



BlueCross BlueShield
of Texas



Medicaid Managed Care Program (STAR) and Children's Health Insurance Program (CHIP) Provider Orientation

Provider Training



A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Introduction



- Welcome to Blue Cross and Blue Shield Texas Medicaid Orientation
- Program Introduction
- Customer Service
- Member Enrollment and Eligibility
- Member Benefits and Services
- Claims and Billing
- Medical Management
- Complaints and Appeals
- Quality Management
- Magellan (Behavioral Health) Services

Blue Cross and Blue Shield of Texas



- Blue Cross and Blue Shield of Texas (BCBSTX) knows health care coverage in Texas; we invented it. We're Texas born and bred, and this is the only place we do business. Our mission since our founding more than 80 years ago has been to provide financially sound health care coverage to as many Texans as possible.

- Blue Cross and Blue Shield Texas will continue to develop relationships between members, providers, and the community for our STAR and CHIP members' better health.
 - Promote better health for our members through Case Management and Disease Management programs
 - Team with the community to provide outreach to members

Texas Managed Care Programs



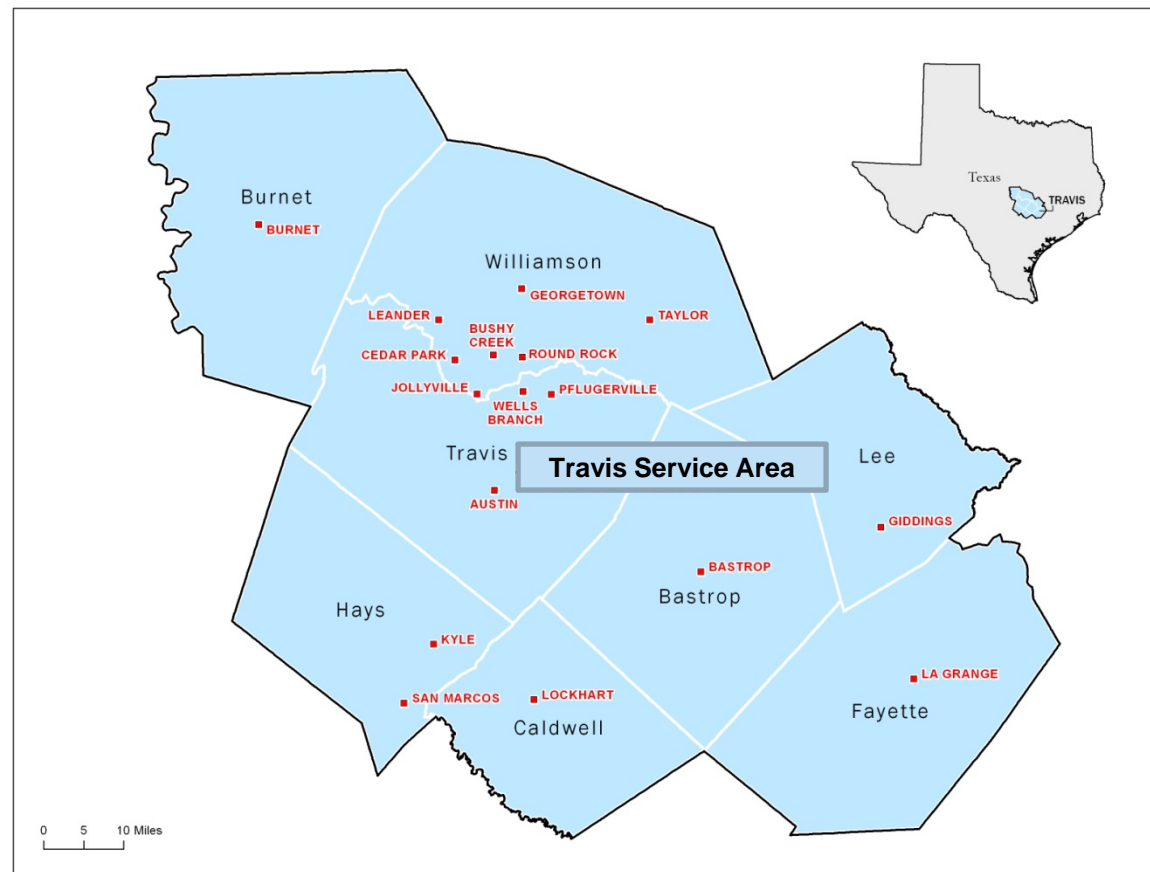
- STAR (State of Texas Access Reform) is the Medicaid managed care program for Texas
- CHIP (Children's Health Insurance Program) is the children's health insurance option
- Blue Cross and Blue Shield of Texas was selected as one of the plans to administer the STAR and CHIP programs for the Texas Health and Human Services Commission (HHSC) in the Travis Service Area
- Other health plans serving in the area include:
 - Sendero Health Plans
 - Seton
 - Superior (Centene) HealthPlan Network
 - Amerigroup-STAR Plus ONLY
 - United Healthcare-STAR Plus ONLY

