Medicaid Managed Care Program (STAR) and Children’s Health Insurance Program (CHIP)

FQHC/RHC Claims and Billing Training

2012 Provider Training
Agenda

- Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Claims and Billing Overview
- Medical Management Overview
- Authorization Process
- Case Management Referral Process
- Provider Resources
Claims and Billing Overview
Coding will mirror TMHP (Texas Medicaid and Healthcare Partnership) guidelines found in the most current Texas Medicaid Provider Procedures Manual.

Access the current procedures manual at www.TMHP.com, click on “providers” and then click on “Reference Material”.

National Drug Code (NDC) for physician-administered prescription drugs.

- Provides a list of NDCs assigned to HCPCS procedure codes
- May not contain a complete listing of all NDCs for any given procedure code.
Submitting Claims

- Timely filing limit is 95 calendar days from the date of service or as stated in your provider contract
  - Electronic Submission
    - The BCBSTX required payer identification number is 84980
    - Web submission through Availity is in development
    - TMHP Claim Portal

- Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
  - The EFT option allows claims payments to be deposited directly into a previously selected bank account
  - Providers can choose to receive ERAs and will receive these advises through their clearinghouse. Enrollment is required
  - Contact EDI Services at 1-800-746-4614 with questions or to enroll
Bill with the Medicaid Patient Control Number (PCN), or Medicaid/CHIP identification number, (field 1a). The BCBSTX alpha administrative code (X) and the BlueCard alpha prefixes are not required but will allow for more efficient processing, especially in retrieving member eligibility information (270/271 transactions) and claims status information (276/277 transactions). If you are utilizing the State portal only use the Medicaid/CHIP identification Number

- STAR: ZGTX Medicaid ID number
- CHIP: ZGCX CHIP ID number
- CHIP Perinate: ZGEX CHIP Perinate ID number

Submit paper claims to:

Blue Cross and Blue Shield of Texas
ATTN: Claims
PO Box 684787
Austin, TX 78768-4787
Providers are prohibited from balance-billing CHIP or STAR Medicaid members for covered services.

Claim Filing With Wrong Plan - if you file with the wrong plan and can provide documentation, you have 95 days from the date of the other carrier’s denial letter or Remittance Advice to resubmit for adjudication.

Claim Payment - your claim will be adjudicated within 30 days from date of receipt. If not, interest will be paid at 1.5% per month (18% per annum).
Provider Appeals

- Providers can appeal Blue Cross and Blue Shield of Texas’s (BCBSTX) denial of a service or denial of payment

- Submit an appeal in writing using the Provider Dispute Resolution Form
  - Submit within **120 calendar days** from receipt of the Remittance Advice (RA) or notice of action letter
  - The Provider Dispute Resolution Form is in development and will be located at [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html)

- Requests for additional information
  - BCBSTX may request additional information or medical records related to the appeal, and providers are expected to comply with the request within **21 calendar days**

- When will the appeal be resolved?
  - Within **30 calendar days** (**standard appeals**) unless there is a need for more time
  - Within **3 business days** (**expedited appeals**) for STAR
  - Within **1 working day** (**expedited appeals**) for CHIP
Provider Appeals

Submit an appeal to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 684249
Austin, TX 78768
External Review

- If a provider is still dissatisfied with BCBSTX’s decision to not pay a claim after the initial appeal process, the provider may request an external review from a non-network provider of the same or related specialty.

- Submit request in writing to:

  Blue Cross and Blue Shield of Texas
  Attn: Complaints and Appeals Department
  PO Box 684249
  Austin, TX 78768
Federally Qualified Health Center/Rural Health Center
FQHC/RHC Covered Services

- FQHC Covered services include:
  - General medical services
  - Adult preventive services
  - Case management
  - Family planning
  - Mental health
  - Texas Health Steps
  - Vision

- RHC Covered services include:
  - General medical services
  - Family Planning
  - Texas Health Steps
FQHC/RHC Overview

- Members will be enrolled to the FQHC at the Tax Identification Number (TIN) level
- FQHC/RHC will be paid their assigned encounter rate for services*
- All services provided that are incident to the encounter should be included in the total charge for the encounter and not billed as a separate service
- FQHC/RHC must bill procedure code T1015
- When submitting a claim for a STAR member that has other insurance, use one of the following CPT codes:
  - CP001 thru CP008

* Forward any new encounter rate letters to ensure correct encounter rate payment to BCBSTX Provider Relation staff
FQHC/RHC Billing Claim Forms

FQHC Claim form
- CMS-1500 paper claim form - *Preferred claim submission method*
- ANSI ASC X12 837P 5010A electronic specifications
- CMS-1450 (UB-04) - *Note: Must use CMS-1500 when billing THSteps*
- ANSI ASC X12 837I 5010A format

