LCCC respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of LCCC respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- a summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC shall directly reimburse the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Licensed Childcare Center – Texas Rising Star Provider

Unit Designation and Payment Rate

The unit designation for out-of-home, licensed childcare center, TRS Provider respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

TRS Provider respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $5.61 per unit.

School Age

TRS Provider respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $5.54 per unit.

Incremental Billing

HHSC permits TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of TRS Provider respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- a summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Licensed Childcare Home

Unit Designation and Payment Rate

The unit designation for out-of-home LCCH respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

LCCH respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $4.90 per unit.

School Age

LCCC respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $4.86 per unit.

Incremental Billing

HHSC permits LCCH respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days,** of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of LCCH respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Licensed Childcare Home Texas Rising Star Provider

Unit Designation and Payment Rate

The unit designation for out-of-home, licensed childcare home, TRS Provider respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

TRS Provider respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $5.17 per unit.

School Age

TRS Provider respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, paid at the rate of $5.62 per unit.

Incremental Billing

HHSC permits TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of TRS Provider respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Registered Childcare Home

Unit Designation and Payment Rate

The unit designation for out-of-home RCCH respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

RCCH respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $4.75 per unit.

School Age

RCCH respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $3.83 per unit.

Incremental Billing

HHSC permits RCCH respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of RCCH respite services, a provider must document:

- date of contact;

- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Registered Childcare Home Texas Star Provider

Unit Designation and Payment Rate

The unit designation for out-of-home, registered childcare home, TRS Provider respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

TRS Provider respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $4.99 per unit.

School Age

TRS Provider respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $4.08 per unit.

Incremental Billing

HHSC permits TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

Minutes	Unit	
15	.25	
30	.5	
45	.75	
60	1.0	

Unit Limitation

Up to **720 cumulative hours**, or **30 calendar days,** of any respite service, or combination of respite services, are permitted to be provided per participant IPC year.

Required Documentation

In order to properly bill for the provision of TRS Provider respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Respite – Out-of-Home Residential Childcare (OTHER)

Unit Designation and Payment Rate

The unit designation for out-of-home, residential childcare, HHSC respite services is daily. Any portion of a 24-hour period is permitted to be billed as one unit.

Foster Family

HHSC residential childcare respite services provided by a foster family are paid at the rate of $88.62 per unit, the mandated minimum in accordance with 40 TAC §700.1753.

Child Placing Agency

HHSC residential childcare respite services provided by a child placing agency are paid at the rate of $67.98 per unit.

General Residential Operation (GRO)

A respite service provider must be a residential child care operation, in accordance with 26 TAC §748 or a Waiver Provider agency certified by HHSC as a Local Mental Health Authority or a Local Behavioral Health Authority and are paid at the rate of $115.44 per unit.

Billing: Specialized Therapies

Types of Specialized Therapies

There are five types of specialized therapies:

1. Animal-Assisted Therapy;
2. Art Therapy;
3. Licensed Nutritional Counseling;
4. Music Therapy; and
5. Recreational Therapy.

Unit Designation

The unit designation for each specialized therapy is 15-minutes. One 15-minute increment is billed as one unit.

Provision of Service

In order to bill for a unit of providing a specialized therapy service, the entire unit must be provided to the participant, face-to-face. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Child and Family Team Meeting

In-Person Participation

In-person participation of a therapist during CFT meetings is strongly encouraged. A therapist who participates in a CFT meeting in person is permitted to bill for a maximum of **one hour**, for each CFT meeting attended.

Phone Participation

50 Miles or More

A therapist who must travel 50 miles or more to attend a CFT meeting is permitted to call in to participate in the meeting. The therapist is permitted to bill for a maximum of **one hour**, for each CFT meeting attended.

Under 50 Miles

A therapist who must travel 49 miles or less to attend a CFT meeting is also permitted to call in to participate in the meeting. The therapist is permitted to bill for a maximum of one unit, or one 15-minute increment, for each CFT meeting attended.

Payment Rate

The payment rate for each specialized therapy is in accordance with the following:

Service	Payment Rate
Animal-Assisted Therapy	$19.36
Art Therapy	$19.36
Music Therapy	$19.36
Nutritional Counseling	$13.82
Recreational Therapy	$19.36

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

Required Documentation

In order to properly bill for the provision of specialized therapy, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Requisition Fee

HHSC directly reimburses the provider for the requisition fee associated with the total per encounter cost, in accordance with the following:

Cost of Service	Payment Rate
Under $500	10% of cost
$500–$999.99	$54.03
$1,000–$1,499.99	$92.85
$1,500–$1,999.99	$105.66
$2,000–$2,499.99	$118.86
$2,500–$2,999.99	$134.21
$3,000–$3,499.99	$140.81
$3,500–$3,999.99	$147.02
$4,000–$4,499.99	$153.62
$4,500–$4,999.99	$160.22
$5,000	$168.96

Exception

Nutritional counseling does not have an associated requisition fee.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the actual direct service cost, up to the per unit maximum. The amount billed will reflect the payment amount to employees or subcontractors.

The CWP is permitted to negotiate payment to its employees or subcontractors, only for services that do not have an associated requisition fee. The CWP must pass the full payment rate to the direct service provider for services that have an associated requisition fee.

Billing: Supported Employment

Unit Designation and Payment Rate

The unit designation for supported employment is 15 minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant face-to-face.