Travis Service Area



Eight Counties:

- Travis
- Bastrop
- Burnet
- Caldwell
- Fayette
- Hays
- Lee
- Williamson





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Customer Service



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Customer Service



- Still committed to providing excellent service to members and providers
- Telephone support
 - Provider: 877-560-8055
 - Member: 888-657-6061
 - TTY: **711**
 - Monday to Friday
 - 8 a.m. to 8 p.m. CT
- Web Support at www.availity.com

Inquiries	Web Portal	Customer Call Center
Eligibility Verification		
Claims Inquiries		
Benefit Verification		
Primary Care Physician Assistance		
Interpreter/Hearing Impaired Services		

Texas Medicaid Nurse Advice Line



- Texas Medicaid Nurse Advice Line
 - 844-971-8906
 - Available 7 days a week
 - 24-hours a day
- Answer provider questions
 - After-hours member eligibility and Primary Care Physician verification
- Answer member questions
 - General health
 - Community health service referrals
- Over 300 audio health topics available to members

Provider Responsibilities



- The Primary Care Physician (PCP) is the member's medical home, and is responsible for providing or arranging:
 - Routine and preventive health care services
 - Specialty referrals
 - No prior authorization required for in network consultations or nonsurgical course of treatment
 - Hospital and emergency services
- All providers are responsible for making referrals and coordinating care for additional services, such as:
 - STAR:
 - Early Childhood Intervention (ECI) case management
 - Texas School Health and Related Services (SHARS)
 - Department of Aging and Disability Services (DADS)
 - Referral for Women, Infants and Children (WIC) Program
 - CHIP:
 - Collaborating with public health entities to refer for tuberculosis and/or sexually transmitted infections/HIV contact
 - Referral for Women, Infants and Children (WIC) Program



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 CHIP

Member Enrollment and Eligibility



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Enrollment



- HHSC delegates to its enrollment broker, Maximus, the responsibility to educate STAR and CHIP eligibles about their health plan options
- Eligible STAR and CHIP individuals and families are asked to select an HMO and an in-network Primary Care Physician (PCP) upon enrollment
 - State assigns member to a STAR plan if information is not received within 45 calendar days; this is called default
 - CHIP eligibles must enroll in a CHIP HMO within 90 days or the member becomes ineligible
 - CHIP eligibles will not default into a medical plan
 - CHIP Perinate is a subset of CHIP (limited benefits apply to expectant mother)
 - CHIP Perinate Newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment

Enrollment (continued)



- Texas State Medicaid Managed Care Program Help Line
 - **866-566-8989**

- New Member Kit sent by Blue Cross and Blue Shield of Texas within five business days of receipt of the enrollment file from Maximus
 - Member identification card
 - Member Handbook
 - Letter with Primary Care Physician choice or assignment
 - Other information about health care and value added services

Eligibility Verification for STAR and CHIP



- Providers must verify eligibility before each service
- Ways to verify STAR and CHIP member eligibility
 - www.availity.com
 - www.passporthealth.com
 - <http://www.emdeon.com/patient-eligibility/>
 - Use the State's Automated Inquiry System (AIS)- for STAR (not CHIP)
 - 800-925-9126
 - Call the BCBSTX Customer Service Center:
 - 877-560-8055
 - Customer Care Representative
 - Interactive Voice Response automated telephone response system

Member Identification Cards



- STAR members receive two identification cards upon enrollment:
 - State issued Medicaid identification card (*Your Texas Medicaid Benefit Card*); this is a permanent card and may be replaced if lost
 - Blue Cross and Blue Shield of Texas member identification card
- CHIP members only receive a Blue Cross and Blue Shield of Texas member identification card, they do not receive a State issued Medicaid identification card
- Identification cards will be re-issued
 - If the member changes his/her address
 - If the member changes his/her Primary Care Physician (PCP)
 - The member may change his/her PCP at any time and the change is effective the day of request
 - Upon member request
 - At membership renewal

Sample Member Identification Cards



➤ Examples of BCBSTX identification cards

STAR alpha prefix: ZGT



Member Name:
<F_NAME M_INIT L_NAME>
Alpha Prefix: ZGT
Subscriber ID: <SBSB_ID>
Medicaid ID Number:
<MEME_MEDCD_NO>

PCP: <PCP_NAME>
<PCP_PHONE>

PCP Effective Date: <EFF DT>
Rx Group No.:
<RX_GROUP2>
Rx BIN: 011552
Rx PCN: TXCAID
PBM: PRIME



bcbstx.com

Show this BCBS card to your health care provider each time you get covered services. Some services may need preapproval. **Directions for what to do in an emergency:** In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. This card is for member ID only and does not prove eligibility.

Muestre la tarjeta BCBS a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.