RHC Claim form
- CMS-1500 paper claim form - *Preferred claim submission method*
- ANSI ASC X12 837P 5010A electronic specifications
- CMS-1450 (UB-04) - *Note: Must use CMS-1500 when billing THSteps*
- ANSI ASC X12 837I 5010A format

Rendering NPI number is not required. May cause claim delays or denials if included with claim submission (Paper - Box 24j on CMS-1500, Electronic - Rendering NPI Loop 2310B, NM109 qualifier field)
FQHC and RHC Modifiers

- AH - Indicate services performed by a clinical psychologist
- AJ - Indicate services performed by a clinical social worker
- AM - Indicate services performed by a physician or team member
- FP - Family Planning Services
- GY - Gynecological Services
- SA - Indicate services were performed by an Advanced Practice Nurse (APN) or Certified Nurse Midwife (CNM) rendering services in collaboration with a physician
- TH - Obstetric Services
- TU - After-hours Care
Benefit Code

- Benefit Code is an additional data element used to identify state programs.
- Claims may reject if Benefit Code is not included.
  - EP1- Texas Health Steps Medical Provider.
- Use the appropriate Benefit Code in Box 11 or 11c for STAR on paper claims and SRB Loop 2000B, SBR03 qualifier field on electronic claims.
Texas Health Steps (THSteps)

THSteps is a program that includes both preventive and comprehensive care services.

For preventive services, use the following guidelines:
- You can bill for acute care services and THSteps and CHIP preventive visits performed on the same day (claims must be billed separately).
- Billing primary coverage is not required for THSteps and CHIP preventive claims.
- Include Benefit Code “EP1” and diagnosis of “V20.2” on Texas Health Steps claims.
- EP1 field 11 or 11c (Benefit Code is not required for CHIP preventive claims).
- V20.2 field 21.
Comprehensive Care Program services include services such as:

- Medical supplies and Durable Medical Equipment (Pharmacy may provide these services)
- Therapies
- Outpatient Rehabilitation
- Private Duty Nursing
- Behavioral Health Services (provided by Magellan)
Comprehensive Care Program services billing guidelines are:

- Provider should use the facility TIN when billing
- Provider must use Facility Billing NPI in Box 33a
- Must include appropriate Benefit Code (EP1)
- Claims may reject if Benefit Code is not included
- Use the appropriate Benefit Code in Box 11 or 11c for STAR on paper claims and SRB Loop 2000B on electronic claims
Billing Sports Physicals
Value Added Service

Sports physicals should be billed with:
- CPT Code 99211 = Office visit
- Must use Modifier 33 with this service
- Diagnosis Code V70.3 = Other general medical examination for administration
- File as a free-standing claim (do not include on the same bill with any other services)

Covered as a Value Added Service (not a benefit of the state’s Medicaid or CHIP programs)
Medical Management Overview
Customer Care Center

- Assists members and providers with benefits, eligibility, primary care physician assignments, or claim information

Customer Care Center Phone Numbers
- Member: 888-292-4480
- Provider: 888-292-4487
- TTY: 888-292-4485

Available Monday through Friday from 7 a.m. to 6 p.m. CT
Prior Authorization vs. Concurrent Review

- **Prior Authorization**
  - Review outpatient requests
  - Examples: Home Care, DME, CT/MRI, etc.

- **Concurrent Review**
  - Review inpatient requests
  - Examples: Acute Hospital, Skilled Nursing Facility, Rehabilitation, etc.
Intake Department

➢ Assists providers in determining if an authorization is required, create cases, and forwards cases to nurses for review as needed

➢ Utilization requests are initiated by the providers by either phone or fax to the Intake Department
  – Intake phone number: **855-879-7178**
  – Intake fax number: **855-879-7180**
  – Intake fax number for concurrent review: **855-723-5102**
Intake Department Continued

- Prior authorization and/or continued stay review phone calls and fax requests from providers
- Phone calls regarding overall questions and/or case status inquiries
- Notification of delivery processing and tracking via phone calls and fax
- Assembly and indexing of incoming faxes
- Out-of-network letter processing
The three most important questions for Utilization Management (UM) requests are:
- What service is being requested?
- When is the service scheduled?
- What is the clinical justification?