Supported employment services are paid at the rate of $6.52 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

In order to properly bill for the provision of supported employment services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.

Billing: Supportive Family-Based Alternative

Unit Designation and Payment Rate

The unit designation for SFA is daily. Any portion of a 24-hour period is permitted to be billed as one unit.

Support Family

SFA services provided by a support family are paid at the rate of $69.25 per unit, the mandated minimum in accordance with 40 TAC §700.1753.

Child Placing Agency

SFA services provided by a child placing agency are paid at the rate of $67.98 per unit.

Unit Limitation

Up to **90 cumulative calendar days** of SFA are permitted to be provided, per participant, per IPC year.

Required Documentation

In order to properly bill for the provision of SFA service(s), a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider's printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors for services provided by a child placing agency; however, a support family must be paid the entire mandated maximum rate.

Billing: Transitional Services

Payment

Transitional services are paid as a one-time, non-recurring expense, to a maximum of $2,500, per participant. Failure to use the full $2,500 at one time will result in a loss of the remainder amount. Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver.

Required Documentation

In order to properly bill for transitional services, a provider must retain receipt(s) of purchase in the participant's file [see POLICY 3700 Record Keeping].

Requisition Fee

HHSC reimburses the CWP for transitional services coordination in the amount of $158.28.

Reimbursement of Service Rate

In addition to the requisition fee, HHSC directly reimburses the CWP for the total amount of assistance, to the allowed maximum.

If transitional services were subcontracted, the CWP must reimburse the subcontractor for the total amount of assistance; however, the CWP retains the requisition fee.

Billing: 18-Year-Old Participants

Intensive Case Management Billing Code

ICM is not a YES Waiver service and reimbursement of this State Plan benefit is outside of the purview of YES.

The TMHP procedure code for delivering ICM to participants who are 18 years of age is T1017 with modifier TG.

Billing: Service Notes

Policy Statement: Managing Claims

In order to receive payment for Waiver services provided, a CWP must enter and manage claims through CMBHS as a service note.

Procedure: Entering Service Notes

1. To enter a service note: There must be a client profile and IPC in CMBHS;
2. In Special Services Documentation, select the 'Client Services Toolbar, YES Waiver Services';
3. The 'Progress Note Type' field automatically populates;
4. The 'Progress Note Type' displays 'YES Waiver Service Note' for each Waiver participant;
5. The number of authorized units for each service, billing units, and the TMHP authorization automatically populate;
6. The CWP must enter data in the following fields:
    a. Service location;
    b. Service date;
    c. Start time and end time;
    d. Service type; and
    e. Service description;
7. The following fields are calculated by CMBHS:
    a. Number of service units used; and
    b. Number of remaining units; and
8. The CWP updates the document status as 'Draft' or 'Ready for Review'; and
9. CMBHS validates all of the required fields and creates a pending claim when the document is saved in 'Ready for Review' status.

A pending claim in 'Ready to Review' status is not considered 'Submitted' until it is addressed as a 'Pending Claim'. Following the steps detailed in 9000.25 is required for submitting a 'Pending Claim'.

Deleting a Service Note

A service note can be deleted from CMBHS before or after submission to TMHP by:

1. Finding the service note in the Client Workspace;
2. Highlighting the service note and selecting 'View'; and
3. Clicking 'Delete' at the top right corner of the page.

A ‘Canceled Claim’ must be created in CMBHS, and once the claim is canceled, the service units from the canceled claim will be re-added to the service authorization.

Billing: Pending Claims

Procedure

To submit a pending claim in CMBHS, a CWP must:

1. Hover over the 'Business Office' tab at the top of the page for the dropdown list;
2. Select 'Search Claims';
3. Select 'Pending Claims';
4. Select 'YES Waiver' as the funding source;
5. Select 'YES Waiver' as the 'Supporting Document (SD) Type';
6. Enter 'Service Begin Date';
7. Enter 'Service End Date';
8. Select 'Search' (limited to a 92-day date range);
9. Search the Pending Claims screen for the billable claim needing to be submitted;
10. Select 'YES Waiver Medicaid' as the 'Contract';
11. Verify accuracy of the information on the claim(s);
12. Select the claims to submit by checking the corresponding box;
13. Click the 'Submit Claims' button to submit claims to TMHP for payment.

Billing: Payment of Claims

Policy Statement

A claim for YES Waiver services is paid by TMHP. In order to receive payment for performing the service(s), a CWP must enter and manage claims through CMBHS as a service note [see POLICY Billing: Service Notes].

Procedure: Claims Management

Initial claims must be submitted to TMHP within **95 calendar days** of the date of the provision of the Waiver service. To ensure accuracy during claim processing, TMHP verifies that all required information is included in the claim.

Payment

A claim that is ready for disposition at the end of each week will be paid via an Electronic Fund Transfer (EFT) or by a single check. The EFT includes an explanation of each payment or denial of payment.

Additional information regarding TMHP's claims filing and reimbursement process is available at:

http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

Appeal of Denied Payment

A provider is permitted to appeal a denial of payment of a claim to TMHP. All appeals of denied claims and/or adjustments on paid claims must be submitted to TMHP within **120 calendar days** from the date of disposition of the Remittance and Status (R&S) Report on which the claim(s) appears.

Additional information regarding TMHP's appeal process is available at: http://www.tmhp.com.