Claims: PO Box 51422
Amarillo, TX 79159-1422

Customer Care/Atención al Cliente
(Medical/Prescription Drug/Vision):
24 hours/7 days a week 1-888-657-6061
TTY: 711
24-Hour Nurse Line/línea
de ayuda de enfermería
disponible las 24 horas: 1-844-971-8906
TTY: 711
Prescription Drug/
Medicamentos Recetados: 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/
Behavioral Health Línea Directa de Servicios:
24 hours/7 days a week 1-800-327-7890
TTY: 1-800-735-2988

For emergency care received outside of Texas:
Hospital and physicians should file claims to the
local BCBS Plan.

Card Issued <DT>

Member Identification Cards Continued



➤ Examples of BCBSTX identification cards

CHIP alpha prefix: ZGC



Member Name:
 <F_NAME M_INIT L_NAME>
 Alpha Prefix: **ZGC**
 Subscriber ID: <SBSB_ID>
 CHIP ID No:
 <CHIP ID No.>

PCP Effective Date: <EFF DT>
 Rx Group No.: <Rx Group>
 Rx BIN: **011552**
 Rx PCN: **TXCAID**
 PBM: **PRIME**



PCP: <PCP_NAME>
 <PCP_PHONE>

Office Visit/
 Visitas al consultorio: <SXX>
 Non-Emergency ER/
 No emergencias en la ER: <SXX>
 Hospital per admit/
 por hospital admiten: <SXX>
 Emergency Room/
 Emergencia en la ER: <SXX>
 Pharmacy (Brand)/
 farmacia (marca): <SXX>
 Pharmacy (Generic)/
 farmacia (generico): <SXX>



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bcbstx.com

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For emergency care received outside of Texas:
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Member Identification Cards Continued



➤ Examples of BCBSTX identification cards

<p>BlueCross BlueShield of Texas A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Equal Opportunity Lender of the Blue Cross and Blue Shield Association.</p> <p>Member Name: <F_NAME M_INIT L_NAME> Alpha Prefix: ZGE Subscriber ID: <SBSB_ID> CHIP ID No: <CHIP ID No.></p> <hr/> <p>Effective Date: <EFF DT> Rx Group No.: <Rx Group> Rx BIN: 011552 Rx PCN: TXCAID PBM: PRIME</p>	<p>CHIP Perinate</p>	<p>BlueCross BlueShield of Texas</p> <p>bcbstx.com/Medicaid</p> <p>Customer Care/Atención al Cliente (Medical/Prescription Drug/Vision): 24 hours/7 days a week 1-888-657-6061 TTY: 711</p> <p>24-Hour Nurse Line/linea de ayuda de enfermería disponible las 24 horas: TTY: 1-844-971-8906 711</p> <p>Prescription Drug/ Medicamentos Recetados: TTY: 1-888-657-6061 711</p> <p>Behavioral Health Services Hotline/ Behavioral Health Línea Directa de Servicios: 24 hours/7 days a week 1-800-327-7390 TTY: 1-800-735-2988</p> <p>Hospital Facility Billing: Professional/Other TMHP Services Billing: P.O. Box 200555 BCBSTX Austin, TX 78720-0555 P.O. Box 51422 Amarillo, TX 79159-1422 Card Issued <DT></p>
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For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBSTX plan.

Show this BCBSTX card to your health care provider each time you get covered services. Some services may need preapproval. Directions for what to do in an emergency: In case of emergency call 911 or go to the closest emergency room. This card is for member ID only and does not prove eligibility.

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For CHIP Perinate newborns no co-payment or cost-sharing for covered services

Claims: PO Box 51422
Amarillo, TX 79159-1422

Show this BCBSTX card to your health care provider each time you get covered services. Some services may need preapproval. Directions for what to do in an emergency: In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. This card is for member ID only and does not prove eligibility.

Muestre la tarjeta BCBSTX a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.

CHIP Perinate alpha prefix: ZGE



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Member Benefits and Services



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STAR Covered Benefits



- Some of the benefits include:
 - Well-child exams and preventive health services, and screening for behavioral health problems and mental health disorders
 - Physician office visits, inpatient and outpatient services
 - Durable Medical Equipment and Supplies
 - Chiropractic Services
 - Emergency Services
 - Family Planning Services (any Medicaid provider in or out of network)
 - Prenatal vitamins – with prescription
 - Transplants
 - Vision Plan by Davis Vision
 - Behavioral Health by Magellan Health Services
 - Pharmacy benefits administered by Prime Therapeutics

CHIP Covered Benefits



➤ Some of the benefits include:

- Well-child exams and preventive health services, and screening for behavioral health problems and mental health disorders
- Physician office visits, inpatient and outpatient services
- Durable Medical Equipment
- Transplants
- Chiropractic Services
- Prenatal vitamins – with prescription
- Vision Plan by Davis Vision
- Behavioral Health by Magellan
- Pharmacy benefits administered by Prime Therapeutics

CHIP Perinate Covered Benefits



- For Mothers that do not qualify for Medicaid, their unborn baby may qualify for perinatal care as a CHIP Perinate member
- Some of the benefits include:
 - Prenatal care through delivery
 - Medically necessary physician office visits
 - Some inpatient and outpatient services
 - Prenatal vitamins – with prescription
 - Laboratory, x-rays and ultrasounds