To access a list of services that require a prior authorization, Medical Policies and/or UM Clinical Guidelines used to review for medical necessity go to the BCBSTX website or request a copy from your Provider Representative

* Website functionality is in development
Please have the following information available when calling the Intake Department at **855-879-7178**

- Member name and identification number
- Diagnosis code(s)
- Procedure code(s)
- Date of service
- Primary Care Physician, specialist and facility names
- Clinical justification for request
- Treatment and discharge plans (if known)
Turn Around Times (TAT)

- Concurrent Stay requests (when a member is currently in a hospital bed)
  - Within **24 hours**

- Prior authorization requests (before outpatient service has been provided)
  - Routine requests: within **three calendar days**
  - Urgent* requests: within **72 hours**

* **URGENT Prior Authorization is defined as a condition that a delay in service could result in harm to a member.**
Nurse Review

Nurses utilize Clinical Guidelines, Medical Policies, Milliman Guidelines, and plan benefits to determine whether or not coverage of a request can be approved

- If the request meets criteria, then the nurse will authorize the request
- Nurses review for medical necessity only, and never initiate denial
- If the request does not appear to meet criteria the nurse refers the request to a Peer Clinical Reviewer (PCR) – a.k.a. Physician Reviewer
Physician Review

- The Peer Clinical Reviewer (PCR) reviews the cases that are not able to be approved by the nurse.

- Only a physician can deny service for lack of medical necessity.

- If denied by the PCR, the UM staff will notify the provider’s office of the denial. Providers have the right to:
  - Request a peer-to-peer discussion with the reviewing physician
    - 877-496-0071
  - Appeal the decision
    - Submit an appeal in writing using the Provider Dispute Resolution Form within 120 calendar days from receipt of the Remittance Advice (RA) or notice of action letter
    - The Provider Dispute Resolution Form is in development and will be located at [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html)
Submitting an Appeal

Submit an appeal to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 684249
Austin, TX 78768
Utilization Management (UM) staff utilize the BCBSTX Network Department to assist with one-time contracts for out-of-network contract negotiations.
Retrospective Requests

- The service has already been performed - medical record documentation needs to be submitted with the claim.
- A UM case will not be started if a retrospective case is called into the Intake Department.
- The Post Service Clinical Claims Review Unit (PSCCR) reviews retrospective cases.
The mission of Case Management (CM) is to empower members to take control of their health care needs by coordinating quality health care services and the optimization of benefits.

The CM team includes credentialed, experienced registered nurses many of whom are Certified Case Managers (CCMs) as well as social workers.

Social workers add valuable skills that allow us to address not only the member’s medical needs, but also any psychological, social and financial issues.
Case Management Referrals

Providers, nurses, social workers and members, or their representative, may refer members to Case Management in one of two ways:

- Call **855-879-7178**
- Fax a completed Case Management Referral Form to **866-333-4827**
  - A Case Manager will respond to the requestor within three business days
A 49 year old, 88 pound woman in end-stage Chronic Obstructive Pulmonary Disease (COPD). Member was referred to CM from a post-discharge call screening following an admission for COPD exacerbation. Co-morbidity of throat cancer which had been diagnosed and treated earlier in the year with chemotherapy and radiation therapy.

- Received Social Worker support for getting home air conditioning fixed by landlord and for obtaining nutritional supplements
- Sent member’s physician paperwork for Abbott Patient Assistance program for prescription
- Obtained a home glucometer from Bayer Customer Service
- Helped spouse find in-home assistance through a community program
- Facilitated collaboration between CM, PA, Customer Care, physicians, hospital staff, home health and medical equipment providers
- Member is now enrolled in hospice and will be disenrolled from CM
Provider Resources
Provider Website

The provider website contains resources such as:

- Access to list of services requiring Prior Authorization
- Access to Prior Authorization Toolkit
- Access to view Clinical Guidelines
- Access to many other very helpful resources and forms

Log on at www.bcbstx.com/provider/network/medicaid.html*

* Website functionality is in development
Prior Authorization Toolkit

- Contains a list of more than 30 procedure specific pre-service forms, including Synagis, bone stimulators, insulin pumps, home oxygen, bariatric surgery, wheelchairs, and more

- The provider completes the form and faxes it to the Intake Department at:
  - 855-879-7180

- If the form is completed fully and criteria is met, the Intake Department can authorize the request without forwarding for a nurse review.
Reviewed on a periodic basis, approximately every two years

The authorization list will be available online at
www.bcbstx.com/provider/network/medicaid.html*

* Website functionality coming soon
To enable the healthiest outcome for both mothers and babies, and to help ensure needed services are obtained in a timely manner, BCBSTX requests, but does not require, that we receive notification of all newborn deliveries within three days of delivery

- Use the Newborn Enrollment Notification Report found on the BCBSTX website
  - Failure to notify us will not result in denial of newborn claims

Routine vaginal or cesarean deliveries do not require medical necessity review/prior authorization

* Website functionality coming soon
Questions?
Thank you for your time!
We look forward to working with you!

Please complete and fax the training evaluation form.