Self Referrals



- STAR and CHIP members may self-refer for the following services:
 - Diagnosis and treatment of sexually transmitted diseases
 - Testing for the Human Immunodeficiency Virus (HIV)
 - Family planning services to prevent or delay pregnancy (STAR Only)
 - Annual Well Woman exam (in-network only)
 - Prenatal services/obstetric care (in-network only)
 - Behavioral Health Services (Magellan Network)

Pharmacy Services



- Pharmacy benefits are administered by Prime Therapeutics
 - Provider Customer Service:
 - **CHIP Pharmacy Help Desk:** 855-457-0403
 - **STAR Pharmacy Help Desk:** 855-457-0405
 - Call for 72 hour emergency supplies while waiting for prior authorization approval
 - Prior authorization:
 - **STAR & CHIP** 855-457-0407
 - Prior authorization fax:
 - **STAR & CHIP** 877-243-6930
 - Prior authorization requests will be addressed within **24** business hours
- Benefit Identification Number (BIN): 011552
- PCN: TXCAID

Pharmacy Services Continued



- The Formulary and clinical edits will mirror Texas Vendor Drug Program

www.txvendordrug.com

- Pharmacy geographical access
 - Within 2 miles of members' home if an urban county
 - within 5 miles of member's home if suburban and 15 miles of member's home if rural
 - 24-Hour Pharmacy: within 75 miles of the members' home

Pharmacy Services Continued



- STAR members have no copay; CHIP members' copay depends on the family's Federal Poverty Level
 - CHIP Perinate unborn children will have prescription coverage with no copay
 - CHIP Perinate newborns will have prescription coverage with no copay
- BlueCross BlueShield of Texas offers e-prescribing abilities through Surescripts for providers to:
 - Verify client eligibility
 - Review medication history
 - Review formulary information
- For additional information visit the website www.txvendordrug.com

Dental Benefits



- All STAR and CHIP members must select a Dental DMO and a main dentist

- Dental Services are provided by one of the following vendors
 - DentaQuest
 - **STAR** 800-516-0165
 - **CHIP** 800-508-6775
 - Managed Care of North America Dental (MCNA)
 - **STAR** and **CHIP** 800-494-6262

STAR Medical Transportation Program



- The Medical Transportation Program (MTP) is provided by Texas Health and Human Services Commission (HHSC)
- STAR members can receive transportation assistance to get to and from a provider, dentist, hospital or drug store. HHSC will do one of the following:
 - Pay for a bus ride or ride sharing service
- If a member has to travel out of town for services, HHSC may pay for lodging and meals for the member and the member's parent/guardian

CHIP Cost Sharing



- Co-payments apply from \$0 to \$100 depending on Federal Poverty Levels (FPL) and type of service
- Co-payment amount is found on the member's identification card
- Once cost-sharing limit is reached the member must call the enrollment broker, Maximus, to report that they met their max
- BCBSTX will receive updated files from Maximus reflecting co-payment maximum reached
 - An identification card will be re-issued to show that co-payments do not apply



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Claims and Billing Overview



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Claims Coding



- 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”

Type of Billed Services



➤ CMS-1500 Professional Services

- Physician and Midlevel services
- Specific Ancillary Services
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Audiology
 - Ambulance
 - Free Standing ASCs
 - Durable Medical Equipment
 - Dietician

Type of Billed Services



➤ CMS-1450 (UB-04) Institutional Services

- Hospitals
- Home Health (and Home Based Therapies)
- Hospital Based ASCs

Submitting Claims



- Timely filing limit is 95 calendar days from the date of service
- Electronic Submission – New Payer ID
 - 66001
- Submit paper claims to:
Blue Cross and Blue Shield of Texas
PO Box 51422
Amarillo, TX 79159-1422

Submitting Claims



- Use correct plan prefix
 - ZGT: STAR
 - ZGC: CHIP
 - ZGE: CHIP Perinate
- 9 digit Medicaid number
- EX: ZGT123456789
- “X” prefix
 - Only valid for claims with DOS **prior to 12/1/2015**
 - Submission of the “X” for DOS **after 12/1/2015** may delay processing of claim

Corrected Claims



➤ Resubmit corrected claims electronically

- Payer ID 66001
- CLM05-3 segment should indicate claims is a voided/corrected claim
- Past Timely appeals for DOS **prior to 12/1/2015** will be accepted until July 1, 2016
- Effective July 2, 2016 all correspondence and claims will be handled by BCBSTX

Submitting Claims Continued



- 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)

Submitting Electronic Claims



- Submit electronic professional claims in 837P format
- Texas Provider Identifier is not required and may delay adjudication of your claim
- Must utilize your National Provider Identifier (NPI) number when billing
 - Paper
 - Rendering NPI field 24j and Billing NPI field 33a*
 - Electronic
 - Rendering NPI Loop 2310B, NM109 qualifier field
 - Billing NPI Loop 2010AA, NM109 qualifier field

*Solo providers must use rendering NPI in both 24j and 33a

Submitting Professional Claims



➤ Referring Provider Requirements

- Providers are required to include the referring or ordering physician's National Provider Identifier (NPI) on claims
- The referring provider's name will be captured in Box 17 on the CMS-1500
- The referring provider's NPI will be captured in Box 17b on the CMS-1500

Benefit Code



- Benefit Code is an additional data element used to identify state programs
- 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, SBR03 qualifier field on electronic claims
- Providers who participate in the following programs will use the associated Benefit Code when submitting claims
 - CCP- Comprehensive Care Program (CCP)
 - ECI - Early Childhood Intervention Providers (ECI)
 - EP1- Texas Health Steps Medical Provider

Texas Health Steps (THSteps)



- THSteps is a program that includes both preventive and comprehensive care services
- For preventive, 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)
 - Rendering NPI number is not required for THSteps check-ups
 - Billing primary coverage is not required for THSteps and CHIP preventive claims
 - Include Benefit Code “EP1” and diagnosis of “Z00121 or Z00129” on Texas Health Steps claims
 - EP1 field 11 or 11c (Benefit Code is not required for CHIP preventive claims)
 - Z00121 or Z00129 field 21

Texas Health Steps Continued



- 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
 - Mental Services (provided by Magellan)

Texas Health Steps Continued



- Comprehensive Care Program services billing guidelines are:
 - Provider must use Rendering NPI Box 24j (if applicable)
 - Provider must use Billing NPI in Box 33a
 - Must include Benefit Code CCP
 - 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 OB/GYN Claims



- STAR Delivery codes should be billed with the appropriate CPT codes
 - 59409 = Vaginal Delivery only
 - 59612 = Vaginal Delivery only, after previous cesarean delivery (10 – 20 years old)
 - 59514 = Cesarean delivery only
 - 59620 = Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery (10 – 20 years old)
 - 59430-TH = Postpartum Care after discharge for STAR members only

Billing OB/GYN Claims



- CHIP Delivery codes should be billed with the appropriate CPT codes
 - 59410 = Vaginal Delivery only (including postpartum care)
 - 59515 = Cesarean delivery only (including postpartum care)
 - 59614 = Vaginal delivery only, after previous cesarean delivery (including postpartum care)
 - 59622 = Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery (including postpartum care)
 - Postpartum Care for CHIP Perinate should be billed with the appropriate delivery including postpartum care CPT code

Billing OB/GYN Claims (cont'd)



- The following modifiers must be included for all delivery claims
 - U1 - Medically necessary delivery prior to 39 weeks of gestation
 - For all Medicaid (STAR) claims submitted with the U1 Modifier, **we will require diagnosis codes to support medical necessity. Any claims billed without one of the approved diagnosis code (any position) will be denied. List of approved diagnosis codes:**
http://www.bcbstx.com/pdf/claim_updated_requirement.pdf
 - U2 - Delivery at 39 weeks of gestation or later
 - U3 - Non-medically necessary delivery prior to 39 weeks of gestation

- Payments made for non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria, will be subject to recoupment. Recoupment may apply to both physician services and hospital fees.

Billing

Alpha Hydroxyprogesterone Caproate



- 17P (Alpha Hydroxyprogesterone Caproate) is a Texas Medicaid Benefit for pregnant clients who have a history of preterm delivery before 37 weeks of gestation.
- Prior Authorization is required for both the compounded and the trademarked drug
- When submitting claims for the compounded drug, use the following code:
 - J1725-TH along with diagnosis code 009211 and the NDC
- When submitting claims for the trademarked drug (Makena), use the following code:
 - J1725-U1 along with the NDC

Billing Sports Physicals Value Added Service



- Complete the Sports and Camp Physical Reimbursement form
 - Education & Reference, Forms, Other
 - \$25.00 reimbursement
 - Submit form within 95 days of date of service



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Complaints and Appeals



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Provider Appeals



- Providers can appeal Blue Cross and Blue Shield of Texas's denial of a service or denial of payment
- Submit an appeal in writing using the Provider Appeal Request Form
 - Submit within **120 calendar days** from receipt of the Remittance Advice (RA) or notice of action letter
 - The Provider Appeal Request Form is located at www.bcbstx.com/provider/network/medicaid.html
- 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

Submitting An Appeal



➤ **Mail:**

Blue Cross and Blue Shield of Texas

Attn: Complaints and Appeals Department

PO Box 27838

Albuquerque, NM 87125-7838

➤ **Fax:** 855-235-1055

➤ **Electronic appeal:** GPDTXMedicaidAG@bcbsnm.com

➤ **Availity.com**

Provider Complaints



- Providers may submit complaints relating to the operations of the plan
 - Providers may file written complaints involving dissatisfaction or concerns about another physician or provider, the operation of the health plan, or a member, that are not related to a claim determination or Adverse Determination
- Complaints are required to include
 - Provider's name
 - Date of the incident
 - Description of the incident
- Timeframes
 - An acknowledgement letter is sent within **five business days** of receipt of the complaint
 - A resolution letter is sent within **30 calendar days** of receipt of the complaint

Submitting A Provider Complaint



- Submit a complaint by mail to:

Blue Cross and Blue Shield of Texas

Attn: Complaints and Appeals Department

PO Box 27838

Albuquerque, NM 87125-7838

- Submit a complaint by email to:

GPDTXMedicaidAG@bcbsnm.com

EFT/ERA



- 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 advices through their clearinghouse. Enrollment is required
 - Contact EDI Services at **1-800-746-4614** with questions or to enroll



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Federally Qualified Health Center/ Rural Health Center



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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

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



- FQHC and RHC - services provided by a health care professional require one of the following 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

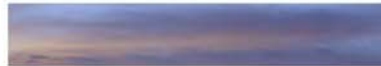


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 CHIP

Ancillary Billing



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Ancillary Services



- Providers who will use CMS-1500 include:
 - Ambulance
 - Freestanding Ambulatory Surgical Center (ASC)
 - Early Childhood Intervention providers
 - Certified Nurse Midwife (CNM)
 - Certified Registered Nurse Anesthetist (CRNA)
 - Durable Medical Equipment (DME)
 - Laboratory
 - Physical, Occupational, and Speech Therapists
 - Podiatry
 - Radiology

Ancillary Services Continued



- Providers who will use CMS-1450 (UB-04) include:
 - Hospital Based ASC
 - Comprehensive Outpatient Rehabilitation Facility (CORF)
 - Home Health Agency
 - Hospital - both inpatient and outpatient
 - Renal Dialysis Center

Ancillary Services Continued



- In general, no additional documentation or attachments are required for services that do not require prior authorization
- The majority of Ancillary claims submitted are for:
 - Laboratory and Diagnostic Imaging
 - Durable Medical Equipment (DME)
 - Home Health (including therapies)
 - Physical, Occupational, and Speech Therapies

Ancillary Services - Lab and Radiology



- Routine Lab and X-ray do not require prior authorization
- When billing for Lab or Radiology, all required information must be included on the claim
- Superbills, or itemized statements are not accepted as claims supplements
- Attested NPI numbers for STAR must be included on the claim
- Any services requiring prior authorization must include the authorization number on the claim form

Ancillary Services - DME



- Durable Medical Equipment (DME) is covered when prescribed to preserve bodily functions or prevent disability
- All custom-made DME must be pre-authorized
- When billing for DME services, follow the general billing guidelines:
 - Use HCPCS codes for DME or supplies

Ancillary Services - Home Health



- Home Health Agencies bill on a CMS-1450 (UB-04) with the exception of DME
- DME provided during a Home Health visit must be billed on a CMS-1500
- Home Health services include:
 - Skilled Nursing
 - Home Health Aides
 - Home Health Physical and Occupational Therapy (Modifier GP for Physical Therapy (PT) and GO for Occupational Therapy (OT) must be billed for these services)

Ancillary Services - PT/OT/SP Therapies



- Independent/group therapists providing PT/OT/SP services in an office, clinic setting, or outpatient setting must bill on a CMS-1500 form
- Prior Authorization will be required for these services, and the authorization number must be included on the claim form
- Please refer to the Texas Medicaid and Healthcare Partnership for a listing of all applicable coding and limitations
- Billing information will be found in the Texas Medicaid Provider Procedures Manual on the TMHP website
 - www.TMHP.com



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Medical Management



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Dedicated Staff To Support Programs



- Medical Director- Jerald Zarin, M.D.

- Physician Advisors

- Registered Nurses with expertise in:
 - Utilization Management
 - Case Management
 - Quality Management

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: 877-560-8055
 - Intake fax number: 855-653-8129

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 claims processing

Calling the Intake Department



- Please have the following information available when calling the Intake Department at 877-560-8055
 - 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)

Utilization Management Prior Authorization Review



- All services provided by out of network providers, except emergency care and family planning, and some services rendered by in network providers; require prior authorization;
- Prior Authorization requests are reviewed for:
 - Member eligibility
 - Appropriate level of care
 - Benefit coverage
 - Medical necessity
- Examples of services requiring Prior Authorization review include, but are not limited to:
 - All inpatient admissions (except routine deliveries)
 - Durable Medical Equipment
 - Select procedures performed (outpatient and ambulatory surgical services)
 - MRI's and CT Scans
- List of Services Requiring Prior Authorization is posted on the BCBSTX website, Forms
 - <http://www.bcbstx.com/provider/medicaid/forms.html>

Prior Authorization Review Process



- Call Utilization Management at **877-560-8055**
- You will need the following information when you call:
 - Member name and Patient Control Number (PCN) AKA Medicaid/CHIP Identification Number
 - Diagnosis with the ICD-10 code
 - Procedure with the CPT, HCPCS code
 - Date of injury/date of hospital admission and third party liability information (if applicable)
 - Facility name (if applicable) and NPI number
 - Specialist or name of attending physician and NPI number
 - Clinical information supporting the request

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 business 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
 - Appeal the decision
 - Submit an appeal in writing using the Provider Appeal Request Form within **120 calendar days** from receipt of the Remittance Advice (RA) or notice of action letter
 - The Provider Appeal Request Form is located at www.bcbstx.com/provider/network/medicaid.html

Single Case Agreements



- Utilization Management (UM) staff utilize the BCBSTX Network Department to assist with one-time contracts for single case agreements

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

Prior Authorization



- The provider completes the form and faxes it to the Intake Department at:
 - **855-653-8129**
- If the form is completed fully and criteria is met, the Intake Department can authorize the request without forwarding for a nurse review

Services Requiring Authorization



- The authorization list is available on line at <http://www.bcbstx.com/provider/medicaid/forms.html>

Case Management



- 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

Cases Appropriate for Case Management

- Medically complex patients with Special Healthcare Needs (HIV/AIDS, Transplants)
- Chronic long-term conditions (diabetes, asthma, hemophilia, sickle cell)
- Patients with frequent emergency room visits or hospital admissions
- High risk pregnancies

Referrals to Case Management



- Providers, nurses, social workers and members or their representative will be able to refer members to Case Management:
 - By calling Blue Cross and Blue Shield of Texas Case Management
 - **877-560-8055**

Abuse, Neglect and Exploitation (ANE)



- Providers must report suspicion of abuse, neglect, and exploitation in any of the following situations to the Department of Family and Protective Services (DFPS)
 - An adult who is elderly or who has a disability
 - An adult who is elderly or who has a disability and is receiving services from:
 - A facility (a mental health facility operated by the Department of State Health Services; a facility licensed under Chapter 252, Health and Safety Code; a program providing services to that person by contract with a mental health facility operated by the Department of State Health Services, a state supported living center or the ICF-IID component of the Rio Grande State Center; a program providing services to that person by contract with a state supported living center or the ICF-IID component of the Rio Grande Center
 - A community center, local mental health authority, and local intellectual and developmental disability authority;
 - A person who contracts with a health and human services agency or managed care organization to provide home and community-based services;
 - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - A managed care organization
 - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
 - An employee, fiscal agent, case manager, or service coordinator of an individual employer participating in the consumer-directed service option, as defined by Section 531.051, Government Code

Abuse, Neglect and Exploitation (ANE)



- A child who is receiving services from:
 - A mental health facility operated by the Department of State Health Services;
 - A facility licensed under Chapter 252, Health and Safety Code;
 - A community center, a local mental health authority, or a local intellectual and developmental disability authority; or
 - A program providing services to that person by contract with a mental health facility operated by the Department of State Health Services, a community center, a local mental health authority, or a local intellectual and developmental disability authority;
 - A state supported living center or a local ICF-IID component of the Rio Grande State Center;
 - A program providing services to that person by contract with a state supported living center of the ICF-IID component of the Rio Grande Center; or
 - An officer, employee, agent, contractor, or subcontractor of a home and community support services agency (HCSSA) licensed under Chapter 142, Health and Safety Code

Abuse, Neglect and Exploitation (ANE)



- Report suspicion of abuse or neglect of a child to DFPS.
 - Contact DFPS
 - Call 1-800-252-5400
 - Online in non-emergency situations @ www.txabusehotline.org

- Report to DADS if the victim is an adult or child who resides in or receives services from:
 - Nursing facilities;
 - Assisted living facilities;
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegations to DFPS;
 - Adult day care centers; or
 - Licensed adult foster care providers
 - Contact DADS:
 - Call 1-800-647-7418

Abuse, Neglect and Exploitation (ANE)



- If unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS
 - Contact Local Law Enforcement

- Failure to Report or False Reporting
 - It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency
 - It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE.
 - Everyone has an obligation to report ANE against a child, an adult that is elderly, or an adult with a disability to DFPS.
 - Includes ANE committed by: family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.



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Quality Management



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Medical Appointment Standards



➤ PCPs and specialists must make appointments for Members from the time of request as follows:

– **General Appointment Scheduling**

- Emergency examinations: immediate access during office hours
- Urgent examinations: within 24 hours of request
- Non-urgent, routine, primary care examinations: within 14 days of request
- Specialty care examinations, within 30 days of request

Medical Appointment Standards



➤ **Services for Members under the Age of 21 Years**

- Initial health assessments: Within 14 days of enrollment for newborns
- Within 60 days of enrollment for other eligible child Members

➤ **Preventive care visits:** according to the American Academy of Pediatrics (AAP) periodicity schedule found within the Preventive Health Guidelines (PHG)

➤ **Services for Members 21 Years of Age and Older**

- Preventive care visit within 90 days

Medical Appointment Standards



➤ Prenatal and Postpartum Visits

- First and second trimesters: Within 14 days of request
- Third trimester: Within five days of request or immediately if an emergency
- High-risk pregnancy: Within five days of request or immediately if an emergency
- Postpartum: Between 28 and 56 days after delivery

Quality Management Services



- Blue Cross and Blue Shield of Texas's Quality Assurance and Performance Program includes
 - Continuously identify, measure, assess and promote improvement of quality outcomes
 - Evaluate performance and effectiveness in meeting the needs and expectations of our internal and external customers
 - Promote processes that reduce medical errors and improve patient safety
 - Promote high quality of care and service and effective utilization of service
 - Provide training and feedback to participating providers on program requirements

Ensuring Quality Through Medical Records and Facility Site Reviews



- The provider is responsible for:
 - Partnering to ensure timely and quality service to members; initial health exam for new members within 90 days of the member's effective date
 - Cooperating with Medical Record Review and HEDIS data collection; we will make every effort to make this convenient
 - Participating in Access to Care Appointment and Availability Surveys
 - Participating in orientations and on going provider training

Children of Migrant Farm Workers



- **Children of Migrant Farm Workers (MFW)** will be identified by the plan and assisted in receiving accelerated services prior to migration
- **Blue Cross and Blue Shield of Texas** is charged with identifying its CMFW population to facilitate coordination of service benefits under the Texas Health Steps umbrella
- **Challenges MCOs Encounter:**
 - Members' frequent relocation due to occupation
 - Invalid phone numbers and/or home addresses
- **Challenges Members Encounter:**
 - Inability to secure a "Medical Home"
 - Increased E.R. Utilization Rates
- **What you can do to help:**
 - Refer families to the Member Advocates **877-375-9097**; we can coordinate with FQHCs in other states





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BCBSTX Additional Information



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Importance of Correct Demographic Information



- Accurate provider demographic information is necessary for accurate provider directories, online provider information, and to ensure clean claim payments
- **Providers are required to provide notice of any changes to their address, telephone number, group affiliation, and/or any other material facts, to the following entities:**
 - BCBSTX- via the *Provider Data Update Notification Form*
 - Health and Human Services Commission's administrative services contractor
 - Texas Medicaid and HealthCare Partnership (TMHP)- via the *Provider Information Change Form* available at www.tmhp.com
- Claims payment will be delayed if the following information is incorrect:
 - Demographics- billing/mailling address (for STAR and CHIP)
 - Attestation of TIN/rendering and billing numbers for acute care (for STAR)
 - Attestation of TIN/rendering and billing numbers for Texas Health Steps (for STAR)

Provider Training Tools



➤ Provider Manual:

- Search capability
- Links between subjects
- Links to forms

➤ Internet Site

- website www.bcbstx.com/provider/network/medicaid.html



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Magellan Behavioral Health Providers of Texas, Inc.



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Magellan Care Management Center



➤ Member and provider hotline **1-800-327-7390**

- Authorizations
- Coordination of Care
- Assistance with discharge planning
- Claims inquiries

24/7/365 Member and Provider Support Available



- After-hours support provided to members and providers by calling **1-800-327-7390**
- Provider relations support through Provider Services Line (PSL) and through Texas based Field Network Provider Relations Team
 - PSL **1-800-788-4005**
 - Texas Field Network Team **1-800-430-0535**, option #4
- Online resources available through www.magellanprovider.com
 - Includes member and provider education materials

Provider Responsibilities



- Prior Authorization is required for mental health and substance abuse services for both STAR and CHIP
 - Direct referral – no PCP referral required to access mental health and substance abuse services
 - Mental health and substance abuse providers contact Magellan for initial authorization except in an emergency
 - Contact Magellan as soon as possible following the delivery of emergency service to coordinate care and discharge planning
 - Provide Magellan with a thorough assessment of the member
 - Contact Magellan if during the course of treatment you determine that services other than those authorized are required

Submitting Claims



- **Electronic Claims submission** via www.magellanprovider.com or through a clearinghouse
- When submitting claims electronically, use submitter ID # 01260

Website Features



- www.magellanprovider.com
- Web site demonstration on home page
- Online provider orientation program
- *Provider Focus* behavioral health newsletter
- Electronic claims submission information
- HIPAA billing code set guides
- MNC and CPGs
- Clinical and administrative forms
- Cultural competency resources
- Demos of all our online tools/applications: go to Education/Online Training
- Behavioral health information for members
- Plus... *Autism Resource Center* on member site at <https://www.magellanassist.com/mem/library/autism.asp>

Texas Medicaid Providers Re-Enrollment Process



- In compliance with Title 42 Code of Federal Regulations (CFR) CFR §455.414, Medicaid providers are required to revalidate their enrollment information
- Revalidation of enrollment information will require existing Medicaid providers to re-enroll by submitting a new enrollment application
- The federal government requires each Texas Medicaid provider to complete the re-enrollment process by September 25, 2016.
- Re-enrollment is the submission of a new Texas Medicaid provider enrollment application, all additional documentation and application fee, if required, to continue the participation in Texas Medicaid
- For more information refer to refer to the **Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions (FAQ)** on www.tmhp.com



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Questions?



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Thank you for your time!
We look forward to working with you!

Please complete the training evaluation form.



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